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FOR PUBLICATION

**UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

KENNETH L. NORD,

*Plaintiff-Appellant,*

v.

THE BLACK & DECKER  
DISABILITY PLAN,

*Defendant-Appellee.*

No. 00-55689

D.C. No.

CV-99-00408-CM

OPINION

Appeal from the United States District Court  
for the Central District of California  
Carlos R. Moreno, District Judge, Presiding

Argued and Submitted

October 16, 2001 – Pasadena, California

Filed July 15, 2002

Before: Betty Binns Fletcher, Dorothy W. Nelson, and  
M. Margaret McKeown, Circuit Judges.

Opinion by Judge B. Fletcher

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**COUNSEL**

Lawrence D. Rohlfig, Esq., Santa Fe Springs, California,  
for the plaintiff-appellant.

Lee T. Paterson, Esq., Los Angeles, California, for the  
defendant-appellee.

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**OPINION**

B. FLETCHER, Circuit Judge:

This case arises under the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. § 1001, *et seq.* Plaintiff Kenneth Nord seeks disability welfare benefits from defendant Black & Decker Disability Benefits Plan (“Black & Decker” or the “Plan”). The district court granted summary judgment in favor of Black & Decker, holding that it did not abuse its discretion by denying Nord disability benefits under the terms of the Plan. Nord appeals. We have jurisdiction pursuant to 28 U.S.C. § 1291. Based on our recent decision in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), we conclude that the district court erred in reviewing the disability determination for an abuse of discretion. We review *de novo* and reverse.

**FACTUAL AND PROCEDURAL BACKGROUND**

Kenneth Nord was formerly employed as a Material Planner for Kwikset Corporation, a subsidiary of the Black & Decker Corporation. Nord’s responsibilities as a Material Planner included ordering goods, interacting with vendors, and maintaining inventory levels. The position is a sedentary one, requiring up to six hours of sitting and up to two hours of standing or walking per day.

Through his employment at Kwikset, Nord was enrolled in the Black & Decker Disability Plan. The language of the Plan grants absolute discretion to the Plan

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Manager to make disability determinations.<sup>1</sup> The Plan also invests the Plan Manager with the authority to delegate one or more of his responsibilities to a Claims Administrator. The third-party Claims Administrator retained while Nord's claim was under review was Metropolitan Life Insurance Company ("MetLife"). The Plan provides long-term benefits coverage for participating employees who are prevented by disability from occupying their regular jobs for the first 30 months of the disability. At issue here is Nord's disability from performing his regular job for 30 months. Continuing benefits are available for those participants who are prohibited from engaging in any gainful employment for which they are qualified due to their disabilities.<sup>2</sup>

In March 1997, Nord consulted Dr. Hartman regarding his experience with intermittent hip and low back pain. Dr. Hartman concluded that Nord suffered from mild degenerative disc disease at the L4-L5 and L5-S1 vertebral

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<sup>1</sup> The Plan provides that:

The determination of disability shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's employment history that the Plan Manager deems satisfactory in its sole and absolute discretion.

<sup>2</sup> The Plan defines "disability" to mean:

the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability), and became with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with any employer for which the Employee is, as of his Disability Date, reasonably qualified by education, training or experience.

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levels.<sup>3</sup> In July 1997, Dr. Hartman diagnosed Nord as suffering from sciatica and disc disease at L4-L5 and placed him on medication. After a one-week trial with that treatment plan, Dr. Hartman concluded that Nord had experienced no improvement, and he took Nord out of work temporarily. He recommended orthopedic consultation while continuing medication. On July 16, 1997, Nord submitted a claim under the Plan for up to 30 months of long-term disability benefits.

On August 13, 1997, Dr. Hartman drafted a letter indicating that Nord was under his medical care and would be unable to return to work until he experienced sufficient recovery from his lumbar disc syndrome. Dr. Hartman wrote an additional letter in March 1998, after Nord had begun treatment by an orthopedist, Dr. Lytton Williams, confirming continuing medical treatment and restating his earlier conclusion that Nord remained unable to return to work. In April 1998, Dr. Hartman performed a physical capacity evaluation in which he estimated that Nord could sit for up to one hour a day and could occasionally lift up to five pounds.<sup>4</sup> Nearly identical findings were made by Nord's treating orthopedic physician, Dr. Williams, around the same time.

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<sup>3</sup> This diagnosis was later reconfirmed by an MRI scan, conducted on July 23, 1997, which showed degenerative disc disease at L4-L5 and L5-S1, with disc desiccation and a mild diffuse bulge.

<sup>4</sup> At the same time, Nord underwent overlapping treatment from two orthopedic doctors, Dr. Silva and Dr. Mumtaz Ali. Both doctors confirmed aspects of Dr. Hartman's diagnosis, including the presence of lumbosacral pain requiring continued treatment with medication and physical therapy.

On February 16, 1998, MetLife informed Nord that his claim had been denied because he did not meet the "own occupation" definition of disability for the first 30 months of coverage. In the same letter, MetLife also informed Nord that he could "request a review of [his] claim" by sending his request to MetLife's "Group Claims Review." Nord requested review of his claim through a letter sent by counsel. Between March 25, 1998 and October 14, 1998, Nord and MetLife exchanged letters and medical documentation in an effort to process the review of his claim.

This review process included the Plan's referral of Nord to Dr. Antoine Mitri for independent evaluation of his medical claims. Dr. Mitri observed Nord to be normal except for some limitations in bending and assuming cramped or unusual positions. Dr. Mitri opined that Nord should be able to perform sedentary work, with no material limitations in his ability to sit, while taking pain reduction medication. However, the review process also included Nord's providing the Plan with a work capacity evaluation performed by Ms. Janmarie Forward, a human resources representative at Black & Decker, who determined that Nord lacked the capacity to perform the requirements of his job because of his physical limitations. Forward based this determination on the assumption that Nord faced chronic myofascial pain and that this experience of pain would make it impossible for him to carry on the necessary interpersonal relationships to perform his job.

