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United States District Court, D. Arizona.

CARLA GUY, Plaintiff,

v.

**RELIANCE STANDARD LIFE INSURANCE COMPANY**, Defendant.

Court No. 2:24-cv-00293-JCG

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Filed 02/20/2026

### Attorneys and Law Firms

Lisa Jeanette Counters, Schiffman Law Office PC, Phoenix, AZ, for Plaintiff.

Arman Robert Nafisi, Wilson Elser Moskowitz Edelman & Dicker LLP, Phoenix, AZ, for Defendant.

### OPINION AND ORDER

Jennifer Choe-Groves\* U.S. District Court Judge

\*1 Before the Court is Carla Guy's ("Plaintiff") civil action to recover long-term disability benefits from Reliance Standard Life Insurance Company ("Defendant" or "Reliance"). Plaintiff seeks to recover long-term disability benefits from Defendant's insurance policy and other forms of equitable relief under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C., Ch. 18, §§ 1001–1461. *See* Compl. (Doc. 1) at ¶¶ 41–44. Plaintiff filed her Opening Brief claiming that Defendant's decision to deny her claim for benefits was arbitrary and capricious. Pl.'s Opening Br. (Doc. 36). Defendant filed its Response Brief in opposition, and Plaintiff filed her Reply Brief. Def.'s Resp. Br. (Doc. 37); Pl.'s Reply Br. (Doc. 40). For the foregoing reasons, the Court holds that Defendant abused its discretion in its denial of Plaintiff's claim for long-term disability benefits and orders judgment in favor of Plaintiff.

### BACKGROUND

Plaintiff began working as an Intensive Care Unit (ICU) Registered Nurse at HonorHealth on February 20, 2017. Joint Admin. Rec. (Doc. 33-1) at 209–10. HonorHealth provided long-term disability insurance through Reliance Standard Life Insurance Company's Long Term Disability Policy, Policy No. LTD 131227 ("Policy" or "Plan"). *Id.* at 2–34. Plaintiff experienced many medical conditions and symptoms from 2018 to 2019<sup>1</sup> and had thyroid removal surgery in March 2019. Joint Admin. Rec. (Doc. 33-4) at 90. Plaintiff stopped working at HonorHealth on March 15, 2020 due to experiencing severe fatigue, brain fog, and joint pain. Joint Admin. Rec. (Doc. 33-1) at 209, 215. Plaintiff applied for long-term disability benefits under the Policy on August 24, 2020. *Id.* at 36.

#### I. Plaintiff's Medical History

Plaintiff first noticed symptoms of joint pain, severe fatigue, brain fog, depression, and anxiety in August 2018. *Id.* at 214. In 1998, Plaintiff was diagnosed with [rheumatoid arthritis](#). Joint Admin. Rec. (Doc. 33-4) at 79. Plaintiff was later informed that she had "[Graves' Disease](#)" rather than [rheumatoid arthritis](#). Joint Admin. Rec. (Doc. 33-3) at 63. Plaintiff was diagnosed with

[fibromyalgia](#) around 2011. See Joint Admin. Rec. (Doc. 33-4) at 376. Before she stopped working officially, Plaintiff did not feel safe working as a nurse because she was experiencing symptoms such as chronic fatigue, daily headaches, anxiety, heart palpitations, shortness of breath, and severe brain fog. Joint Admin. Rec. (Doc. 33-2) at 106. Plaintiff had her thyroid surgically removed in March 2019 due to [hyperthyroidism](#) and her [Graves' disease](#) diagnosis. See Joint Admin. Rec. (Doc. 33-4) at 90. She struggled with fluctuating cortisol levels and continued to show symptoms of [Cushing's disease](#) in 2021. Joint Admin. Rec. (Doc. 33-5) at 163. On May 11, 2022, Plaintiff had a left adrenal [adenoma](#) surgically removed. Id. at 155.

