[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 17-15162
Non-Argument Calendar

D.C. Docket No. 3:16-cv-00389-RV-EMT

TIMOTHY P. O'LEARY,

Plaintiff - Appellant,

versus

AETNA LIFE INSURANCE COMPANY,

Defendant - Appellee.

Appeal from the United States District Court
for the Northern District of Florida

(October 1, 2018)

Before JORDAN, JILL PRYOR and HULL, Circuit Judges.

PER CURIAM:

Plaintiff Timothy O'Leary filed suit pursuant to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, challenging the decision of defendant Aetna Life Insurance Company to terminate

his long-term disability benefits. The district court granted summary judgment in favor of Aetna. O'Leary, proceeding *pro se* on appeal, continues to challenge Aetna's decision terminating his benefits. In reviewing the decision from Aetna, the ERISA plan administrator, we consider whether the decision was reasonable and entitled to deference. We conclude that a reasonable basis supported Aetna's decision to terminate O'Leary's benefits and that its decision was not arbitrary and capricious. We thus affirm the district court.

I. FACTUAL BACKGROUND

In 2006, O'Leary was injured in a serious motorcycle accident. At the time of the accident, O'Leary was employed as the Director of Information Technology for the New England Regional Council of Carpenters. The New England Regional Council of Carpenters participated in the Association of Community Service Agencies' Group Insurance Trust, which had a long-term disability insurance policy with coverage underwritten by Aetna.

Under the terms of the long-term disability policy, a claimant is entitled to benefits for a period of up to 24 months if he is incapable of performing the material duties of his occupation due to disease or injury. A claimant is entitled to benefits beyond the initial 24-month period if he is incapable of working "any reasonable occupation" due to disease or injury. Doc. 19-10 at

156.[1] Under the policy, a "reasonable occupation" refers to any [sic] "any gainful activity for which [the claimant is]; or may reasonably become; fitted by: education; training; or experience," and for which the claimant earns at least a specified minimum level of income. *Id.* at 171. A disabled claimant generally remains eligible for benefits until Aetna finds that he is no longer disabled. The policy gives Aetna "discretionary authority to determine whether and to what extent employees and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this Policy." *Id.* at 196.

After the accident, O'Leary filed a claim with Aetna for long-term disability benefits. Aetna approved O'Leary's claim, finding that he was disabled because he was unable to perform the material duties of his occupation due to injury or illness. After O'Leary received 24 months of benefits, Aetna continued to pay him long-term disability benefits, meaning it found that he was incapable of working any reasonable occupation. O'Leary also applied for benefits and received benefits from the Social Security Administration, which found that he was disabled.

In 2015—approximately nine years after the motorcycle accident—Aetna decided to terminate O'Leary's benefits. Aetna informed O'Leary that the evidence in its file no longer supported a conclusion that he was entitled to benefits under the policy. Aetna explained that it had conducted surveillance on O'Leary, which

---

[1] Citations to "Doc. #" refer to numbered entries on the district court's docket.

showed that he was able to drive, tote a garbage can to his garage, and dance at a nightclub. Aetna also indicated that its decision was based on the opinion of an independent physician who had reviewed O'Leary's medical records and spoken with O'Leary's physician. Aetna acknowledged that the Social Security Administration had determined that O'Leary was disabled, but Aetna explained that its decision was based on new information that had been unavailable to the Social Security Administration when it awarded O'Leary benefits. Aetna informed O'Leary that he was entitled to appeal the decision and that he could submit additional medical evidence.

O'Leary appealed the termination of his benefits and submitted additional medical records to Aetna. After receiving the records, Aetna requested independent peer reviews from additional physicians. The physicians who performed these peer reviews opined that O'Leary's medical records showed that he was no longer functionally impaired. After considering this additional evidence, Aetna upheld the decision to terminate benefits. Aetna explained that after performing a "comprehensive review of all records in [O'Leary's] claim file," it found that there was a lack of evidence establishing O'Leary's inability to perform the duties of any reasonable occupation. Doc. 19-5 at 170. Aetna explained that the evidence it considered included the surveillance of O'Leary as well as peer review reports from the physicians who had reviewed O'Leary's medical records.

O'Leary then filed suit in federal district court challenging Aetna's decision. Aetna and O'Leary filed cross motions for summary judgment. The district court denied O'Leary's motion and granted Aetna's motion, explaining that Aetna's decision to deny benefits was "reasonable and not arbitrary and capricious." Doc. 32 at 12. This is O'Leary's appeal.

II. STANDARD OF REVIEW

"We review *de novo* a district court's ruling affirming . . . a plan administrator's ERISA benefits decision, applying the same legal standards that governed the district court's decision." *Blankenship v. Metro. Life Ins.*, 644 F.3d 1350, 1354 (11th Cir. 2011). Although ERISA itself does not provide a standard for courts reviewing the benefits decisions of plan administrators, we have established the following six-step framework for reviewing a plan administrator's decision:

> (1) Apply the *de novo* standard to determine whether the claim administrator's benefits-denial decision is "wrong" (i.e., the court disagrees with the administrator's decision); if it is not, then end the inquiry and affirm the decision.
>
> (2) If the administrator's decision in fact is "*de novo* wrong," then determine whether he was vested with discretion in reviewing claims; if not, end judicial inquiry and reverse the decision.