MetLife made a final recommendation to the Plan Manager to deny Nord's claim, and the Plan Manager accepted that recommendation. In a letter dated October 27, 1998, the Plan Manager informed Nord by letter of the

outcome of this initial step in his appeal and explained how Nord could perfect his appeal under ERISA. Black & Decker indicated that it had rejected the opinion of Forward that Nord's pain syndrome prevented him from resuming work in his former position.

Nord filed this action in the district court on January 14, 1999, asserting that Black & Decker's denial of his disability benefits violated ERISA. On February 28, 2000, the parties filed cross-motions for summary judgment. The district court granted the defendant's motion and denied Nord's motion. The court found that Black & Decker did not abuse its discretion by denying Nord's disability claim. Nord appeals the district court's order.

### STANDARD OF REVIEW

We review the district court's order granting summary judgment *de novo*. See *Robi v. Reed*, 173 F.3d 736, 739 (9th Cir. 1999). In addition, we review *de novo* "the district court's choice and application of the standard of review applicable to decisions of plan administrators in the ERISA context." *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1138 (9th Cir. 2001); see also *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997).

In reviewing a grant of summary judgment, we "must determine whether the evidence, viewed in a light most favorable to the nonmoving party, presents any genuine issues of material fact and whether the district court correctly applied the law." *Warren v. City of Carlsbad*, 58 F.3d 439, 441 (9th Cir. 1995); Fed. R. Civ. P. 56(c). See also *Pomerantz v. County of Los Angeles*, 674 F.2d 1288, 1290 (9th Cir. 1982) (holding that the same standard applies for

review of denial of summary judgment). An issue is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

## DISCUSSION

### *District Court's standard of review for Black & Decker's disability determination*

The district court reviewed Black & Decker's termination of Nord's disability benefits under an abuse of discretion standard, despite Nord's allegations that Black & Decker was operating under a conflict of interest. Nord relies on the opinion of Black & Decker's own human resources representative and the opinions of three treating physicians that Nord was no longer capable of occupying his former position. He argues that Black & Decker's arbitrary rejection of these opinions constitutes material, probative evidence that it was operating under an actual conflict. Nord further argues that, because Black & Decker was operating under a conflict of interest, the district court should have reviewed the administrator's decision *de novo*.

The standard of judicial review for a disability determination by an insurer covered under ERISA varies depending on the plan language. We review *de novo* the decision of a plan administrator to deny benefits "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *see also Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999). The plan language must be explicit. *See Kearney v.*

*Standard Ins. Co.*, 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc) (holding that plan language stating that the insurer will pay benefits “upon receipt of satisfactory written proof” of disability was ambiguous, and thus did not confer discretion). When the plan language confers discretion, we review the decision of the plan administrator under an abuse of discretion standard. *Tremain*, 196 F.3d at 976.

In this case, the plan language clearly confers discretion upon the Plan Manager both to determine benefits eligibility and to interpret the terms of the Plan.<sup>5</sup> However, the fact that the terms of the Plan confer broad discretionary authority upon the plan administrator does not end our inquiry into the proper standard of review. An insurer with a “dual role as the administrator and funding source for the [p]lan” has an inherent conflict of interest. *Lang*, 125 F.3d at 797. In *Firestone Tire & Rubber Co.*, the Supreme Court stated that “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion.” 489 U.S. at 115 (internal quotation marks omitted). We have held that our review in such cases is “still for abuse of discretion, [but it] is less deferential.” *Tremain*, 196 F.3d at 976 (internal quotation marks omitted).

Black & Decker admits that it acts as both the funding source and the plan administrator with regard to the Plan. It notes that administration of the Plan in Nord’s

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<sup>5</sup> See *supra* note 1.

case had been delegated to MetLife, a third-party administrator. However, MetLife acted as the agent of Black & Decker and not as the independent executor of a true trust.<sup>6</sup> *See Lang*, 125 F.3d at 798 (stating that “plans such as this one, funded by insurers and also administered by them, are not true trusts”). Therefore, Black & Decker, through MetLife, was operating under an inherent conflict of interest.

The “less deferential” standard of review for cases involving conflicts consists of two steps:

First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary’s self-interest caused a breach of the administrator’s fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary *has* made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

*Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995). By providing material, probative evidence of a conflict, Nord would create a rebuttable presumption that the Plan’s decision violated its fiduciary responsibilities. The Plan would then “bear[] the burden of rebutting the

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<sup>6</sup> MetLife processes the insured’s claim and makes a recommendation whether to grant or deny benefits; Black & Decker’s Plan Manager makes the final disability determination after receiving MetLife’s recommendation.

presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits.” *Lang*, 125 F.3d at 798. If the plan fails to carry its burden, then we review *de novo* its decision to deny benefits. *Tremain*, 196 F.3d at 976.

This appeal is controlled by our recent ruling in *Regula v. Delta Family-Care Disability Survivorship Plan*. In *Regula*, we rejected the district court’s application of the abuse of discretion standard to a claim for wrongful termination of disability benefits because the district court had failed to evaluate whether the insurer’s apparent conflict of interest had affected its determination. If so, we would require that the court review the plan administrator’s decision *de novo*. *Regula*, 266 F.3d at 1145-46; *see also Lang*, 125 F.3d at 799-800 (“The district court did not conduct the appropriate conflict of interest analysis and hence accorded [the insurer] a deference to which it was not entitled.”). Our prior decisions have established that material, probative evidence of a conflict may consist of inconsistencies in the plan administrator’s reasons, *Lang*, 125 F.3d at 799, insufficiency of those reasons, *Tremain*, 196 F.3d at 977, or procedural irregularities in the processing of the beneficiaries claims, *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1110 (9th Cir. 1999). In *Regula*, we held that rejection of the opinions of the beneficiary’s treating physicians could likewise establish conflict where the rejection is not “sufficiently supported by the record.” 266 F.3d at 1147. On remand, we directed the district court to consider Delta’s departure from the prevailing opinions of *Regula*’s treating physicians as material, probative evidence of an actual conflict of interest but to allow Delta to rebut that evidence in a manner consistent with our prior

precedent. *See Lang*, 125 F.3d at 798; *see also Tremain*, 196 F.3d at 978.

