APPENDIX TABLE OF CONTENTS

APPENDIX TABLE OF CONTENTS – Continued

NOT RECOMMENDED FOR PUBLICATION
File Name: 23a0338n.06

Case No. 22-1960

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JACQUELINE AVERY, Plaintiff - Appellant, v. SEDGWICK CLAIMS MANAGEMENT SERVICES, INC. and FCA US LLC LONG-TERM DISABILITY BENEFIT PLAN, Defendants - Appellees.	)	ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN OPINION (Filed Jul. 24, 2023)

Before: McKEAGUE, GRIFFIN, and MURPHY, Circuit Judges.

McKEAGUE, Circuit Judge. For roughly two years, Jacqueline Avery received long-term disability benefits from her former employer, Chrysler Group LLC (Chrysler), through its FCA US LLC Long Term Disability Benefit Plan (the Plan). The Plan's third-party claims administrator, Sedgwick Claims Management Services, Inc. (Sedgwick), later terminated those benefits after concluding that Avery no longer qualified as "totally disabled" within the meaning of the Plan. Avery brought this action under 29 U.S.C. § 1332(a)(1)(B)

of the Employee Retirement Income Security Act of 1974 (ERISA) to recover and reinstate her long-term disability benefits. The district court granted judgment on the administrative record in favor of Sedgwick and the Plan, and Avery now appeals. For the following reasons, we affirm.

I

A. Factual Background

In 2006, Jacqueline Avery was on a camping trip when she fell and fractured her right ankle. She largely recovered, but severe pain in her right leg spontaneously returned in 2011. At the time, Avery worked for Chrysler as a finance specialist, and the persistent pain began to impede her ability to work. In July 2011, Avery was diagnosed with "advance peripheral deyelinatibe and axonal polyneuropathy [of the] lower legs," and her last date worked was July 15, 2011. A.R. 195.

Avery initially applied for and received short-term disability benefits under Chrysler's Disability Absence Plan. But when her eligibility for short-term benefits expired, Avery converted her claim into one for long-term benefits. To be eligible for long-term disability benefits, the Plan states in ungrammatical fashion that a participant must "be 'totally disabled' because of disease or injury so as during the first 24 months of disability to be unable to perform the duties of the Participant's occupation, and after the first 24 months of

disability be unable to engage in regular employment or occupation with the Corporation." A.R. 1206.

Due to the nature of Avery's condition, Sedgwick referred Avery's claim to two board-certified neurologists, Dr. Hermann Banks, M.D., and Dr. David Gaston, M.D., for independent medical examinations. Dr. Banks opined that Avery suffered from "[r]ight lower extremity pain with paresthesia and dysesthesia" and recommended that Avery not return to work. A.R. 793. Dr. Gaston similarly identified "exquisite pain on motion of the right distal leg and foot," and diagnosed Avery with Complex Regional Pain Syndrome Type II. Relying on the results of these medical examinations, among other medical records, Sedgwick approved Avery for long-term disability benefits effective August 10, 2012, on the basis of "totally disabling condition(s) of Right Lower Extremity Neuropathy & reflex sympathetic dystrophy lower extremity." A.R. 1055.

Pursuant to the terms of the Plan, Sedgwick also required Avery to apply for Social Security Disability Insurance (SSDI) benefits. The Social Security Administration (SSA) awarded Avery monthly SSDI benefits in the amount of $2,024, retroactive to January 2012. Sedgwick then requested and received reimbursement for overpayment in the amount of $15,069.42.

Throughout 2013 and early 2014, Avery continuously furnished medical records from her treating physicians to substantiate her disability, and Sedgwick repeatedly approved Avery's long-term disability benefits under the Plan. But in June 2014, Chrysler's

Special Investigations Unit surveilled Avery and purportedly observed her driving—something she is medically restricted from doing. Chrysler also suspected that Avery was running a business out of her home. This prompted Chrysler to request an additional independent medical examination. Sedgwick scheduled the requested medical exam with Dr. Joel Shavell, D.O., who is board certified in internal medicine and rheumatology; he examined her on July 15, 2014. Dr. Shavell observed that Avery "walked in quickly with a normal gait and had no problems getting undressed, and no problems getting in and out of the room; no problems moving, and no problems functionally." A.R. 977. Based on these observations, Dr. Shavell concluded:

> At this time, I do not see any evidence of a regional complex pain issue, and normally with these pain syndromes, they are so severe and difficult that patients hardly recover fully. They have some residual, such as walking with a limp, or inability to move a leg, as well as sensitivity to touch. These would be some of the findings that would be common and Ms. Avery exhibits none of them. . . .
>
> Based on the fact that I do not find a regional complex pain issue, and because she does not have a venous issue, and based on the fact that when I examined her ankle she [can] bear weight on the ankle, on her heels and toes despite her weight, I do not find any physical evidence to substantiate at this point any disability whatsoever. It is my opinion that

> she can return to full duty work, as of today's date.

A.R. 978-79.

After receiving the results of the independent medical examination, Sedgwick notified Avery via letter dated July 21, 2014, that she had been found able to work, and requested that she report to her plant medical department for further evaluation. Sedgwick indicated that Avery's benefits "may be suspended effective July 21, 2014, pending the outcome of the ability to work examination." A.R. 974. On July 22, 2014, Avery reported to Chrysler's medical department where the plant medical doctor determined that Avery was able to return to work.

During the evaluation, a plant medical nurse provided Avery with a copy of Dr. Shavell's narrative report. Believing the report to be filled with "bold face lies," Avery called Sedgwick to complain. A.R. 944. A Sedgwick representative instructed Avery to formalize her complaints in writing, which she did a few days later. On July 28, 2014, Avery sent a letter to Sedgwick "to appeal [her] recent return to work decision" and "to challenge several statements" made by Dr. Shavell. A.R. 964-66. On August 4, 2014, Sedgwick acknowledged receipt of Avery's "request for appeal" and indicated that her claim would be reviewed by Sedgwick's Appeals Unit. A.R. 957. On August 8, 2014, Sedgwick called Avery to ask whether she intended to provide any additional information or documentation. Avery responded that she did not. A.R. 949.

Internal documents indicate that Sedgwick's July 21, 2014, letter was neither a formal nor final denial letter, as it did not "outlin[e] the reason for denial or [detail] appeal rights. The letter only request[ed] that the claimant RTW [return to work]." A.R. 458. Rather, Sedgwick did not issue its formal benefits determination until roughly one month later, via letter dated August 20, 2014, wherein Sedgwick set forth the Plan's eligibility criteria, articulated the reasons for its benefits denial, and outlined the appeals procedures. Nonetheless, Sedgwick continued to treat Avery's July 28, 2014, letter as an appeal and reviewed Avery's claim in the ordinary course.

As part of this review process, Sedgwick referred Avery's claim for an independent record review (IRR) with Dr. David Hoenig, M.D., a specialist in neurology and pain medicine. Dr. Hoenig reviewed Avery's medical records and concluded that "[b]ased on the documentation provided, and from a neurological perspective only, [Avery] is not disabled from performing any work as of 07/22/14." A.R. 663.

By letter dated September 12, 2014, Sedgwick formally denied Avery's appeal. The letter indicated that the decision was "the Claim Administrator's final decision," and that Avery had "the right to bring a civil action under ERISA" and was "entitled to receive[ ], upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to [her] claim for benefits." A.R. 659.

Avery did not respond until more than eight months later, when her attorney sent a letter to Sedgwick on May 18, 2015, demanding that "Ms. Avery's benefits be immediately reinstated with retroactive pay forthwith." A.R. 654. Attached to this demand was a letter from Dr. Brengel, Avery's primary care doctor who specializes in family medicine, wherein Dr. Brengel disputed Dr. Shavell's findings and attempted to bolster Avery's claimed disability. Specifically, Dr. Brengel referenced "an EMG performed by K. Fram, M.D., in December of 2014," and indicated that "Dr. Fram believes that Ms. Avery has reflex sympathetic dystrophy in her right lower extremity by history, chronic S1 radiculopathy bilaterally, severe peripheral polyneuropathy, and bilateral tarsal tunnel syndrome." A.R. 655. On this basis, Dr. Brengel concluded that Plaintiff "remain[ed] disabled due to the difficulties with her right leg." *Id.*

Despite having no obligation to do so, Sedgwick responded to the letter by initiating a "re-review" of Avery's claim. A.R. 651. As part of this voluntary re-review, Sedgwick offered Avery an opportunity to submit additional medical information and documentation before July 28, 2015, but Avery never submitted additional records.[1] Sedgwick also referred Avery's claim to Dr. Mark N. Friedman, D.O, a board-certified neurologist and specialist in internal medicine, for another IRR. Dr. Friedman reviewed Avery's medical records and concluded that Avery "is not disabled from

[1] Avery claims she never received this letter. *See* Appellant's Br. at 21.

performing any work as of 07/22/14." A.R. 601. Relying on Dr. Friedman's report, Sedgwick upheld its decision to terminate Avery's long-term disability benefits. By letter dated September 30, 2015, Sedgwick informed Avery that she no longer satisfied the Plan's eligibility requirements. The letter also outlined her appeal rights. Avery did not appeal that decision.

B. Procedural Posture

Avery filed suit in the Eastern District of Michigan pursuant to Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), to recover long-term disability benefits allegedly owed to her under the terms of the Plan. The complaint appears premised on Sedgwick's September 12, 2014, denial, which Avery refers to as "the final decision on Ms. Avery's claim." R. 1, PID 11. It does not reference Sedgwick's voluntary re-review or the decision issued on September 30, 2015.

She also filed a "Statement of Procedural Challenge," alleging various procedural errors committed by Sedgwick and requesting that the court schedule a status conference to address discovery. Defendants filed a "Motion to Strike Statement of Procedural Challenge," which the district court construed as a motion to review and reject Avery's Statement. The district court rejected Avery's Statement, finding that no valid procedural challenge was presented justifying further discovery.

Thereafter, the parties filed competing motions for judgment on the administrative record. The district

court denied Avery's motion and granted judgment on the administrative record in favor of Sedgwick and the Plan. This appeal followed.

II

"We review *de novo* the decision of a district court granting judgment in an ERISA disability action based on an administrative record." *DeLisle v. Sun Life Assurance Co. of Can.*, 558 F.3d 440, 444 (6th Cir. 2009) (internal quotation marks omitted). And when the insurance plan administrator is vested with discretion to interpret the plan, we review the administrator's decision to deny benefits under the arbitrary and capricious standard. *Helfman v. GE Grp. Life Assurance Co.*, 573 F.3d 383, 392 (6th Cir. 2009). Here, neither party disputes that the Plan gives Sedgwick this discretion. We therefore review Sedgwick's decision to terminate Avery's long-term disability benefits under the arbitrary and capricious standard. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).[2] Finally,

---

[2] Relying on the Second Circuit's opinion in *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016), Avery argues that the de novo standard of review should apply to our review of the administrator's decision to terminate benefits *because* Sedgwick allegedly failed to comply with the claims procedure regulation. Appellant's Br. at 25. In *Halo*, the Second Circuit held that "a plan's failure to comply with the Department of Labor's claims-procedure regulation, 29 C.F.R. § 2560.503-1, will result in that claim being reviewed *de novo* in federal court, unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the regulation in the processing of a particular claim was inadvertent *and*

we review de novo "the question of whether the procedure employed by the fiduciary in denying the claim meets the requirements of Section 1133." *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 806 (6th Cir. 1996).

A. Sedgwick Satisfied ERISA Procedural Requirements

On appeal, Avery raises a series of procedural objections, broadly arguing that Sedgwick violated ERISA claims procedures, and that in so doing, Sedgwick denied her claim a full and fair review. Specifically, Avery alleges the following: (1) Sedgwick's initial denial letter failed to comply with ERISA requirements, (2) Sedgwick did not afford Avery a reasonable opportunity to appeal, (3) Sedgwick did not provide Avery with an opportunity to supplement the administrative record, (4) Dr. Shavell lacked the required training and experience, and (5) Sedgwick omitted relevant documents from the administrative record. Addressing each procedural objection in turn, we conclude that Sedgwick substantially complied with ERISA claims procedures.

ERISA Procedural Requirements

We begin with a brief overview of the ERISA regulations that govern employee benefit claims procedures. ERISA ensures that fiduciaries administer employee

---

harmless." 819 F.3d at 45. However, this circuit has yet to adopt such a rule, and we decline to do so here.

benefit plans "solely in the interest of the participants and beneficiaries." 29 U.S.C. §§ 1104(a)(1), 1001(b). Under ERISA, the Secretary of Labor has the authority to enact regulations that govern the administration of employee benefit claims. *Id.* §§ 1133, 1135. Section 1133 provides that every employee benefit plan must:

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Id. § 1133. We have held that the "essential purpose" of these requirements is twofold: "(1) to notify the claimant of the specific reasons for a claim denial, and (2) to provide the claimant with an opportunity to have that decision reviewed by the fiduciary." *Wenner v. Sun Life Assurance Co. of Can.*, 482 F.3d 878, 882 (6th Cir. 2007) (emphasis and citation omitted).

In deciding whether a plan has satisfied the requirements of § 1133, we employ a "substantial compliance" test. *Id.* Under this test, all communications between the claimant and the administrator are considered. "If the communications between the administrator and participant as a whole fulfill the twin purposes of § 1133, the administrator's decision will be

upheld even where the particular communication does not meet those requirements." *Id.* (internal quotation marks omitted).

Additional procedural safeguards are codified in 29 C.F.R. § 2560.503-1, titled "Claims procedure." Specifically, "in the context of an administrative appeal of an adverse benefits determination, 29 C.F.R. § 2560.503-1(h)(2) outlines the essential procedural requirements for a full and fair review." *Balmert v. Reliance Standard Life Ins. Co.*, 601 F.3d 497, 502 (6th Cir. 2010). That provision provides, in part:

> [T]he claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures— . . .
>
> (ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
>
> (iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. . . .
>
> (iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether

> such information was submitted or considered in the initial benefit determination.

29 C.F.R. § 2560.503-1(h)(2). Furthermore, "group health plans," such as the Plan that is at issue in this case, are required to comply with the following:

> (i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
>
> (ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; [and]
>
> (iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, . . . the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. . . .

Id. § 2560.503-1(h)(3)(i)-(iii).

Notice and an Opportunity to Appeal

Avery's first procedural objection takes issue with Sedgwick's July 21, 2014, letter. She argues that the letter failed to "inform her that she could submit comments or other information, that she could obtain documents relevant to her claim in order to prepare an appeal, and did not describe any appeal procedures." Appellant's Br. at 31-32. In response, Sedgwick argues that its letter was neither a formal benefit determination nor final claim denial. Rather, the letter merely intended to advise Avery of the results of her independent medical examination and to instruct her to report to her plant medical department for an ability-to-work determination. Sedgwick contends that *later* communications—such as the August 20, 2014, letter terminating Avery's benefits, the September 12, 2014, letter denying Avery's appeal, and the September 30, 2015, letter upholding the benefits denial upon re-review—constitute benefits determinations, and that each complied with ERISA.

We need not resolve whether Sedgwick's July 21, 2014, letter was in fact a formal benefit determination, because Sedgwick's collective communications with Avery substantially complied with ERISA's procedural requirements. *See Kent*, 96 F.3d at 807 (holding that, despite technical deficiencies in the insurer's denial letters, "when viewed in light of the myriad of communications between claimant, her counsel and the insurer, [the letters] were sufficient to meet the purposes of Section 1133 in insuring that the claimant understood the reasons for the denial of the claim as

well as her rights to review of the decision"). Although Sedgwick's July 21, 2014, letter undoubtedly fell short of meeting the requirements articulated in § 2560.503-1(h), its August 20, 2014, denial letter corrected any deficiencies. Avery was made aware of the reasons for Sedgwick's benefits denial (i.e., the results of Dr. Shavell's independent medical examination) and of her appeal rights. Collectively, therefore, Sedgwick's communications with Avery satisfied the dual purposes behind (and plain text of) Section 1133. *See Wenner*, 482 F.3d at 882; *Putney v. Med. Mut. of Ohio*, 111 F. App'x 803, 807 (6th Cir. 2004) (finding that an administrator's failure to satisfy ERISA notice requirements was "neither significant nor outcome determinative" where the "procedural failures did not prevent [the claimant] from gaining information necessary to contest his denial of benefits").

Avery's argument that Sedgwick deprived her of an opportunity to appeal its adverse benefit decision fails for similar reasons. First, on July 28, 2014, Avery "appealed" the results of Dr. Shavell's independent medical examination, albeit before receiving Sedgwick's August 20, 2014, letter. Sedgwick ultimately treated Avery's July 28, 2014, letter as a proper and timely appeal, and it reviewed Avery's claim as it would any other appeal. Thereafter, Sedgwick effectively afforded Avery a second appeal by voluntarily re-reviewing her claim in 2015. And finally, Sedgwick provided Avery with an opportunity to appeal its September 30, 2015, decision, which upheld the termination of her long-term

disability benefits upon re-review, but Avery chose not to appeal that decision.

