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United States District Court, S.D. Indiana, Indianapolis Division.

KAREN MORATZ, Plaintiff,
v.
RELIANCE STANDARD LIFE INSURANCE COMPANY, Defendant.

No. 1:23-cv-00616-RLY-MKK
|
Filed 09/19/2024

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

RICHARD L. YOUNG, JUDGE United States District Court Southern District of Indiana

Plaintiff Karen Moratz seeks long-term disability ("LTD") benefits under an employee welfare benefits plan sponsored by the Indianapolis Symphony Orchestra ("ISO"). Defendant Reliance Standard Life Insurance Company, the plan administrator, denied her claim initially and on administrative appeal. Moratz now brings suit under the **Employee Retirement Income Security Act** ("**ERISA**"), 29 U.S.C. § 1001 *et seq.*, asserting Reliance wrongfully denied her benefits. Both parties have moved for summary judgment pursuant to Federal Rule of Civil Procedure 56. (Filing Nos. 20, 22). For the reasons set forth below, the court **GRANTS** Defendant's motion and **DENIES** Plaintiff's motion.

I. Background

A. Relevant Policy Provisions

The eligibility requirements of the ISO Group LTD Policy ("the Policy") issued by Reliance state that "[a] person is eligible for insurance" if they are "a member of an Eligible Class, as shown on the Schedule of Benefits page." (Filing No. 19-1 at 21; *see also id.* at 11 (defining "Eligible Person" as "a person who meets the Eligibility Requirements")). The Policy insures two eligible classes, which include "[e]ach active, Full-time employee, except any person employed on a temporary or seasonal basis," who falls into Class 1 or Class 2. (*Id.* at 9). Class 2 includes musicians. (*Id.* (defining Class 2 as "Musician, Stagehand and Librarian")).

Under the Policy, "Actively at Work" and "Active Work" are defined as "actually performing on a Full-time basis the material duties pertaining to [a person's] job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of an Injury or Sickness." (*Id.* at 11). For Class 2, "Full-time" is defined as working "for a minimum of 20 hours during a person's regular work week." (*Id.*).

The Policy's Termination of Individual Insurance provision states, in relevant part, that an insured's insurance "will terminate" on "the date the Insured ceases to meet the Eligibility Requirements." (*Id.* at 21).

The Policy grants Reliance, as the claims review fiduciary, "the discretionary authority to interpret the Policy ... and to determine eligibility for benefits and the amount of any benefits payable." (*Id.* at 17).

B. Moratz's Employment with the ISO

Moratz is a flutist who started working for the ISO, which employs full-time musicians, in 1989. (*Id.* at 167–68; Filing No. 19-3 at 146, 156). At the beginning of 2020, Moratz was employed as the principal flutist, but she was furloughed in March 2020 because of the **COVID-19** pandemic. (Filing No. 19-1 at 168, 172). In December 2020, while on furlough, Moratz began experiencing **COVID-19** symptoms around the time her husband tested positive for **COVID-19**. (Filing No. 19-3 at 147). Moratz reports that she never "fully recovered" and has experienced "chronic long-haul **Covid** symptoms," including tinnitus and dizziness, since then. (Filing No. 19-1 at 172; *see, e.g.*, Filing No. 19-3 at 147).

On September 1, 2021, the ISO invited the furloughed musicians to return to work. (*See* Filing No. 19-3 at 143). Moratz contends that she was rehired and returned to work on that date. (*See, e.g.*, Filing No. 19-3 at 149 ("On September 1, 2021, I signed a new employment agreement with ISO and was employed full-time by ISO for the first 14 days of September, 2021."); *id.* at 165 ("Effective September 1, 2021, Karen Moratz was employed full-time and actively at work full-time as Principal Flutist ...."). From September 15, 2021, to March 2022, Moratz was placed on sick leave. (*Id.* at 149).

C. Moratz's Application for Benefits

On February 12, 2022, Moratz applied for LTD benefits under the Policy. (*See* Filing No. 19-1 at 172). Moratz's claim application consisted of (1) an Employer's Statement, (*id.* at 167–70); (2) a signed authorization, (*id.* at 171); (3) an Employee's Statement with several attachments, including a "memo" written by Moratz, (*id.* at 172–82); (4) a Physician's Statement, (*id.* at 183–84); and (5) medical records, (Filing No. 19-2 at 1–45).