In *Regula*, the conflict of interest issue was not litigated in the district court but was entertained by us on appeal because of its relevance to determining the standard of review. 266 F.3d at 1145-46. Therefore, we did not rule on the existence of a conflict of interest in that case. *Id.* at 1147. Rather, we remanded to the district court so that the defendant insurer would have an opportunity to rebut the material, probative evidence of conflict that we ascertained in our review of the district court record. *Id.*

In the case before us, the district court rejected Nord's argument that inconsistencies and procedural irregularities in Black & Decker's administration of his claim demonstrated the insurer's conflict of interest. In particular, the district court held that Black & Decker's rejection of the conclusion of its own human resources representative, Forward, was not material, probative evidence of a conflict. Forward opined that Nord was unable, due to his medical condition, to perform the functions of a Material Planner. Forward's opinion was solicited by the administrator; she relied on Dr. Mitri's assessment as provided by the administrator. To contradict her opinion out of hand is not only high-handed but also certainly some evidence of a conflict.<sup>7</sup>

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<sup>7</sup> In addition, Nord claims that the Plan violated its administrative procedural requirements by failing to provide, in its letter of October 27, 1998, specific reasons for rejecting the opinion of Forward. However, Black & Decker's letter was sufficiently responsive in that it provided the insurer's reasons for its ultimate decision to deny benefits. Black & Decker was under no duty to rebut with specificity all evidence adduced

(Continued on following page)

The district court erred also in its refusal to view Black & Decker's rejection of the prevailing opinions of Nord's treating physicians as germane to a determination of whether the Plan's administration was impaired by a conflict of interest. As discussed above, Nord was diagnosed with degenerative disc disease, sciatica, and myofascial pain syndrome. This diagnosis was confirmed by an MRI and CT scan and was not contradicted by Dr. Mitri, the independent clinician retained by Black & Decker to evaluate Nord's claim. Nord's primary treating physician, Dr. Hartman, concluded after a physical capacity evaluation that Nord could sit for up to one hour a day and could carry up to five pounds.<sup>8</sup> Black & Decker's own description of the physical requirements for a Material Planner indicate that the person occupying the position would have to sit for up to six hours a day and carry up to 20 pounds.<sup>9</sup> In addition, Dr. Hartman wrote two letters to Black & Decker in which he stated that Nord's medical condition prevented him from returning to work even though Nord had made improvements with physical therapy and

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by Nord to support his claim. *Vizcaino v. Microsoft Corp.*, 120 F.3d 1006, 1016 (9th Cir. 1997) (en banc) (Fletcher, B., J., concurring in part and dissenting in part) (stating that under ERISA the reasons for a denial of benefits "must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial") (quoting *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997)).

<sup>8</sup> This diagnosis of Nord's physical abilities was confirmed by an additional examination by Dr. Williams, who opined that Nord could sit for one hour at a time and for one hour during a day, and that he could occasionally lift up to five pounds.

<sup>9</sup> Nord represents that while working in his former position he was sometimes required to lift up to 60 pounds.

medication. Dr. Hartman's diagnosis, as well as his prescribed course of treatment, were confirmed by Nord's other treating physicians, Drs. Williams and Silva.

Dr. Mitri disagreed with Nord's treating physicians in two principal respects: First, Dr. Mitri found that Nord suffered from only minor limitations to his range of motion and in his ability to sit for long periods of time if he took his pain medication. The medications to which Dr. Mitri referred in drawing this conclusion (Relafen, Davrocet, and Flexeril) are all medications that were prescribed by Drs. Hartman and Silva for Nord at various stages throughout their treatment of his condition. Second, Dr. Mitri concluded that Nord could lift and carry up to 15 pounds less than 20% of the business day. Thus, Dr. Mitri concluded that, under medication, Nord could perform "sedentary work with some walking interruption in between."

Thus, the long-term treating physicians and Black & Decker's independent (but one-time) clinical examiner disagreed. The same clinical materials were available to both. In such a circumstance, under the treating physician rule, the plan administrator can reject the conclusions of the treating physicians only if the administrator "gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record.'" *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999) (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995)).

Nowhere in the record is any reason advanced as to why the treating physicians' opinions were unreliable and Dr. Mitri's more reliable. No evidence has been advanced that Nord's treating physicians considered inappropriate

factors in making their diagnosis or that Nord's physicians lacked the requisite expertise to draw their medical conclusions. Instead, the administrator appears merely to have preferred to rely upon the more favorable conclusions of its own examiner. Given its dual role as funding source and administrator for the Plan, we conclude Black & Decker breached its fiduciary duty to Nord as a beneficiary of the Plan due to a conflict of interest.

Because the issue of an apparent conflict of interest was litigated below, Black & Decker received ample opportunity to demonstrate that its termination of Nord's benefits was free from conflict by advancing sound reasons for its denial of benefits. It has provided none. Rather, it has simply asserted at every turn, and again before this Court, that it was under no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative. We faced an analogous situation in *Tremain*, where we ruled that the district court had erred by failing to consider evidence even though it was outside of the administrative record in determining whether a conflict of interest had impaired the insurer's benefits determination. 196 F.3d at 976-77. Based on the evidence before us, presented to the district court before it granted the insurer's motion for summary judgment, we concluded that the insurer's inconsistent reasons for denying the beneficiary's claim constituted material, probative evidence of a conflict (a conclusion not reached by the district court) and that the insurer had failed to present any evidence to rebut the presumption that a conflict of interest had impaired its determination. *Id.* at 977.