Given this posture, Avery cannot argue that she was denied a reasonable opportunity to appeal Sedgwick's decision. Put plainly, Avery *did* appeal the termination of her long-term disability benefits—twice. And when afforded an additional opportunity to appeal Sedgwick's final benefits determination in 2015, Avery declined to do so. In sum, we simply cannot see how Sedgwick's procedures fell short of providing Avery's claim a meaningful review.

Opportunity to Supplement and Access the Record

Next, Avery contends that "Sedgwick did not provide [her] with an opportunity to submit comments or documents in response to the initial benefit decision before issuing the final decision," in violation of 29 C.F.R. § 2560.503-1(h)(2)(ii). Reply Br. at 10. Again, we disagree.

Before issuing its initial benefits denial, Sedgwick contacted Avery to ask whether she intended to provide any additional information, to which she responded "no." A.R. 949. Likewise, during its voluntary re-review, Sedgwick afforded Avery the opportunity to supplement the record with any additional medical information or documentation, but Avery declined to do so. Most important, however, is that Avery *did* submit comments in response to Dr. Shavell's independent medical examination, and those comments were considered throughout the appeals process. For instance,

Dr. Hoenig's IRR report references Avery's "appeal letters" dated July 28, 2014. And Dr. Friedman's IRR report notes that, "[o]n 07/28/14, the claimant wrote an appeal letter refuting many of the physical examination findings, observations, and conclusions by Dr. Shavell." A.R. 607. Nevertheless, the applicable regulations do not require plan administrators (or their consultants) to reference a claimant's comments with particularity. They merely require that plans "[p]rovide claimants *the opportunity to submit* written comments." 29 C.F.R. § 2560.503-1(h)(ii) (emphasis added). And in this case, for the reasons already stated, Sedgwick and the Plan provided Avery this opportunity.

Relatedly, Avery argues that Sedgwick failed to provide her "with reasonable access to all of the information relevant to her claim for benefits," in violation of 29 C.F.R. § 2560.503-1(h)(2)(iii). Reply Br. at 10. We find no evidence in the record to support this assertion. While claimants are entitled to reasonable access to records relevant to their claim, this access is provided "upon request." 29 C.F.R. § 2560.503-1(h)(2)(iii). And there is no indication that Avery ever requested access to records or that she was denied access following such request.

Dr. Shavell's Training and Experience

Next, Avery argues that Dr. Shavell "did not have appropriate training and experience in the field of neurology" necessary to evaluate her condition, in violation of 29 C.F.R. § 2560.503-1(h)(3)(iii). Appellant's Br.

at 23. Again, Avery's procedural challenge lacks merit. Although it is true that Dr. Shavell is not a board-certified neurologist, his independent medical examination was not the basis for Sedgwick's final determination. Rather, Sedgwick relied on IRRs conducted by two board-certified neurologists, Dr. Hoenig and Dr. Friedman, to terminate Avery's long-term disability benefits.

Furthermore, the requirement that a group health plan "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment," applies only "in deciding an appeal of any adverse benefit determination." 29 C.F.R. § 2560.503-1(h)(3)(iii). Because Dr. Shavell was not consulted in deciding an appeal, his training and experience is procedurally irrelevant.

Documents Omitted from the Administrative Record

Finally, Avery argues that Sedgwick deliberately omitted relevant documents from the administrative record. Specifically, she alleges that Sedgwick failed to include evidence of "actual surveillance" and omitted documents related to her Social Security disability award. Appellant's Br. at 33-34. Again, Avery's allegation lacks support.

Sedgwick included within the administrative record an email description of surveillance that took place in April 2014. At the time, Chrysler's Corporate Investigations department observed Avery driving on several occasions and suspected that she may be running

a business out of her home. An investigator communicated these observations and suspicions to Chrysler's Special Investigations Unit via email. But beyond this email description, which is already included in the administrative record, there is no indication that any other documentation pertaining to Chrysler's surveillance—written, visual, or otherwise—even exists. Avery's suggestion that "actual surveillance" has been omitted from the administrative record is pure speculation.

And the same is true for Social Security Disability records. The administrative record includes evidence of the following: the Plan's requirement that Avery apply for Social Security disability benefits, evidence of Avery's application for Social Security disability benefits, the Social Security Administration's monthly SSDI benefit award of over $2,000, and Sedgwick's reimbursement in the amount of over $15,000 for overpayment. Avery speculates that, because Sedgwick facilitated her Social Security application process, Sedgwick must possess additional documents related to her Social Security disability award. But again, this is mere speculation. Avery cannot identify any documents within Sedgwick's possession that have been omitted from the administrative record. If Avery wished to include additional Social Security documentation in the administrative record, she should have requested said documents from the SSA directly and supplemented the record when given the opportunity to do so.

B. Sedgwick's Decision Was Not Arbitrary or Capricious

Having addressed Avery's procedural objections—i.e., objections to *how* the benefits decision was made—we turn to Avery's contention that Sedgwick simply made the wrong decision. As stated above, because the Plan grants Sedgwick the discretionary authority to determine eligibility for benefits and to construe the Plan's terms, we review Sedgwick's decision to terminate Avery's long-term disability benefits under the arbitrary and capricious standard. *McClain v. Eaton Corp. Disability Plan*, 740 F.3d 1059, 1064 (6th Cir. 2014); *see also Firestone*, 489 U.S. at 115.

Arbitrary and capricious review "is the least demanding form of judicial review of administrative action." *Williams v. Int'l Paper Co.*, 227 F.3d 706, 712 (6th Cir. 2000). Under this extremely deferential standard, we need only decide "whether the plan administrator's decision was rational in light of the plan's provisions." *Id.* (internal quotation marks omitted). We will uphold Sedgwick's decision if "it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Baker v. United Mine Workers of Am. Health & Ret. Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991). "[T]he ultimate issue in an ERISA denial of benefits case is not whether discrete acts by the plan administrator are arbitrary and capricious but whether its ultimate decision denying benefits was arbitrary and capricious." *Spangler v. Lockheed Martin Energy Sys., Inc.*, 313 F.3d 356, 362 (6th Cir. 2002). The burden is on the claimant to show that the administrator acted

arbitrarily. *Farhner v. United Transp. Union Discipline Income Prot. Program*, 645 F.3d 338, 343 (6th Cir. 2011).

With that being said, the arbitrary and capricious standard is not "without some teeth." *McDonald v. W.-S. Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003) (citation omitted). "[M]erely because our review must be deferential does not mean our review must also be inconsequential. While a benefits plan may vest discretion in the plan administrator, the federal courts do not sit in review of the administrator's decisions only for the purpose of rubber stamping those decisions." *Moon v. Unum Provident Corp.*, 405 F.3d 373, 379 (6th Cir. 2005). Instead, "[s]everal lodestars guide our decision: the quality and quantity of the medical evidence; the existence of any conflicts of interest; whether the administrator considered any disability finding by the Social Security Administration; and whether the administrator contracted with physicians to conduct a file review as opposed to a physical examination of the claimant." *Shaw v. AT&T Umbrella Ben. Plan No. 1*, 795 F.3d 538, 547 (6th Cir. 2015) (internal quotation marks omitted). In conducting our review, we may generally "consider only the evidence available to the administrator at the time the final decision was made." *Id.*

Avery alleges that Sedgwick's benefits denial was arbitrary and capricious because Sedgwick (1) ignored favorable evidence, (2) improperly relied on file reviews conducted by physicians who were not provided adequate documentation, and (3) ignored the Social

Security Administration's disability finding. We will address each substantive challenge in turn.

Sedgwick's Review of the Evidence

First, Avery argues that Sedgwick "ignored and selectively reviewed" the evidence. Appellant's Br. at 41. Avery is correct that "administrators may not selectively review the administrative record by picking out the opinions of the doctors that support their decisions while ignoring the opinions of a participant's treating doctors that do not." *Autran v. Proctor & Gamble Health & Long-Term Disability Benefit Plan*, 27 F.4th 405, 415 (6th Cir. 2022). Instead, administrators must "consider all opinions on both sides of a disputed disability question." *Id.*

But here, we find that the physicians whom Sedgwick consulted to evaluate Avery's claim engaged in a fulsome review of the record—including the medical evidence provided by Avery's treating physicians. Dr. Hoenig, for example, reviewed records from Avery's primary care physician, Dr. Brengel. Dr. Hoenig also reviewed the independent medical examination reports from Dr. Banks and Dr. Gaston, both of whom had previously found Avery totally disabled. Dr. Hoenig even attempted (to no avail) to contact Dr. Nounou, one of Avery's treating physicians, to discuss Avery's history. Although a plan administrator need not "accord special deference to the opinions of treating physicians," *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003), the record reveals that Sedgwick

took Avery's doctors' opinions seriously. Indeed, Dr. Hoenig referred to their findings as "clinical[ly] significant." A.R. 663. Relying on Dr. Hoenig's file review, among other medical records, Sedgwick concluded that the documentation provided did not support Avery's claimed disability.

A year later, upon re-review of Avery's claim, Sedgwick consulted Dr. Friedman, who also engaged in a comprehensive review of the record. Like Dr. Hoenig, Dr. Friedman reviewed extensive medical records, including those provided by Avery's treating physicians, as well as the results of Dr. Banks' and Dr. Gaston's independent medical examinations. Dr. Friedman contacted and spoke with a nurse in Dr. Nounou's office. And Dr. Friedman even credited Avery's subjective reports of pain: "the claimant reports that she has ongoing symptoms related to complex regional pain syndrome including walking with a limp and sensitivity to touch to the legs. She reported that she was bedridden several days per week and had difficulties doing daily activities such as cooking, cleaning, and shopping." A.R. 600. Nonetheless, in reviewing Avery's medical records, Dr. Friedman concluded that, "[b]ased on the clinical evidence provided for review, the employee does not require any restrictions on their work duties at any point during the dates of claimed disability in order to return to work." A.R. 601. Relying on Dr. Friedman's report, Sedgwick upheld its termination of Avery's long-term disability benefits, citing "no sufficient clinical evidence to support any restrictions and limitations." A.R. 593.

In rejecting the opinion of a treating physician, a plan administrator need only offer "reasons for adopting an alternative opinion" to survive arbitrary and capricious review. *Shaw*, 795 F.3d at 549. And "a lack of objective medical evidence upon which to base a treating physician's opinion has been held sufficient reason for an administrator's choice not to credit [an] opinion." *Gilewski v. Provident Life and Accident Ins. Co.*, 683 F. App'x 399, 406 (6th Cir. 2017). Here, Sedgwick rejected the opinions of Avery's treating physicians based on the opinions of Dr. Hoenig and Dr. Friedman, who concluded that the objective medical evidence in Avery's file did not support her claimed disability. And we can discern no selective review by the physicians who reviewed Avery's files. Indeed, their differences from earlier opinions can be explained by the "extensive treatment" that Avery underwent in the interim—treatment that drastically reduced her pain levels. A.R. 608. Accordingly, we find that Sedgwick engaged in a deliberate, principled reasoning process when it decided to terminate Avery's long-term disability benefits.

Sedgwick's Reliance on Independent Record Reviews

Next, Avery argues that "Sedgwick's reliance on record review consultants who were not provided appropriate records . . . was also arbitrary and capricious." Appellant's Br. at 36. As an initial matter, we note that Sedgwick's decision to conduct IRRs—or "file reviews"—rather than physical examinations is a factor that we must consider in determining whether

Sedgwick acted arbitrarily or capriciously, but that there is "nothing inherently objectionable about a file review by a qualified physician in the context of a benefits determination." *Calvert v. Firstar Fin., Inc.*, 409 F.3d 286, 296 (6th Cir. 2005). Instead, an administrator's decision to conduct an IRR in lieu of a physical examination is "just one more factor to consider in our overall assessment of whether [the administrator] acted in an arbitrary and capricious fashion." *Id.* at 295.

At different points in the review process, Sedgwick referred Avery's claim to two independent physician consultants, Dr. Hoenig and Dr. Friedman, for file reviews. Both doctors reviewed Avery's medical records, but neither physically examined her, before providing thorough reports. In their IRRs, Dr. Hoenig and Dr. Friedman identified the medical records that they reviewed and provided detailed accounts of Avery's medical history. Both doctors also acknowledged Avery's prior limitations and credited her treating physicians' observations. However, despite this favorable evidence, both Dr. Hoenig and Dr. Friedman identified contrary evidence that cut against Avery's claimed disability. For example, Dr. Hoenig noted that "[t]he last neurological exam in the medical record is from February 6, 2013," and that "after her spinal cord stimulator (SCS), she has a normal neurological exam." A.R. 663. And Dr. Friedman observed that Dr. Nounou, one of Avery's treating physicians, had not recommended any specific restrictions after a July 2014 endovenous ablation procedure. Given this evidence, Dr. Hoenig and Dr.

Friedman concluded that Avery was not disabled from performing any work, and those conclusions were reasonable.

Calvert is distinguishable. There we found that an insurance company acted arbitrarily and capriciously when it based its benefits determination on a "clearly inadequate" file review, because it, among other things, failed to identify the records reviewed, ignored favorable evidence, and reached conclusions that squarely contradicted objective evidence. 409 F.3d at 296. But here, both Dr. Hoenig and Dr. Friedman recited Avery's medical history in detail, specifically noted favorable evidence, and even credited Avery's treating physicians. Furthermore, neither doctor made any credibility findings. *See Judge v. Metro. Life Ins. Co.*, 710 F.3d 651, 663 (6th Cir. 2013) ("This court has found fault with file-only reviews in situations where the file reviewer concludes that the claimant is not credible without having actually examined him or her"). The file reviews at issue here were thus adequate.

As for Avery's assertion that Dr. Hoenig and Dr. Friedman were not provided appropriate records to review, Avery has not identified any post-termination medical records that exist, let alone records that support her claimed disability. The closest thing to medical evidence made available post-termination is Dr. Brengel's April 2015 letter, which Dr. Friedman reviewed. However, because Dr. Brengel's letter "did not include any new examination findings or results of [EMG] testing," Dr. Friedman concluded that his position remained unchanged. A.R. 592-93. In sum, Sedgwick's

reliance on independent record reviews did not render its final benefits determination arbitrary and capricious.

The Social Security Administration's Disability Finding

Finally, Avery argues that Sedgwick's decision was arbitrary and capricious because it did not address the fact that Avery successfully applied for Social Security disability benefits. "[I]f the plan administrator (1) encourages the applicant to apply for Social Security disability payments; (2) financially benefits from the applicant's receipt of Social Security; and then (3) fails to explain why it is taking a position different from the SSA on the question of disability, the reviewing court should weigh this in favor of a finding that the decision was arbitrary or capricious." *Bennett v. Kemper Nat. Servs.*, 514 F.3d 547, 554 (6th Cir. 2008).

It is undisputed that Sedgwick required Avery to apply for Social Security benefits, and that Sedgwick benefited financially from reimbursement payments. It is also undisputed that Sedgwick neglected to reference Avery's Social Security award in either its initial denial of Avery's appeal or in its final determination upon re-review. Nevertheless, *Bennett* merely instructs "that a failure to take into account a Social Security disability award is to be *weighed* in favor of a finding that the decision was arbitrary and capricious, not that such a decision is arbitrary and capricious per se." *Morris v. Am. Elec. Power Long-Term Disability Plan*,

399 F. App'x 978, 986 (6th Cir. 2010). And it is not necessary for a plan administrator to "expressly distinguish a favorable SSA determination in denying disability benefits under the plan." *Leffew v. Ford Motor Co.*, 258 F. App'x 772, 779 (6th Cir. 2007).

Although Sedgwick's decision to terminate Avery's benefits, despite the SSA's earlier disability finding, weighs "slightly in [Avery]'s favor when it comes to evaluating whether that decision was arbitrary and capricious," *Morris*, 399 F. App'x at 986, it is not enough to convince us that Sedgwick acted arbitrarily on the whole. For one, the SSA's disability determination was made two years prior to Sedgwick's decision to terminate Avery's benefits. *See Cox v. Standard Ins. Co.*, 585 F.3d 295, 303 (6th Cir. 2009). And at the time Sedgwick made its decision, it possessed additional medical evidence that the SSA did not, including the results of Dr. Shavell's independent medical examination, the plant medical physician's ability-to-work determination, and IRRs from Dr. Hoenig and Dr. Friedman. *See id.*

Moreover, the fact that Avery qualified for Social Security disability benefits does not necessarily mean that she should qualify for benefits under the Plan, because "a claim for benefits under an ERISA plan often turns on the interpretation of plan terms that differ from SSA criteria." *Whitaker v. Hartford Life and Acc. Ins. Co.*, 404 F.3d 947, 949 (6th Cir. 2005). For instance, Sedgwick—unlike the SSA at the time of its decision—was not required to defer to the opinions of Avery's treating physicians. *See O'Bryan v. Consol Energy Inc.*, 477 F. App'x 306, 308 (6th Cir. 2012) (per curiam). We

therefore conclude that Sedgwick's failure to address the SSA's disability determination did not render Sedgwick's decision arbitrary and capricious.