> (3) If the administrator's decision is "*de novo* wrong" and he was vested with discretion in reviewing claims, then determine whether "reasonable" grounds supported it (hence, review his decision under the more deferential arbitrary and capricious standard).
>
> (4) If no reasonable grounds exist, then end the inquiry and reverse the administrator's decision; if reasonable grounds do exist, then determine if he operated under a conflict of interest.
>
> (5) If there is no conflict, then end the inquiry and affirm the decision.
>
> (6) If there is a conflict, the conflict should merely be a factor for the court to take into account when determining whether an administrator's decision was arbitrary and capricious.

Id. at 1355.

III. DISCUSSION

We now apply this six-part framework to review Aetna's decision terminating O'Leary's long-term disability benefits. We affirm because, even assuming that it was *de novo* wrong, Aetna was vested with discretion to review claims and reasonable grounds support its decision.

Regarding the first step, we assume for purposes of this appeal that Aetna's decision to terminate benefits was *de novo* wrong. Moving to the second step, the

parties disagree about whether the policy vested Aetna with discretion to review claims. The policy in the record states that Aetna has "discretionary authority to determine whether and to what extent employees and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this policy." Doc. 19-10 at 196. O'Leary argues that the quoted provision comes from a policy that went into effect in 2013 and thus does not address whether the earlier group policy, which governs the claim in this case, gave Aetna discretion to review claims. After O'Leary raised this argument in his summary judgment brief in the district court, Aetna filed an affidavit acknowledging that the provision in the record comes from a 2013 policy but explaining that this language also appeared in the earlier policy that applies to O'Leary. In the district court, O'Leary failed to answer or respond to Aetna's affidavit evidence. Because O'Leary never contested the affidavit, the district court found that he had conceded that the relevant policy gave Aetna discretion in reviewing claims. O'Leary raised no argument before the district court challenging the affidavit as improper—for example, by arguing that it should not be considered because it was not part of the administrative record—so we will consider the contents of the uncontested affidavit. *See Norelus v. Denny's, Inc.*, 628 F.3d 1270, 1296 (11th Cir. 2010) (recognizing the "well-established rule against reversing a district court judgment on the basis of issues and theories that were never presented to that court" because "issues not raised in the district

court should not be considered on appeal").[2] After considering the affidavit, we conclude that the policy vested Aetna with discretion in reviewing claims.

At the third step, we conclude that reasonable grounds supported Aetna's decision to terminate O'Leary's benefits. We acknowledge that there is some evidence in the administrative record—including O'Leary's self-reported symptoms and opinions from some medical providers—that would support a conclusion that O'Leary remained disabled and entitled to benefits. But other evidence in the administrative record—including the surveillance footage of O'Leary and the opinions of the physicians who reviewed O'Leary's medical records—supports the conclusion that O'Leary's functioning was no longer impaired. Because Aetna was entitled to rely on the surveillance evidence and the assessments of O'Leary's capabilities by independent physicians who reviewed O'Leary's medical files, its decision was not arbitrary and capricious.[3] *See*

---

[2] Even if O'Leary had raised a challenge to the affidavit in the district court, he abandoned the issue by failing to raise any argument on appeal that the district court erred in considering the affidavit. *See Sapuppo v. Allstate Floridian Ins.*, 739 F.3d 678, 680 (11th Cir. 2014). Although O'Leary is proceeding *pro se* on appeal and we construe his brief liberally, "issues not briefed on appeal by a *pro se* litigant are deemed abandoned." *Timson v. Sampson*, 518 F.3d 870, 874 (11th Cir. 2008).

[3] O'Leary argues that Aetna should have given greater weight to the opinion of a consulting psychologist who determined that O'Leary had an impaired memory and would experience "marked difficulty" in returning to his prior employment. Doc. 19-8 at 156. Because O'Leary had received more than 24 months of benefits under the policy, however, he was entitled to benefits

Turner v. Delta-Care Disability & Survivorship Plan, 291 F.3d 1270, 1274 (11th Cir. 2002) (concluding that administrator's decision that claimant was no longer eligible for benefits was not arbitrary and capricious when it relied on, among other evidence, surveillance reports); *Blankenship*, 644 F.3d at 1357 (concluding that administrator did not act unreasonably in relying on file reviews from independent doctors instead of in-person, physical examinations of the claimant).