Therefore, following our precedent in *Tremain* and *Regula*, we conclude that the disability determination

must be reviewed *de novo*. Under *de novo* review, the question becomes whether there is a genuine issue of material fact as to whether Nord is disabled. See *Newcomb v. Standard Ins. Co.*, 187 F.3d 1004, 1006 (9th Cir. 1999). After cross-motions for summary judgment, we find that, although further record development for *de novo* review is sometimes appropriate, see *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 943-44 (9th Cir. 1995), it is unnecessary in this case. Indeed, Black & Decker asserted in the district court that no additional evidence was necessary for an adequate *de novo* review. See Defendant's Memorandum of Points and Authorities in Opposition to Plaintiff's Motion for Summary Judgment at 17 & n.6. The administrative record reveals no genuine dispute as to whether Nord is disabled within the meaning of the plan for the first 30 months of coverage.

The only evidence advanced by Black & Decker to dispute the evidence of Nord's disability is Dr. Mitri's opinion that Nord is capable of performing sedentary work. A scintilla of evidence or evidence that is not significantly probative does not present a genuine issue of material fact. *Addisu v. Fred Meyer, Inc.*, 198 F.3d 1130, 1134 (9th Cir. 2000). We conclude that the lone opinion of Dr. Mitri, the doctor hired by Black & Decker, could not reasonably overcome all the other evidence demonstrating that Nord is disabled. Dr. Mitri's opinion is overwhelmed by substantial evidence in the record, including the opinions of three treating physicians that Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner. Viewing the administrative record as a whole, we conclude that no reasonable

trier of fact could conclude that Nord is not disabled. Therefore, we grant Nord's motion for summary judgment.

### CONCLUSION

For the foregoing reasons, we reverse the ruling of the district court holding that Black & Decker was not operating under a conflict of interest. Upon a *de novo* review of the administrative record, we find that there is no triable issue of fact regarding Nord's disability and hold that Nord is entitled to disability benefits for the first 30 months of his disability.

REVERSED.

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JUDGMENT

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UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT

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NO. 00-55689  
CT/AG#: CV-99-00408-CM  
CT/AG#: CV-99-00408-CM

KENNETH L. NORD

Plaintiff-Appellant

v.

THE BLACK & DECKER DISABILITY PLAN

Defendant-Appellee

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APPEAL FROM the United States District Court for the Central District of California, Los Angeles.

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California, Los Angeles and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is reversed.

Filed and entered: July 15, 2002

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UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA

KENNETH L. NORD,

Plaintiff,

v.

THE BLACK & DECKER  
DISABILITY PLAN,

Defendant.

Case No. CV 99-0408 CM

ORDER GRANTING  
DEFENDANT'S MOTION  
FOR SUMMARY  
JUDGMENT AND DENYING  
PLAINTIFF'S MOTION FOR  
SUMMARY JUDGMENT

(Filed Mar. 22, 2000)

On February 28, 2000, Plaintiff's Motion for Summary Judgment and Defendant's Motion for Summary Judgment came before the Court on regular hearing. Having read and considered the moving papers, oppositions, and replies; the entire record in this action; and all other admissible evidence and argument offered in relation to the Motions, the Court hereby *grants* Defendant's Motion for Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment for the following reasons.

I.

Summary of Relevant Facts

This ERISA action arises from Plaintiff's claim for long-term disability benefits from Defendant. Plaintiff is a former employee of Kwikset Corporation ("Kwikset"), a subsidiary of Black & Decker Corporation. As a Kwikset employee, Plaintiff was entitled to participate in the Black & Decker Disability Plan (the "Plan"). Under the terms of the Plan, "disability" was defined as follows:

the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability and beginning with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with an employer for which the Employee is, as of his Disability Date, reasonably qualified by education, experience or training. Declaration of Raymond J. Brusca In Support of Defendant's Motion, Exh. B at 24.

On or about July 15, 1997, Plaintiff ceased working in his position as a Material Planner for Kwikset and submitted his claim for long-term disability benefits. A review of Plaintiff's administrative claim file reveals the following facts relevant to the disposition of the instant Motions:

– On or about March 10, 1997, Plaintiff consulted with Leo Hartman, M.D. because of the presence of intermittent pain in the lower back and hips for the preceding three or four weeks;

– Between March 1997 and August 1997, Plaintiff was regularly treated by Dr. Hartman for lower back pain, sciatica, leg pain, and degenerative disc disease. As part of his treatment by Dr. Hartman, pain killers were prescribed for Plaintiff;

– On or about August 13, 1997, Dr. Hartman recommended that Plaintiff seek an orthopedic consultation from Ismael Silva, M.D.;

– Also on or about August 13, 1997, Dr. Hartman wrote a letter in which he indicated that Plaintiff was

under his medical care and could not return to work until Plaintiff's lumbar disc syndrome had sufficiently recovered;

– As result of Plaintiff's consultation with Dr. Silva, Dr. Silva diagnosed Plaintiff with lumbosacral pain and prescribed physical therapy;

– On or about the same time as Dr. Silva's prescription of physical therapy for Plaintiff, Dr. Hartman also prescribed physical therapy for Plaintiff;

– Dr. Silva's treatment of Plaintiff included prescription painkillers as well as ordering an EMG and nerve conduction studies of Plaintiff's lower extremities in order to rule out disc disease;

– The results of the EMG and nerve conduction studies ordered by Dr. Silva suggested mild bilateral L5 radiculopathy;

