IN THE DISTRICT COURT OF
THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

RICHARD ELIA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**CIVIL ACTION FILE NO.**
	)	**1:19-cv-01102-WMR**
COX ENTERPRISES, INC., COX WELFARE BENEFITS PLAN, and AETNA LIFE INSURANCE COMPANY,	)	
	)	
Defendants.	)	

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT WITH BRIEF IN SUPPORT

Pursuant to Federal Rule of Civil Procedure 56, Plaintiff Richard Elia hereby moves this Court for partial summary judgment against all Defendants seeking a finding as a matter of law that the ERISA Plan documents at issue do not confer discretion on Defendant Aetna to determine benefits eligibility, and a determination that the standard of review applicable to any factual findings relating to the termination of Mr. Elia's benefits is *de novo*.

TABLE OF AUTHORITIES

Cases

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SUMMARY OF ARGUMENT

A threshold question in every ERISA lawsuit is determination of the judicial standard of review to be applied to the plan administrator's decision. The default judicial standard of review is "de novo," meaning the court reviews the claim without deference to the administrator. Only where the official plan documents (as opposed to plan summaries) *explicitly* and *unambiguously* confer "discretion" will the more deferential "abuse of discretion" standard of review apply. The grant of discretion must unambiguously reach both the relevant *act* under review and the *legal entity* performing that act.

Mr. Elia's benefits were denied by Defendant Aetna, acting pursuant to an administrative services contract with the named Plan Administrator, Cox Enterprises, Inc. Defendants have already signaled their intention to seek deferential review of this decision. (Doc. 17, Planning report). However, this Court should not defer to Aetna in any degree because, as demonstrated below, the Plan documents do *not* confer discretion on Aetna to make long term disability benefits decisions.

The original version of the Plan, enacted in 2002, named Defendant Cox as Plan administrator, and conferred *limited* discretion on Cox to *construe Plan terms*. The Plan failed to grant discretion to Cox (or anyone else) to determine eligibility for benefits. A 2007 Plan amendment authorized Cox to delegate its limited discretion to construe plan terms to another entity via an administrative services

contract (ASC). At no time was the plan amended to grant *any* entity discretion to determine benefits eligibility. Thus, any attempt to confer discretion on Aetna via the ASC, or by any other documents outside the completely integrated Plan, is ineffective. Because the Plan documents fail to confer discretion on Aetna to determine benefits eligibility, this Court must review Aetna's decision to terminate Plaintiff's benefits *de novo*, i.e., without deference.

ARGUMENT

I. TO OVERCOME DE NOVO REVIEW, A GRANT OF DISCRETION MUST BE EXPLICIT AND UNAMBIGUOUS, IT MUST REACH THE ENTITY SEEKING DEFERENCE, AND IT MUST REACH THE SPECIFIC ACTS AS TO WHICH DEFERENCE IS SOUGHT.

Summary judgment is appropriate where there is no genuine dispute as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). The ERISA standard of review is a question of law for the court, to be decided by examining "the language of the plan documents to determine whether a claims administrator is vested with the discretionary authority." *Anderson v. Unum Life Ins. Co. of Am.*, 414 F.Supp.2d 1079, 1095 (M.D.Ala. 2006). Thus, as a matter of pure contract interpretation, it is "particularly suited for disposition by summary judgment." *Metalex Corp. v. Uniden Corp. of Am.*, 863 F.2d 1331, 1333 (7th Cir. 1988). *See also*, *Saregama India Ltd. v. Mosley*, 635 F.3d 1284, 1290 (11th Cir. 2011) ("The interpretation of a contract, or agreement, presents a question of law, [cit], as does the determination of whether a contract is ambiguous [cit.].").

The ERISA statute does not specify the standard of review under which the district court is to perform its duty. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108-09 (1989). In *Bruch,* the United States Supreme Court held that the default ERISA judicial standard of review is "*de novo*." Under the *de novo* standard of review "no deference" is accorded to the administrator's decision. *Williams v. BellSouth Telecommunications, Inc.*, 373 F.3d 1132, 1137 (11th Cir.2004). However, when the plan contains an adequately clear grant of discretion to the administrator, the "abuse of discretion" standard of review applies. *Id.*, at 115. Under this standard "the function of the court is to determine whether there was a reasonable basis for the decision based upon the facts as known to the administrator at the time the decision was made." *Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1139 (11th Cir.1989).

Determining the ERISA standard of review is vitally important because "[t]he very existence of 'rights' under [ERISA] Plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has and the more important it may be to him, therefore, to supplement his ERISA plan with other forms of insurance." *Herzberger v. Standard Insurance Co*., 205 F.3d 327, 331 (7th Cir.2000). Indeed, some courts have noted the standard of review to be occasionally outcome determinative. *See. e.g., Fessenden v. Reliance Standard Life Ins. Co.*, 2018 WL 461105, at *1 (N.D.Ind. Jan. 17, 2018) (explicitly

finding the weight of the credible evidence to support disability, but concluding judicial deference required upholding an adverse decision).