In the employee statement (signed and dated in January 2022), Moratz stated that she first noted and sought treatment for her symptoms in December 2020. (*Id.* at 174–75). She stated that the day she was "first unable to work on a full time basis" was December 11, 2020. (*Id.* at 174). She reported that her "last day ... worked before the disability" was March 13, 2020. (*Id.*). She checked a box indicating she had not returned to work since then. (*Id.*).

In the employer statement (signed and dated in January 2022), Larry Baysinger, the ISO's Vice President of Human Resources, wrote that the last day Moratz "actually worked" was March 18, 2020, when she was "furloughed due to [the] pandemic." (*Id.* at 168). He reported Moratz's "date of disability" as February 16, 2021. (*Id.* at 169).

In the memo attached to her claim forms, Moratz explained she had been "furloughed due to **COVID** for the better part of the 2019-20 season as well as much of the 2020-21 season." (*Id.* at 172). She wrote that "[u]pon the ISO's return for" the 2021-22 season, she had "been forced to take sick leave as a direct consequence of [her] long-haul **Covid** symptoms." (*Id.*). Her "goal" was to "return to work ... for the 2021-22 Spring/Summer concert season." (*Id.*).

D. Denial and Appeal

On February 18, 2022, Reliance notified Moratz that her claim for LTD benefits was denied. (*Id.* at 152). In its denial letter, Reliance set forth the following explanation for its determination that she was not eligible for benefits:

> The employer's portion of your LTD Claim Application indicates that the last day you worked was March 18, 2020 and that you were subsequently furloughed. When you ceased working on a Full-time basis on March 18, 2020, you were no longer part of an Eligible Class of employees .... As such, your coverage under the terms of [the] Policy ... would cease on March 19, 2020, in accordance with the Policy's TERMINATION OF INDIVIDUAL INSURANCE provision .... Although [Reliance] has extended LTD coverage for 90 days due to **COVID** related furloughs, the 90th day would have been June 16, 2020, and

> the information on file documents you report being unable to work due to **COVID-19** as of December 20, 2020, after both the March 19, 2020 and June 16, 2020 date.

(*Id.* at 153).

On August 31, 2022, Moratz submitted an administrative appeal of Reliance's denial of her LTD benefits claim. (Filing No. 19-3 at 52). On appeal, Moratz argued she became re-eligible for benefits on September 1, 2021, (*id.* at 54–55), and submitted evidence showing she was rehired by the ISO on September 1, (*see, e.g.*, *id.* at 165 (statement from Baysinger that "[e]ffective September 1, 2021," Moratz "was employed full-time and actively at work full-time"); *id.* at 167–68 (Moratz's employment contract stating "[e]mployment begins the 1st day of September, 2021"); *id.* at 149 (Moratz: "On September 1, 2021, I signed a new employment agreement with ISO ...."); *id.* at 131–45, 156–61 (declarations from colleagues stating Moratz returned to work in September 2021)). Further, Moratz argued she worked full time the first two weeks of September 2021 until she became totally disabled on September 15, 2021. (*See id.* at 54–55, 78–79; *see also id.* at 149 (Moratz: "I ... was employed full-time by ISO for the first 14 days of September, 2021. On September 15, 2021, it was apparent I could not perform my duties as a musician at ISO.")).

On January 27, 2023, Reliance notified Moratz of its decision to uphold its initial denial of her claim. (Filing No. 19-1 at 161). Reliance first explained:

> According to the evidence in [Moratz's] file, Ms. Moratz ceased working on a Full-time basis on March 18, 2020.... [I]n response to the **COVID-19** pandemic, we administratively extended insurance coverage for 90 consecutive calendar days from the date of an event change due to **COVID** related furloughs. The 91st day would have been June 16, 2020. The information submitted for our review indicates [Moratz] was unable to work due to **COVID-19** as of December 20, 2020, which is beyond the 90 day extension. Therefore, we agree that [Moratz] did not have coverage when she became disabled on December 20, 2020.

(*Id.* at 164).

Reliance also explained that an independent physician had reviewed Moratz's file and concluded that her medical information did not support "functional limitations sufficient to preclude working during the period of March 18, 2020 to present." (*Id.* at 164). Reliance considered updated medical information submitted by Moratz and still concluded "there was no supporting medical evidence of a functional impairment during the period of March 18, 2020 to December 2020 to the present." (*Id.* at 165). In sum, Reliance concluded:

> ... Ms. Moratz was not eligible for benefits, under the above-mentioned policy at the date of disability on December 20, 2020. Furthermore, as stated above, Ms. Moratz was not precluded from work function beyond March 18, 2020. Considering the totality of the claim file documentation, we agree with the Claim Department's decision to deny benefits in accordance with the Policy's [sic]. [Moratz] was not considered Totally Disabled at the date beyond March 18, 2020, nor did she have LTD coverage beyond June 18, 2020.