– On or about January 12, 1998, Kwikset provided a statement regarding Plaintiff's claim for long-term disability benefits to Metropolitan Life Insurance Company ("MetLife"), the Plan's Third Party Claims Administrator. In that statement, Kwikset described Plaintiff's position as a Material Planner as requiring between five and six hours of sitting per day, one and two hours of standing, one and two hours of walking, the need to use the head and neck in the same position between one and two hours per day, looking up between one and two hours per day, and looking down between one and two hours a day. Kwikset further represented that the Material Planner position required occasional lifting and carrying of objects weighing up to 20 pounds, continuous interpersonal relationships, frequent exposure to stressful situations,

exposure to moving equipment and machinery, and overtime on a routine basis;

– On or about January 17, 1998, Plaintiff provided a response to a Personal Profile Evaluation as part of Metlife's assessment of his claim for long-term disability benefits. In the Personal Profile Evaluation, Plaintiff reported that he could not sit for more than 10 to 15 minutes at a time without pain, that he could not stand or walk for more than 10 to 15 minutes without pain, that pain radiated down his left leg and at times also down his right leg, that he walked until he experienced pain and then sat in a recliner and stood at intervals during a typical day, that he had no difficulty caring for his personal needs, that he did housework and that he got assistance from his mother with housework, that his father provided him assistance with shopping, that it takes him longer to mow his lawn because of his pain, and that his recreational activities included fishing and hunting although he had not been hunting since November of 1996. Plaintiff further stated that he expected to return to his job as a Material Planner if and when he could sit without pain; that, in the meantime, he did not expect to return to any other type of work on a full-time or part-time basis; and that he had no other sources of income;

– On or about January 23, 1998, Plaintiff returned to Dr. Silva for evaluation. Dr. Silva noted continued complaints of back pain, bilateral lumbosacral radiculopathy, and the continued use of prescription medication to control pain. Dr. Silva also found decreased lumbosacral range of motion and the presence of paralumbar muscle spasm;

– On or about February 16, 1998, MetLife wrote a letter to Plaintiff regarding his claim. In the letter, MetLife

disallowed Plaintiff's claim for benefits. In so doing, MetLife cited Plaintiff's responses in his Personal Profile Evaluation as well as Plaintiff's medical history since the onset of his lower back pain. MetLife's letter also notified Plaintiff of his right to seek review of its denial of Plaintiff's claim by the Plan's Group Claims Review;

– On or about March 4, 1998, Plaintiff returned to Dr. Hartman with continuing complaints of lower back pain. Dr. Hartman noted the presence of recurring low back pain consistent with a herniated disc. Dr. Hartman recommended continuing the present treatment regiment and seeking an orthopedic follow-up from Lytton Williams, M.D.;

– On or about March 23, 1998, Dr. Hartman wrote a letter concerning Plaintiff. In the letter, Dr. Hartman confirmed Plaintiff's continuing treatment for lumbar disc syndrome. Dr. Hartman also stated that Plaintiff would not be able to work until his condition was sufficiently controlled and that Plaintiff would likely be of work until December 31, 1998;

– On or about March 25, 1998, Plaintiff, through his counsel, formally requested review of the denial of his claim;

– On or about March 26, 1998, Plaintiff underwent a lumbar discogram and a CT scan of the lumbar spine both based upon a clinical history of degenerative disc disease. The discogram revealed a concordant pain pattern at L4-5 and L5-S1. The CT scan revealed annular thinning of the intervertebral discs and loss of disc space at L4-5 and L5-S1;

– On or about April 2, 1998, Dr. Williams completed a Physical Capacity Evaluation Plaintiff. Dr. Williams opined that Plaintiff could sit for one hour at a time and for one hour total during a day; that Plaintiff could occasionally lift or carry up to five pounds; that Plaintiff could not use his feet for repetitive movements; that Plaintiff could only occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about April 9, 1998, Dr. Hartman completed a Physical Capacity Evaluation of Plaintiff. Dr. Hartman opined that Plaintiff could sit for one hour at a time and for a total of one hour per day; that Plaintiff could occasionally lift up to five pounds; that Plaintiff could not use his feet for pushing or pulling of light controls; that Plaintiff could occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about June 22, 1998, MetLife advised Plaintiff that it had scheduled an independent medical examination of Plaintiff as part of its administration of Plaintiff's claim;

– On or about July 17, 1998, Antoine Mitri, M.D. conducted an independent neurological examination of Plaintiff pursuant to MetLife's request. Dr. Mitri concluded that Plaintiff suffered from degenerative disc disease and chronic myofascial pain syndrome. Dr. Mitri further concluded that there was no evidence of lumbosacral nerve root compression. Consequently, Dr. Mitri opined that Plaintiff should be able to do sedentary work with intermittent walking as necessary;

– On or about July 17, 1998, Dr. Mitri completed a Certified Consultant's Evaluation Summary Form as part

of MetLife's administration of Plaintiff's claim. In that form Dr. Mitri noted the presence of lumbosacral degenerative disc disease and chronic myofascial pain syndrome and that Plaintiff had suffered from low back pain for 15 years. Dr. Mitri opined that Plaintiff would have some limitations with respect to stairs and ladders and that Plaintiff would need to completely avoid scaffolding and heights. Dr. Mitri further found limitations with respect to cramped or unusual positions, pushing, pulling, or twisting of arm and leg controls, repetitive movements of hands or feet, and operating vehicles. Dr. Mitri completely forbade climbing, balancing, bending, stooping, squatting, and the operation of heavy equipment. Dr. Mitri opined that Plaintiff could perform sedentary work with occasional walking;

- At some point prior to October 20, 1998, Janmarie Forward, a Black & Decker human resources employee, completed a Work Capacity Evaluation sent to her by Plaintiff's counsel;

- On or about October 27, 1998, Black & Decker upheld MetLife's denial of Plaintiff's claim. Black & Decker based its decision on its conclusion that Plaintiff could return to work in his own occupation which was, in turn, based on the evidence in Plaintiff's administrative claim file;

- Subsequent to its decision to uphold the denial of Plaintiff's claim, Black & Decker requested a review of the medical records and correspondence relating to Plaintiff's claim by James Ebeling, M.D. Dr. Ebeling concluded that Plaintiff should be able to do sedentary work and he agreed with MetLife's decision to deny Plaintiff's claim.