A. Defendants Must Prove an Express and Unambiguous Grant of Discretion.

The Eleventh Circuit has not directly addressed the issue, but most courts agree that the party seeking deference bears the burden of proving that Plan language clearly confers discretionary authority. *See, e.g., Sharkey v. Ultramar Energy Limited*, 70 F.3d 226, 230 (2nd Cir.1995) ("[T]he party claiming deferential review should prove the predicate that justifies it."); *See also*, *Wilson v. Walgreen Income Protection Plan for Pharmacists and Registered Nurses, Walgreen Co.*, 942 F.Supp.2d 1213, 1248 (M.D.Fla. 2013).

The Eleventh Circuit has long required "*express* language *unambiguous* in its design" to confer discretionary authority on the administrator. *Hunt v. Hawthorne Associates, Inc.*, 119 F.3d 888, 912 (11th Cir.1997) (emphasis supplied) (quoting *Kirwan v. Marriott Corp.*, 10 F.3d 784, 788 (11th Cir.1994) (de novo review applies "unless the plan *expressly* provides the administrator discretionary authority to make eligibility determinations or to construe the plan's terms.") (emphasis supplied)). Therefore, a grant of discretion may not be vague, nor may it be inferred.

B. The Grant of Discretion Must be Directed to the Entity Seeking Deference and Must Reach the Acts in Question.

Any grant of discretion must be directed to the *legal entity* seeking deference.

A grant of discretion to one legal entity does not extend even to related entities under a larger corporate enterprise. *See McDonnell v. First UNUM Life Ins. Co.*, 551 F.3d 126 (2d Cir.2008) (reviewing the case de novo because claims decision was made by employees of UNUM Group, whereas First Unum was the named fiduciary in the plan); *See also*, *Mazzacoli v. Continental Cas. Co.*, 322 F.Supp.2d 1376, 1381 (M.D.Fla.2004) ("Eleventh Circuit precedent is clear that where an unauthorized party denies plan benefits, that denial is reviewed under the de novo standard.") (citing *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 291 (11th Cir.1989)).

Furthermore, the grant of discretion must reach the *acts* for which the entity seeks deference. In *Culp v. Cain*, 414 F.Supp.2d 1118, 1124 (M.D.Ala. 2006) (citation omitted) (emphasis supplied), the court noted, "An administrator is vested with discretion only if the plan instrument, in this case the summary description, *explicitly* grants discretion to the administrator *over specific activities*. Thus, a court may look only to the terms of the plan instrument to determine if the plan administrator is vested with discretion *over a certain matter*." It should be noted that in *Bruch* and all the Eleventh Circuit cases that followed, (*e.g. Kirwan, HCA, supra*) the court has consistently distinguished discretion "to determine eligibility for benefits" from discretion "to construe the terms of the plan." Those are two distinct

activities, and discretion to perform one should not extend to the other, at least not in the absence of explicit Plan language granting both.[1]

Defendants thus bear the burden of demonstrating that clear and unambiguous language exists in the plan documents granting discretion: (1) to Aetna, as opposed to some other legal entity; (2) to make benefits eligibility decisions, as opposed to some other discretionary act; and (3) under the long-term disability component of the Plan (the "LTD Program"), as opposed to some other Plan component, like life or health insurance. Defendants are unable to meet their burden because the completely integrated plan contains no grant of discretion to Aetna to decide eligibility for LTD benefits. Therefore, this Court must review this case *de novo*.

II. THE STANDARD OF REVIEW IS DE NOVO BECAUSE NONE OF THE PLAN DOCUMENTS CLEARLY AND UNAMBIGUOUSLY GRANT DISCRETION TO AETNA.

A. The Official Plan Documents Do Not Grant Aetna Discretion.

Despite direct requests to Defendants dating back to June 14, 2018, they did not produce the Plan documents until May 14, 2019, after this lawsuit was initiated. *See* Affirmation of Jeffrey S. Warncke, attached as Exhibit 1, ¶¶ 31 - 34. As of May 14, 2019, Plaintiff learned that the Plan named Cox Enterprises, Inc. as the official

[1] It cannot be overstated how easily administrators can "expressly and unambiguously" confer discretion in their plans. It requires one or two sentences, anywhere in the official plan, including words to the effect that: "The Fiduciary/Plan Administrator/Claims Administrator has complete discretion to interpret the terms of the plan and to determine participants' eligibility for benefits." Given the substantial advantage that the inclusion of these clauses gives defendants in litigation, the natural result has been the nearly ubiquitous implementation of discretionary clauses. Thus, while announcing that de novo is the default rule in ERISA cases, the Supreme Court simultaneously created a framework that could ultimately result in nearly all ERISA cases being reviewed deferentially.