Sedgwick's Decision Was Supported by Substantial Evidence

Sedgwick terminated Avery's long-term disability benefits after deciding that she was no longer "totally disabled" under the meaning of the Plan. The district court concluded that substantial evidence supported Sedgwick's decision. We agree.

In reviewing the quality and quantity of the evidence in the administrative record, we have said that "substantial evidence" is "more than a mere scintilla." *McDonald*, 347 F.3d at 171 (citation omitted). "It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (citation omitted). "The fact that the evidence might also support a contrary conclusion is not sufficient to render the plan administrator's determination arbitrary and capricious." *Hurse v. Hartford Life & Accident Ins. Co.*, 77 F. App'x 310, 318 (6th Cir. 2003).

The administrative record in this case contained more than adequate evidence for Sedgwick to conclude that Avery was no longer totally disabled under the terms of the Plan. First, Dr. Shavell examined Avery in July 2014, and offered detailed observations that indicated "good range of motion," "no evidence of any loss of strength," and a generally "normal exam." A.R. 978. From these findings, Dr. Shavell concluded, "I do not

see any evidence of a regional complex pain issue. . . . I do not find any physical evidence to substantiate at this point any disability whatsoever." A.R. 978-79. Next, Sedgwick required Avery to report to Chrysler's plant medical department for an ability-to-work determination. There, the plant medical physician observed, "[s]he is alert and oriented. . . . Right and left lower legs—no stasis dermatitis. Normal dorsalis pedis pulse. No pretibial edema. She walked without a limp." A.R. 946. On that basis, the plant medical department determined that Avery could return to work with no restrictions.

Sedgwick then referred Avery's claim to Dr. Hoenig for a file review. Dr. Hoenig reviewed Avery's extensive medical records and concluded that after Avery's "spinal cord stimulator (SCS), she ha[d] a normal neurological exam" and was "not disabled from performing any work as of 07/22/14." A.R. 663. Finally, Sedgwick initiated a voluntary re-review, referring Avery's claim to Dr. Friedman for another file review. Dr. Friedman reviewed Avery's medical records and concluded that there was "no sufficient clinical evidence to support any restrictions and limitations." A.R. 601.

To be sure, Avery's treating physicians repeatedly diagnosed Avery with Complex Regional Pain Syndrome and venous insufficiency. But even when "the evidence may be sufficient to support a finding of disability, if there is a reasonable explanation for the administrator's decision denying benefits in light of the plan's provisions, then the decision is neither arbitrary nor capricious." *Schwalm v. Guardian Life Ins. Co. of*

Am., 626 F.3d 299, 308 (6th Cir. 2010). And here, no fewer than four physicians concluded that Avery is no longer totally disabled. If this did not amount to "a reasonable explanation for the administrator's decision," it would be difficult to say what would. In conclusion, we find that substantial evidence supported Sedgwick's decision to terminate Avery's long-term disability benefits.

III

For the foregoing reasons, the district court's judgment is affirmed.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 22-1960

JACQUELINE AVERY,

Plaintiff - Appellant,

v.

SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.; EXTENDED DISABILITY BENEFIT OF THE CHRYSLER GROUP LLC GROUP INSURANCE PROGRAM,

Defendants - Appellees.

Before: McKEAGUE, GRIFFIN, and MURPHY, Circuit Judges.

JUDGMENT

(Filed Jul. 24, 2023)

On Appeal from the United States District Court for the Eastern District of Michigan at Port Huron.

THIS CAUSE was heard on the record from the district court and was submitted on the briefs without oral argument.

IN CONSIDERATION THEREOF, it is ORDERED that the judgment of the district court is AFFIRMED.

ENTERED BY ORDER OF THE COURT

/s/ Deborah S. Hunt
Deborah S. Hunt, Clerk

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JACQUELINE AVERY,

Plaintiff,

v. Case No. 20-11810

SEDGWICK CLAIMS MANAGEMENT SERVICES, INC. and EXTENDED DISABILITY BENEFIT OF THE CHRYSLER GROUP LLC GROUP INSURANCE PROGRAM,

Defendants. /

OPINION AND ORDER GRANTING DEFENDANTS' MOTION FOR JUDGMENT ON THE ADMINISTRATIVE RECORD AND DENYING PLAINTIFF'S MOTION FOR JUDGMENT

(Filed Sep. 21, 2022)

Plaintiff Jacqueline Avery brings this action under 29 U.S.C. § 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA") to recover benefits allegedly owed by Defendant FCA US LLC Long Term Disability Benefit Plan ("Plan[1]"), as administered by Defendant Sedgwick Claims Management Services, Inc. ("Sedgwick"). (ECF No. 1.) Currently

[1] The parties identify this as the correct name of the plan (ECF No. 4, PageID.17; ECF No. 27, PageID.1496.)

before the court are the parties' cross-motions for judgment. (ECF Nos. 27-28.) Having reviewed the briefs, the court concludes that a hearing is not necessary. *See* E.D. Mich. LR 7.1(e)(2). For the reasons stated below, the court will grant Defendants' motion and deny Plaintiff's motion.

I. BACKGROUND[2]

A. The Plan

To provide long-term disability benefits to its eligible employees, FCA US, LLC ("FCA")[3] sponsored the Plan and acts as the Plan Administrator. (AR 1203.)[4] In this capacity, FCA has "the full and absolute authority to take all measures deemed necessary, appropriate or useful to administer the Plan in accordance with its terms and applicable law." (AR 1212-13.) These include "the power to determine eligibility." (AR 1213.) FCA may "allocate and delegate its responsibilities . . . [and] employ such persons (including . . . TPAs [third-party administrators]) as may be required to assist in administering the Plan." (*Id.*) FCA may also "designate [a TPA] to carry out fiduciary responsibilities under th[e] Plan." (AR 1212.) Sedgwick is the TPA who "processes

---

[2] The court admonishes Plaintiff for her failure to "include Proposed Findings and Conclusions . . . consisting of separate, numbered paragraphs each of which states, reasonably [and] concisely, a separate material fact or conclusion" as required by the court's order. (ECF No. 8, PageID.48; ECF No.17, PageID.263.)

[3] FCA is formerly named DaimlerChrysler Corporation.

[4] "AR [page number]" refers to the pages in the sealed Administrative Record (ECF Nos. 20-25.)

claims for the [Plan] pursuant to a service contract with [FCA]". (AR 1205; ECF No. 27, PageID.1503; ECF No. 28, PageID.1572.)

Plaintiff was a Participant in the Plan. To be eligible for benefits, she must meet specified conditions, including that she must:

> (e) be "totally disabled" because of disease or injury so as during the first 24 months of disability to be unable to perform the duties of the Participant's occupation, and after the first 24 months of disability be unable to engage in regular employment or occupation with [FCA].
>
> (f) apply for LTD benefits[5] and furnish satisfactory proof of disability in accordance with Section 4.02 . . . ; and
>
> (g) Include satisfactory evidence that he or she made proper application for all "Other Income Benefits" described in Section 5.03.

(AR 1206.) Section 4.02 of the Plan provides: that "[p]roof of the continuance of the disability must be furnished at such intervals as the TPA may reasonably require." (AR 1206.) Section 5.03 says that "[t]he Plan

---

[5] Section 7.04 provides, "Any Participant shall be entitled to file a written claim for benefits with the TPA setting forth the benefits for which he or she feels entitled and the reason therefor. If the TPA receives an oral claim for benefits, it shall advise such individual to file a written claim . . . The TPA shall determine the Participant's rights to benefits within 90 days after receipt of the written claim . . . " (AR 1213.)

Administrator or the TPA has the right to require as part of the proof of claim for LTD benefits satisfactory evidence of [information relating to Other Income Benefits]." (AR 1210.)

B. Sedgwick's Review of Plaintiff's Claim

Plaintiff worked for FCA until July 2011, at which point she went on medical leave. (AR 180, 195; ECF No. 1, PageID.3.) She applied for and received short-term disability benefits.[6] (AR 358.) When that ran out in July 2012, Plaintiff made a claim for long-term disability benefits under the Plan.

As required by Sedgwick, Plaintiff applied for and was eventually awarded benefits under the social security disability insurance ("SSDI") program.[7] (AR 42, 251, 255, 258-59, 585.) Thanks to this, in September 2012, the Plan recovered over $15,000 of claim payment previously made to Plaintiff. (AR 518, 544-45, 905.)

Sedgwick initially approved Plaintiff's claim for benefits under the Plan in August 2012 "based on the accepted, totally disabling condition(s) of Right Lower Extremity Neuropathy & Reflex Sympathetic Dystrophy Lower Extremity." (AR 1167.) Sedgwick possessed the following documents, which apparently supported

---

[6] It is not disputed that Sedgwick also processed Plaintiff's short-term disability claim.

[7] The Social Security Administration ("SSA") administers this program.

Plaintiff's entitlement to benefits as of June 2, 2014 (AR 1055):

- August 18, 2011 note of Plaintiff's visit to Kingston Family Health Care (AR 345-49): On that day, Plaintiff presented with lower extremity pain previously diagnosed as neuropathy in lower right leg. (AR 345.) She was diagnosed with "mononeuritis of lower limb." (AR 348.)
- August 19, 2011 "Lower Extremity" form signed by Darla Mays, PA-C (AR 351-56): Plaintiff was certified as being disabled from right leg neuropathy. (AR 351.)
- October 14, 2011 report of the October 11, 2011 independent medical examination ("IME") with Dr. Hermann Banks, a board-certified neurologist (AR 789-94): Dr. Banks diagnosed Plaintiff with "[r]ight lower extremity pain with paresthesia and dysesthesia as described in addition to edema" and confirmed the appeared presence of neuropathy. (AR 793.) Dr. Banks recommended that Plaintiff remain off work for eight weeks with the hope of identifying the origin of her edema during that time. (*Id.*)
- January 9, 2012 note of the January 4 visit for leg pain with Dr. Michael Louwers and neurologist Dr. Ronald Wasserman at the University of Michigan Back and Pain Center ("U of M") (AR 313-15): Plaintiff was diagnosed with complex regional pain syndrome type I in the right leg. (AR 314.)

- January 19, 2012 report of an IME performed that day by neurologist Dr. David Gaston (AR 297-303): Dr. Gaston diagnosed Plaintiff with "Complex Regional Pain Syndrome Type II in view of the associated peripheral neuropathy." (AR 302). Plaintiff was found "disabled . . . for approximately 4 months." (AR 303.)

- May 9, 2012 "Lower Extremity" form signed by Dr. Robert Brengel, Plaintiff's primary care doctor whose specialty is family medicine (AR 227-29, 691-695): Dr. Brengel indicated that Plaintiff was disabled from "Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy" with co-morbid conditions being obesity, depression, osteopenia, and dyslipidemia. (AR 227, 691.) Enclosed were notes of Plaintiff's visits to U of M on April 2 and 9, 2012, which remarked improvements and reduced pain after the catheter insertion to Plaintiff's leg on March 12, 2012 (AR 696-703.)

- June 26, 2012 "General Diagnosis" form signed by Dr. Brengel (AR 227-29): Dr. Brengel indicated the same diagnoses as on May 9 form. (AR 227.) Enclosed were Dr. Brengel's handwritten notes, records of Plaintiff's visits to U of M on April 2 and 30, 2012, and an outpatient chemical and pain medication management consultation with Dr. Herbert Malinoff on June 12, 2012. (AR 230-49.) The notes of the April 30 visit indicated that Plaintiff had not been doing well and her pain had returned after the catheter was removed on April 9. (AR 238-39.)

- September 10, 2012 and January 8, 2013 "General Diagnosis" forms signed by Dr. Brengel (AR 819-24, 1146-48): Dr. Brengel identified "Complex Regional Pain Syndrome" as Plaintiff's disabling diagnosis with co-morbid conditions of depression, opiate dependence, and obesity. (AR 819, 1146.)

- February 6, 2013 note of Plaintiff's visit that day with Dr. Matthew Wixson and Dr. Wasserman at U of M (AR 1107-1110): On that day, Plaintiff reported over 90 percent pain improvement and having weaned off oxycodone. (AR 1108.)

- March 4, 2013 note of a follow up visit on that day with Dr. Golshid Tazhibi and Dr. Wasserman at U of M (AR 1104-06): Then, Plaintiff reported "80% relief of her pain." (AR 1105.)

- June 4, 2013 note of visit with Dr. Majed A. Nounou, a cardiologist (AR 1099-1100): Plaintiff complained of pain, numbness, tingling, and swelling in her right lower leg. (AR 1099-1100.) Dr. Nounou ordered a venous mapping and diagnosed Plaintiff with venous insufficiency, varicose veins of lower extremities, obesity, depressive disorder, hypertension, pain in limb, and edema. (AR 1100.)

- June 4, 2013 "Lower Extremity" form signed by Dr. Brengel (AR 827-30): Dr. Brengel certified "Complex Regional Pain Syndrome" as Plaintiff's disabling diagnosis with obesity as the co-morbid condition. (AR 827.)

- June 24, 2013 report of a "Bilateral Lower Extremity Venous Study," ordered by Dr. Wasserman and reviewed by Dr. Shaun Gabriel (AR 843-44); Plaintiff presented with "[right lower extremity] chronic pain and swelling." (AR 843.) The preliminary review of the imaged veins on both legs ruled out deep vein thrombosis but revealed evidence of reflux. (AR 843-44.)

- August 12, 2013 note of a follow-up visit with Dr. Nounou (AR 845-49): Dr. Nounou confirmed that Plaintiff's "venous mapping showed severe bilateral greater saphenous venous insufficiency" with "more symptoms on the right." (AR 846.) Dr. Nounou suggested (and eventually performed[8]) an endovenous ablation procedure on Plaintiff's right leg. (AR 847.)

- January 1, 2014 "Lower Extremity" form signed by Dr. Brengel (AR 837-40): Dr. Brengel certified that Plaintiff was disabled by Reflex Sympathetic Dystrophy in right leg and had co-morbid conditions of obesity, lumbar radiculopathy, and peripheral vascular insufficiency. (AR 837.)

- April 24, 2014 "Certificate of Continuous Disability" signed by Plaintiff (AR 864-65): Plaintiff identified her disabling conditions as "Complex Regional Pain Syndrome & Venous reflux disease." (AR 864.) She described her limitations as being "unable to stand for

[8] This procedure was performed on February 12, 2014. (AR 880-81.)

longer than 10 minutes, walk for more than 500 feet, [and] knee[;] bending cannot be done without excessive swelling or chronic pain [; and] [c]oncentrating is very difficult to do [due to] [c]hronic pain meds." (*Id.*)

- April 17, 2014 note of a visit with Dr. Nounou to follow up on the right leg ablation (AR 1072-74): Dr. Nounou decided to wait on the ablation procedure on the left leg and discussed the possibility of ablating below the knee of the right leg based on venous mapping results. (AR 1074.)

- May 21, 2014 "Lower Extremity" form signed by Dr. Brengel (AR 988-91, 1057-60): Dr. Brengel indicated that Plaintiff was disabled by reflex sympathetic dystrophy in her right leg and had co-morbid conditions of leg pain, obesity, lumbar radiculopathy, and peripheral vascular insufficiency. (AR 988, 1057.)

On June 11, 2014, Sedgwick received an email from FCA's Corporate Investigations, which indicated that Plaintiff was seen driving – which she was medically restricted from doing – and suspected with running a business out of her home. (AR 935-36.) This prompted Sedgwick's request that Plaintiff undergo an IME with Dr. Joel Shavell, board certified in internal medicine and rheumatology, for an evaluation of her neuropathy and reflex sympathetic dystrophy in the right leg diagnoses. (AR 975-79.)

Dr. Shavell examined Plaintiff on July 15, 2014.[9] (AR 975.) He took Plaintiff's medical history, reviewed her medical records,[10] and performed a physical examination of Plaintiff. (AR 975-78.) During the physical examination, Dr. Shavell noticed Plaintiff "walked in quickly with a normal gait and had no problems getting undressed, . . . getting in and out of the room[,] . . . moving, and . . . functionally." (AR 977.) Dr. Shavell described his findings in his report:

> Lower extremities revealed no pain, good range of motion of the hips, knees, ankles and feet, no swelling, no redness, no warmth, and no coldness. A normal exam is noted. At the onset of the physical examination, as I was taking a pressure, she was able to fold her knees and legs under her like a Buddha position on the table, and was then able to get up quickly from a supine position, without any weakness or loss of strength in the lower or upper extremities. I also measured her calf, which was one inch from the inferior patella; the right leg was 19 and the left leg was 18, no real significant abnormality. Neurologically, Romberg revealed she was able to balance herself, she walked herself, she started to

---

[9] On that day, FCA also scheduled a surveillance of Plaintiff at Dr. Shavell's office. (AR 940.)

[10] These included: "plant notes," "notes from Marlette Regional Hospital," an Attending Physician Statement, signed by Robert Brengel, D.O.," "progress notes from Robert Brengel, D.O.," notes from the Heart & Vascular Institute of Michigan, Majed A. Nounou, M.D.," and "records from University of Michigan Health System, Ronald Arthur Wasserman, M.D." (AR 976-77.)