(*Id.* at 165).

Finally, Reliance noted, "According to Ms. Moratz's employer she was rehired on September 1, 2021 and stopped working again on September 15, 2021. Based upon the new hire date of September 1, 2021, Ms. Moratz can file a new LTD claim." (*Id.*).

Any other facts necessary to resolve the motions will be addressed in the Discussion Section below.

II. Legal Standard

A. Summary Judgment Standard

Summary judgment is appropriate if "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). A genuine dispute about a material fact exists only "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). When reviewing cross-motions for summary judgment, the court views "all facts and inferences in the light most favorable to the nonmoving party on each motion." *Lalowski v. City of Des Plaines*, 789 F.3d 784, 787 (7th Cir. 2015). "The existence of cross-motions for summary judgment does not ... imply that there are no genuine issues of material fact." *R.J. Corman Derailment Servs., LLC v. Int'l Union of Operating Eng'rs, Loc. Union 150*, 335 F.3d 643, 647 (7th Cir. 2003).

B. ERISA Standard of Review

The parties disagree on the proper standard of review to be applied to Reliance's denial of Moratz's claim. Moratz argues a *de novo* standard applies, and Reliance argues an arbitrary-and-capricious standard applies.

In reviewing a denial of benefits under an **ERISA** plan, the court applies a *de novo* standard of review, unless the plan grants the administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan grants such authority, the court "typically review[s] the denial of benefits under an arbitrary and capricious standard." *Fessenden v. Reliance Standard Life Ins.*, 927 F.3d 998, 1001 (7th Cir. 2019) (Barrett, J.). Here, the parties agree that the plan grants Reliance discretionary authority that would, ordinarily, make an arbitrary-and-capricious standard appropriate.

But Moratz nonetheless argues that a *de novo* standard applies because Reliance issued its final decision in her administrative appeal too late. *See id.* at 999–1000 (holding a *de novo* standard applies where an administrator fails to timely issue its final decision, even if the plan grants discretionary authority); 29 C.F.R. § 2560.503-1(i)(1)(i), (i)(3)(i), (i)(4) (setting time procedures for deciding administrative appeals). For several reasons, Moratz is likely correct. That said, the court need not resolve the issue of which standard applies because the result is the same under either standard. For the reasons discussed below, even applying the less deferential *de novo* standard, the court concludes Reliance correctly denied Moratz's claim.

Under a *de novo* standard of review, the question before the court is whether Reliance "was correct in deciding" to deny Moratz benefits. *Wilczynski v. Kemper Nat'l Ins.*, 178 F.3d 933, 934–35 (7th Cir. 1999). The court "mak[es] an independent decision about" the plaintiff's "entitlement to benefits," reaching "an independent decision on both the legal and factual issues that form the basis of the claim." *Diaz v. Prudential Ins. Co. of Am.*, 499 F.3d 640, 643 (7th Cir. 2007). "[W]hat happened before the plan administrator is irrelevant in a de novo review case." *Dorris v. Unum Life Ins. Co. of Am.*, 949 F.3d 297, 304 (7th Cir. 2020). Under a *de novo* standard, the court may consider evidence outside the administrative record, *id.* at 304, but here, neither party has elected to submit evidence beyond what was considered by Reliance during the administrative process.

III. Discussion

A. Coverage Under the Policy

The court begins by determining whether Moratz was covered under the Policy.

A claim for LTD benefits under the Policy must provide "enough information so that" Reliance is "able to identify the Insured as being covered under" the Policy. (Filing No. 19-1 at 16); *see* 29 C.F.R. § 2560.503-1(e) (defining a claim as "a request for ... benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims"). To be eligible under the Policy, a person, put simply, must be an "active, [f]ull-time employee." (Filing No. 19-1 at 9, 21). A person is no longer eligible for benefits under the Policy on the date they "cease[ ] to meet the[se] Eligibility Requirements." (*Id.* at 21).