## II. The Policy

\*2 The Policy's insuring clause states that it will pay a monthly benefit if an insured meets the following criteria: (1) is "Totally Disabled" as the result of a "Sickness or Injury" covered by the Policy; (2) is under the regular care of a "Physician;" (3) has completed the "Elimination Period;" and (4) submits satisfactory proof of "Total Disability" to Reliance. Joint Admin. Rec. (Doc. 33-1) at 22. The Policy's definition of "Totally Disabled" and "Total Disability" involves the following requirements:

"Totally Disabled" and "Total Disability" mean, that as a result of an Injury or Sickness:

(1) during the Elimination Period and for the first 24 months for which a Monthly Benefit is payable, an Insured cannot perform the material duties of his/her Regular Occupation; (a) "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness an Insured is capable of performing the material duties of his/her Regular Occupation on a part-time basis or some of the material duties on a fulltime basis. An Insured who is Partially Disabled will be considered Totally Disabled, except during the Elimination Period; (b) "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability; and

(2) after a Monthly Benefit has been paid for 24 months, an Insured cannot perform the material duties of Any Occupation. We consider the Insured Totally Disabled if due to an Injury or Sickness he or she is capable of only performing the material duties on a part-time basis or part of the material duties on a full-time basis.

Id. at 14. "Injury" is defined as "bodily Injury resulting directly from an accident, independent of all other causes" and "[t]he Injury must cause Total Disability which begins while insurance coverage is in effect for the Insured." Id. at 13. "Sickness" is defined as an "illness or disease causing Total Disability which begins while insurance coverage is in effect for the Insured." Id. at 14. Once Reliance receives written proof of "Total Disability" covered by the Policy, Reliance pays any benefits due to the claimant. Id. at 18.

The Policy places limitations on recovering benefits for mental or nervous disorders. See id. at 26. The Policy does not pay out monthly benefits for a "Total Disability" caused by or contributed to by mental or nervous disorders beyond "an aggregate lifetime maximum duration of twelve (12) months[.]" Id. An exception to this limitation is if the insured is in a hospital or institution at the end of the twelve-month period. Id.

## III. Reliance's Initial Denial of Plaintiff's Long-Term Disability Benefits

Defendant denied Plaintiff's application for long-term disability benefits on December 14, 2020. Id. at 183–88. Defendant determined that Plaintiff retained the ability to perform the material duties of her job. Id. at 184. This determination was made after reviewing the information in Plaintiff's claim file and her information provided from multiple medical providers. See id. Defendant concluded that Plaintiff's medical records showed that she was "symptomatic with multiple complaints of fatigue, heart palpitations, intermittent shortness of breath, and severe brain fog[.]" but determined that her physical exam findings did not support her subjective complaints. Id. at 185. The claim denial cited Plaintiff's ability to travel and lack of any indication that her daily life was restricted. Id. Defendant claimed that Plaintiff's records "reflect a level of functionality that would not preclude work function" and determined that Plaintiff did not meet the Policy's definition of "Total Disability." Id.

## IV. Reliance's Final Denial of Plaintiff's Long-Term Disability Benefits

\*3 Plaintiff appealed Defendant's denial of her long-term disability benefits claim and asserted that Defendant's denial was wrong and unsupported by the record. See Joint. Admin. Rec. (Doc. 33-2) at 272–84. Plaintiff submitted additional medical documentation with her appeal. See id. at 283–84. Reliance initially reviewed Plaintiff's claim and determined that it required review by an independent physician before making a final determination. Joint Admin. Rec. (Doc. 33-1) at 190. Dr. Reginald A. Givens reviewed Plaintiff's medical records and prepared a report for Defendant's review of the claim. See Joint Admin. Rec. (Doc. 33-5) at 293–303. Dr. Givens reviewed the entire medical record and had a teleconference with Plaintiff's primary care physician, Dr. Catherine T. Chuang, on February 14, 2023. Id. at 293, 300. An attempt to speak to Plaintiff's treating nurse practitioner Keira E. Stevens was unsuccessful after staff informed Dr. Givens that she no longer worked at her office. Id. Dr. Givens concluded that “from March 19, 2020 through September 14, 2022,” Plaintiff was impaired such that she could not perform her job and would not be capable of performing another occupation for a different employer. Id. at 302. The report also determined that “[f]rom September 15, 2022, forward, the claimant was not impaired[.]” Id.