O'Leary also argues that Aetna's decision to terminate benefits was unreasonable because it was inconsistent with the determinations of the Social Security Administration and MassHealth (Massachusetts's state Medicaid administrator) that he was disabled and entitled to benefits. We certainly accept that a court "may consider the Social Security Administration's determination of disability in reviewing a plan administrator's determination of benefits." *Whatley v. CNA Ins.*, 189 F.3d 1310, 1314 n.8 (11th Cir. 1999) (internal quotation marks omitted). And this reasoning from *Whatley* further suggests that a court may consider the determination of disability by a state agency, like MassHealth, when reviewing a plan administrator's decision denying benefits. But the decisions of the Social Security Administration and a state Medicaid

---

only if he was incapable of working "any reasonable occupation." Doc. 19-10 at 156. The consulting psychologist did not address this standard because he considered only whether O'Leary would have difficulty meeting the responsibilities associated with his prior employment. In light of the limited nature of the psychologist's opinion, we conclude that it was reasonable for Aetna not to assign greater weight to this opinion.

administrator finding that the claimant was disabled are "not considered dispositive on the issue of whether a claimant satisfies the requirement for disability under an ERISA-covered plan." *Id.*

O'Leary nevertheless contends that it was unreasonable for Aetna to terminate his benefits because it failed to consider MassHealth's 2015 determination that he was disabled. We have held that it is unreasonable for a plan administrator to deny benefits when the administrative record did not contain information from the claimant's social security file because a plan administrator is not free, after sending a claimant to the Social Security Administration to seek alternative compensation, "to ignore the evidence generated by the [Social Security] process." *Melech v. Life Ins. Co. of N. Am.*, 739 F.3d 663, 675 (11th Cir. 2014). We assume for purposes of this appeal that likewise it would be unreasonable for a plan administrator to deny benefits without considering information from the claimant's file before a state agency that found he was disabled.

But even with this assumption, O'Leary's argument fails because he cannot show that Aetna refused to consider MassHealth's decision or the records that were before MassHealth. It's true that Aetna's decision upholding the denial of benefits did not mention that MassHealth found O'Leary to be disabled in 2015. But Aetna stated that it had considered "every piece of information" in his file, which included Mass Health's disability determination. Doc. 19-5 at 167. And the substance of Aetna's decision confirms that it considered the records that were before MassHealth: Aetna

discussed the findings of the psychologist who evaluated O'Leary at MassHealth's request. Given the substance of Aetna's decision on appeal, we reject O'Leary's argument that Aetna failed to consider MassHealth's determination that he was disabled or the records that MassHealth reviewed in making its disability determination.

At the fourth step of our framework, we conclude that Aetna operated under a conflict of interest at the time that it terminated O'Leary's benefits because it both made eligibility decisions and paid awarded benefits out of its own funds. *See Blankenship*, 644 F.3d at 1355. Because there was a conflict of interest, the fifth step of the framework is inapplicable.

Turning to step six, we must take Aetna's conflict of interest into account to determine whether Aetna's decision to terminate benefits was arbitrary and capricious. We have explained that even when a plan administrator has a conflict of interest, "courts still owe deference to the plan administrator's discretionary decision-making as a whole." *Id.* (internal quotation marks omitted). Put differently, a structural conflict of interest is only "a factor" in our review, and our "basic analysis still centers on assessing whether a reasonable basis existed for the administrator's benefits decision." *Id.* (internal quotation marks omitted). Even considering Aetna's conflict as a factor, we cannot say that its decision to deny benefits was unreasonable or arbitrary and capricious given the surveillance video and the physician's assessments contained in the administrative record.

IV. CONCLUSION

For the foregoing reasons, we affirm the district court's judgment.

AFFIRMED.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

TIMOTHY P. O'LEARY

VS CASE NO. 3:16cv389-RV/EMT

AETNA LIFE INSURANCE COMPANY

JUDGMENT

(Filed Oct. 20, 2017)

Pursuant to and at the direction of the Court, it is

ORDERED that the Defendant's, AETNA LIFE INSURANCE COMPANY, Motion for Summary Judgment is GRANTED and Plaintiff's, TIMOTHY P. O'LEARY, Motion for Summary judgment is DENIED. Judgment is entered in favor of the Defendant and against the Plaintiff, together with taxable costs.

JESSICA J. LYUBLANOVITS
CLERK OF COURT

October 20, 2017
DATE

/s/ Sylvia Williams
Deputy Clerk: Sylvia Williams

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA PENSACOLA DIVISION

TIMOTHY P. O'LEARY,
Plaintiff,

v.

AETNA LIFE INSURANCE COMPANY,
Defendant.
/

Case No.:
3:16cv389-RV/EMT

ORDER

(Filed Oct. 19, 2017)

Timothy P. O'Leary was involved in a motorcycle accident in 2006, after which he received long term disability (LTD) and waiver of premium (WOP) life insurance benefits pursuant to an employer welfare benefit plan. Several years later, in 2015, the administrator of the plan, Aetna Life Insurance Company, terminated those benefits, and this ERISA action followed. Discovery is closed, and the parties have filed cross motions for summary judgment (docs. 19, 21).