Looking at Moratz's claim application, it is clear Reliance was correct to deny Moratz's claim on the basis that she was not eligible for benefits. Both Moratz and the ISO reported that Moratz's last day of work before the onset of her disability was in March 2020 when she was furloughed. Moratz's employee statement confirmed she had not returned to work since March 2020. Once she was furloughed, Moratz ceased being an active, full-time employee. (*See* Filing No. 19-1 at 11 (defining "full time" for Class 2, which includes musicians, as working "for a minimum of 20 hours during a person's regular work week")). Under the Policy terms, her coverage would therefore have terminated in March 2020, but Reliance extended LTD coverage for an additional ninety days for **COVID**-related furloughs, meaning Moratz's coverage terminated, at the latest, in June 2020. Both potential dates of disability reported in Moratz's claim forms—December 2020 and February 2021—were during Moratz's furlough and, more importantly, well after June 2020, when her coverage ended. (*See* Filing No. 19-1 at 174–75 (employee statement reporting her symptoms began in December 2020 and that she first was unable to work on a full-time basis in December 2020); *id.* at 172 (memo explaining she was furloughed and later began experiencing long **COVID** symptoms in December 2020); *id.* at 169 (employer statement reporting Moratz's date of disability as February 16, 2021)). The only conclusion that can come from Moratz's claim forms is that she was not eligible for LTD benefits based on the dates of disability set forth in her claim.

Moratz agrees she was not insured in December 2020 and February 2021 during the furlough. Instead, she argues that she became re-eligible for LTD benefits when she was rehired by the ISO on September 1, 2021, and that she was seeking benefits commencing on September 15, 2021, *not* any date during the furlough. She contends this should have been obvious to Reliance when it first reviewed her claim application. [1] In support, she points to the memo attached to her claim forms, in which she stated that "[u]pon the ISO's return for" the 2021-22 season, she had "been forced to take sick leave" because of her symptoms and that her goal was to return to work in spring/summer 2022. (Filing No. 19-1 at 172). But even viewing these statements in the light most favorable to Moratz, they do not show that she was rehired and returned to work on September 1, that she was working full time at any point in 2021 or 2022, or that her date of disability was September 15.

Moratz also raised these same arguments on administrative appeal—that she became re-eligible for benefits on September 1, became totally disabled under the Policy on September 15, and was only seeking benefits commencing on September 15. On appeal, she submitted evidence suggesting she was rehired on September 1 and worked full time for the first two weeks of September 2021. Moratz suggests this cures any issue with her original claim forms. But she is incorrect. It may very well be true that Moratz was rehired and working full time in September 2021, [2] but her arguments about the September 2021 dates were inappropriate on appeal and simply came too late.

A claimant may not present a new or different claim for benefits on administrative appeal. A claimant is bound to the claim she sets forth in her initial application. *See Diaz*, 499 F.3d at 643 (explaining the court "must come to an independent decision on ... [the] issues that form the basis of *the claim*" in determining under a *de novo* review whether the claimant is "entitled to the benefits *he sought* under the plan" (emphasis added)); *cf. Reynolds v. Tangherlini*, 737 F.3d 1093, 1099 (7th Cir. 2013) (explaining that, in Title VII cases, the scope of the EEOC charge "limits the scope of subsequent civil proceedings"). After all, the purpose of an administrative appeal is to provide the claimant an opportunity to present additional arguments and submit evidence related to her claim, *not* file a new claim or to amend the claim described in her application. *See* 29 C.F.R. § 2560.503-1(h)(1)–(2) (requiring plans to provide claimants "a reasonable opportunity to appeal" that provides "a full and fair review of the claim" and that allows claimants "to submit written comments, documents, records, and other information relating to the claim for benefits"); (Filing No. 19-1 at 19 (stating Reliance provides claimants "one appeal" of an adverse determination that provides "the opportunity to send [Reliance] written comments, documents, records, and other information related to the Insured's claim for benefits")); *cf. Gonzalez v. Feinerman*, 663 F.3d 311, 315 (7th Cir. 2011) ("[A plaintiff] cannot amend his complaint on appeal."). Additional information a claimant submits on appeal should "perfect the claim," rather than present a

new claim. 29 C.F.R. § 2560.503-1(g)(1)(iii) (requiring a plan's initial benefit determination to explain what "additional material or information [is] necessary for the claimant to perfect the claim").