II.

Applicable Standard

Summary judgment is appropriate when “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(c). In a trilogy of 1986 cases, the Supreme Court clarified the applicable standards for summary judgment. See *Celotex Corporation v. Catrett*, 477 U.S. 317 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); *Matsushita Electrical Industry Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986).

The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Anderson*, 477 U.S. at 256. Whether a fact is material is determined by looking to the governing substantive law; if the fact may affect the outcome, it is material. *Id.* at 248. If the moving party seeks summary adjudication with respect to a claim or defense upon which it bears the burden of proof at trial, its burden must be satisfied by affirmative, admissible evidence. By contrast, when the non-moving party bears the burden of proving the claim or defense, the moving party can meet its burden by pointing out the absence of evidence submitted by the non-moving party. The moving party need not disprove the other party’s case. See *Celotex*, 477 U.S. at 325.

If the moving party meets its initial burden, the “adverse party may not rest upon the mere allegations or denials of the adverse party’s pleadings, but the adverse party’s response, by affidavits or as otherwise provided in

this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e).

In assessing whether the non-moving party has raised a genuine issue, its evidence is to be believed, and all justifiable inferences are to be drawn in its favor. *Anderson*, 477 U.S. at 255 (citing *Adickes v. S. H. Kress and Company*, 398 U.S. 144 (1970)). Nonetheless, "the mere existence of a scintilla of evidence" is insufficient to create a genuine issue of material fact. *Id.* at 252. As the Supreme Court explained in *Matshushita*,

When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts. . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no "genuine issue for trial."

*Id.*, 475 U.S. at 586-87.

To be admissible for purposes of summary judgment, declarations or affidavits must be based on personal knowledge, must set forth "such facts as would be admissible in evidence," and must show that the declarant or affiant is competent to testify concerning the facts at issue. Fed. R. Civ. P. 56(e). Declarations on information and belief are insufficient to establish a factual dispute for purposes of summary judgment. *Taylor v. List*, 880 F.2d 1040, 1045 (9th Cir. 1989).

Summary judgment is not treated as "a disfavored procedural shortcut" but as "an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive determination of every action.'" *Celotex*, 477 U.S. at 327 (quoting Fed. R. Civ. P. 1).

III.

Analysis and Discussion

*Exhaustion of Administrative Remedies*

As a general rule, “[an ERISA] claimant must avail himself or herself of a plan’s own internal review procedures before bringing suit in federal court.” *Diaz v. United Agricultural Employee Welfare Benefit Plan and Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995) (citing *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980)), *see also Pengilly v. Guardian Life Insurance Co. of America*, 81 F.Supp.2d 1010, 1022 (N.D.Cal. 2000) (setting forth the specific terms of a disability policy’s appeal’s procedures in order to analyze the issue of exhaustion of administrative remedies). “Although not explicitly set out in the statute, the exhaustion doctrine is consistent with ERISA’s background, structure and legislative history and serves several important policy considerations, including the reduction of frivolous litigation, the promotion of consistent treatment of claims, the provisions of a nonadversarial method of claims settlement and a proper reliance on administrative expertise.” *Diaz*, 50 F.3d at 1483. “Furthermore, prior fully considered actions by . . . trustees interpreting their plans and perhaps also further refining and defining the problem in given cases, may well assist the courts when they are called upon to resolve the controversies.” *Pengilly*, 81 F.Supp.2d at 1022 (citing *Amato v. Bernard*, 618 F.2d at 568).

The Summary Plan Description (“SPD”), *see Brusca Decl. Exh. A*, clearly provides that a claimant may appeal to the Plan Administrator within 60 days of the initial denial of a claim and that the Plan Administrator will render its decision on the appeal within another 60 days.

Furthermore, the Plan Document itself, *see* Brusca Decl., Exh. B, provides that initial determinations of claims applications will be made by the Plan Manager or by a third party Claims Administrator who is providing administrative services to the Plan. *See* Brusca Decl., Exh. A, §9.07(A). Under the terms of the Plan Document, a claimant may appeal an initial denial of benefits to the Plan Manager within 60 days of the initial denial. *See id.* at §9.07(B). Finally, the Plan Document provides that the appeal will be decided by an Appeals Committee within 60 days of the date the claimant makes the appeal. *See id.* at §9.07(C).

Plaintiff argues that he exhausted his administrative remedies under the Plan Document and the SPD when he received a letter dated October 27, 1998 from Black and Decker, *see* Brusca Decl., Exh. D, notwithstanding the fact that this letter purported to inform Plaintiff of his right under ERISA to have claim reviewed on appeal yet again. Specifically, Plaintiff claims that the October 27, 1998 letter was notification of a final, binding decision on his appeal of MetLife's initial denial of his claim in its position as Third Party Administrator.

Defendant, however, characterizes MetLife's initial denial as a kind of recommendation to the Plan Manager which the Plan Manager upheld after further investigation. *See* Brusca Decl. ¶¶11-19. Therefore, according to Defendant, under the terms of the Plan and the SPD, Plaintiff was still entitled to an appeal to the Plan's Appeals Committee. *See id.* ¶¶20-22. Because, according to Defendant's position, Plaintiff did not pursue an appeal to the Plan's Appeals Committee, this action is barred for failure to exhaust administrative remedies. *See* Defendant's Motion at 3-6, Defendant's Opposition at 4-5.