Defendant had Dr. Leonard J. Sonne review Plaintiff's medical record to provide an internal medicine perspective. See id. at 306–24. Dr. Sonne reviewed Plaintiff's records and unsuccessfully attempted to speak to Plaintiff's treating nurse practitioner Keira Stevens. Id. at 321. The report from Dr. Sonne claimed that there was no documentation of an internal medicine restriction, limitation, or impairment from March 19, 2020, and afterwards. Id. The report noted that many of Plaintiff's medical office visits were telemedicine visits and argued that because Plaintiff traveled to take care of extended family with **COVID**, Plaintiff could have been doing her regular job. Id. at 321–22. Dr. Sonne concluded that Plaintiff “could have been doing her regular job from March 19, 2020, and ongoing.” Id. at 323.

## LEGAL STANDARD

“The civil enforcement provisions of ERISA, codified in [29 U.S.C.] § 1132(a), are ‘the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits.’” Gabriel v. Alaska Elec. Pension Fund, 773 F.3d 945, 953 (9th Cir. 2014) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987)). The statute carefully curated an enforcement scheme and “[c]ourts may not infer [additional] causes of action in the ERISA context[.]” Id. (quotations omitted) (citing Mertens v. Hewitt Assocs., 508 U.S. 248, 254 (1993)). “Traditional standards of summary judgment generally do not apply in the typical ERISA benefits denial case.” Talbot v. Reliance Standard Life Ins. Co., No. CV-14-00231-PHX-DJH, 2018 WL 10419233, at \*9, n.6 (D. Ariz. Feb. 7, 2018), aff'd, 790 F. App'x 129 (9th Cir. 2020). An ERISA case concerning the denial of benefits involves a unique standard of review and a motion for summary judgment is often “merely the conduit to bring the legal question before the district court and the usually tests of summary judgment, such as whether a genuine dispute of material facts exists, do not apply.” Stephan v. Unum Life Ins. Co. of Am., 697 F.3d 917, 930 (9th Cir. 2012) (citing Nolan v. Heald College, 551 F.3d 1148, 1154 (9th Cir. 2009)). Thus, the Court ordered merits briefing from the Parties in lieu of Rule 56 motions. See Case Mgmt. Order (Doc. 25) at ¶ 8.

### I. Standard of Review

District courts apply a de novo standard of review for ERISA claims involving the denial of benefits. Firestone Tire & Rubber Co. v. Bruch (“Firestone”), 489 U.S. 101, 115 (1989). The standard of review shifts from de novo to abuse of discretion if a benefits plan “unambiguously” provides discretion to the plan administrator. Abatie v. Alta Health & Life Ins. Co. (“Abatie”), 458 F.3d 955, 963 (9th Cir. 2006) (citing Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc)). There are no “magic” words that signal discretion on the part of the plan administrator. Id. The United States Supreme Court has indicated that a plan gives discretion if the administrator has the power to construe terms in the plan. Id. (citing Firestone, 489 U.S. at 109); see also id. at 964 (“We have held that ERISA plans are insufficient to confer discretionary authority on the administrator when they do not grant any power to construe the terms of the plan.”). When a plan administrator is given discretion and is “operating under a conflict of interest,” that conflict must be weighed as a factor in determining whether there is an abuse of discretion. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 111 (2008) (emphasis omitted) (citing Firestone 489 U.S. at 115).