> walk on her heels and toes, of course she is very heavy, and could not do this for a long time, but she was able. There was absolutely no evidence of any loss of strength. I then checked her grossly for any neurological deficits in her lower extremities, and there were no significant neurological deficits. She did have a slightly hyporeflexic knee on the right; however, I did not pursue it because the strength in her legs was more than adequate. The range of motion on the knees was adequate and there were no indications that she had any neurological. Again, I would like to note that it is my opinion that the ability to sit perpendicularly on the examination table with feet and legs turned in cannot be performed with complex pain syndrome, for which she has had treatment in Ann Arbor.

(AR 978.)

Dr. Shavell concluded that he did not see any evidence of a regional complex pain issue because Plaintiff exhibited no normal symptom thereof. (*Id.*) He attributed the swelling of the leg to Plaintiff's obesity "because tissue compresses on vein and vein w[ould], at times, cause swelling of the leg." (*Id.*) He emphasized the fact that Plaintiff could bear weight on her ankle, heels, and toes despite her weight. (AR 979.) Ultimately, Dr. Shavell opined that Plaintiff's disability was unsubstantiated and that she could return to full duty immediately. (*Id.*)

On July 17, 2014, Plaintiff saw Dr. Nounou for venous mapping results. (AR 970-72.) Plaintiff presented

complaints of pain and edema in both legs and feet (worse in the right), numbness in her toes, and burning sensation in her ankles. (AR 970.) No diagnosis was discussed at this visit and no specified plan of care was recorded. (AR 970, 972.)

After receiving Dr. Shavell's report, on July 21, 2014, Sedgwick sent a letter to Plaintiff to inform her that the IME found her capable of working. (AR 974.) The letter directed Plaintiff to come to the medical department in her worksite to be evaluated for returning to work and said that her benefits "may be suspended effective July 21, 2014 pending the outcome of the ability to work examination." (*Id.*)[11] Sedgwick also called Plaintiff, and in response to the request that she undergo an evaluation at work, Plaintiff said that she had been in bed for three days and could not drive. (AR 943.)[12]

Nonetheless, on July 22, 2014, Plaintiff showed up to the onsite examination as requested. (AR 945.) The plant nurse saw Plaintiff walking in by herself with steady gait. (*Id.*). According to the plant doctor, Plaintiff was alert, oriented, and calm in the waiting room,

---

[11] On the same day, Sedgwick "backed down [Plaintiff's] benefits based on IME results" to July 21, 2014 and removed the July 25, 2014 scheduled payment. (AR 943.)

[12] While Defendants argue that "[a]t that point, Sedgwick had not issued a determination on Plaintiff's continued eligibility for LTD Plan benefits (rather, Sedgwick had only advised her . . . that she was to work for a determination of her ability to work)" (ECF No. 28, PageID.1579-80), the claim notes marked July 21, 2014 as "[d]enial letter date." (*See* AR 950.)

but appeared anxious in the exam room, which she attributed to pain. (*Id.*) An examination of Plaintiff's lower right and left legs revealed no stasis dermatitis, normal dorsalis pedis pulse, and no pretibial edema. (*Id.*) Additionally, she was seen walking without a limp. (*Id.*)

Also on July 22, 2014, Plaintiff received Dr. Shavell's IME report, which she told Sedgwick was "bold face lies." (AR 944.) Plaintiff stated that her home health workers could verify that "she is in bed more than not." (*Id.*) In response to Plaintiff's inquiry into an appeal, Sedgwick told her to "submit a letter substantiating her dispute of the exam," which would be forwarded to the "Appeal unit." (AR 945.)

On July 28, 2014, Plaintiff submitted a letter "to appeal [her] recent return to work decision." (AR 964-72.) Therein, she provided an overview of her medical history, ending with her last visit with Dr. Nounou on July 17, 2014. (AR 964.) She explained that she had not been coming to see her neurologist at U of M because she was "trying to take care of the secondary issue of venous insufficiency," but once it was resolved, she would resume the neurology treatment. (*Id.*) Further, Plaintiff made specific challenges to Dr. Shavell's statements and findings in his report. (AR 964-65.) Plaintiff included with her letter several documents: (1) a list of past appointments at U of M, the latest being July 8, 2013 with Dr. Wasserman (AR 967), (2) a report of the bilateral lower extremity venous study on June 24, 2014 (AR 968-69), and (3) the note of her visit on July 17, 2014 with Dr. Nounou (AR 970-72).

On August 4, 2014, Sedgwick sent Plaintiff a letter to "acknowledge receipt of [her] request for appeal of Long Term Disability Benefit" and informed her that her "appeal was received by Sedgwick on July 30, 2014." (AR 957.) Sedgwick further indicated that Plaintiff's "request for appeal of denied extended disability benefits will be reviewed by [its] Appeals Units and [she] will receive a written response by September 13, 2014." (*Id.*)

On August 8, 2014, Sedgwick called Plaintiff to ask if she was planning on providing any additional information, which she responded "no." (AR 949.) Also on that day, Sedgwick reviewed its files and noted as "[d]iscrepancies, errors, issues" the facts that there was "no denial [letter] outlining the reason for denial or with appeal rights" and "the letter [sent to Plaintiff] only request[ed] that [she return to work]." (AR 950.) Another note entry identified "issue[s]" of "letter on file notes suspension of benefits, not denied" and "no appeal rights included in the letter." (AR 951.)

On August 20, 2014, a longer letter was prepared, restating that Plaintiff no longer satisfied the eligibility requirement based on her IME result. (AR 954-55.) The letter directed Plaintiff to report to FCA's Human Resources department for an evaluation of her ability to return to work, and said that pending its outcome, her benefits "may be terminated effective July 21, 2014." (*Id.*) The letter then informed Plaintiff of her right to appeal within 180 days by submitting a written request with additional comments, documents, or records relating to her claim. (*Id.*) She was also told of

her right to request a copy of the documents, records, or other information in Sedgwick's possession that were relevant to her claim. (*Id.*)

On August 25, 2014, Sedgwick called Plaintiff advising her of the August 20 letter, which was sent that day. (AR 452.) Sedgwick told her that she would not need to report to Human Resources. (*Id.*) Sedgwick then confirmed with Plaintiff that her claim was still on appeal. (AR 453.)

As part of the appeal process, Sedgwick consulted with Dr. David Hoenig, a board-certified neurologist, for an independent record review ("IRR") on September 4, 2014. (AR 660-64.) After unsuccessfully attempting to discuss with Dr. Nounou and going through numerous medical records, Dr. Hoenig opined that Plaintiff was not disabled from performing work as of July 22, 2014. (*Id.*) He elaborated, "The last neurological exam in the medical record is from February 2, 2013. After her spinal cord simulator (SCS), [Plaintiff] has a normal neurological exam." (AR 663.) However, Dr. Hoenig affirmed that Plaintiff had neurological deficits from complex regional pain syndrome between July 21, 2011 and February 6, 2013, during which she would require work restrictions. (*Id.*)

On September 12, 2014, Sedgwick sent Plaintiff a letter indicating that her appeal was denied. (AR 658-59.) The letter said that the review included medical documentation from Plaintiff's treating sources and independent medical examiners (AR 658.) It also informed Plaintiff of Dr. Hoenig's IRR, his unsuccessful

attempts to speak with Dr. Nounou, and his conclusion and rationale. (AR 658-69.) The letter ended with the advisement of "the Claim Administrator's final decision" and Plaintiff's rights to sue and access her records. (*Id.*)

Eight months later, on May 18, 2015, Plaintiff's attorney sent a letter to Sedgwick demanding that Plaintiff's benefits be "immediately [and] retroactively" reinstated. (AR 654.) Enclosed thereto was a letter from Dr. Brengel dated April 15, 2015, which disputed Dr. Shavell's findings. (AR 655.) Dr. Brengel also indicated that Plaintiff "had an EMG performed by K. Fram, M.D., in December of 2014 and ongoing treatment from that point." (*Id.*) He then relayed that "Dr. Fram believe[d] that [Plaintiff] ha[d] reflex sympathetic dystrophy in her right lower extremity by history, chronic S1 radiculopathy bilaterally, severe peripheral polyneuropathy, and bilateral tarsal tunnel syndrome." (*Id.*) Dr. Brengel concluded that Plaintiff "remain[ed] disabled due to the difficulties with her right leg." (*Id.*)

On July 8, 2015, Sedgwick sent a letter informing Plaintiff that her claim was "under re-review" and that she can submit additional medical information by July 28, 2015. (AR 651.) No additional information was provided. However, Plaintiff claims that she never received this letter because it was sent to an outdated address. (ECF No. 29, PageID.1607.)

For the re-review, Sedgwick obtained a new IRR by neurologist Dr. Mark Friedman. (AR 599-602). On

August 6, 2015, Dr. Friedman opined that Plaintiff was not disabled from performing any work as of July 22, 2014 "[b]ased on the clinical objective evidence" in Plaintiff's medical documentation up until July 2014. (AR 601.) On September 16, 2015, having reviewed Dr. Brengel's April letter, Dr. Friedman held to his previous determination, reasoning that the letter "did not include any new examination findings or results of the testing." (AR 595.)

By a letter dated September 30, 2015 to Plaintiff's attorney, Sedgwick indicated that the discontinuation of Plaintiff's benefits was upheld. (AR 592-93.) The letter enumerated the reviewed medical documentation, described Dr. Friedman's IRR, his discussion with a nurse at Dr. Nounou's office, and his findings of no clinically supported disability after July 22, 2014. (*Id.*) Plaintiff was given an opportunity to appeal this updated determination, but she did not do so. (*Id.*)

II. STANDARD

The court must first decide what standard of review applies. Plaintiff argues that a de novo standard applies because (1) the Plan does not "appear on its face to grant [] discretion to Sedgwick" and "it is not clear that a decision by Sedgwick is entitled to differential review", and (2) "it is indisputable in this case that Sedgwick did not comply with the Department of Labor claims regulations." (ECF No. 27, PageID.1527.) Defendants challenge these contentions, maintaining

that the court should conduct its review using the arbitrary and capricious standard.

A. Grant of Discretion

"A federal court considering a [denial of benefit] claim [under § 1132(a)(1)(B)] starts with the presumption that it should review the administrator's denial of benefit de novo. If, however, the terms of the plan give the administrator discretionary power to make benefits decisions, the court reviews the administrator's denial under a differential arbitrary-and-capricious standard." *Card v. Principal Life Ins. Co.*, 17 F.4th 620, 624 (6th Cir. 2021) (internal citations omitted). The Sixth Circuit "'has consistently required that a plan contain a *clear* grant of discretion' to the administrator or fiduciary before applying the deferential arbitrary and capricious standard." *Frazier v. Life Ins. Co. of N. Am.*, 725 F.3d 560, 566 (6th Cir. 2013) (emphasis in original) (citing *Perez v. Aetna Life Ins.*, 150 F.3d 550, 555 (6th Cir. 1998)). But no "magic words" are necessary, *id.*, and "[t]he mere fact that language could have been clearer does not necessarily mean that it is not clear enough," *Perez*, 150 F.3d at 558 (citing *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 381 (6th Cir. 1996)).

Here, the court finds that Sedgwick is "a fiduciary to whom [FCA] granted discretion for the more lenient standard to apply." *Frazier*, 725 F.3d at 566. A plan "may expressly provide for procedures for allocating fiduciary responsibilities." *Id.* (citing 29 U.S.C.

§ 1105(c)(1)). Plaintiff concedes that "[t]here is no dispute that [the] Plan grants the 'Plan Administrator' to determine eligibility for benefits, [and] the Plan Administrator . . . is FCA." (ECF No. 27, PageID.1527.) As Defendants point out, the Plan authorizes FCA to delegate "fiduciary responsibilities" to a TPA to interpret the Plan and determine the eligibility for benefits thereunder. (ECF No. 28, PageID.1585-86.)[13] Here, the record shows, and it is undisputed,[14] that FCA delegated its claim administration function to Sedgwick. *See Lee v. MBNA Long Term Disability & Benefit Plan*, 136 F. App'x 734, 742 (6th Cir. 2005) (holding that if the plan grants the plan administrator discretionary authority and the plan administrator "properly designates another fiduciary" to exercise that discretion, then the arbitrary and capricious standard applies to the decisions of both the plan administrator and the designated third party).

Contrary to Plaintiff's contention, the grant of discretion to the TPA – Sedgwick – is clear from the Plan's language. For example, to be eligible for benefits, a Participant must "apply . . . and furnish satisfactory proof of disability in accordance with Section 4.02," which provides that "[p]roof of the continuance of the disability must be furnished at such intervals as the TPA may reasonable require." (AR 1206.) The Participant must

---

[13] The Plan expressly shields the Plan Administrators from any liability "for an act or omission of the person(s) to whom any duties are delegated." (AR 1211.)

[14] Plaintiff has consistently described Sedgwick as "the claim administrator" of the Plan. (*See e.g.*, ECF No. 27, PageID.1503.)

also "include satisfactory evidence that [] she made proper application for all 'Other Income Benefits' described in Section 5.03," and that section specifies that "[t]he TPA "has the right to require as part of the proof of claim for LTD benefits satisfactory evidence" of other income benefits (AR 1206, 1210.)[15] Courts in the Sixth Circuit have routinely held that this sort of language granted discretion to the claim administrators. *Perez*, 150 F.3d at 556 (holding that the language in the Plan allowing the defendant to request satisfactory evidence, review it, and make a benefit determination clearly granted discretion); *Yeager*, 88 F.3d at 380-81 (holding that the plan's requirement that claimant submit "satisfactory proof of Total Disability to us" was sufficient grant of discretion to warrant application of arbitrary and capricious standard of review); *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 983 (6th Cir.1991) (granting discretion "on the basis of medical evidence satisfactory to the Insurance Company"); *Leeal v. Cont'l Cas. Co.*, 17 F. App'x 341, 343 (6th Cir. 2001) (upholding the district court's finding that discretionary authority was conferred based on language about written proof of loss, time payment of claim, and particularly the requirement that claimant submit "due written proof of loss" to receive benefit); *Fendler v. CNA Grp. Life Assur. Co*, 247 F. App'x 754, 759 (6th Cir. 2007) ("Our circuit has repeatedly held that this "due proof" language confers discretion on the claims

[15] The Plan also provides that "a decision on any matter within the discretion of the . . . TPA . . . shall be binding on all Participants." (AR 1214.)

administrator to determine what type of proof is 'due,' such that the court must apply the arbitrary and capricious standard of review.") (citation omitted); *Zack v. McLaren Health Advantage, Inc.*, 340 F. Supp. 3d 648, 656 (E.D. Mich. 2018) (Berg, J.) ("This Circuit has interpreted language involving 'proof of loss' as indicating the claims administrator to whom a participant is instructed to submit that 'proof of loss' has full discretion to administer the plan."); *Weathers v. Mutual of Omaha Ins. Co.*, No. 2:08-cv-14788, 2009 WL 1620417 (E.D. Mich. Jun. 9, 2009) (Cleland, J.) (holding that the language of the Plan stating that benefits for loss will be paid "upon receipt of due written proof" and reserving the right to "make a decision" only after the plan administrator receives "information necessary to evaluate the claim" vested discretion).

B. Procedural Errors

Plaintiff also argues that the *de novo* standard applies because Sedgwick failed to comply with the Department of Labor ("DOL") claim-procedure regulations. (ECF No. 27, PageID.1527.)[16] The court notes that the Sixth Circuit has not issued a clear guidance on whether the de novo standard applies in a case involving procedural deficiencies, but at least two district

[16] Plaintiff does little to develop this argument in the "Standard of Review" section of her motion. (ECF No. 27, PageID.1527.) However, the court presumes that the alleged "indisputable" nonconformances to the DOL's claims-procedure regulation in support of the de novo standard are the same as those later presented in her brief. (ECF No. 27, PageID.1527, 1529-33.)

courts' opinions, which were highly regarded on appeal, have adopted this rule.[17] But in any case, Plaintiff has previously had a full opportunity to assert procedural challenges. (ECF Nos.8, 9, 14.) On December 4, 2020, she filed a "Statement of Procedural Challenge" claiming ten errors that supposedly prevented her from getting a "full and fair review of her claim." (ECF No. 9, PageID.52.) Defendants then moved the court to reject Plaintiff's statement and responded to the deficiencies alleged by Plaintiff in details. (*See* ECF No. 12.) In turn, Plaintiff conceded that some of the points she had raised were not procedural, but were substantive challenges. (ECF No. 14, PageID.180.) She then focused her arguments on only two contentions, which led the court to assume that she had conceded the others. (*Id.*, PageID.179-80; ECF No. 16, PageID.255.)