Plan Administrator and described Cox's authority under the Plan as follows:

> *8.1 Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator [Cox]. It shall be a principal duty of the Plan Administrator* ***to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan.*** *The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan:*
>
> *(a)* ***To make and enforce such rules and regulations*** *as it deems necessary and proper for the efficient administration of the Plan****, including the establishment of any claims procedures*** *that may be required by applicable provisions of law;*
>
> *(b)* ***To interpret the Plan****, its interpretation thereof, to be final and conclusive on all persons claiming Benefits under the Plan;*
>
> *(c)* ***To decide*** *all questions concerning the Plan and* ***the eligibility of any person to participate in the Plan****;*[2]
>
> *(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan;*
>
> *(e) To make all reports or other filings necessary to meet the reporting disclosure requirements of ERISA which are the responsibility of "plan administrators" under ERISA;*
>
> *(f) To distribute to each Participant of a Program a summary plan description and summary of material modification of the Program as required by ERISA. To the extent required by ERISA, to furnish a summary plan description and summary of material modifications to beneficiaries; and*
>
> *(g)* ***To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities*** *under the Plan, any such allocation, delegation or designation to be in writing and to be acknowledged by both the Plan Administrator and the other person.*

(AR 00014-00015) [3] (emphasis supplied).

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[2] Determining eligibility to participate in a plan relates to who is covered as a participant, as distinct matter from determining eligibility to recover benefits under a Plan. *See*, *e.g.*, *Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1344-45 (11th Cir.1994) (discussing plaintiff's claim to estop defendants from denying him coverage, i.e., his eligibility for coverage).

[3] References such as this in this brief are to the Bates page number of the "administrative record" produced informally to Plaintiffs by Defendant in this litigation on May 14, 2019. Defendants have agreed to file the record with the court

In 2007, Cox amended Section 8.1(b), as follows:

> *Section 8.1(b) of the Plan is amended by deleting the same in its entirety and by substituting the following therefor:*
>
> *"**Except as provided in an administrative services contract** or contracts between the Company or the Participating Employer and the Claims Administrator, **to interpret the Plan**, its interpretation thereof, to be final and conclusive on all persons claiming Benefits under the Plan;"*

(AR 00033) (emphasis supplied). Under both the original and amended versions of the Plan, there is no grant of discretion to Cox reaching the *act* here in question: deciding Mr Elia's eligibility for continuing benefits. In 2002, Cox's original discretion was limited to *interpreting* the Plan. (AR 00014, ¶ 8.1(b)). In 2007 the Plan was amended to allow Cox to delegate its limited discretion to interpret the Plan to another entity (including Aetna) by way of an administrative services contract, but this is the only mention of discretion *of any kind* in the entire Plan. There is no grant of discretion to Cox or any other entity in any part of the Plan to determine eligibility for benefits.

Even as of this filing, Defendant still has not produced its Administrative Services Contract No. 050398 (the "ASC"), presumably an agreement between Defendants Cox (the plan administrator) and Aetna (the claims administrator) relating to this Plan. (AR 00042) (Summary of Coverage noting that ASC No. 50398

at the time of this first use. Simultaneously we are asking Defendants to file the record now. We presently do not have a docket number to which we can refer.

applies to this Plan). We can only guess at whether the ASC contains any kind of grant of discretion to Aetna. Even assuming it does, it cannot be sufficient to overcome *de novo* review of Aetna's decisions about eligibility for benefits. This is true because the ASC is not part of the integrated Plan, because Cox cannot delegate discretion the Plan does not provide it in the first place, and because the Plan, even as amended, limits the discretion that Cox can delegate via an administrative services contract to plan interpretation *only*.

i. The ASC is not a plan document.

The ASC cannot grant discretion to Aetna because the ASC is not a Plan document. *See Shaw v. Connecticut General Life Ins. Co.*, 353 F.3d 1276, 1283 (11th Cir.2003) (citing *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 38–39 (11th Cir.1989) ("[ERISA] actions must be reviewed de novo *unless* ***the plan*** *expressly gives the administrator discretionary authority* to make eligibility determinations or to construe the plan's terms.") (emphasis supplied)).

Because the grant of discretion must be contained within the plan documents, defining the scope of the plan at issue becomes critical to determining the standard of review. ERISA defines the word "plan" as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both," 29 U.S.C. § 1002(3), and it requires that a "plan shall be established and maintained pursuant to a written instrument," id. at § 1102(a)(1). Under ERISA, Congress set "an elaborate scheme

in place for enabling beneficiaries to learn their rights and obligations at any time, a scheme that is built around *reliance on the face of written plan documents*." *Curtiss–Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (emphasis supplied). In *Curtiss-Wright*, the Supreme Court explained that "[a] written plan is to be required in order that every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan." *Id.* (emphasis in original) (quoting H.R.Rep. No. 93–1280, p. 297 (1974) U.S. Code Cong. & Admin.News pp. 4639, 5077, 5078).