\*4 The Supreme Court clarified that the term “factor” in *Firestone* implies that “when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one.” *Id.* at 117. The significance of a conflict of interest as a factor in the abuse of discretion analysis will depend upon the circumstances of the particular case. *Id.* at 108; see also *Abatie*, 458 F.3d at 968 (“[W]eighing a conflict of interest as a factor in abuse of discretion review requires a case-by-case balance[.]”). The Supreme Court has held that a “conflict of interest” exists when a plan administrator both evaluates claims for benefits and pays benefits claims. *Id.* at 112; see also *Abatie*, 458 F.3d at 965 (“We have held that an insurer that acts as both the plan administrator and the funding source for benefits operates under what may be termed a structural conflict of interest.”). When presented with all the facts and circumstances, the Court “must decide in each case how much or how little to credit the plan administrator’s reason for denying insurance coverage.” *Abatie*, 458 F.3d at 968. The United States Court of Appeals for the Ninth Circuit (“Ninth Circuit”) has explained that the level of skepticism a reviewing court views a conflicted administrator’s decision with depends upon the circumstances. See *id.*

## II. Conflicts of Interests and Levels of Skepticism

The Court should apply different levels of skepticism when conflicts of interest are present, depending on various factors such as “inconsistent reasons for denial or evidence of malice.” *Salomaa v. Honda Long Term Disability Plan* (“*Salomaa*”), 642 F.3d 666, 674 (9th Cir. 2011); *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868 (9th Cir. 2008) (“[W]hen reviewing a discretionary denial of benefits by a plan administrator who is subject to a conflict of interest, we must determine the extent to which the conflict influenced the administrator’s decision and discount to that extent the deference we accord the administrator’s decision.”). The presence of a conflict of interest does not shift the standard of review back to de novo. See *Conkright v. Frommert*, 559 U.S. 506, 512 (2010) (“[A] deferential standard of review remains appropriate even in the face of a conflict.”). A “deferential standard” does not mean that the plan administrator will prevail on the merits. *Id.* at 521. “It means only that the plan administrator’s interpretation of the plan ‘will not be disturbed if reasonable.’ ” *Id.* (quoting *Firestone*, 489 U.S. at 111); *Salomaa*, 642 F.3d at 675 (“Reasonableness does not mean that we would make the same decision. We must judge the reasonableness of the plan administrator skeptically where, as here, the administrator has a conflict of interests.”). The Ninth Circuit applies its standard three-factor test for abuse of discretion in a factual determination to claims in the ERISA context. *Salomaa*, 642 F.3d at 676. The standard includes considering whether a decision was “(1) illogical, (2) implausible, or (3) without support in inferences that may be drawn from the facts in the record.” *Id.* (quoting *United States v. Hinkson*, 585 F.3d 1247, 1262 (9th Cir. 2009) (en banc)).

Enhanced skepticism is warranted when the facts and circumstances of a case indicate that a conflict of interest “may have tainted the entire administrative decisionmaking process[.]” *Montour v. Hartford Life & Accident Ins. Co.* (“*Montour*”), 588 F.3d 623, 631 (9th Cir. 2009). The conflict is less important when the plan administrator takes “active steps to reduce potential bias and to promote accuracy[.]” *Harlick v. Blue Shield of California* (“*Harlick*”), 686 F.3d 699, 707 (9th Cir. 2012). Such steps include utilizing a “neutral, independent review process,” or “segregating employees who make coverage decisions from those who deal with the company’s finances.” *Id.* (citations omitted). If a structural conflict of interest exists without “evidence of malice, of self-dealing, or of a parsimonious claims-granting history[.]” the court may view the decision with a low level of skepticism. *Abatie*, 458 F.3d at 968. A court may weigh a conflict more heavily if “the administrator provides inconsistent reasons for denial,” “fails adequately to investigate a claim or ask the plaintiff for necessary evidence,” “fails to credit a claimant’s reliable evidence,” “has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly[.]” or “by making decisions against the weight of evidence in the record.” *Id.* at 968–69 (citing *Lang v. Long-Term Disability Plan*, 125 F.3d 794, 799 (9th Cir. 1997); *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463–64 (9th Cir. 1997); *Black & Decker Disability Plan v. Nord* (“*Black & Decker*”), 538 U.S. 822, 834 (2003)).