I. Applicable Law

A. Summary Judgment Standard

Summary judgment is appropriate if all the pleadings, discovery, affidavits, and disclosure materials on file show that there is no genuine disputed issue of material fact, and the movant is entitled to judgment as

[sic] matter of law. *See* Fed. R. Civ. P. 56(a) and (c). The plain language of Rule 56 mandates the entry of summary judgment, after adequate time for discovery and upon motion, against any party who fails to make a showing sufficient to prove the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. *Celotex Corp. v. Catrett,* 477 U.S. 317, 322, 106 S. Ct. 2548 (1986).

Summary judgment is inappropriate "[i]f a reasonable factfinder evaluating the evidence could draw more than one inference from the facts, and if that inference introduces a genuine issue of material fact[.]" *Allen v. Board of Public Educ. for Bibb County*, 495 F.3d 1306, 1315 (11th Cir. 2007). An issue of fact is "material" if it might affect the outcome of the case under the governing law. *Anderson v. Liberty Lobby Inc.*, 477 U.S. 242, 248, 106 S. Ct. 2505 (1986). It is "genuine" if the record, viewed as a whole, could lead a reasonable factfinder to return a verdict for the non-movant. *Id.* In considering a motion for summary judgment, the nonmovant's evidence is to be believed and all reasonable inferences drawn in its favor. *See Trucks Inc. v. United States*, 234 F.3d 1340, 1342 (11th Cir. 2000) (citing *Anderson, supra*).

B. ERISA

In the Eleventh Circuit, judicial review of a challenged benefits decision under ERISA is "limited to consideration of the material available to the administrator at the time it made its decision." *Blankenship v.*

Metropolitan Life Ins. Co., 644 F.3d 1350, 1354 (11th Cir. 2011). Based on the administrative record, the court must perform the following multi-step analysis:

> (1) Apply the *de novo* standard to determine whether the claim administrator's benefits-denial decision is "wrong" (i.e., the court disagrees with the administrator's decision); if it is not, then end the inquiry and affirm the decision.
>
> (2) If the administrator's decision is in fact "*de novo* wrong," then determine whether he was vested with discretion in reviewing claims; if not, end judicial inquiry and reverse the decision.
>
> (3) If the administrator's decision is "*de novo* wrong" and he was vested with discretion in reviewing claims, then determine whether "reasonable" grounds supported it (hence, review his decision under the more deferential arbitrary and capricious standard).
>
> (4) If no reasonable grounds exist, then end the inquiry and reverse the administrator's decision; if reasonable grounds do exist, then determine if he operated under a conflict of interest.
>
> (5) If there is no conflict, then end the inquiry and affirm the decision.
>
> (6) If there is a conflict, the conflict should merely be a factor for the court to take into account when determining whether an administrator's decision was arbitrary and capricious.

Id. at 1355 (citation omitted).

In the court's initial *de novo* review, the plaintiff "bears the burden to prove that [he] is disabled." *Glazer v. Reliance Standard Life Ins. Co.*, 524 F.3d 1241, 1247 (11th Cir. 2008). If the plaintiff does not carry his burden of proving a disability, then the administrator's decision was not "wrong," and the court ends its inquiry and enters summary judgment for the administrator. *See id.* at 1246-47. If the court reaches the "arbitrary and capricious" stage of review, the plaintiff bears the burden of showing that the administrator's decision was arbitrary and capricious. *Capone v. Aetna Life Ins. Co.*, 592 F.3d 1189, 1195-96 (11th Cir. 2010). Pursuant to that standard, the court will affirm if the administrator's decision is *reasonable* given the available evidence, even though the court might have made a different decision if it had been the original decision-maker. *See Griffis v. Delta Family–Care Disability*, 723 F.2d 822, 825 (11th Cir. 1984) (court in ERISA case "limited to determining whether [the administrator's decision] was made rationally and in good faith—not whether it was right"); *accord, e.g.*, *Carr v. Gates Health Care Plan*, 195 F.3d 292, 294 (7th Cir. 1999) ("Under the arbitrary and capricious standard, it is not [the court's] function to decide whether [it] would reach the same conclusion as the Plan or even rely on the same authority.").

A conflict of interest will exist where—as here—the ERISA plan administrator makes eligibility decisions and pays benefits out of its own funds. *Blankenship*, 644 F.3d at 1355. When such a conflict exists, reviewing courts still owe deference to the administrator's

discretionary decision-making. *Id.* The conflict should "merely be a factor" for the court to consider in determining if the benefits decision was arbitrary and capricious. *Id.* The presence of a conflict of interest—which the Eleventh Circuit has noted is "an unremarkable fact in today's marketplace"—provides no license, by itself, for a court to enforce its own preferred *de novo* ruling about a benefits decision. *Id.* at 1356. As indicated, the court's analysis ultimately centers on assessing whether a "reasonable basis" existed for the benefits decision. *Id.* at 1355. *"If the 'evidence is close,' then the administrator did not abuse its discretion, and the requisite deference compels the affirmance of the administrator's decision." Murray v. Hartford Life and Acc. Ins. Co.*, 623 F. Supp.2d 1341, 1352 (M.D. Fla. 2009), *aff'd*, 363 Fed. Appx. 710 (11th Cir. 2010) (citation omitted).