To maintain this scheme, ERISA also requires that each plan "provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan." 29 U.S.C. § 1102(b)(3). By explicitly requiring that each plan specify the amendment procedures, Congress rejected the use of informal written agreements to modify an ERISA plan. *See Alday v. Container Corp. of Am.*, 906 F.2d 660, 665 (11th Cir.1990) (citing *Nachwalter v. Christie*, 805 F. 2d 956, 960 (11th Cir.1986)).

Turning to the Plan at issue, paragraph 13.1 of the Official Plan Documents provides: "Entire Agreement. This Plan and all of the Supplements to this Plan shall constitute the entire agreement under this Plan." (AR 00024). This is commonly called a "merger clause." Paragraph 2.22 in turn defines the "Plan" as "the amended

and restated Cox Enterprises, Inc. Welfare Benefit Plan *as set forth herein*, *together with any amendments and supplements*." (AR 00004) (emphasis supplied).

As to interpreting the legal effect of the merger clause, it must be noted that paragraph 13.5 of the Plan contains a Georgia choice of law provision. (AR 00025) ("[T]his Plan and all rights hereunder shall be governed, construed, administered, and enforced according to the laws of the State of Georgia," unless preempted by ERISA or other applicable federal law.). ERISA itself does not provide any guidance on how a court should interpret the provisions of a plan. *See Dixon v. Life Ins. Co. of N. Am.*, 389 F.3d 1179, 1183 (11th Cir.2004).

Georgia law, incorporated into the Plan by paragraph 13.5, recognizes that "[t]he purpose of merger clauses is to preclude any unilateral modifications of a written contract through evidence of pre-existing terms that were not incorporated into the written contract." *Thomas v. Garrett*, 265 Ga. 395, 396 (Ga. 1995). Once the parties' agreement has been reduced into a final, written contract, "all prior negotiations, understandings, and agreements on the same subject are merged into the final contract and are accordingly extinguished." *See First Data POS, Inc. v. Willis*, 273 Ga. 792, 546 S.E.2d 781, 784 (Ga. 2001) (quoting *Health Serv. Ctrs., Inc. v. Boddy*, 257 Ga. 378, 359 S.E.2d 659, 661 (Ga. 1987); *See also*, OCGA § 13–2–2(1).

In this case, there is reason to believe that the ASC is a document that *predates* the effective date of the Plan. (AR 00041) (document from 1990 referencing ASC No. 050398). Furthermore, the ASC does not fall within the scope of the documents enumerated in paragraph 2.22 describing the integrated Plan. Thus, by the Plan's own unambiguous terms, the ASC is not part of the Official Plan Documents, nor is there any evidence it should be considered an amendment or supplement to the Plan. (AR 00003, ¶ 2.22). Therefore, the ASC cannot be a plan document.

If Cox intended for the ASC to be considered a Plan document, it could easily have indicated as much in the Plan. In *Kinser v. Plans Admin. Committee of Citigroup, Inc.*, 488 F.Supp.2d 1369, 1378 (M.D.Ga. 2007), the court applied a deferential standard of review upon finding that the ASC, which contained the grant of discretion, "is incorporated into the Plan. The terms of the Plan define the LTD Plan" to include "*third party administrative contracts*." (emphasis in original). There is no such reference in paragraph 2.22 of the Cox Plan.

In *Shaw v. Connecticut General Life Ins. Co.*, 353 F.3d 1276, 1283 (11th Cir.2003), the Eleventh Circuit addressed the standard of review where the plan contained a merger clause and the grant of discretion was located outside the completely integrated plan. The insurer argued that abuse of discretion applied. The court disagreed, stating:

> Plainly, the grant of discretionary authority to a plan administrator is a material term . . . The parties did not include such a grant within the

> underlying contract. Moreover, they both agreed to an integration clause . . . and designed a specific procedure for modification of the contract. *If the employer and the insurance company wish to include a term as critical as a grant of discretionary authority to the plan administrator, then they can be expected either to write that term into the underlying contract or amend the contract according to their own, expressly agreed-upon procedures*.

Id., at 1283 (emphasis supplied); *See also*, *Cosey v. Prudential Ins. Co. of Am.*, 735 F.3d 161, 170 (4th Cir.2013) (holding grant of discretion contained in administrative services contract was ineffective where ASC was not integrated into the final plan).