---

[17] In *Bustetter v. Standard Ins. Co.*, 529 F. Supp. 3d 693 (E.D. Ky. 2021), the Eastern District of Kentucky noted the lack of clear guidance from the Sixth Circuit and said that "until the Sixth Circuit provides additional guidance, . . . [it] will follow the prevailing view in the circuits and apply de novo review for violation of the 2002 version of the regulations." *Id.* at 703. The Sixth Circuit affirmed *Bustetter* and applauded it as a "notably thorough and well-reasoned opinion." *Bustetter v. Standard Ins. Co.*, No. 21-5441, 2021 WL 5873159, at *1 (6th Cir. Dec. 13, 2021). In *Myers v. Iron Workers Dist. Council of S. Ohio & Vicinity Pension Tr.*, No. 2:04-CV-966, 2005 WL 2979472, at *6 (S.D. Ohio Nov. 7, 2005), the Southern District of Ohio also applied the de novo standard of review "[c]onsidering the conflicting and potentially changing law on the subject of what standard of review applies in a case involving the procedural deficiencies." *Id.* at *6. The Sixth Circuit adopted the reasoning in *Myers*' "comprehensive and well-reasoned opinion." *Myers v. Iron Workers Dist. Couns. of S. Ohio & Vicinity Pension Tr.*, 217 F. App'x 526 (6th Cir. 2007).

One of Plaintiff's unabandoned challenges was Defendants' alleged failure to properly notify her of the initial benefit discontinuation and give her a reasonable opportunity to appeal. (ECF No. 16, PageID.255.) In its September 14, 2021 opinion and order, the court found that Plaintiff did not present a meaningful procedural defect with the notification and appeals process. (ECF No. 16, PageID.256-58.) Despite this, Plaintiff's motion now asserts the same arguments (ECF No. 27, PageID.1531, 1533). The law-of-the-case doctrine mandates that "findings made at one point in the litigation become the law of the case for subsequent stages of that same litigation." *Rouse v. DaimlerChrysler Corp. UAW*, 300 F.3d 711, 715 (6th Cir.2002). "The doctrine also bars challenges to a decision made at a previous stage of the litigation which could have been challenged in a prior appeal, but were not." *Id.* If Plaintiff thought the court had been misled in finding no procedural error with the notification and appeals of her claim, she should have challenged the ruling at that time by moving to reconsider or seeking an appeal. But Plaintiff did not do so. That finding became the law of the case as of September 14, 2021, and the court will not revisit it here since Plaintiff has not persuasively presented any "extraordinary circumstances" warranting a revisitation.[18] *Christianson v. Colt Indus. Operating Corp.*, 486 U.S. 800, 817 (1988).

---

[18] For example, Plaintiff's reply brief ostensibly asserts that the court erroneously analogized this case to *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803 (6th Cir. 1996), because "*Kent* predates the adoption of the Department of Labor

Plaintiff also asserts as a procedural deficiency Sedgwick's "fail[ure] to 'consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment' . . . when it relied on Dr. Shavell's report for its July 21, 2014 denial." (ECF No. 27, PageID. 1532). This contention has already been waived with Plaintiff making no passable effort to address it in responding to Defendants' motion to reject her procedural challenge statement. (*See* ECF No. 16, PageID.253.) Besides, it is not a valid point. The requirement of a "consult[tation] with a health care professional who has appropriate training and experience in the field of medicine" only applies "in deciding an appeal of any adverse benefit determination." 29 C.F.R. § 2560.503-1(h)(iii). Here, in determining Plaintiff's appeal, Sedgwick consulted with Dr. Hoenig, a board-certified neurologist, whose specialty is undisputedly appropriate in this instance.

---

claims-procedure regulation." (ECF No. 29, PageID.1601.) This contention is misplaced; the *Kent* court specifically described the notice requirement in the "regulation codified at Title 29 Code of Federal Regulation Section 2560.503-1":

> These regulations specify that a fiduciary shall establish a claim procedure which informs a claimant of a denial of a claim within 90 days of receipt of the claim. The regulations further specify that the procedure should inform the claimant of the specific reasons for denial of the claim including pertinent plan provisions relating to the denial, and should inform the claimant of his or her right to seek review of the claim decision.

Kent, 96 F.3d at 806.

In her reply, Plaintiff also notes how her surveillance was omitted from the administrative record. (ECF No. 29, PageID.1602.) This contention has already been raised in this case, though it was not one of Plaintiff's original alleged errors (ECF No. 9; *see* ECF No. 16, PageID.253-54.) Instead, Plaintiff brought this argument up in response to Defendant's motion to reject her procedural challenge statement. (ECF No. 14, PageID.180.) While Plaintiff now makes a more substantial effort in elaborating this point, it fails for the same reason the court gave on September 14, 2021. (ECF No. 16, PageID.255-56, n.2.) That is, Plaintiff still does not articulate what ERISA procedural protection was violated by her surveillance not being included in the administrative record. (*Id.*)

Accordingly, Plaintiff has failed to advance any substantial procedural defect to support a de novo review of Defendants' decision.[19]

---

[19] For this reason, remand is not an appropriate remedy in this case. *See Moore v. Lafayette Life Ins. Co.*, 458 F.3d 416, 436 (6th Cir. 2006) ("[A]dministrators need only substantially comply with . . . ERISA notice requirements in order to avoid remand.") (citation omitted. But even if there was a substantial procedure error, the court notes that remand would only constitute a "useless formality." *Duncan v. Minnesota Life Ins. Co.*, 845 F. App'x 392, 402–03 (6th Cir. 2021). As explained below, Plaintiff had ample opportunity to submit additional evidence to substantiate her claim of disability after July 2014, and Defendants invited her to submit that evidence. Plaintiff also had the opportunity to submit evidence in support of her procedural challenges, yet she has never provided, or even suggested what new evidence could have been provided that would warrant a reversal of Defendants' decision.

C. Arbitrary and Capricious Standard

With the Plan granting Sedgwick discretionary authority and no showing of any meaningful procedural error, the arbitrary and capricious standard of review applies. "Under this deferential standard, when it is possible to offer a reasoned explanation, based on the evidence for a particular outcome, that outcome is not arbitrary or capricious." *Cox v. Standard Ins. Co.*, 585 F.3d 295, 299 (6th Cir. 2009); *Williams v. International Paper Co.*, 227 F.3d 706, 712 (6th Cir. 2000) (citation omitted). The court must uphold the administrator's decision "if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence," even if the evidence could support a finding of disability. *Baker v. United Mine Workers of Am. Health & Ret. Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991); *Schwalm v. Guardian Life Ins. Co. of Am.*, 626 F.3d 299, 308 (6th Cir. 2010).

However, even with the high deference, "federal courts do not sit in review of the administrator's decisions only for the purpose of rubber stamping those decisions." *Moon v. Unum Provident Corp.*, 405 F.3d 373, 379 (6th Cir. 2005); *accord*, *e.g.*, *Kramer v. Paul Revere Life Ins. Co.*, 571 F.3d 499, 507 (6th Cir. 2009). The court is guided by "[s]everal lodestars . . . : the quality and quantity of the medical evidence; the existence of any conflicts of interest; whether the administrator considered any disability finding by the Social Security Administration; and whether the administrator contracted with physicians to conduct a file review as opposed to a physical examination of the claimant." *Shaw*

v. AT & T Umbrella Ben. Plan No. 1, 795 F.3d 538, 547 (6th Cir. 2015) (quotation marks and citation omitted). Generally, "a court may consider only the evidence available to the administrator at the time the final decision was made." *Id.*

Plaintiff bears the burden of proving that Defendants' denial of her benefits was arbitrary and capricious. *Farhner v. United Transp. Union Discipline Income Prot. Program*, 645 F.3d 338, 343 (6th Cir. 2011).

III. DISCUSSION

Plaintiff argues that the discontinuation of her benefits as of July 2014 was arbitrary and capricious because (1) Sedgwick ignored the SSA decision awarding SSDI benefits to Plaintiff (ECF No. 27, PageID.1534-36), (2) Sedgwick ignored information submitted by Plaintiff's treating physicians, but instead relied heavily on non-treating physicians' conclusions without an actual neurological exam. (*Id.*, PageID.1536-39, 1541-44), and (3) Sedgwick ignored Plaintiff's comments regarding Dr. Shavell's IME and report (*Id*, PageID.1539-41). The court addresses these contentions in turn and finds that Defendants' decision was not arbitrary and capricious.

A. SSA Disability Determination

"An ERISA plan administrator's failure to address the Social Security Administration's finding that the

claimant was "totally disabled" is [a] factor that can render the denial of further long-term disability benefits arbitrary and capricious." *Glenn v. MetLife*, 461 F.3d 660, 669 (6th Cir. 2006). In *Bennett v. Kemper National Services, Inc.*, 514 F.3d 547 (6th Cir. 2008), the Sixth Circuit said:

> if the plan administrator (1) encourages the applicant to apply for Social Security disability payments; (2) financially benefits from the applicant's receipt of Social Security; and then (3) fails to explain why it is taking a position different from the SSA on the question of disability, the reviewing court should weigh this in favor of a finding that the decision was arbitrary and capricious.

Id. at 553. "It is not necessary, however, that the plan administrator expressly distinguish a favorable SSA determination in denying disability benefits under the plan." *Leffew v. Ford Motor Co.*, 258 F. App'x 772, 779 (6th Cir. 2007) (citing *Whitaker v. Hartford Life & Accident Ins. Co.*, 404 F.3d 947, 949 (6th Cir. 2005)).[20]

Undisputedly, Sedgwick required Plaintiff to apply for SSDI benefits, in compliance of which she did and was eventually granted disabled status by the SSA in August 2012. (AR 995.) After Plaintiff was awarded SSDI benefits, the Plan benefited financially: in addition to reducing its prospective financial burden (*see*

---

[20] Plaintiff has conceded that the version of the claim-procedure regulation in effect in 2014 does not explicitly require a denial of benefits notification o address a contrary SSA's determination. (ECF No. 14, PageID.178.)

AR 1209), it recouped over $15,000 previously paid to Plaintiff (AR 518, 544.) Sedgwick did not explain in any of its denial letters to Plaintiff why it took a different position that what was adopted by the SSA. (AR 592-93, 656-57, 883-84, 974.) Accordingly, under *Bennett*, the court "should weigh this in favor of a finding that the decision was arbitrary and capricious." 514 F.3d at 553. However, this does not mean that the failure to explain the decision is arbitrary and capricious per se. *Morris v. Am. Elec. Power Long-Term Disability Plan*, 399 F. App'x 978, 986 (6th Cir. 2010) ("[T]he language of *Bennett* indicates that a failure to take into account a Social Security disability award is to be *weighed* in favor of a finding that the decision was arbitrary and capricious, not that such a decision is arbitrary and capricious per se.") (emphasis in original).

Although the dissonance with the SSA's decision weighs against Defendants, that weight is not enough to tip the scale in Plaintiff's favor in this case. First, there is no information on the SSA's determination of Plaintiff's disability, and this determination was made two years before Sedgwick decided to discontinue Plaintiff's benefits. *See Cox*, 585 F.3d at 303. Additionally, as indicated below, Plaintiff fails to show that the process and substance of Sedgwick's review warrants a finding that its decision was arbitrary and capricious. *See Wooden v. Alcoa, Inc.*, 511 F. App'x 477, 485 (6th Cir. 2013) (upholding the defendant's decision to terminate the plaintiff's benefit because even though the defendant's cavalier treatment of the SSA's determination weighed in favor of finding that the defendant was

arbitrary and capricious, the review of the medical evidence and the conflict of interest did not); *Hurse v. Hartford Life and Accident Ins. Co.*, 77 F. App'x 310, 318 (6th Cir.2003) (finding that the mere fact that the defendant's conclusion "differs from that of the ALJ does not make it arbitrary and capricious" when "[t]he medical evidence . . . was clearly susceptible to opposite conclusions as to the nature of [the plaintiff's] disability"); *Stano v. Lumbermens Mut. Cas. Co.*, No. 06-CV-10842-DT, 2007 WL 171601, at *5 (E.D. Mich. Jan. 18, 2007) (Cleland, J.) ("Even if Defendant completely failed to consider the SSA's decision, and it is not clear that it did, this is only one factor for the court to consider . . . Because Defendant has offered a reasoned explanation, based on the evidence, for its outcome, that outcome is not arbitrary or capricious.") (alteration, quotation marks, and citations omitted)

B. Medical Evidence

"Generally, when a plan administrator chooses to rely upon the medical opinion of one doctor over that of another in determining whether a claimant is entitled to ERISA benefits, the plan administrator's decision cannot be said to have been arbitrary and capricious because it would be possible to offer a reasoned explanation, based upon the evidence, for the plan administrator's decision." *McDonald v. W.-S. Life Ins. Co.*, 347 F.3d 161, 169 (6th Cir. 2003) Additionally, "plan administrators are not obliged to accord special deference to the opinions of treating physicians." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 825

(2003). However, they "may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Id.* at 834. "[T]hey must instead give reasons for adopting an alternative opinion." *Curry*, 400 F. App'x at 59 (citing *Elliot v. Metro. Life Ins.*, 473 F.3d 613, 620 (6th Cir. 2006)). An acceptable reason could be that the treaters' opinion lacks supporting objective evidence, *see Morris*, 399 F. App'x at 986-87, *Curry*, 400 F. App'x at 59, or that the treating sources lack expertise in the relevant field, *Black & Decker Disability Plan*, 538 U.S. at 832, *Simpson v. Liberty Life Assurance Co. of Boston*, No. 06-11077, 2007 WL 2050428, at *4 (E.D. Mich. July 17, 2007) (Cox, J.) (adopting report and recommendation).

Moreover, "nothing inherently objectionable about a file review . . . in the context of a benefits determination" unless it proves "clearly inadequate." *Calvert v. Firstar Finance, Inc.*, 409 F.3d 286, 296 (6th Cir. 2005). Inadequacies can arise where:

- the file reviewer "concludes that the claimant is not credible without having actually examined him or her," *Judge v. Metro. Life Ins. Co.*, 710 F.3d 651, 663 (6th Cir. 2013), *Smith v. Cont'l Cas. Co.*, 450 F.3d 253, 263 (6th Cir. 2006);
- the file reviewer made conclusions that are "incredible on their face" when compared to the objective data and "thorough objectively verifiable determinations of the SSA and [the claimant's] treating physician, *Calvert*, 409 F.3d at 296-97, *Koning v. United of Omaha*

Life Ins. Co., 627 F. App'x 425, 434 (6th Cir. 2015); or

- "only [the administrator's] physicians, who had not examined [the claimant], disagreed with the treating physicians", *Hoover v. Provident Life and Acc. Ins. Co.*, 290 F.3d 801, 809 (6th Cir. 2002).

Here, it was not arbitrary for Sedgwick to discontinue Plaintiff's benefits after it received Dr. Shavell's IME finding of no evidence of a regional complex plain issue as of July 2014. (AR 975-79.) In so doing, Sedgwick did not ignore contrary opinions of Plaintiff's treating physicians. Plaintiff has not been able to point to any medical opinions rendered by her treaters around July 2014 that she was totally disabled. Indeed, the record shows Plaintiff visited Dr. Nounou a couple of days after her IME with Dr. Shavell, and no diagnosis, plan of care, or limitations were noted at this visit. (AR 970.) The only thing Sedgwick received after July 2014 with an opinion from her treating physicians about her condition was a letter from Dr. Brengel dated April 15, 2015, and that was nine months later. To the extent Plaintiff attacks Dr. Shavell for not being a neurologist, most of the opinions relied by Plaintiff were made by treating sources who are not neurologists.

In reviewing Plaintiff's appeal, Sedgwick also did not arbitrarily rely on the file review by Dr. Hoenig. Plaintiff fails to advance any genuine challenges to the file review process and Dr. Hoenig's conclusion. First, while she claims that "[i]t appears that Sedgwick provided Dr. Hoenig with only a selection of records from

June 24, 2011 to January 2014," (ECF No. 27, PageID.1523,) this contention is contradicted by the list of the records provided for review indicated in Dr. Hoeng's report (AR 660).