## III. Procedural Irregularities

\*5 The standard of review discussed above pertains “when a plan participant disagrees with the administrator’s interpretation of the record or with its application of the plan’s terms to the facts.” *Id.* at 971. There are different concerns when the plan administrator fails to abide by the procedural requirements of ERISA and the plan. *Id.* “[P]rocedural violations of ERISA do not alter the standard of review [from abuse of discretion review to de novo review] unless the violations are so flagrant as

to alter the substantive relationship between the employer and employee,” causing the plan beneficiary “substantive harm.” Id. (alteration in original) (quoting Gatti v. Reliance Standard Life Ins. Co. (“Gatti”), 415 F.3d 978, 985 (9th Cir. 2005)). No deference is warranted when a plan administrator’s actions fall “so far outside the strictures of ERISA that it cannot be said that the administrator exercised the discretion” granted by ERISA or the plan. Id. at 972.

However, a procedural irregularity in processing an ERISA claim generally does not justify de novo review. Id. (citing Gatti, 415 F.3d at 985). Similar to a conflict of interest, a procedural irregularity should be a factor weighed in deciding whether an administrator’s decision was an abuse of discretion. Id. If an administrator demonstrates that it “engaged in an ongoing, good faith exchange of information between the administrator and the claimant,” the court should give the administrator’s decision “broad deference notwithstanding a minor irregularity.” Id. (quotations omitted) (quoting Jebian v. Hewlett-Packard Co. Emp. Benefits Org. Income Prot. Plan, 349 F.3d 1098, 1107 (9th Cir. 2003)). “A more serious procedural irregularity may weigh more heavily.” Id.

## DISCUSSION

Plaintiff contends that Defendant abused its discretion in denying her claim for long-term disability benefits because Reliance discredited her subjective complaints, disregarded medical evidence from her treating providers without valid explanation, and failed to conduct an adequate investigation by neither completing an independent medical examination nor a vocational analysis. Pl.’s Opening Br. at 11, 19, 21–22. Defendant argues that Plaintiff has not met her burden to prove physical disability to entitle her to ERISA benefits. Def.’s Resp. Br. at 9–10. Defendant claims that it did not disregard medical evidence and determined that the record evidence did not support a finding of physical disability. Id. at 10–26. Defendant contends that the Social Security Administration’s decision to award disability benefits to Plaintiff was not binding on Reliance and that it was not required to conduct an independent medical examination or an analysis of Plaintiff’s occupation. Id. at 26–28.

Both Plaintiff and Defendant agree that the standard of review is abuse of discretion because the Policy gives Reliance “discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits.” See Pl.’s Opening Br. at 10; Def.’s Resp. Br. at 7; Joint Admin. Rec. (Doc. 33-1) at 18. The Parties also concur that there is a structural conflict because Reliance determines plan eligibility and pays any benefits due. See Pl.’s Opening Br. at 10–11; Def.’s Resp. Br. at 8. Defendant argues that Plaintiff’s claim was properly denied based on the facts and not influenced by the structural conflict present, but Plaintiff argues that Reliance’s decision was impacted by its conflict of interest and that the Court’s review of the decision must be “tempered by skepticism.” Def.’s Resp. Br. at 8; Pl.’s Opening Br. at 11–12. The Court will consider each of Plaintiff’s claims independently and in totality to determine if Defendant abused its discretion in denying Plaintiff’s claim.

### I. Objective Evidence for Plaintiff’s Subjective Complaints

Reliance decided that Plaintiff’s long-term disability benefits claim was supported from a “mental nervous perspective[,]” but that her physical complaints could not be substantiated by the record. Joint Admin. Rec. (Doc. 33-1) at 196. Plaintiff argues that Reliance examined her diagnoses and symptoms in a piecemeal fashion and failed to see that her physical conditions were responsible for her symptoms and cognitive difficulties. Pl.’s Opening Br. at 13. In considering whether Reliance abused its discretion, the Court must determine if the decision was illogical, implausible, or without support from inferences that could reasonably be drawn from facts on the record. Salomaa, 642 F.3d at 676.