Various courts have come to the same conclusion when addressing other types of documents not integrated into the plan. *See Oldoerp v. Wells Fargo & Co. Long Term Disability Plan*, 2012 WL 6053147 (9th Cir. Nov. 21, 2012) (SPD and ERISA information document); *Gebert v. Thrivent Financial for Lutherans Group Disability Income Ins. Plan*, 2013 WL 6858531, at *5-*7 (E.D.Wisc. Dec. 30, 2013) (SPD & ERISA Statement of Rights); *Barbu v. Life Ins. Co. of N. Am.*, 2013 WL 6690402, at *4-*9 (E.D.N.Y. Dec. 19, 2013) (Appointment of Claim Fiduciary document).

The fact that Defendants have refused to produce the ASC to Plaintiff (and presumably routinely withhold it from all Plan participants) is also problematic to the extent the Supreme Court has recognized that Plan participants have a right to rely "on the face of written plan documents." *Curtiss–Wright*, *supra*, 514 U.S. at 83; *See also*, *Stephanie C. v. Blue Cross Blue Shield of Mass. HMO Blue, Inc.*, 813 F.3d

420, 429 (1st Cir.2016) ("Any terms that concern the relationship between the claims administrator and the beneficiaries cannot be held against the beneficiaries where . . . the terms appear in a financing arrangement between the employer and the claims administrator that was *never seasonably disseminated to the beneficiaries against whom enforcement is sought*.") (emphasis supplied).

Given the critical importance of the standard of review and the ease with which it can be clearly and unambiguously communicated in the Plan documents, Cox's convoluted attempt to grant Aetna discretion (whether via an ASC or any other document not clearly included within the integrated plan) cannot be allowed to determine the standard of review. Therefore, the standard of review should be *de novo*.

ii. The ASC Cannot Grant Aetna Discretion to Determine Eligibility for Benefits Because the Plan Did Not Grant Cox that Discretion.

To the extent Cox relies on a delegation of its fiduciary duties to Aetna, it can only delegate the authority it has, which is to interpret the Plan. It cannot delegate what the Plan does not provide it in the first place, namely discretion to determine eligibility for benefits. It is a matter of common sense that where the Plan does not grant the Plan Administrator discretion, the Plan Administrator cannot create that discretion by delegating its duties to another entity. *See*, *e.g.*, *Rodriguez-Abreu v. Chase Manhattan Bank, N.A.*, 986 F.2d 580, 584 (1st Cir.1993) ("Because the

relevant plan documents did not grant discretionary authority to the Plan Administrator and the Named Fiduciaries did not expressly delegate their discretionary authority to the Plan Administrator, we find that the district court correctly employed the de novo standard of review."). Because the Plan here never conferred discretion on Cox in the first place to make benefits decisions, Cox cannot delegate such discretion to Aetna or anyone else, by ASC or otherwise. You cannot give what you do not have.

The distinction between the discretionary acts of (1) making benefits determinations and (2) interpreting plan terms is recognized in *Bruch* and maintained in subsequent standard of review cases in this Circuit. For instance, *Cagle v. Bruner*, 112 F.3d 1510, 1517 (11th Cir.1997), provides an example of how the two types of discretion are frequently granted separately and in different parts of the plan. *Id.* ("The Declaration of Trust in this case reserves 'full authority to determine eligibility requirements for benefits,' while the Rules and Regulations reserve discretion in the Fund to interpret ambiguous sections of the plan."). In *Culp v. Cain*, 414 F.Supp.2d 1118, 1124 (M.D.Ala. 2006), the court noted that the "administrator is vested with discretion only if the plan instrument . . . *explicitly* grants discretion to the administrator over *specific activities*." (emphasis supplied). Indeed, "[a] plan can give an administrator discretion in some areas but not in others." *Miller v. PNC Financial Services Group, Inc.*, 278 F.Supp.3d 1333, 1352

(S.D.Fla. 2017) (holding that an administrative services contract not mentioned in the plan was not a plan document and did not grant discretion) (citation omitted).

In *Bruch* itself the Supreme Court discussed the two types of discretionary acts as separate and independent: "Firestone can seek no shelter in these principles of trust law, however, for there is *no evidence that under Firestone's termination pay plan the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference*." 489 U.S. at 102 (emphasis supplied). In fact, *Bruch* only provided the framework for addressing the standard of review in cases involving plan interpretation. *Id.*, at 108 ("The discussion which follows is limited to the appropriate standard of review in § 1132(a)(1)(B) actions challenging *denials of benefits based on plan interpretations*.") (emphasis supplied); *See also*, *Williams v. BellSouth*, 373 F.3d 1132, 1134 n.3 (11th Cir.2004) ("Firestone actually addressed the standard for judicial review of an administrator's plan interpretations (i.e., its interpretation of what plan provisions mean), whereas here we are dealing with a plan administrator's factual determinations (i.e., that Williams was in fact not disabled under the plan because she was not completely unable to work)."). Thus, *Bruch* went out of its way to highlight the distinction between discretion to interpret a plan and discretion to make factual findings.