Similarly, Plaintiff's claim that "Sedgwick frustrated any opportunity for [Plaintiff] to submit documentation regarding her condition" lacks support. As of the date of Dr. Hoenig's review, Plaintiff had already provided documents with her July 28, 2014 letter. (AR 967-72.) On August 8, 2014, she was asked if she planned to provide any additional documentation, and she responded negatively. (AR 949.) She was again informed of her rights to provide documentation when she received the August 20, 2014 letter, yet none was provided.[21] Ultimately, it was Plaintiff who bore the burden to furnish satisfactory proof of disability and continuation thereof under the Plan. (AR 1206); *see Miller*, 925 F.2d at 984-85 (interpreting the plan provision, which stated that "on demand from the insurance company, further satisfactory proof, in writing, must be submitted to the insurance company that the disability continues," as putting the burden on the participant to prove continuing disability); *Likas v. Life Ins. Co. Of N. Am.*, 347 F. App'x 162, 167 (6th Cir. 2009) (holding that similar plan language made clear that plaintiff must provide continued proof of his disability and the

[21] While Plaintiff blames this on the timing of Sedgwick's appeal decision, despite having opportunities to do so in this case, she has never suggested what documents could have been provided that would warrant an alteration of Defendants' decision.

defendant does not bear the burden of showing that plaintiff's eligibility has ended).[22]

As Plaintiff acknowledges, Dr. Hoenig did not dispute the treating sources' opinions; indeed, he consulted them and incorporated the same medical restrictions and limitations prescribed by her physicians in his report. (ECF No. 27, PageID.1524; ECF No. 29, PageID.1606-07; AR 661-63.) He even tried to speak to the doctor who last treated Plaintiff. (AR 661.) Dr. Hoenig also made no credibility assessment of Plaintiff. (*See* AR 661-63.) His explanation for his conclusion – the lack of sufficient objective evidence – was a valid reason and is unchallenged by Plaintiff. *Morris*, 399 F. App'x at 986-87; *Curry*, 400 F. App'x at 59. Furthermore, Dr. Hoenig was not the only physician who found that Plaintiff was not disabled as of July 22, 2014. Dr. Shavell and FCA's plant doctor both examined Plaintiff and came to the same conclusion. (AR 945-46, 975-79.) Thus, Sedgwick could rely on Dr. Hoenig's review because his procedure was reasonable, his finding was rational, and there is not a sufficient reason to reject

---

[22] Plaintiff argues that Defendants were required to make a vocational assessment to determine whether Plaintiff could perform her own job or regular employment with FCA. (ECF No. 27, PageID.1541.) The record shows that an ability-to-work evaluation was conducted on July 22, 2014. To the extent Plaintiff argues that Defendants must identify a job that she could perform to find that she was not totally disabled, the Sixth Circuit has also "rejected a legal rule requiring administrators to introduce vocational evidence identifying jobs that participants can perform." *Autran v. Procter & Gamble Health & Long-Term Disability Benefit Plan*, 27 F.4th 405, 417 (6th Cir. 2022) (citing *Judge*, 710 F.3d at 662-63).

his review. *See e.g.*, *Judge*, 710 F.3d at 663 (holding that the reliance on a file review was proper as "the file reviewers made no credibility determinations about Judge and did not second-guess Judge's treating physicians" and their findings "simply echo those of [the plaintiff's] own doctors, make note where the reports lack objective medical evidence in support of the boxes checked, and point out the internal inconsistencies").

That Sedgwick's decision was not arbitrary and capricious is further demonstrated by its willingness to re-review Plaintiff's claim in July 2015, despite having no obligation to do so. In upholding its decision, Sedgwick relied on a separate IRR by another neurologist, Dr. Friedman. (AR 599-603.) As with Dr. Hoenig's review, Plaintiff does not advance any meaningful challenge to Dr. Friedman's process and findings. Again, Plaintiff faulted Sedgwick for not allowing her to provide documentation, except she did provide documentation in May 2015 (albeit insufficient) (AR 654-55) and Sedgwick tried to communicate to her that she could do so (AR 651). Plaintiff said she never received the July 8, 2015 communication, because it was sent to her old address. (ECF No. 29, PageID. 1607.) However, nothing indicates that this was done intentionally, nor does Plaintiff claim that she had updated Sedgwick with her new address.[23] Contrary to Plaintiff's assertion, Dr. Friedman did not just rely primarily on Dr. Shavell's findings (AR 601), though it was reasonable

[23] It was incumbent on Plaintiff to "promptly furnish . . . information as is necessary to provide benefits under the terms of th[e] Plan." (AR 1217)

for Dr. Friedman to consider them as they were made during the pertinent time – July 2014. In addition to reviewing Dr. Shavell's report, Dr. Friedman also considered the notes of Dr. Nounou, who saw Plaintiff on July 17, 2014, and contacted his office. (AR 599-601.) Dr. Friedman was able to confirm with a nurse at Dr. Nounou's office that no disability issue was noted during that appointment or thereafter. (AR 600.)

Like Dr. Hoenig, Dr. Friedman did not ignore the opinions of Plaintiff's treating physicians. He reviewed them and provided a neurology synopsis of them in his report, including those supporting previous disabilities. (*Id.*) He made no assessment of Plaintiff's credibility and even incorporated her account as described in the July 28, 2014 letter. (*Id.*). Other than Dr. Shavell's IME report (AR 975-79) and Dr. Nounou's note of the July 17, 2014 visit (AR 970-72), there is no other objective medical information for Plaintiff's condition in or around July 2014. Nine months after, Dr. Brengel second-handedly relayed that another physician, Dr. K. Fram, performed an EMG of Plaintiff and believed that Plaintiff had medical issues. (AR 655.) However, no test result was provided, nor were there any records substantiating Dr. Fram's alleged beliefs. Dr. Friedman did not totally ignore what Dr. Brengel wrote in his April 2015 letter; instead, he justifiably found it unconvincing given that it "did not include any new examination findings or results of the testing." (AR 595.) In short, Dr. Friedman's conclusion that insufficient clinical evidence supported Plaintiff's disabilities, restrictions, or limitations was not "incredible

on its face." In fact, Plaintiff concedes that this was "not surprising." (ECF No. 29, PageID.1608.)[24]

Accordingly, the court finds that Defendants did not unjustifiably ignore the opinions of Plaintiff's treaters, nor did they arbitrarily or capriciously rely on their physicians' findings in discontinuing Plaintiff's benefits.

C. Plaintiff's Comments

Lastly, Plaintiff condemned Defendant's decision as arbitrary and capricious because Sedgwick totally ignored her response to Dr. Shavell's IME report. (ECF No. 27, PageID.1539-40.) Plaintiff has failed to come forward with any evidence supporting this contention. While Sedgwick did not expressly address her comments, silence is not evidence of disregard. *See Hurse v. Hartford Life & Accident Ins. Co.*, 77 F. App'x 310, 318 (6th Cir. 2003) ("We are not persuaded that Hartford's silence with regard to the SSA record and findings is evidence that it did not consider them . . . "). Plaintiff also has failed to advance any authority or Plan language suggesting that Sedgwick had an obligation to specifically elaborate what it thought of Plaintiff's remarks. (ECF No. 29, PageID.1604.)

To the contrary, as Defendants point out, the regulations only require Sedgwick to "*[p]rovide a review*

---

[24] Additionally, Plaintiff concedes that "the [administrative] record [in this case] is insufficient for the Court to make th[e] determination" that Plaintiff is entitled to benefits. (ECF No. 29, PageID.1608.)

that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim . . . " 29 C.F.R. § 2560.503-1(h)(2)(iv) (emphasis added). Here, not only is there no indication that Sedgwick wholly disregarded Plaintiff's comments, but Sedgwick also deemed them material enough to provide them to Dr. Hoenig and Dr. Friedman for their review. (AR 660, 599.) And Dr. Friedman specifically incorporated Plaintiff's comments from her letter to his report. (AR 600.) Thus, the court finds that Sedgwick met its obligation to provide a review that considers Plaintiff's comments. 29 C.F.R. § 2560.503-1(h)(2)(iv). However, having already done that, nothing in the Plan, the regulations, or the case law required Sedgwick to credit Plaintiff's comments over contrary objective evidence (or lack thereof). *See Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 382 (1996) (holding that administrator did not act arbitrarily in discounting claimant's "subjective complaint [,that] are easy to make, but almost impossible to refute").

In short, Plaintiff has failed her burden of showing that Defendants wholesale ignored her comments or acted arbitrarily in not relying on them.

IV. CONCLUSION

Defendants' decision to discontinue Plaintiff's benefits as of July 22, 2014 was the result of a deliberate and principled reasoning process and supported by substantial evidence. Accordingly,

IT IS ORDERED that Plaintiff's "Motion for Judgment" (ECF No. 27) is DENIED.

IT IS FURTHER ORDERED that Defendants' "Motion for Judgment on the Administrative Record" is GRANTED.

s/Robert H. Cleland /
ROBERT H. CLELAND
UNITED STATES DISTRICT JUDGE

Dated: September 21, 2022

I hereby certify that a copy of the foregoing document was mailed to counsel of record on this date, September 21, 2022, by electronic and/or ordinary mail.

s/Lisa Wagner /
Case Manager and Deputy Clerk
(810) 292-6522

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JACQUELINE AVERY,

Plaintiff,

v. Case No. 20-11810

SEDGWICK CLAIMS MANAGEMENT SERVICES, INC. and EXTENDED DISABILITY BENEFIT OF THE CHRYSLER GROUP LLC GROUP INSURANCE PROGRAM

Defendants. /

OPINION AND ORDER GRANTING DEFENDANTS' MOTION TO REJECT PROCEDURAL CHALLENGE

(Filed Sep. 14, 2021)

Plaintiff Jacqueline Avery, an employee of Chrysler Group, LLC ("Chrysler"), brings this action under 29 U.S.C. § 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA) to recover benefits allegedly owed by an employer-provided long-term disability plan ("Defendant Plan[1]") and administered

[1] The court notes that there is evidently some confusion between the parties about which Chrysler long-term disability plan is the proper Defendant in the present dispute. (*See* ECF No. 14, PageID.177 n.1.) The court expects counsel for the respective

by Defendant Sedgwick Claims Management Services, Inc. ("Sedgwick"). (ECF No. 1.) Currently before the court is Plaintiff's Statement of Procedural Challenge (ECF No. 9) and Defendants' response, styled as a "Motion to Strike Statement of Procedural Challenge." (ECF No, 12.) The court construes the motion as one to review and reject, rather than to "strike" the filed paper from the record. Having reviewed the briefs, the court concludes that a hearing is not necessary. See E.D. Mich. LR 7.1(e)(2). For the reasons stated below, the court agrees that Plaintiff has not presented a proper procedural challenge and will therefore REJECT the Statement of Procedural Challenge, and will limit review to the administrative record.

I. BACKGROUND

Plaintiff worked as a financial specialist at Chrysler in Michigan until July 2011. She allegedly became disabled "as a result of complex regional pain syndrome, venous reflux disease, and neuropathy, complicated by other conditions" in her lower extremities. (ECF No. 1, PageID.3; ECF No. 12, PageID.96.) After receiving short-term disability, Plaintiff was approved for long-term disability benefits in August 2012 by Defendant Sedgwick. (ECF No. 1, PageID.4.) As required by the terms of Defendant Plan, Plaintiff applied for Social Security Disability benefits in August 2012 and was approved based on her application

---

parties to confer and reach a resolution on this point as the answer should be easily obtainable.

and medical information without the need for a hearing. (*Id*, PageID.5.) Plaintiff's benefits under the plan were then offset by her Social Security payments. (*Id.*)

Sedgwick continued to authorize extensions of Plaintiff's benefits until July 2014 when it notified Plaintiff that she would be required to attend an independent medical examination with Dr. Joel Shavell, who is board certified in internal medicine and rheumatology. (*Id*, PageID.6.) On July 21, 2014, Sedgwick sent a letter to Plaintiff stating that the "recent IME examination" found that she was "[a]ble to work." (ECF No. 12-1, PageID.134.) The letter told Plaintiff to "report to your plant medical department for a determination of your ability to return to work" and advised that Plaintiff's benefits "may be suspended effective July 21, 2014 pending the outcome of the ability to work examination."

At the onsite examination Chrysler's physician found that Plaintiff was able to return to work (*Id.*, PageID.122), and on August 20, 2014, Sedgwick sent Plaintiff a longer letter stating that "[b]ased upon the results of the your recent IME examination, in which you were found able to work, the eligibility requirement is no longer satisfied." (*Id.*, PageID.123.) The letter also said that Plaintiff was to report to the Chrysler Human Resources Department "for a determination of your ability to return to work" and laid out the process and deadlines for filing an appeal. (*Id.*)

Before even receiving this second notification, however, in late July 2014, Plaintiff filed a detailed

letter "appeal[ing] [the] recent return to work decision communicated to me on July 22, 2014," by "challeng[ing] several statements" in Dr. Shavell's IME report, a copy of which Plaintiff had obtained "during [her] visit to Chrysler." (*Id.*, PageID.125-27.)

After an independent record review conducted by neurologist David Hownig, Sedgwick informed Plaintiff on September 12, 2014 that her appeal was being denied. (*Id.*, PageID.110.) Plaintiff hired an attorney and, on May 18, 2015, submitted another letter to Sedgwick requesting that her benefits be "immediately [and] retroactively" reinstated. She attached a letter from Dr. Robert Brengel, Plaintiff's treating physician, indicating Plaintiff was still disabled. (*Id.*, PageID.106.) Sedgwick then conducted another review of Plaintiff's file and obtained a new independent record review by a neurologist. (*Id.*, PageID.97-98.) In September 2015, Sedgwick again found that Plaintiff was not disabled. (*Id.*) The new letter indicated that Plaintiff had forty-five days to appeal the updated determination. (*Id.*) She did not file another appeal. Instead, Plaintiff commenced the present ERISA suit in July 2020. (*See* ECF No. 1)

II. STANDARD

The general rule is that a district court should base its review of an ERISA-based claim of an alleged denial of benefits solely upon the administrative record. *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 619 (6th Cir. 1998). The district court may consider

other evidence "only if that evidence is offered in support of a procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part." *Id.* "If a court finds that due process was not denied, however, then it is appropriate for the district court to deny further discovery into substantive areas, or else a plaintiff could circumvent the directive of *Wilkins* merely by pleading a due process problem." *Moore v. Lafayette Life Ins. Co.*, 458 F.3d 416, 431 (6th Cir. 2006); *Putney v. Medical Mutual of Ohio*, 111 F. App'x 803, 807 (6th Cir. 2004).

III. DISCUSSION

Plaintiff has filed a "Statement of Procedural Challenge" highlighting ten alleged procedural errors which she contends prevented her from being afforded a "full and fair review of her claim." (ECF No. 9, PageID.52.)

1. Sedgwick hired a doctor who is not a neurologist, Dr. Joel Shavell, to evaluate Ms. Avery's neurological disorders, and Sedgwick did not send the doctor a complete set of medical records to review (Complaint, ¶¶ 29-33, ECF No. 1, PageID.7);

2. Sedgwick discontinued Ms. Avery's benefits after initially approving them for several years solely on the basis of Dr. Shavell's flawed evaluation (Complaint, ¶ 35, ECF No. 1, PageID.7);

3. In issuing its decision, Sedgwick failed to apply the correct definition of disability under the terms of the Chrysler Plan (Complaint, ¶¶ 36-37, ECF No. 1, PageID.7-8);

4. Sedgwick did not perform an assessment of Ms. Avery's employability that was consistent with the terms of the Chrysler Plan (Complaint, ¶ 38, ECF No. 1, PageID.8);

5. Sedwick's adverse benefit determination letter to Ms. Avery failed to comply with ERISA regulations in that it did not explain Ms. Avery's appeal rights, did not notify Ms. Avery that she had a right to obtain all of the information relevant to her claim, and did not explain what information was needed for Ms. Avery to perfect her claim (Complaint, ¶ 39, ECF No. 1, PageID.8);

6. Contrary to acceptable procedure for ERISA benefit claims, Sedgwick's adverse benefit determination letter failed to address in any way the fact that Ms. Avery has been approved for Social Security Disability benefits, despite the fact that Sedgwick had required Ms. Avery to apply for those benefits and Sedgwick claimed an overpayment and offset based on Ms. Avery's receipt of Social Security Disability benefits (Complaint, ¶ 40, ECF No. 1, PageID.9);

7. Sedgwick also totally ignored favorable evidence from Ms. Avery's treating physicians without any explanation, and Sedgwick

heavily relied on its own consultant who was not board-certified in the relevant specialty (Complaint, ¶ 40, ECF No. 1, PageID.9);

8. Sedgwick ignored the favorable findings of two doctors who performed earlier IMEs (Complaint, ¶ 46, ECF No. 1, PageID.10);

9. Sedgwick denied an appeal by Ms. Avery and issued a final adverse benefit determination that again failed to use the correct definition of disability from the plan, failed to address the fact that Ms. Avery was getting Social Security Disability benefits, failed to address her treating physician opinions, and relied entirely on the opinion of a hired consultant (Complaint, ¶ 48, ECF No. 1, PageID.10);

10. Sedgwick did not follow the claim procedures of the Chrysler Plan, failing to notify Ms. Avery that she might have a further avenue for appeal, and instead notifying her that: "The decision is the Claim Administrator's final decision. You have the right to bring a civil action under ERISA 502(a)." (Complaint, ¶¶ 49-51, ECF No. 1, PageID.10-11);

(ECF No. 9, PageID.51-52.) Plaintiff's original filing argued that these alleged procedural errors entitle her to obtain discovery from outside the administrative record under *Wilkins*. (*Id.*) Defendants filed a "Motion to Strike Plaintiff's Statement of Procedural Challenge" providing a detailed response to all ten

deficiencies alleged by Plaintiff. (*See* ECF No. 12.) In Plaintiff's most recent briefing, she now concedes that:

> Defendants are correct that a few of the points raised in Plaintiff's Statement of Procedural Challenge typically get resolved without expanding the administrative record. An argument that the administrator 'ignored favorable evidence submitted by [her] treating physicians, selectively reviewed the evidence it did consider from the treating physicians, failed to conduct its own physical examination, and heavily relied on non-treating physicians' can be factors weighing in favor of finding the administrator's decision to be arbitrary and capricious.