II. Background

The following facts are taken primarily from Aetna's statement of facts (which, in turn, are derived from the administrative record). These facts are undisputed.[1]

---

[1] Although the plaintiff does not dispute these facts, he does include additional facts in support of his motion for summary judgment. However, those additional facts are largely irrelevant and have no bearing on the outcome of this litigation. For example, the plaintiff spends a considerable amount of time detailing his physical condition and the treatment that he received after the motorcycle crash in 2006 (doc. 21-1 at 3-10, 17-18). However, resolution of this case does not turn on his condition and treatment

In 2006, the plaintiff was employed as Director of Information Technology for New England Carpenters Benefit Fund (NECBF). His job was classified as sedentary. NECBF sponsored an employee welfare benefit plan (the Plan) for eligible employees (including plaintiff), and it provided both LTD benefits and life insurance coverage. The Plan was funded by a group insurance policy issued by Aetna (the Policy). The Policy provided Aetna with discretionary authority to determine whether and to what extent eligible employees and beneficiaries are entitled to benefits, and to construe any disputed or doubtful terms of the Policy.[2]

Under the Policy, LTD benefits are payable for up to 24 months to a claimant who is prevented by illness or injury from performing the duties of his occupation.

---

after the crash but, rather, whether he was disabled when his benefits were terminated years later, in 2015. *See, e.g.*, *Howard v. Hartford Life and Acc. Ins. Co.*, 929 F. Supp. 2d 1264, 1287 (M.D. Fla. 2013), *aff'd*, 563 Fed. Appx. 658 (11th Cir. 2014) ("where LTD benefits are once approved, and subsequently terminated, a claimant retains the burden of proving continued disability after benefits are discontinued"); *Moeller v. Guardian Lift Ins. Co.*, 2011 WL 7981954, *9 (M.D. Fla. 2011) (recognizing that the outcome-determinative question before the court was "whether [the plaintiff] was disabled as of the date [the administrator] terminated benefits").

[2] In his summary judgment motion, the plaintiff argued that Aetna had discretionary authority for life insurance claims but *not* LTD claims. Aetna responded with an affidavit and reference to the Policy, establishing that it had discretionary authority to decide both claims. The plaintiff did not answer or respond to this evidence in his subsequent reply to Aetna's response, thereby impliedly conceding the point.

For continued LTD benefits to be payable thereafter, the claimant must be incapable of working in *any* reasonable occupation, with "reasonable occupation" defined as any gainful activity for which the claimant is or may become fitted by education, training, or experience, and which provides a specified minimum level of income. The Policy additionally states that if LTD benefits are commenced, they will terminate on the day the claimant ceases to be disabled or fails to furnish proof of a continuing disability. The life insurance coverage includes a WOP benefit for participating employees who are totally disabled, i.e., unable to work in any job.

On July 12, 2006, the plaintiff was involved in a motorcycle crash, after which he claimed disability effective on July 13, 2006, due to postconcussion syndrome and chronic lower-back pain. He was awarded federal disability benefits from the Social Security Administration (SSA) on January 9, 2007, and his LTD claim was approved on February 6, 2007, based upon Aetna's determination that he was "totally disabled from [his] own occupation." On August 8, 2007, the plaintiff was approved for the life insurance WOP benefit. He was subsequently approved for continuing LTD benefits pursuant to the "any reasonable occupation" test, as his treating physicians continued to describe his post-concussion symptoms (headaches, dizziness, nausea, confusion, and difficulty with concentration and memory), as well as chronic back pain.

On April 3, 2014, the plaintiff was examined by treating orthopedic physician, Dr. Steven Sewall,

regarding his back pain complaints. Dr. Sewall opined that "from a musculoskeletal viewpoint his limiting factor would be his thoracic area where he has some residual stiffness and soreness. In view of this he would be unable to do work that required lifting greater than 50 pounds on a regular basis, or activities that would require prolonged sitting, standing or walking." On April 9, 2014, plaintiff's primary care physician, Dr. Charles Rosenbaum, completed an Attending Physician's Statement advising that plaintiff was not able to work due to symptoms of back pain, vertigo, headaches, and nausea. That same day, plaintiff responded to a questionnaire from Aetna seeking updated information about his physical condition and activities. Asked what condition(s) prevented him from working, he replied: "Severe Back Pain & Vertigo." The plaintiff stated that his activities were limited to "TV & Radio." In an Attending Physician's Statement dated June 5, 2014, treating neurologist Dr. Paulo Andre stated that the plaintiff was unable to work due to "excruciating symptoms" of chronic back pain, headaches, nausea, vertigo, and visual disturbance. In a treatment note dated June 27, 2014, Dr. Andre referenced plaintiff's complaints of chronic pain, weakness, and "constant dizziness." The plaintiff told Dr. Andre that he feels "like an 85-year-old man" when he wakes up in the morning and that he "cannot even shop by himself. His fiancé shops for him." On October 8, 2014, he advised Dr. Rosenbaum he was unable to put on his shoes. In a telephonic interview with Aetna on December 3, 2014, the plaintiff stated that he rarely left home, spent most

of his time lying down and watching TV or listening to the radio, and was unable to fold laundry.