For that reason, following *Bruch,* the various circuit courts of appeals each addressed, as an issue distinct from plan interpretation, whether plan administrators'

factual determinations would be evaluated under the same standard set forth in Bruch or by some other standard. After *Bruch* insurers and plan administrators began arguing that their factual determinations should *always* be reviewed for abuse of discretion, even in the absence of plan language granting that type of discretion. The courts of appeals rejected this argument and uniformly held deferential review of factual findings would apply only if there was a grant of discretion to determine eligibility for benefits. *See Shaw*, 353 F.3d at 1282 (holding *de novo* review applies to plan administrator's fact-based determination in absence of plan language granting discretionary authority); *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 250-51 (same); *Rowan v. Unum Life Ins. Co. of Am.*, 119 F.3d 433, 435–36 (6th Cir.1997); *Ramsey v. Hercules Inc.*, 77 F.3d 199, 204–05 (7th Cir.1996); *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir.1991); *Reinking v. Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1213–14 (4th Cir.1990), *overruled on other grounds by Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir.1993).

Thus, plan interpretation and fact-finding as to eligibility for benefits are separate and distinct discretionary acts, and each requires its own *unambiguous* grant of discretion. Because the grant of discretion to Cox in this Plan is limited to construing Plan terms, Defendants have no basis on which to seek judicial deference to Aetna's factual findings leading to the termination of Mr. Elia's benefits.

B. The 1990 Letter Cannot Confer Discretion Because it is Not a Plan Document and It Does Not Refer to this Plan.

In an informal email exchange with defense counsel, Defendants have stated they will rely upon a letter dated January 10, 1990, (a true and correct copy of which is attached as Exh. 13) to contend that Aetna has discretion under the Plan. (*See also* Exh. 1, ¶¶ 35-41; Exh. 12). The 1990 letter states that Aetna is designated as the "Named Fiduciary" with "complete authority to review all denied claims for benefits under the Plan's Contract No. 050398." (AR 00041). Further, the letter states that "Aetna shall have the discretionary authority to determine, subject to the terms of the Plan, whether and to what extent participants and beneficiaries are entitled to benefits, and to construe disputes or doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously." *Id.* Plaintiff concedes that if this language had been included in the Plan documents, it would be sufficient to trigger deferential review of Aetna's factual findings. However, *several* facts demonstrate that the above letter is *not* part of the current Plan. First, the letter predates the effective date of the Plan by approximately 12 years and was therefore merged out of existence under the 2002 Plan by the merger clause at paragraph 13.1.

Cox never intended to integrate this then-twelve-year-old document into the 2002 Plan. Cox could easily have done so by reference or by copying its operative language into the body of the Plan. However, the 1990 letter is *not* incorporated by

reference anywhere in the body of the Plan documents, nor is it even mentioned in passing. Moreover, the letter is neither incorporated by reference nor mentioned in any of the *several* Plan amendments which followed since 2002. (*See* Plan Amendments at AR 29-39). Cox has had many opportunities – every time the Plan was amended, *or at any other time since 2002* – to either refer to the 1990 letter or to include its language in the Plan. Despite repeated Plan amendments, Cox did neither, demonstrating its intent *not* to integrate the 1990 letter.

Furthermore, the 1990 letter itself clearly states that it applies to a different plan than the one at issue. By its own terms, the letter expressly relates to Aetna's authority under "the Cox Enterprises Group Insurance Plans ('Plan')," which is a *different plan* from the one at issue in this case. *Compare* (AR 00041) *with* (AR 00004, ¶ 2.22) (defining the Plan as "the amended and restated Cox Enterprises, Inc., Welfare Benefit Plan as set forth herein, together with any amendments and supplements."). The name of the 1990 Plan thus differs from the 2002 plan.

The overall circumstances prove the 1990 letter was *never* intended to relate to the 2002 Plan, nor was it ever intended to be *amended* into the Plan. The fact that the letter was first produced in litigation – despite Mr Elia's previous direct request for all Plan documents - - is telling. (*See* Declaration of Jeff Warncke, Exh. 1; *See also* Section C. below). The 1990 letter appears to have been belatedly dug up by Defendants in litigation to try to fool Mr. Elia into believing Aetna has discretion.