(ECF No. 14, PageID.180 (quoting *Shaw v. AT&T Umbrella Benefit Plan No. 1*, 795 F.3d 538, 547 (6th Cir. 2015)).) Plaintiff did not specify which of the ten objections raised in the procedural challenge she is abandoning, so the court will assume that Plaintiff has conceded all challenges not directly argued in her briefing.

Plaintiff's latest briefing continues to argue that the following procedural errors occurred. First, Plaintiff contends that Defendants failed to provide proper notification of the initial denial of benefits and that the timing of the notification also meant the denial of a reasonable opportunity to appeal. (*Id.*, PageID.175-76.) Second, Plaintiff argues that Defendants failed to properly consider the Social Security Administration's

finding that Plaintiff was disabled.[2] (*Id.*, PageID.179-80.)

A. Notification

The court first finds that Plaintiff has failed to alleged a plausible procedural violation with regards to EIRSA's notification requirement because the alleged "procedural failures did not prevent [Plaintiff] from gaining information necessary to contest h[er] denial of benefits." *See Putney v. Med. Mut. of Ohio*, 111 F. App'x 803, 807 (6th Cir. 2004). The crux of Plaintiff's argument is that the July 21, 2014 letter sent to Plaintiff constituted a "notification of a benefit determination" that failed to "provide adequate notice in writing . . . , setting forth the specific reasons for such denial, . . . and . . . afford[ing] a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review." 29 U.S.C.A. § 1133; *see also* 29 C.F.R. § 2560.503-1(g) (2014) (setting forth specific information that must be included in a benefits determination letter).

---

[2] Plaintiff's latest briefing now also argues that "[Plaintiff] should have access to all [of Chrysler's] related corporate and personal records" because the administrative record contains an email from corporate security to Sedgwick indicating that Chrysler had conducted surveillance on Plaintiff. (ECF No. 14, PageID.180.) Plaintiff however fails to articulate what procedural protection was violated by this email being included in the administrative record in the first place. Consequently, Plaintiff has not plausibly alleged that she has "been substantially denied [any] procedural protections afforded by ERISA." *See Moore v. Lafayette Life Ins. Co.*, 458 F.3d 416, 431 (6th Cir. 2006).

It is undisputed that the July 21 letter did not provide a detailed determination of Defendants' decision to deny Plaintiff further disability benefits and did not include any information on how an appeal could be filed. (*See* ECF No. 12-1, PageID.134.) Defendants factually dispute whether this letter constituted a benefits determination or merely communicated the findings of Dr. Shavell's IME. (ECF No. 12, PageID.72.) And Defendants point to Sedgwick's detailed August 20, 2014 letter—which more closely hewed to the requirements of 29 C.F.R. § 2560.503-1(g)—as the document meant to notify Plaintiff of a final benefits determination. (ECF No. 12-1, PageID.123.)

The court need not wade into this factual dispute because the Sixth Circuit found in *Kent v. United of Omaha Life Ins. Co.* that an insurer "*substantially complied* with E.R.I.S.A.'s procedural requirements" when the claimant was provided with two consecutive letters that collectively complied with ERISA's notification requirement. 96 F.3d 803, 807 (6th Cir. 1996) (emphasis added). In *Kent*, the insurer's notification procedures "were technically deficient because the [contents of the] first letter did not meet the requirements of the statute and regulation, and the second letter was untimely (it being issued more than 90 days after the decision to deny the claim)." *Id.* But the court determined that "when viewed in light of the myriad of communications between claimant, her counsel and the insurer, [the letters] were sufficient to meet the purposes of Section 1133 in insuring that the claimant

understood the reasons for the denial of the claim as well as her rights to review of the decision." *Id.*

In the present case, Defendants' substantial compliance with the notification requirements is even more readily apparent, because unlike in *Kent*, even if the court assumes that, as Plaintiff alleges, both letters were attempts at notifying Plaintiff of a final benefit determination, Sedgwick's second letter provided a timely correction undisputedly within the ninety-day notification window required by the regulation. Therefore, any alleged "procedural failures" with regards to the notification letters cannot plausibly said to be "substantial" under Sixth Circuit case law because the alleged procedural violations "did not prevent [Plaintiff] from gaining information necessary to contest [her] denial of benefits." *Putney*, 111 F. App'x at 807.

Plaintiff likewise has failed to allege any meaningful procedural defect in the appeals process. While Plaintiff's decision to file an appeal before she had received the more detailed August 20, 2014 denial letter may have caused some confusion, it is undisputed that Sedgwick not only acted on the contents of the initial appeal but also allowed the Defendant another "rereview" of its determination in 2015 once she had retained counsel. (*See* ECF No. 15-2, PageID.216-17.) Sedgwick responded to the July 2014 appeal—raising questions about Dr. Shavell's IME—by engaging a neurologist to conduct an independent record review. (*See* ECF No. 15-2, PageID.227-31.) And, after the appeals deadline listed in its August 20, 2014 letter, Sedgwick voluntarily reexamined the file and had yet another

neurologist conduct an independent record review in 2015 when Plaintiff's attorney submitted a new letter from her primary care physician supporting her claim. (*See* ECF No. 12-1, PageID.99-100, 106-07.) Plaintiff does not deny such reviews occurred and has not clearly articulated how these two appeals together did not provide Plaintiff with a meaningful chance of review. Plaintiff cannot complain she was unaware that she had the opportunity to file a second appeal when she actually filed one; therefore, the court finds Plaintiff has not plausibly alleged a significant deficiency in the appeals process.

B. Failure to Consider the Social Security Determination

Plaintiff next argues that a procedural flaw in the review of her claim exists because the Defendants failed to properly consider the Social Security Administration's determination that Plaintiff was disabled. While the current version of the ERISA "Claims Procedure" regulation requires that a denial of benefits notification address a contrary Social Security Disability determination, Plaintiff now concedes the version of the regulation in effect during 2014 had no explicit requirement. (ECF No. 14, PageID.178.) *See* 29 C.F.R. § 2560.503-1 (2014). Instead, Plaintiff argues that

> the amended regulations [now in effect] merely clarify the existing requirement to provide each claimant with a full and fair review, and the Sixth Circuit has long adhered to the

> jurisprudential rule that, 'if the plan administrator (1) encourages the applicant to apply for Social Security disability payments; (2) financially benefits from the applicant's receipt of Social Security; and then (3) fails to explain why it is taking a position different from the SSA on the question of disability, the reviewing court should weigh this in favor of a finding that the decision was arbitrary or capricious.'

(*Id.*, PageID.178-79 (quoting *Bennett v Kemper National Services*, 514 F.3d 547, 554 (6th Cir. 2008)).) A close reading of *Bennett* however shows that it stands only for the proposition that a defendant's failure to consider an SSA disability determination is a factor that "weighs in favor of finding that [the insurer] failed to engage in a deliberate, principled reasoning process" under the arbitrary and capricious standard of review. *Bennett*, 514 F.3d at 554 (quotation omitted). The *Bennett* decision nowhere indicates that an insurer's failure to consider an SSA determination constitutes a procedural error that necessitates extra discovery. Plaintiff can certainly argue that the failure to consider the SSA disability determination supports a finding that Defendant's determination "cannot withstand scrutiny under the arbitrary or capricious standard of review," but it does not constitute grounds for more discovery. *See id.*

Perhaps anticipating this conclusion, Plaintiff, in the alternative, now argues that further discovery is needed "because Sedgwick not only required Ms. Avery

to apply for Social Security, but controlled the entire process through which Ms. Avery obtained her benefits." (*Id.*, PageID.179.) The Defendants, in response, argue that the record shows that "there is no evidence to support Plaintiff's argument that Sedgwick administered Plaintiff's application for SSDI, because it did not." (ECF No. 15, PageID.208.) The court first notes that Plaintiff's new factual allegation was first raised in her responsive briefing and is not contained in the initial complaint. (*See* ECF No. 1, PageID.9 (noting only that "Sedgwick had required Ms. Avery to apply for [the SSDI] benefits").) Plaintiff's new argument includes no citations to any facts in the record. Because Plaintiff has not "provided any facts to support a claim that discovery might lead to such evidence," the court finds that this "mere allegation," is insufficient to establish a plausible procedural defect claim that requires additional discovery. *Putney*, 111 F. App'x at 807.

IV. CONCLUSION

For the reasons stated above, the court finds that Plaintiff has failed to raise significant procedural defects that justify further discovery. Accordingly,

IT IS ORDERED that "Defendants' Motion to Strike Plaintiff's Statement of Procedural Challenge" (ECF No. 12) is GRANTED and Plaintiff's Statement of Procedural Challenge (ECF No. 9) is REJECTED.

No valid procedural challenge is presented justifying further discovery.

s/Robert H. Cleland
ROBERT H. CLELAND
UNITED STATES DISTRICT JUDGE

Dated: September 14, 2021

I hereby certify that a copy of the foregoing document was mailed to counsel of record on this date, September 14, 2021, by electronic and/or ordinary mail.

s/Lisa G. Wagner
Case Manager and Deputy Clerk
(810)292-6522

No. 22-1960

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JACQUELINE AVERY, Plaintiff-Appellant, v. SEDGWICK CLAIMS MANAGEMENT SERVICES, INC. AND FCA US LLC LONG-TERM DISABILITY BENEFIT PLAN, Defendants-Appellees.	)	ORDER (Filed Aug. 24, 2023)

BEFORE: McKEAGUE, GRIFFIN, and MURPHY, Circuit Judges.

The court received a petition for rehearing en banc. The original panel has reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. The petition then was circulated to the full court.* No judge has requested a vote on the suggestion for rehearing en banc.

---

* Judge Davis recused herself from participation in this ruling.

Therefore, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Deborah S. Hunt
Deborah S. Hunt, Clerk

29 U.S.C. § 1133. Claims procedure.

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

[For Claims Filed *After* January 1, 2002]

[Code of Federal Regulations]
[Title 29, Volume 9]
[Revised as of July 1, 2004]
From the U.S. Government Printing Office via GPO Access
[**CITE: 29CFR2560.503-1**]

[Page 528-538]

TITLE 29 – LABOR

CHAPTER XXV – EMPLOYEE BENEFITS SECURITY ADMINISTRATION, DEPARTMENT OF LABOR

PART 2560 RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT
– Table of Contents

29 C.F.R. § 2560.503-1 Claims procedure.

(a) **Scope and purpose.** In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) **Obligation to establish and maintain reasonable claims procedures.** Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims,

notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously

jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees) –

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference –

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) **Group health plans.** The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section –

(1) (i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section,

the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that –

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by

paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) **Plans providing disability benefits.** The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) **Claim for benefits.** For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) **Timing of notification of benefit determination.**

(1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the

claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of –

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments –

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in

accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination

(whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and

the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards

on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) **Manner and content of notification of benefit determination.**

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant –

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the

plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) **Appeal of adverse benefit determinations.**

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures –

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures –

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit

determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which –

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) **Timing of notification of benefit determination on review.**

(1) In general.

(i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to

hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special

circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after

receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) Post-service claims.

(A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the

date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) Disability claims.

(i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is

required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(i) **Manner and content of notification of benefit determination on review.** The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits –

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an

explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(k) **Preemption of State law.**

(1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2) (i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust

such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) **Failure to establish and follow reasonable claims procedures.** In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) **Definitions.** The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)

(i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations –

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving

urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit

resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

(7) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) **Apprenticeship plans.** This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) **Applicability dates.** This section shall apply to claims filed under a plan on or after January 1, 2002.

65 FR 70265, Nov. 21, 2000, as amended at 66 FR 35887, July 9, 2001]

[redacted] 06/11/2014 SI RBOSTICK
email from Chrysler STU

From: Barry Whiteside
[redacted]
Sent: Wednesday, June 11, 2014
8:08 AM
To: Chrysler SIT); Craig Banasiak
Cc: Mark Babcock
Subject: Avery, Jacqueline

We have looked at Avery on five occasions beginning on April 14, 2014. She resides in Kingston, Michigan. Although not confirmed, it appears that she may be running some sort of business out of her home. Each morning another woman shows up at the home. Avery usually leaves to take her children to school, stops at McDonalds, then goes back home. On the three occasions that she was seen driving, she spent 33 minutes in the car, 40 minutes in the car, and 42 minutes in the car. She contends that she cannot spend more than 10-15 minutes in the car. Nothing remarkable was observed regarding her ability to ambulate during the short times that she was seen doing so.

It is suspected that she might be running a business out of her home due to the fact that she used to live at and address in Cleburne, Texas that is now the operating center for an Internet business called "Ashleys Green Products." There is a least one other woman who shows up at Avery's home the same time each day, and there is a large dumpster in the driveway. Attempts to swipe a bag of garbage were unsuccessful. Other than Avery's early morning travels, not much other activity was observed. Internet searches relating to Avery, her home, and any businesses operating out of her home proved fruitless.

I recall that she had not filed the proper paperwork with Sedgwick by April 30, 2014, and her EDE had been suspended.

Craig, let me know if you think we have anything regarding her driving for well over the 15 minutes that she claims she can only do.

Otherwise, give me some direction as to what further steps, if any, that you would like us to pursue.

Barry Whiteside
Chrysler Group LLC
Corporate Investigations
[redacted]

[redacted] 06/25/2014 SI RBOSTICK
email from Chrysler

From: Craig Banasiak
[redacted]
Sent: Wednesday, June 25, 2014 1:18 PM
To: Barry Whiteside
Cc: Bostick, Robert; Peters, Melissa
Subject: RE: Avery, Jacqueline

Barry – I received the following recommendation from the PDR who wrote "I think we should do another IME for sure maybe even follow her around day before and of. We should provide a job description and I think it is very possible the IME would find her able with PQX, at the very least." I concur with that approach.

Melissa/Robert – Please coordinate the scheduling of an IME if it is deemed appropriate. If an IME is scheduled, please coordinate the scheduling of SIU with Barry.

Regards,

Craig Banasiak
Manager, Corporate Group Insurance
Human Resources
Chrysler Group LLC
[redacted]
[redacted]

[redacted]

[redacted] IM PATSYB

Sent special exam date to SR Melissa to verify if exam date and time appropriate.
[Time Note Created : 2:27 PM]

[redacted] 07/02/2014 IM PATSYB

Special DEP/IME exam tentatively scheduled

Claim # [redacted] Jacqueline Avery
7-15-14 @ 2:00pm
Joel Shavell, D.O.
Internal Medicine
23077 Greenfield Rd
Suite 158
Southfield, MI 48075
[redacted]
80.8 Miles

Special exam 3:30 pm

[redacted]

[redacted] 07/02/2014 SI RBOSTICK
email to Chrysler SIU

From: Bostick, Robert
Sent: Wednesday, July 02, 2014 4:20 PM
To: Barry Whiteside
Subject: FW: Avery, Jacqueline

Barry,

FYI – see below.

ROBERT BOSTICK | Litigation Consultant
Sedgwick Claims Management Services, Inc.
Chrysler Group Service Ctr.
[redacted]

From: Peters, Melissa
Sent: Wednesday, July 02, 2014 3:34 PM
To: Chrysler SIU
Cc: Bostick, Robert
Subject: FW: Avery, Jacqueline

Barry,

The exam is scheduled as follows.

Claim # [redacted] Jacqueline Avery
7-15-14 @ 2:00pm

Joel Shavell, D.O.
Internal Medicine
23077 Greenfield Rd
Suite 158
Southfield, MI 48075
[redacted]
80.8 Miles

Special exam 3:30 pm

The Surveillance appointment is set for 3:30pm at the same location with Dr. Shavell. Do we have enough surveillance to take to the DEP MD after the appt or do you just want to follow her from the appt? Please let me know what works for you.

Melissa A Peters, AIC, AIS I Absence Management Team Lead
Sedgwick Claims Management Services, Inc.
Phone: [redacted]
Direct: [redacted]
Fax: [redacted]
[redacted] [redacted]

[redacted] 07/07/2014 SI PETERSM
Requested special exam be rescheduled for a few days after the IME.

[redacted] [redacted]

[redacted] 07/08/2014 CM JCROW
Called EE at [redacted] re: IME scheduled.

EE took down the following information. Advised letter was sent, but in case she did not receive the letter in time.

7-15-14 8 2:00pm
Joel Shavell, D.O.
Internal Medicine
23077 Greenfield Rd
Suite 158
Southfield, MI 48075
EE stated " Oh, this is that run down place." Confirmed EE had been there before. She thought she had been

Gave phone number for directions: [redacted]

Chrysler Group Service Center
Disability Operations
PO Box 14575
Lexington, KY 40512-4575

[LOGO]
sedgwick©

Phone: (888) 322-4462
Fax: (888) 244-6261

07/21/2014

JACQUELINE AVERY
4003 CLOTHIER RD.
KINGSTON, MI 48741

RE: Long Term Disability Benefits
Claim Number: [redacted]

Dear JACQUELINE AVERY :

Under the Chrysler Group LLC Long Term Disability Benefit Plan (the "Plan") benefits are provided to employees who are totally disabled because of disease or injury so as during the first 24 months of your disability to be unable to perform the duties of your occupation, and after the first 24 months of disability be unable to engage in regular employment or occupation.