\*6 The Ninth Circuit held in Salomaa that “conditioning an award on the existence of evidence that cannot exist is arbitrary and capricious.” Id. at 678. In Salomaa, the plaintiff was diagnosed with chronic fatigue syndrome and a lack of objective physical findings formed the basis for the denial of his long-term medical disability benefits claim. Id. at 669–70. The Ninth Circuit concluded that denial on that basis was illogical because objective measures such as laboratory tests are not used to establish the existence of chronic fatigue syndrome. Id. at 677. “Many medical conditions depend for their diagnosis on patient reports

of pain or other symptoms,” and, in such cases, a disability insurer cannot “condition coverage on proof by objective indicators such as blood tests where the condition is recognized yet no such proof is possible.” Id. at 678.

Reliance acknowledged in its first claim denial that the record indicated that Plaintiff was unable to work as of March 19, 2020 due to anxiety, depression, fatigue, [hypothyroidism](#), palpitations, and shortness of breath. Joint Admin. Rec. (33-1) at 195. The denial noted that Plaintiff’s medical records showed her to be “symptomatic with multiple complaints of fatigue, heart palpitations, intermittent shortness of breath and severe brain fog[.]” Id. However, the denial claimed that her “testing and diagnostics were unremarkable” and did not support her subjective complaints. Id. Plaintiff appealed this decision, submitted additional medical records, and Reliance conducted a second review of her claim. Id. at 195–96. Because it was still unclear to Reliance if Plaintiff was unable to return to work, Reliance sought independent physicians to review her claim. Id. at 196.

Plaintiff was diagnosed with [chronic fatigue syndrome](#) and reported symptoms of fatigue, joint pain, brain fog, depression, and anxiety as the reasons she felt she was disabled. Id. at 214, 229–31. The Ninth Circuit said that “[t]here is no blood test or other objective laboratory test for [chronic fatigue syndrome](#).” Salomaa, 642 F.3d at 677. Reliance denied Plaintiff’s claim because she did not have objective evidence for an illness that lacks objective testing. See id. Reliance required objective evidence of Plaintiff’s symptoms such as chronic fatigue and severe brain fog to substantiate Plaintiff’s complaints of fatigue and severe brain fog in order for her to recover long-term disability benefits under the Policy. See Joint Admin. Rec. (Doc. 33-1) at 195. Reliance required objective evidence despite Plaintiff’s medical care providers repeatedly reporting that she was living with multiple diagnoses and being treated for symptoms that reasonably related to her diagnoses. Joint Admin. Rec. (Doc. 33-2) at 2 (showing that on April 30, 2020, Plaintiff was still struggling with physical symptoms from her [scleroderma](#) diagnosis, and had depression and anxiety); (Doc. 33-1) at 229–31 (showing that on May 15, 2020, Plaintiff was seen for fatigue and foot pain and her diagnoses included chronic fatigue, [scleroderma](#), and dyspnea); (Doc. 33-1) at 232–33 (showing that on May 18, 2020, Plaintiff showed mixed signs of [scleroderma](#) and had a history of shortness of breath and Raynauds).

One of Plaintiff’s multiple diagnoses was [chronic fatigue syndrome](#), and Defendant recognized that her medical reports substantiated that she had complained many times of fatigue. Joint Admin. Rec. (Doc. 33-1) at 195, 231. It is inconsistent with the Ninth Circuit’s holding in Salomaa to allow Reliance to require Plaintiff to demonstrate through objective tests that she suffered from chronic fatigue syndrome when such objective evidence cannot exist. 642 F.3d at 678. To agree with Defendant’s decision that only Plaintiff’s [mental disabilities](#) are substantiated by the record requires ignoring inferences that can be reasonably drawn from facts on the record, such as that her physical conditions related to or impacted her mental conditions. The Court concludes that Defendant’s decision to deny benefits due to a lack of objective evidence for Plaintiff’s chronic fatigue symptoms was unreasonable and warrants reviewing the decision with heightened skepticism.