In a late breaking development, on July 10, 2019, the day before this brief was to be filed, Defendants filed with the Court what they contend are the official Plan documents. (See, Doc. 29-1, Dft. Brf. On Mtn to Quash). In their brief in support of the Motion to Quash, Defendants discuss the Plan terms at length, referring to the official Plan document as the "the Wrap Plan." (Doc 29.1, pp. 9-14). Defendants filed as Docket Number 29-3 what they described as "a true and correct copy of the Wrap Plan.' (doc. 29-1, p. 10). Defendants' filing appears to lay to rest what documents are, or are not, included as official Plan documents. The 1990 letter is not included. Defendants filing should therefore act as an admission *in judicio* that the 1990 letter is not part of the Plan. It therefore cannot confer discretion, contrary to counsel's representation to Plaintiff's counsel in the email of May 1, 2019.

C. Defendant's Two Conflicting Plan Summaries Cannot Grant Discretion.

Besides the documents discussed above, the only others Defendants have produced to Mr. Elia *allegedly* describing the Plan terms have been two conflicting versions of a plan summary. The first summary was produced by Aetna along with Aetna's claim file on compact disc on July 17, 2018. (Hereafter "the 2018 Summary," a copy of which is attached as Exhibit 5). The 2018 Summary was produced in response to Mr. Elia's requests for all documents relating to the Plan, directed to Defendants during the pre-suit administrative process. (*See* Exh. 1, ¶¶ 8-25). Until this lawsuit was filed, the 2018 Summary was the *only* document

Defendants provided Mr. Elia to ascertain his rights under the Plan. *Id.*

The 2018 Summary provides that Cox, *not* Aetna, is granted discretion to interpret the terms of the Plan and to determine eligibility for benefits. Exh. 5, at 107 ("[T]he plan administrator [Cox] has the complete discretion and authority to make factual findings regarding a claim *and* to interpret the terms of the plan as they apply to the claim.") (emphasis supplied).[4] The 2018 Summary (again the only document to which Plaintiff had access until recently) limits *Aetna*'s discretion under the LTD Program to having "final authority to determine *the amount* of benefits that will be paid on any particular benefit claim." *Id.*, at 107 (emphasis added). The 2018 Summary does not give Aetna authority to make factual determinations nor to determine *whether* benefits are due.

The 2018 Summary reinforces the notion that Cox did not intend to vest Aetna with discretion to make factual findings as to LTD claims. This is true because, as to other components of the same Plan, namely the life insurance and Accidental Death & Personal Loss (AD&PL) programs, the 2018 Summary clearly states Aetna has discretion to make eligibility decisions and to construe plan terms. *See*, *Id.* at 107. For both these components of the Plan, Aetna is described as claim fiduciary

[4] Note that Cox's use of the word "and" in this sentence suggests that Cox understands that making factual findings is a separate discretionary act from interpreting plan terms. As discussed above, this grant of discretion also goes beyond the discretion the Plan actually confers on Cox to interpret plan terms only.

It should also be noted that, even as to Cox, the 2018 Summary's alleged grant of discretion is broader than the Plan it purports to summarize. As noted above, the Plan limits Cox's discretion to interpreting the Plan.

with "complete discretionary authority to review all denied claims for benefits *and to determine whether and to what extent employees and beneficiaries are entitled to benefits*." *Id.* (emphasis supplied). As to the LTD program, the 2018 Summary is conspicuously silent on *both* counts as to Aetna. Cox is clearly capable of writing an "express and unambiguous" grant of discretion to Aetna, because it did so as to two other Plan programs and *chose not to* as to the LTD Program.

When Aetna produced its administrative claim file for litigation, it included a *different* plan summary (the "Litigation Summary") with discretionary terms directly contradicting the Plan and the 2018 Summary. (AR 00667-00797). The Litigation Summary provides that "Cox has selected Aetna to be the claims administrator to process LTD benefit claims. Aetna is the claim fiduciary with *complete discretionary authority to review all denied claims for benefits and to determine whether and to what extent employees and beneficiaries are entitled to benefit*s." (AR 00761) (emphasis supplied). Once again, Cox demonstrates its ability to draft an express and unambiguous clause granting *both types* of discretion to Aetna; it simply failed to do so in the official Plan Documents, i.e. the "Wrap Plan" filed by Defendants as Docket No. 39-3.

However, even pretermitting the question of which summary would apply,[5]

[5] This also raises many questions as to why two different summaries exist that both ostensibly apply to the same Plan, but which directly contradict each other on critical Plan terms. Cox has offered no explanation as to this question, nor any indication when each was created, nor any explanation why Plaintiff was furnished one summary in 2018 and a different one in litigation.

neither summary is capable of granting discretion. The Litigation Summary specifically disclaims the ability to govern the terms of the Plan, stating that it "is *not a part of the official plan* documents that govern the terms of the plan," that "*the plan documents are the controlling legal documents*," and that in the event of conflict with the plan, "*the plan documents will govern*." (AR 00767) (emphasis supplied). The 2018 Summary contains a nearly identical disclaimer. Exh. 5, at 105. Defendants cannot rely upon the terms of either summary to confer discretion where each specifically disclaims the power to dictate the terms of the Plan. *See Glocker v. W.R. Grace & Co.*, 974 F.2d 540, 542 (4th Cir.1992) ("Grace, having represented to its employees that the Plan —not the handbook—governed questions about benefits, cannot now repudiate this representation and rely on statements in the handbook that are less favorable to Mrs. Glocker.").