The results of your recent IME examination indicate that you no longer meet the above provision as you were found to be:

X Able to work
☐ Able to work with restrictions

Based upon this information, we are requesting that you report to your plant medical department for a determination of your ability to return to work. **Note: If your area has a Centralized Employment Center, you need to report there.** Your benefits may be

suspended effective July 22, 2014 pending the outcome of the ability to work examination.

If you have any questions or require additional information about this letter, please call the Chrysler Group Service Center at [redacted], Monday through Friday between 8:00 a.m. and 9:30 p.m. Eastern Time zone, to speak with a Customer Service Representative.

Sincerely,

Chrysler Group Service Center

Rev. 03/2014

Monday, July 28, 2014

Patsy Ball-Johnson
Sedgwick CMS DEP
Chrysler Services Center

RE: Jacqueline Avery – Claim #: [redacted]

Dear Ms. Ball-Johnson:

I am writing to appeal my recent return to work decision communicated to me on July 22, 2014. During my visit to Chrysler, I was able to obtain a copy of the Nationwide I.M.E. report dated July 15, 2014. I would like to challenge several statements and provide supporting documentation where necessary.

First, Dr. Shavell states that I was last seen at the University of Michigan by Dr. Wasserman on February 6, 2012 in which I reported 90% improvement and that I have not been seen in Ann Arbor since. Please see the attached U of M Health record which shows that I was continually seen through July 8 2013. During this visit I was diagnosed with possible Venus Insufficiency (REFLUX) in both the left and right leg. Because this was a secondary issue to the CPRS (Complex Regional Pain Syndrome) and not one that Dr. Wasserman could personally treat, I chose to see a specialist closer to home for transportation reasons. Please note that the February 6, 2012 visit showing 90% improvement was related to a popliteal nerve block that was at that time inserted into my right leg and not at all related to recovery from CPRS.

I began seeing Dr. Nounou on August 1, 2013 in which the supporting documentation shows that I do indeed

have Venus Insufficiency in both legs. The left leg is diagnosed as being mild to moderate while the right leg is classified as moderate severe. On February 12, 2014 I had a venous ablation procedure in which the saphenous vein did not close all the way as anticipated. I continue to see Dr. Nounou this year with my last visit being on July 17, 2014.

In addition, the reason I have not returned to U of M is because I am trying to take care of the secondary issue of venous insufficiency to determine if the continue chronic pain and other symptoms are related to the venous insufficiency or the CRPS. I will return to U of M to continue my treatment with Dr. Wasserman once my issue is resolved with Dr. Nounou.

Secondly, I would like to challenge and clarify several of Dr. Shavell's statements. In regards to the January 10, 2014 visit in which a lower lumbar scan was performed, this is solely related to a fall on ice in which I was experiencing weeks of lower back pain. The slight bulge in the L4-L5 region was the culprit and has no relation to either of my ongoing medical issues previously discussed. Also, the Doppler performed on June 20, 2013 was to check for DVT and not specifically REFLUX which was diagnosed a month later.

Dr. Shavell stated that he is unclear why I have not gone back to U of M in over 2 years (false statement) and why I continue to go to Dr. Nounou without a follow-up Doppler. As you can see by the supporting documentation, I have had several Doppler's and even an Ablation Procedure under the care of Dr. Nounou. I

am unclear why Dr. Shavell is confused because I gave him Dr. Nounou's contact information to confirm my issues, which is apparent he did not do. Therefore, I am also including my health record from the Heart and Vascular Institute of Michigan showing my diagnosis and treatments.

Dr. Shavell also states that during his general examination I walked quickly with a normal gait. In fact, I continue to walk with a limp on my right side which gets more severe the longer and farther I walk. This can be substantiated by both my husband and the caregiver who brought me in for this exam. Additionally, walking to the office of Dr. Shavell, the caregiver jokingly asked if she was going to have to carry me because I was having difficulty walking. He also stated that lower extremities revealed no pain, no swelling, and no coldness. I respectively disagree with these statements as I did indicate to him that my current pain level was a 6 and that my right foot felt colder with numbness in my toes, and at times my right foot feels extreme tingling/prickly like it is on fire. In addition, during the examination he did mumble that there was a slight different is temperature to the touch but nothing significant. He also checked sensitivity in both legs at which time I did indicated numbness and pressure pain in several areas on the right lower extremity and ankle area. I am not sure why this is not indicated in the report. Furthermore, Dr. Shavell stated that I sat in a "Budda" style on his examination table and was able to get up from a supine position without any difficulty. I adamantly challenge both states because at

no time then or now am I able to sit in this fashion and I was only able to sit up by rolling onto my side and using the table to assist me because he refused to offer me any assistance in doing so. Dr. Shavell also stated that I was able to walk on my heals and toes but with some difficulty. In fact, when requested to perform this test I indicated that I was not able to do so and did not want to even attempt as I recently rolled my right ankle and was scared of doing it again. He then stated that was understandable and did not require me to proceed any further. Furthermore, Dr. Shavell stated that I was able to sit perpendicularly on the examination table with my feet and legs turned in and therefore he believes that I do not suffer from CRPS. The truth is that I did sit for a few minutes with my legs hanging off the examination table but then turned sideways so that my legs were extended and supported on the table with me sitting upright. I even stated to Dr. Shavell that I had to raise my legs in that manner because the pain was increasingly getting worse. He then became annoyed and stated that he needed to check my reflexes. I therefore, returned to the requested position but promptly replaced my legs back on the table when he finished.

Finally, in his opinion section Dr. Shavell states that he did not see any evidence of CRPS. He further stated that " . . . normally with these pain syndrome they are so severe and difficult that patients hardly recover fully. They have some residual, such as walking with a limp, or inability to move a leg, as well as sensitivity to touch." As previously stated, I continue to walk with a

limp and do have some sensitivity touch. Please note that my I have also been through aggressive treatment to help desensitize my leg including using sandpaper and other extremely abrasive materials during the period that my popliteal nerve blocks were in place. This was also communicated to Dr. Shavell during my exam. Therefore, my extreme sensitivity has been lowered to more tolerable levels but the internal chronic pain continues. I am truly confused by this statement and can only wonder if he could have possibly become confused with a different patient. I do not want to believe that his false statements in this report were done with intent malice. While I have pointed out several discrepancies, Dr. Shaven did in fact state that I am bedridden for several days a week, have difficulty doing daily activities such as cooking, cleaning, and shopping. In fact, these activities are very much limited as to also limit the chronic pain from day to day. If necessary, I am able to provide written statement from family, friends, and third party caregivers of my inability to perform daily tasks related to the chronic pain.

Dr. Shavell, final opinion stated, "Based on the fact I do not find a regional complex pain issue, and because she does not have a venous issue, and based on the fact that when I examined her ankle she is (sic) bear weight on the ankle, on her heels and toes despite her weight, I do not find any physical evidence to substantiate at this point any disability whatsoever. It is my opinion that she can return to full duty work, as of today's date." Based on my medical records, this letter of clarification, and my supporting documentation included

with this letter, I believe that I have indeed proven that I do continue to suffer from CPRS, and that I do have a venous insufficiency issue, and that his false statement regarding my ability to walk on my heals and toes is unexplainable by me given the fact that I did not even attempt to do so.

Please let me know if you require any additional information to reverse the return to work authorization. I need to continue with my treatments in hopes for a full recovery so that I can indeed return to work with the ability to actually perform all of my job requirements.

Sincerely,

Jacqueline Avery
Chrysler ID: [redacted]

Chrysler Group Service Center
Disability Operations
PO Box 14575
Lexington, KY 40512-4575

[LOGO]
Sedgwick CMS
Sedgwick Claims
Management Services, Inc.
Phone: (888) 322-4462
Fax: (888) 244-6261

August 20, 2014

Jacqueline Avery
4003 Clothier Rd.
Kingston, MI 48741

RE: Long Term Disability Benefits (LTD)
Claim Number: [redacted]

Dear Ms. Avery:

Under the Chrysler Group LLC Long Term Disability Benefit Plan (the "Plan") benefits are provided to employees who are totally disabled because of disease or injury so as during the first 24 months of your disability to be unable to perform the duties of your occupation, and after the first 24 months of disability he unable to engage in regular employment or occupation with the Company. Based upon the results of your recent IME examination, in which you were found able to work, the eligibility requirement is no longer satisfied (Article IV, Eligibility),

Based upon this information, we are requesting that you report to your Human Resource for a determination of your ability to return to work. Your benefits may be terminated effective July 21, 2014 pending the outcome of the ability to work examination.

You may appeal this decision by sending a written request within 180 calendar days of the date you receive this letter to:

Chrysler Group Service Center
Appeals Unit
P.O. Box 14575
Lexington, KY 40512-4575

Please include in your appeal letter the reason(s) you believe your claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate for us to give your appeal consideration. Upon request and free of charge, Sedgwick Claims Management Services, Inc. will provide you with reasonable access to and a copy of the documents, records, or other information we have that are relevant to your claim.

If you choose to appeal, all claim information will be evaluated and you will be advised of the determination of your appeal within 45 calendar days after we receive your written request for appeal If special circumstances require an extension of time, you will be notified of such extension during the 45 calendar days following receipt of your request. Under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, you have a right to file a civil suit following a denial of an appeal.

If you have any questions or require additional information about this letter, please call the Chrysler Group Service Center at **1-888-322-4462**, Monday through Friday between 8:00 a.m. and 9:30 p.m. Eastern Time

zone, to speak with a Customer Service Representative.

Sincerely,

Chrysler Group Service Center

Rev. 08/2014

[LOGO]
Sedgwick CMS
Chyrsler Service Center
Disability Operations
P. O. Box 14576 Lexington, KY 40512-4575
Phone: 888-322-4462 Fax 889-2114-6561

September 12, 2014

Jacqueline Avery
4003 Clothier Rd
Kingston, MI 48741

RE: Long Term Disability
Claim Number: [redacted]

Dear Ms. Avery:

We completed our review of your claim and appeal under your employer's Long-Term Disability Benefit Plan.

Under the Chrysler Group LLC Long Term disability Benefit Plan, (the "Plan") benefits are provided to employees who are totally disabled because of disease or injury so as during the first 24 months of your disability to be unable to perform the duties of your occupation, and after the first 24 months of disability be unable to engage in regular employment or occupation with the Company.

Our review included medical documentation dated June 24, 2011 through June 24, 2013 from Lapeer Regional Medical Center; Marlette Regional Hospital; Kingston Family HealthCare; Caro Community Hospital; H. Banks, M.D.; University of Michigan Hospital

and Health Centers; B. Brengel, D.O.; Heart & Vascular Institute of Michigan; Huron Medical Center; H. Banks, M.D.; D. L. Gaston, M.D.; J. M. Shavell, D.O.; and Lapeer Regional Medical Center.

Additionally, your file was referred to David Hoenig, M.D., a board-certified specialist in Neurology and Pain Medicine for an independent review.

Dr. Hoenig attempted to complete a teleconference with Dr. Nounou on August 28, 2014 and August 29, 2014. Although messages were left regarding the nature of the call, no return call was received.

The specialist in Neurology and Pain Medicine noted that, based on the documentation provided, you are not disabled from performing any work as of July 22, 2014. The last neurological examination in the medical record is from February 6, 2013. After your spinal cord stimulator, you have had a normal neurological examination.

The decision is the Claim Administrator's final decision. You have the right to bring a civil action under EEISA 502(a). You are entitled to received, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

We regret that our response would not have been more favorable.

Should you have any questions, place feel free to contact our office at 800-243-3970.

Sincerely,

/s/ Michael Middleton
Michael Middleton
Appeals Specialist
Sedgwick Appeals Unit

Sedgwick Appeals Unit
P.O. Box 14446
Lexington, KY 40512-4446

[LOGO]
sedgwick©

Phone: (800) 248-3970
Fax: (888) 488-9536

July 8, 2015

Jacqueline Avery
4003 Clothier Rd
Kingston, MI 48741

RE: FCA US LLC
Claim Number: [redacted]

Dear Ms. Avery:

Your file is under re-review. If you have any additional medical information for the re-review, the deadline to submit additional medical information is July 28, 2015.

Sincerely,

/s/ Michael Middleton

Michael Middleton
Appeals Specialist
Sedgwick

Sedgwick Appeals Unit
P.O. Box 14446
Lexington, KY 40512-4446

[LOGO]
sedgwick©

Phone: (800) 248-3970
Fax: (888) 488-9536

September 30, 2015

Linda R. Drillock
3030 Main Street
Marlette, MI 48453

RE: Long Term Disability
Claimant: Jacqueline Avery
Claim Number: [redacted]

Dear Ms. Drillock

We completed our review of your client's claim under her employer's Long Term Disability Benefit Plan.

Under the FCA US LLC Long Term Disability Plan, (the "Plan") benefits are provided to employees who are totally disabled because of disease or injury.

4.01 Eligibility. To be eligible for LTD benefits, the Participant must satisfy each of the following conditions:

(A) complete one month of Continuous Service with the Corporation;

(B) be covered under the LTD Plan when total disability began;

(C) have exhausted DAP Payments or Special DAP Payments and any unused earned vacation entitlement;

(D) be under the continuous care of a legally qualified Physician who certified the total disability

(E) be "totally disabled" because of disease or injury so as during the first 24 months of disability to be unable to perform the duties of the Participant's occupation, and after the first 24 months of disability be unable to engage in regular employment or occupation with the Corporation;

(F) apply for LTD benefit and furnish satisfactory proof of disability in accordance with Section 4.02 below, and

(G) include satisfactory evidence that he or she made proper application for all "Other income Benefits" described in Section 5.03

Our review included medical documentation dated June 24, 2011 through April 15, 2015 from Lapeer Regional Medical Center; Marlette Regional Hospital; Kingston Family HealthCare; Caro Community Hospital; H, Bands, M.D.; University of Michigan Health System; R. T. Brengel, D.O.; Huron Medical Center; M. A. Nounou, M.D.; H. Banks, M.D.; D. L. Gaston, M.D.; J. M. Shavell, D.O.; Lapeer Regional Medical Center; and Dr. Hoenig.

Additionally, the file was referred to Mark Friedman, D.O., a board-certified specialist in neurology for an independent review.

Dr. Friedman attempted to complete a teleconference with Dr. Nounou but Dr. Friedman was put in touch

with the nurse who indicated that Dr. Nounou last saw Ms. Avery on July 19, 2014 (although the medical records indicate that date is actually July 17, 2014). Dr. Nounou's nurse reported Ms. Avery had a recent procedure in the office regarding her right greater saphenous vein and the treatment recommendations for venous insufficiency were compression stockings and no smoking. Dr. Nounou did not specifically address disability issues then or beyond that time.

The specialist in neurology noted that Ms. Avery presented with a history of pain in her legs, right worse than left that was felt to be due to a complex regional dystrophic pain. Ms. Avery underwent extensive treatment and by March 2013, she reported 80-90% improvement in pain. In August 2013, Dr. Nounou evaluated Ms. Avery for complaints of right lower extremity pain due to severe bilateral greater saphenous venous insufficiency with more symptoms in the right leg. In February 2014, Ms. Avery underwent endovenous ablation of incompetent vein. On July 19, 2014, Dr. Nounou saw Ms. Avery in follow-up regarding pain and edema in both legs (right worse) related to peripheral venous insufficiency. No specific restrictions were recommended. An Independent Medical Examination on July 15, 2014 indicated that there was no evidence of a regional complex pain issue. Skin of her lower extremities had normal color and turgor. There was no problem with major venous problems.

Based on the notes from Dr. Nounou and Dr. Shavell and the discussion with Dr. Nounou's office, there is insufficient information to support that Ms. Avery was

disabled as of July 22, 2014 and there is no sufficient clinical evidence to support any restrictions and limitations

Based on this information Ms. Avery no longer satisfies the terms of the FCA US LLC Extended Disability Plan; therefore, we must uphold the denial of her claim at this time. You or Ms. Avery may appeal this decision by sending a written request within 180 calendar days of the date you receive this letter to:

FCA Service Center
Appeals Unit
P.O. Box 14575
Lexington, KY 40512-4575

Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to the claim that you deem appropriate for us to give the appeal consideration. Upon request and free of charge, Sedgwick will provide you with reasonable access to and a copy of the documents, records, or other information we have that are relevant to your claim.

If you or Ms. Avery chooses to appeal, all claim information will be evaluated and you will be advised of the determination of the appeal within 45 calendar days after we receive your written request for appeal. If special circumstances require an extension of time, you will be notified of such extension during the 45 calendar days following receipt of your request. Under Section 502(a) of the Employee Retirement Income

Security Act (ERISA) of 1974, as amended, you have a right to file a civil suit following a denial of an appeal.

We regret that our response has not been more favorable.

Should you have any questions, place feel free to contact our office at 800-248-3970.

Sincerely,

FCA Service Center