Moreover, claimants are required to exhaust administrative remedies before filing an **ERISA** suit. *See Fessenden*, 927 F.3d at 1001 (citing *Edwards v. Briggs & Stratton Ret. Plan*, 639 F.3d 355, 360 (7th Cir. 2011)). Allowing a claimant to change claims on appeal would frustrate the policies supporting the exhaustion requirement. *See, e.g.*, *Kross v. W. Elec. Co.*, 701 F.2d 1238, 1245 (7th Cir. 1983) (explaining the exhaustion requirement ensures that parties have the opportunity to settle claims in a nonadversarial setting and that courts receive "prior fully considered" decisions from plans "interpreting their plans" and "refining and defining the problem[s] in given cases" (quoting *Amato v. Bernard*, 618 F.2d 559, 567–68 (9th Cir. 1980))).

Therefore, here, the ultimate question before the court is whether Moratz "was entitled to the benefits [s]he sought" under the Policy in her claim application. *Diaz*, 499 F.3d at 643. Moratz's claim set forth dates of disability during a furlough when Moratz was undisputedly not covered by the Policy. On appeal, she submitted evidence of a new date of eligibility and a new date of disability that were not mentioned in her claim application. Moratz did not cite, and the court could not find, a single case where a claimant was permitted, on administrative appeal, to change the dates of a claim or submit evidence that she became re-eligible for benefits. Thus, although the court may consider the full administrative record under *de novo* review, the court focuses on "the legal and factual issues that form the basis of the claim" Moratz originally submitted and determines, as discussed above, that she was not eligible for benefits at dates set forth in her claim. *Id.* at 643. If Moratz wanted to seek LTD benefits based on an eligibility date of September 1, 2021, and a total disability date of September 15, 2021, she should have filed a new claim. [3]

Reliance is therefore entitled to summary judgment.

B. Plaintiff's Motion for Leave to File Surreply Brief

As a final note, Moratz moved for leave to file a surreply to address arguments about Indiana Code § 27-8-5-19(c)(5) raised in Reliance's reply brief. (Filing No. 28). Because the court never reached the parties' arguments about the Policy's pre-existing condition clause and Indiana insurance law, neither a surreply (nor a sur-surreply from Reliance) are necessary. The court did not consider Moratz's proposed surreply (attached to her motion) in reaching its conclusion on the parties' cross-motions and would come to the same conclusion regardless of whether it accepted the surreply (or a sur-surreply). Accordingly, the court **DENIES** Moratz's motion as **MOOT**.

IV. Conclusion

For the reasons discussed above, Plaintiff's Motion for Summary Judgment (Filing No. 20) is **DENIED**. Defendant's Motion for Summary Judgment (Filing No. 22) is **GRANTED**. Additionally, Plaintiff's Motion for Leave to File Surreply Brief (Filing No. 28) is **DENIED** as **MOOT**. Final judgment shall issue by separate order.

IT IS SO ORDERED this 19th day of September 2024.

Distributed Electronically to Registered Counsels of Record.

All Citations

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Footnotes

1 At no point does Moratz explain why, in January 2022, both she *and* the ISO reported that she had not worked since March 2020 if she had actually worked several days in September 2021. She merely asserts that Baysinger "mistakenly," "erroneously," and "incorrectly" reported the wrong date. (*E.g.*, Filing No. 24, Pl.'s Resp. Br. at 6, 18).

2 Moratz insists that it is undisputed that she was rehired by the ISO on September 1, 2021, and working full time. (*See, e.g.*, Filing No. 21, Pl.'s Br. in Supp. at 23 ("It is undisputed Karen was re-employed by ISO on September 1, 2021, and met the Policy's eligibility requirement."); Filing No. 24, Pl.'s Resp. Br. at 19–20 ("There does not exist a dispute Karen was employed full-time by ISO as a musician ... effective September 1, 2021.")). This is not the case. As an initial matter, the employer and employee statements in Moratz's claim application indicate she never returned to work with the ISO after March 2020. Additionally, as Reliance points out, Moratz's employment contract, which states "[e]mployment begins the 1st day of September, 2021," was not signed by Moratz until December 20, 2021, and states it was entered into on the "4th day of November, 2021." (Filing No. 19-3 at 167–68).

3 Moratz argues that because she submitted her proofs of loss after her rehire date of September 1, 2021, within the time period set by the Policy, she was not required to file a new claim. However, the fact that the claim may have been timely filed does not address the issues discussed above—namely that her claim did not mention a rehire date of September 1 or a disability date of September 15.

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