The Court holds that Plaintiff has exhausted his administrative remedies by making his initial claim and seeking review by the Plan Manager which resulted in the denial in the October 27, 1998 letter. There is no ambiguity in the SPD about the internal appeals process and to the extent there is any ambiguity in the Plan Document itself, *see* Brusca Decl. Exh. B at §§9.07(A)-(B), Plaintiff should not be prejudiced thereby. The SPD clearly provides that Plaintiff is entitled to one level of internal appeal after the initial denial; the Plan Document has similar terms. Nothing in these documents puts a claimant on notice of the fact that an initial denial by the Third Party Claims Administrator might be a mere recommendation that must be ratified by the Plan Manager before an actual internal appeal can take place. Furthermore, the initial denial letter sent to Plaintiff by MetLife, *see* Brusca Decl. Exh. C at 147, also states that Plaintiff had 60 days to request a review of MetLife's initial denial. This language may have reasonably led Plaintiff and his counsel to conclude that the October 27, 1998 denial was the product of the only level of internal appeal to which Plaintiff was entitled under the SPD and the Plan Document. Consequently, the Court concludes that Plaintiff exhausted his administrative remedies and that, therefore, this action is not barred.<sup>1</sup>

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<sup>1</sup> Tellingly, the draft version of Black & Decker's October 28, 1998 denial letter which was written by MetLife stated that the decision to uphold MetLife's denial "is the final decision on review and constitutes completion of the full and fair review required by Mr. Nord's Plan and federal law." The draft denial letter further states "Please be advised that under the provisions of his Plan, no further administrative appeals are available to him concerning his disability benefit." Rohlfiing Decl.,

(Continued on following page)

*Appropriate Standard of Review / Conflict of Interest*

An ERISA plan administrator's decision to deny benefits is subject to de novo review unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Tremain v. Bell Industries*, 196 F.3d 970, 976 (9th Cir. 1999) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). When such discretion is conferred, the exercise of that discretion is subject to review for abuse of discretion. *Tremain*, 196 F.3d at 976 (citing other Ninth Circuit caselaw).

"If, however, the plan administrator is also the insurer, that conflict of interest must be weighed as a factor in determining whether there is an abuse of discretion." *Id.* (citing *Snow v. Standard Insurance Co.*, 87 F.3d 327, 330 (9th Cir. 1996)). In such a circumstance, a "less deferential" abuse of discretion standard is employed. *Tremain*, 196 F.3d at 976 (citing *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.* 125 F.3d 794, 798 (9th Cir. 1997)).

"If, however, the program participant presents material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary, a rebuttable presumption arises in favor of the participant." *Tremain*, 196 F.3d at

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Exh. 2 at Bates No. BD 0039. Although the final version tracks MetLife's draft in many respects, the final version does not contain the above-quoted language. See Brusca Decl., Exh. D at 159 (Bates No. BD 0042).

976 (citing *Lang*, 125 F.3d at 798). "The plan then bears the burden of rebutting the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits. *Tremain*, 196 F.3d at 976 (citing *Lang*). If the plan fails to carry this burden of rebutting the presumption, the fiduciary or administrator's decision to deny benefits is reviewed de novo. *Tremain*, 196 F.3d at 976 (citing *Lang*). Sufficient evidence of an actual conflict of interest includes, *inter alia*: (1) inconsistent position on the part of the administrator/fiduciary or (2) an administrator/fiduciary's failure to follow its own internal procedures or ERISA's mandatory claims procedures. See *Ellis v. Egghead Software Short-Term and Long-Term Disability Plans*, 64 F.Supp.2d 980, 985 (E.D.Wash. 1999) (citing *Lang*, 125 F.3d at 799, and *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109-12 (9th Cir. 1999)).

Plaintiff concedes that the Plan Document grants discretion to the Plan Administrator. See Plaintiff's Motion at 4. Defendant likewise concedes that there is an apparent or technical conflict of interest due to Black & Decker's dual role as insurer and administrator. See Defendant's Motion at 11. However, Plaintiff has not sufficiently met his burden to invoke de novo review. See Defendant's Opposition at 10-15. More specifically, under *Ellis*, Plaintiff has not demonstrated that Defendant assumed inconsistent positions during the pendency of the internal claims assessment and internal appeal. Furthermore, to the extent that Defendant may have deviated from the SPD's and Plan Document's stated procedures for an internal appeal, this issue has been resolved in Plaintiff's favor above as it relates to exhaustion of administrative remedies and Plaintiff also has not shown that this

deviation caused a breach of fiduciary duty owed to him. *See Tremain*, 196 F.3d at 976 (plaintiff must produce sufficient evidence to show that the conflict of interest caused a breach of a fiduciary duty owed to him), *cf. Dames*, 49 F.Supp.2d at 1201 (a plaintiff is not entitled to a substantive remedy for violation of ERISA's reporting and disclosure requirements unless she can show reliance or prejudice).

Consequently, the Court holds that notwithstanding Defendant's apparent or technical conflict of interest, Defendant's decision to deny Plaintiff's claim for disability benefits is subject to review for abuse of discretion.

*Propriety of Defendant's Denial of  
Plaintiff's Claim for Benefits*

"It is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Atwood v. Newmont Gold*, 45 F.3d 1317, 1323-24 (9th Cir. 1995). "The mere fact that the plan administrator's decision is directly contrary to some evidence in the record does not show that the decision is clearly erroneous." *Snow v. Standard Insurance Co.*, 87 F.3d 327, 331 (9th Cir. 1996). "Rather, 'review under the clearly erroneous standard is significantly deferential, requiring a 'definite and firm conviction that a mistake has been committed.'" *Id.* (citing *Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 508 U.S. 602, 623 (1993)). "That standard certainly does not permit the overturning of a decision where there is substantial evidence to support the decision, that is, where there is 'relevant evidence [that] reasonable minds might accept as adequate to support a

conclusion even if it is possible to draw two inconsistent conclusions from the evidence.’” *Snow*, 87 F.3d at 331-32 (citing *Maynard v. City of San Jose*, 37 F.3d 1396, 1404 (9th Cir. 1994)). Finally, several courts have held that crediting the opinions of an independent medical examiner over the opinions of a claimant’s treating physicians is not clearly erroneous or an abuse of discretion. *See, e.g., Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Gruman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D. Cal. 1999) (Collins, J.) (citing other cases) (finding that the administrator’s decision to deny benefits was justified by sufficient evidence despite the fact that it contradicted the opinions of plaintiff’s treating physicians).