More importantly, the Supreme Court held in *CIGNA Corp. v. Amara*, 563 U.S. 421, 437-38 (2011), that conflicts between plan summaries and the underlying plan *must* be resolved in favor of the plan. The Court noted that "the syntax of [ERISA § 102(a)], requiring that participants and beneficiaries be advised of their rights and obligations 'under the plan,' suggests that the information *about* the plan provided by those disclosures is not itself *part of* the plan." *Id.* (emphasis in original). The Court further explained that a contrary holding would interfere with "the basic summary plan description objective: clear, simple communication," as well as

impermissibly mix the distinct responsibilities of the plan sponsor (employer) and the plan administrator, which are not always the same entity. *Id.* In short, a plan summary cannot control when it conflicts with the plan.

Even before *Amara*, several circuits, including the Eleventh, had held that under the circumstances of this case the plan summary cannot control. *See Shaw*, 353 F.3d at 1283 (holding that plan summary which conflicted with underlying plan did not control where it was not integrated into the plan and was not an amendment made pursuant to the plan's amendment procedure); *Schwartz v. Prudential Ins. Co. of Am.*, 450 F.3d 697 (7th Cir.2006) (same); *Grosz–Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154 (9th Cir.2001) (same). Thus, even if the 2019-produced Litigation Summary did somehow supplant the 2018 summary as to a claim that arose before 2018, neither summary can expand the limited discretion the Plan confers on Cox, and which Cox attempted to delegate to Aetna by 2007 amendment, merely to interpret the Plan.

CONCLUSION

Aetna's termination of Mr. Elia's disability benefits did not rely on an issue of Plan interpretation. Aetna's decision was based on (an ostensible, but dubious) weighing of evidence and a *factual* finding that Mr. Elia was no longer disabled. As to that issue, the Plan never unambiguously conferred discretion on Cox as named Plan Administrator to make eligibility decisions in the first place, nor does the Plan

state unambiguously that Cox's findings are to be conclusive or accorded deference. Cox has done nothing to amend the Plan to fix that shortcoming in the 17 years since the Plan was adopted. The Wrap Plan (Doc. 29-3), as of the current, amended version, still limits Cox's discretion to interpreting plan terms *only*, and later amendments merely broadened Cox's ability to delegate that *limited* discretion pursuant to an administrative services contract. All other documents that purport to grant discretion on Aetna are excluded from the final integrated plan by the terms of the plan and its merger clause.

Cox's convoluted and ambiguous attempts to *claim* discretion as a litigation tactic are without support under the plain terms of its own Plan documents. Plaintiff requests that this Court grant his motion for partial summary judgment holding that *de novo* review applies to this case as to Aetna's factual findings.

Respectfully submitted, this the 11th day of July, 2019.

EVANS WARNCKE ROBINSON, LLC

By: */s Jeffrey S. Warncke*
Jeffrey S. Warncke
Georgia Bar No. 737850

Attorney for Plaintiff
191 Peachtree Street NE
Suite 3980
Atlanta, Georgia 30303
P: 404.841.9400
F: 888.738.5949
E: j.warncke@ewrlawfirm.com

CERTIFICATE OF TYPE SIZE COMPLIANCE

The foregoing pleading is prepared in Times New Roman, 14 point, in accordance with Local Rule 5.1C, ND GA and Standing Order No. 16-01.

Respectfully submitted, this the 11th day of July, 2019.

/s/Jeffrey S. Warncke
Jeffrey S. Warncke

CERTIFICATE OF SERVICE

I hereby certify that on July 11, 2019, that a copy of the foregoing document has been served upon the following listed persons electronically via the CM/ECF system:

Alexander B. Feinberg
Attorney for Defendant
MAYNARD, COOPER & GALE, P.C.
1901 Sixth Avenue North
Suite 2400, Regions/Harbert Plaza
Birmingham, AL 35203-2618
E: a.feinberg@maynardcooper.com

EVANS WARNCKE ROBINSON, LLC

By: */s/Jeffrey S. Warncke*
Jeffrey S. Warncke
GA Bar No.: 737850

Attorney for Plaintiff
191 Peachtree Street NE
Suite 3980
Atlanta, GA 30303-1713
Tel No.: 404.841.9400
Fax No.: 888.738.5949
E-mail: j.warncke@ewrlawfirm.com