Very shortly thereafter, in early 2015, Aetna commissioned a social media and surveillance investigation of the plaintiff. The investigation revealed him to be a loyal fan of a music group called "Dirty Deeds," a tribute band devoted to the music of the hard rock band AC/DC. It was learned that he had attended at least four Dirty Deeds concerts on or about August 8, 2014, October 31, 2014, December 6, 2014, and January 17, 2015. The investigation was documented through photographs posted on the internet, showing the plaintiff partying with friends at the concerts. On March 7, 2015, the investigator took video surveillance of him and a woman presumed to be his fiancé attending a Dirty Deeds concert at a nightclub called "Speakers."[3] Showing no visible sign of any discomfort or unsteadiness, the plaintiff spent 2.5 hours in the club, moving about freely, drinking alcohol, dancing, and singing with the band.[4]

---

[3] The plaintiff was apparently a long-time patron of Speakers as he gave the club a favorable on-line review in August 2007—more than a year *after* claiming disability—in which he stated: "I always enjoy myself when I go."

[4] The video surveillance has been filed with the court, and I have reviewed the footage in full. The plaintiff maintains that although Aetna "makes a very big deal [about] the surveillance video," I should not consider it because it is unauthenticated hearsay and "[t]he Federal Rules of Evidence do not go out the window just because this is an ERISA case." The plaintiff is incorrect. *See, e.g., Herman v. Hartford Life and Acc. Ins. Co.*, 508 Fed. Appx. 923, 928 (11th Cir. 2013) ("Herman's hearsay argument is misplaced, as the district court's review was limited only by what was

An independent peer review was conducted—at Aetna's request—by board certified occupational medicine physician Joseph Rea, M.D., who reviewed relevant records and the surveillance material and furnished a report to Aetna dated April 29, 2015. As part of his review, Dr. Rea conferred telephonically with treating physician Rosenbaum, who had reviewed the surveillance video (forwarded to him by Aetna) and said that he found it "amusing." Stating that he had last seen plaintiff in February 2015, Dr. Rosenbaum commented that he had placed "no specific limitations" on his activities. Noting the "vast discrepancies" between the plaintiffs "observed activities" and his subjective reporting (and the reports of his treating

---

available to the plan administrator, not by the Federal Rules of Evidence.") (citing and quoting *Black v. Long Term Disability Insurance*, 582 F.3d 738, 746 n.3 (7th Cir. 2009) ("The Federal Rules of Evidence . . . do not apply to an ERISA administrator's benefits determination, and we review the entire administrative record, including hearsay evidence relied upon by the administrator.")); *see also Berg v. BCS Fin. Corp.*, 2006 WL 273541, at *15 n.12 (N.D. Ill. 2006) (rejecting argument that court in ERISA case "cannot consider these documents on summary judgment because they are hearsay and not properly authenticated"). To the extent the plaintiff further contends that the surveillance footage is inadmissible because "Defendant has not laid a sufficient foundation that the individual depicted in the video is in fact Plaintiff"—even though it was produced to him months ago and he coyly does not deny that it *is* him—that argument is patently without merit. *See, e.g., Crouch v. Aetna Life Ins. Co.*, 2005 WL 1828663, at *3 (N.D. Tex. 2005) (rejecting plaintiff's argument that surveillance video was "inherently unreliable" and noting that "Plaintiff himself had the opportunity to review the videotape and if in fact the subject appearing in the exhibit was not him to have stated the same," and therefore his assertion of unreliability was "patently lacking in merit").

providers), Dr. Rea found "no evidence of a functional impairment."

On April 30, 2015, Dr. Rea's report was faxed to treating physician Rosenbaum with a request that he advise if he disagreed with Dr. Rea's findings. No response was received from Dr. Rosenbaum. In correspondence dated May 11, 2015, Aetna notified plaintiff of its decision to terminate LTD benefits based on the surveillance evidence and Dr. Rea's report. Acknowledging plaintiff's receipt of federal disability benefits from the SSA beginning in January 2007, Aetna explained that its decision was based on "new information" that had been unavailable to the SSA when the agency made its determination pursuant to applicable federal regulations.