In his briefing, Plaintiff’s two main arguments in support of overturning Defendant’s decision to deny him disability benefits are that: (1) Defendant’s decision is contrary to the opinions provided by Janmarie Forward, a Black & Decker employee, in a Work Capacity Evaluation and (2) Defendant’s decision credits the medical opinions of an independent medical examiner over the opinions of his Plaintiff’s treating physicians. *See* Plaintiff’s Motion at 11-19.

In making these arguments, Plaintiff essentially argues that Defendant’s decision was based on factual findings which were clearly erroneous. It is clear under *Snow*, however, that the fact that Defendant’s decision contradicts some evidence in the administrative record is not sufficient to overturn Defendant’s decision. Consequently, the fact that an individual like Ms. Forward who apparently lacks any expertise or credentials in medicine, disability evaluation, and vocational evaluation has

expressed an opinion contrary to Defendant's ultimate decision is not sufficient reason to overturn Defendant's decision given the other evidence in the administrative record.<sup>2</sup> Furthermore, it is also clear that Defendant need not credit the opinion of Plaintiff's treating physician over the opinions of an independent medical examiner. See *Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D.Cal. 1999) (Collins, J.) (citing other cases). This is especially the case when MetLife gave Plaintiff and Plaintiff's treating physicians an opportunity to comment on the independent medical examiner's opinions, see Brusca Decl. Exh. D. at

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<sup>2</sup> Item 6 of the Work Capacity Evaluation reads as follows:

Dr. Mitri describes Kenneth Nord as suffering from degenerative disc disease and a chronic myofascial pain syndrome. You have indicated in your employer statement provided to Metropolitan that the work of a material planner requires continuous interpersonal relationships and frequent exposure to stressful job situations. Assume that Kenneth Nord would have a moderate pain that would interfere with his ability to perform intense interpersonal communications or to act appropriately under stress occasionally (up to one-third) during the day. Could [an] individual of those limitations perform the work of a material planner?" Brusca Decl, Exh. C at 40.

Ms. Forward responded "no" to Item 6. *Id.* furthermore, in its October 27, 1998 denial letter, Black & Decker specifically referenced Ms. Forward's response in the Work Capacity Evaluation and stated "The results of that evaluation are not sufficient to reverse our decision." Brusca Dec, Exh. D. at 159. Furthermore, as Defendant persuasively argued at the hearing on the instant Motions, Ms. Forward's response to Item 6 of the Work Capacity Evaluation did not take account of the prescription painkillers Plaintiff had been taking virtually since the onset of his lower back pain in early 1997.

159, and Plaintiff apparently never took advantage of this opportunity. *Cf. Dames*, 49 F.Supp.2d at 1202 (fact that administrator did not consider untimely submitted medical opinions is not evidence of taint sufficient to invoke de novo review because of conflict of interest; decision not to consider untimely evidence was exactly the kind of exercise of discretionary authority which administrator was entitled to make).

Finally, at the hearing on the instant Motions, Plaintiff's counsel emphasized a conversation between the Plan Manager, Raymond Brusca, and Ms. Forward, the Black & Decker human resources employee who provided responses on a Work Capacity Evaluation sent to Black & Decker by Plaintiff. Although Defendant admits that a conversation took place, Defendant has not disclosed the exact details of the conversation. In his declaration, Mr. Brusca does state that he discussed the specific duties of the Material Planner position, the freedom of movement Plaintiff had in that position, and the availability of aid to Plaintiff in lifting in that position if aid were necessary. Brusca Decl. ¶17.

At the hearing, Plaintiff's counsel pointed to this conversation both as evidence sufficient to meet Plaintiff's burden of demonstrating an actual conflict of interest and as evidence of an abuse of discretion on Defendant's part. The Court disagrees. Given Ms. Forward lack of expertise or credentials, her responses in the Work Capacity Evaluation cannot be said to constitute material evidence as Plaintiff claims. Consequently, any conversation between Mr. Brusca and Ms. Forward whether disclosed or undisclosed also cannot constitute evidence sufficient to demonstrate an actual conflict of interest or an abuse of discretion.

In sum, because an administrator's decision is not based on clearly erroneous factual findings when it conflicts with some evidence in the administrative record and because Defendant need not credit the opinions of Plaintiff's treating physicians over those of an independent medical examiner, the Court holds that Defendant did not abuse its discretion in denying Plaintiff's claim for benefits. *See Snow*, 87 F.3d at 331-32, *Voight*, 28 F.Supp.2d at 578-81, *Jordan*, 63 F.Supp.2d at 1161-64, *see also* Defendant's Opposition at 16-23, Defendant's Reply at 6-11, Defendant's Motion at 7-17.

IV.

Conclusion

For the foregoing reasons, the Court finds that Defendant has met its burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that it is entitled to judgment as a matter of law. Also for the foregoing reasons, the Court finds that Plaintiff has not met his burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that he is entitled to judgment as a matter of law. Therefore, the Court hereby *grants* Defendant's Motion for Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment.

IT IS SO ORDERED.

DATED: March 22, 2000.

/s/ Carlos R. Moreno  
Carlos R. Moreno  
United States District Judge

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