In correspondence dated May 18, 2015, treating physician Rosenbaum advised Aetna that "[m]y capacity to evaluate [plaintiff's] condition is limited. He ambulates and converses normally. He has findings consistent with Degenerative Joint Disease in his hips and shoulders. He converses normally, but claims to fatigue after five minutes of focused activity." In correspondence dated June 4, 2015, Aetna notified the plaintiff of its decision to discontinue the WOP benefit on the ground that he was able to return to work "in some capacity." The decision was based primarily on Dr. Rea's independent peer review and Dr. Rosenbaum's failure to disagree with it after being afforded the opportunity to do so. The plaintiff was advised of his right to appeal the decision and his right to bring civil litigation under ERISA if the decision was upheld

on appeal. The plaintiff retained counsel and, in correspondence dated November 5, 2015, he appealed the benefits termination decision. Challenging Aetna' s decision, the plaintiff claimed to be disabled by chronic back pain and post-concussion syndrome. Submitted with the LTD appeal was a letter dated July 21, 2015 from Dr. Rosenbaum, stating in its entirety:

> Timothy O'Leary has requested that I send a letter in addition to the clinical records previously submitted supporting his appeal of [the] denial of his disability benefits. Mr. O'Leary suffers from Post Traumatic Encephalopathy with persistent difficulty focusing on reading and other tasks, and from Thoracic Spondylosis with chronic neck, chest wall, and back pain. If I can be of further assistance, please call.

The plaintiff also submitted a letter, dated October 22, 2015, from his treating neurologist, Dr. Andre, who recounted plaintiff's medical history and opined that he had remained permanently disabled since reaching maximum medical improvement in 2007. The disabling symptoms were said to be dizziness, difficulty concentrating, and chronic diffuse musculoskeletal pain. Dr. Andre further stated that the activities seen in the surveillance footage were within the limitations of the plaintiff's disability. Dr. Andre's letter was accompanied by a letter from Dr. Rosenbaum, dated November 4, 2015, in which Dr. Rosenbaum advised that he agreed with the opinions expressed in Dr. Andre's October 22nd correspondence. The plaintiff also sent a treatment note, dated September 17, 2015, from his

treating orthopedist, Dr. Sewall, who opined after examining him that he would be capable of alternating sitting/standing and walking "for about 4 hours at a time and should be allowed to recline for up to 60 minutes."

At Aetna's request on appeal, independent peer reviews were conducted by board certified occupational medicine physician Melissa Cheng, M.D., and consulting neuropsychologist Gitry Heydebrand, Ph.D., both of whom furnished a report dated February 9, 2016. After reviewing the medical records and attempting unsuccessfully to confer with Dr. Rosenbaum over the phone, Dr. Cheng concluded that

> The physical examination on 09/17/2015 revealed some mild loss of motion of his neck in extension and rotation, but the reflexes, sensation, strength and range of motion of the upper extremities was normal. [The plaintiff] exhibited good motion of his lumbar spine. The reflexes, sensation, strength and range of motion of the upper and lower extremities was intact. . . . The surveillance reports provided indicated that the claimant's reported functional disability was not consistent with the observation of his activity. There was no clinical physical evidence to support any functional impairment from 05/12/2015 to present for [the plaintiff].

Dr. Cheng further advised there was no evidence of impairing side effects from the plaintiff's pain medications. Noting that long-term effects from post-concussion syndrome (such as would still be present

ten (10) years after the concussion-causing accident) are "fairly rare" and "require thorough documentation to be convincing," reviewing neuropsychologist Heydebrand reported there was no clinical evidence or test findings to "support a conclusion of neuropsychological dysfunction" of sufficient severity to cause functional impairment.

By letter dated February 23, 2016, Aetna notified the plaintiff, through counsel, of its decision to uphold on appeal the termination of LTD benefits effective May 12, 2015, based on the video surveillance, the peer review reports, and the lack of medical evidence establishing his inability to perform the duties of any reasonable occupation. This lawsuit followed.

The plaintiff alleges in the operative complaint that Aetna breached the Plan by terminating his LTD benefits (count 1) and his WOP benefits (count 2). Aetna moves for summary judgment. It argues that the benefits decisions were not wrong; but, even if they were, it had a reasonable basis for those decisions and, therefore, they were not arbitrary and capricious. The plaintiff argues the opposite in his cross motion.

III. Discussion

This is not a close case and does not require extended discussion. Indeed, I am inclined to hold at the

first step in analysis that the benefits decisions were not wrong.[5]

---

[5] The plaintiff's arguments to the contrary are not persuasive. For example, the plaintiff points to the SSA's federal disability benefits determination—which was made in 2007, the year after the crash and several years before the surveillance footage was taken—as evidence that Aetna's benefits decisions were wrong. However, as one district court has recently noted:

> [T]he "approval of disability benefits by the SSA is not considered dispositive on the issue of whether a claimant satisfies the requirement for disability under an ERISA-covered plan." *Oliver v. Aetna Life Ins. Co.*, 613 Fed. Appx. 892, 897 (11th Cir. 2015); *see also Vivas v. Hartford Life and Acc. Ins. Co.*, 49 F. Supp.3d 1124, 1137 (S.D. Fla. 2014) (recognizing that SSA and ERISA disability standards are "different in critical ways," and ruling that "this Court cannot find [administrator's] decision to terminate [plaintiff's] LTD benefits unreasonable based on the SSA's favorable finding of disability under its requirements") (emphasis in original); *Richards v. Hartford Life and Acc. Ins. Co.*, 356 F. Supp. 2d 1278, 1289 (S.D. Fla. 2004), *aff'd*, 153 Fed. Appx. 694 (11th Cir. 2005) (noting that SSA's disability determinations are generally "not persuasive in ERISA benefits cases."). This is so because the "legal principles controlling the Social Security [disability] analysis are different from those governing the ERISA analysis." *Herman v. Met. Life Ins. Co.*, 689 F. Supp. 2d 1316, 1326 (M.D. Fla. 2010). Moreover, when an ERISA claim administrator has "different information" from what was available to the SSA, this commonplace circumstance is one of the "many reasons not to consider a decision by the social security administration" for ERISA purposes. *Fife v. Coop. Ben. Admin., Inc.*, 2014 WL 4470718, *23 (N.D. Ala. Sept. 10, 2014); *Sobh v. Hartford Life and Acc. Ins. Co.*, No. 8:15-cv-716, 2015 WL 7444336, *8-9 (M.D. Fla. Nov. 5, 2015), *aff'd*, 658 Fed.

But I need not rule on that issue. Assuming *arguendo* that the benefits decisions were *de novo* wrong, the evidence before the administrator was, at best, close. To be sure, despite his subjective complaints of pain and the alleged limitations that rendered him a virtual invalid (i.e., he felt like an 85 year old man who spent most of his days laying down and watching TV and listening to the radio because he was "constantly dizzy;" could not shop by himself; could not put on his shoes; and could not fold his laundry), the social media and surveillance investigation of his activities in late 2014-early 2015 indicated something else entirely. It was not unreasonable for Aetna to discount his self-reported symptoms—and the opinions of his treaters who relied, in large part, on those self-reported symptoms in rendering their opinions—but instead to rely on the surveillance video footage and the reviewing physicians who found that evidence of significant functional impairment was lacking.

In short, the challenged benefits decisions were probably not wrong, but they were most certainly not "arbitrary and capricious." *See, e.g.*, *Howard v. Hartford Life and Acc. Ins. Co.*, 563 Fed. Appx. 658, 663 (11th Cir. 2014) (administrator's decision not arbitrary

---

Appx. 459 (11th Cir. 2016) (entering summary judgment for ERISA administrator despite its "failure to give significant weight to the decision of the Social Security Administration," because ERISA administrator's determination was based on "new evidence" not submitted to SSA).

Ness v. Aetna Life Ins. Co., ___ F. Supp. 3d ___, 2017 WL 2800521, at *10 (S.D. Fla. 2017).

and capricious where the plaintiff's "credibility was seriously called into question by the surveillance video which shows her engaging in activities grossly inconsistent with her description of her abilities, and in stark contrast to her own treating physicians' assessments, which were based on [her] subjective complaints").[6] Therefore, as a matter of law, Aetna's decision and action with respect to the plaintiff in this case was reasonable and not arbitrary and capricious.

IV. Conclusion

For the foregoing reasons, the defendant's motion for summary judgment (doc. 19) is hereby GRANTED. The plaintiff's motion for summary judgment (doc. 21) is DENIED. The clerk is directed to enter judgment in favor Aetna, together with taxable costs, and close this case.

---

[6] The plaintiff has cited several cases out of the Sixth Circuit purporting to stand for the view that relying on opinions of reviewing physicians rather than conducting a live in-person examination of the claimant may be arbitrary and capricious. However, that is not the law of this circuit. *See, e.g., Howard v. Hartford Life and Acc. Ins. Co.*, 563 Fed. Appx. 658, 663-64 (11th Cir. 2014) (stating that, in the Eleventh Circuit, "an administrator's 'use of 'file' reviews by independent doctors—instead of live, physical examinations' is not arbitrary and capricious, 'particularly in the absence of other troubling evidence' ") (quoting *Blankenship*, *supra*, 644 F.3d at 1357).

DONE and ORDERED this 19th day of October 2017.

/s/ Roger Vinson
ROGER VINSON
Senior United States
District Judge

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 17-15162-JJ

TIMOTHY P. O'LEARY,

Plaintiff - Appellant,

versus

AETNA LIFE INSURANCE COMPANY,

Defendant - Appellee.

Appeal from the United States District Court
for the Northern District of Florida

ON PETITION(S) FOR REHEARING AND
PETITION(S) FOR REHEARING EN BANC

(Filed Oct. 31, 2018)

BEFORE: JORDAN, JILL PRYOR and HULL, Circuit Judges

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc

(Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Jill Pryor
UNITED STATES
CIRCUIT JUDGE