## II. Disregarded Medical Evidence

\*7 Plaintiff argues that Defendant rejected the opinions of her treating providers without explanation and relied on paper reviewers to deny her claim, who did not speak to her treating providers and cherry-picked critical evidence. Pl.’s Opening Br. at 11–12. Defendant argues that the evidence failed to establish that Plaintiff suffers from a physical disability. See Def.’s Resp. Br. at 29. The claim denial states that Reliance reviewed medical records from “Family Care, Pulmonology, Rheumatology, Urology, Gynecology, and Psychiatry” to determine that Plaintiff retained her ability to perform the material duties of her job. Joint Admin. Rec. (33-1) at 195. Reliance stated that it sympathized with Plaintiff’s reported symptoms but believed that “her condition was not of such severity to render her unable to physically perform the material duties of her Regular Occupation as of March 19, 2020.” Joint Admin. Rec. (33-1) at 197.

Reliance’s denial claimed that around the time Plaintiff stopped working on March 19, 2020, “there was no documentation from an internal medicine perspective that included any restrictions/limitations or impairment from a physical perspective.” Id. This claim does not address medical documentation on the record from after March 19, 2020 that discusses issues with Plaintiff’s physical condition. See id. at 229–31 (documenting a May 15, 2020 appointment for fatigue and foot pain); 232–34 (documenting a May 18, 2020 referral appointment to a pulmonology specialist that noted mixed signs of [scleroderma](#), a

history of shortness of breath and Raynauds); 243–46 (documenting a May 1, 2020 appointment with a rheumatology specialist for complaints of fatigue, joint swelling, [hypertension](#), and [carpal tunnel](#) in her right wrist).

The Policy defines total disability as when, as a result of an injury or sickness, during the elimination period of 180 days and the first 24 months for which a monthly benefit is payable, “an Insured cannot perform the material duties of his/her Regular Occupation[.]” *Id.* at 10, 14. Additionally, total disability must be when as a result of an injury or sickness, after a monthly benefit has been paid for 24 months, “an Insured cannot perform the material duties of Any Occupation.” *Id.* at 14. For purposes of calculating total disability, Plaintiff could not work beginning on March 19, 2020, making her 180-day elimination period until September 15, 2020, and the subsequent 24-month period from September 15, 2020, to September 15, 2022. Reliance's denial claimed that by June 10, 2020, Plaintiff had resumed medication for her anxiety and depressive symptoms and “it would be reasonable to allow up to four weeks” for this medication to assist in regulating her symptoms. *See id.* at 195. Defendant points to a medical record from an appointment on July 16, 2020, when Dr. Chuang evaluated Plaintiff, that said she was “in New Mexico tending to sick family[.]” *Id.* at 289; Def.'s Resp. Br. at 10. Defendant argues that this “[casts] serious doubt on Plaintiff's claim that she was ever physically disabled.” Def.'s Resp. Br. at 10. Defendant argues that it weighs heavily against Plaintiff's claim of physical disability that three months prior to September 15, 2021, her behavioral health was the primary focus of her treatment. *Id.* at 11.

These determinations again do not address the medical documentation on the record that range from August 2020 to at least September 2022, that discusses issues with Plaintiff's physical condition. Joint Admin. Rec. (33-3) at 47–52 (documenting appointments on August 21, 2020 and September 4, 2020 when a physical exam noted musculoskeletal tenderness and pain); Joint Admin. Rec. (33-4) at 377–80 (documenting an appointment on January 21, 2021 reporting unbearable fatigue, arm weakness, and dropping objects); Joint Admin. Rec. (33-5) at 300 (confirming that Dr. Chuang told Dr. Givens that Plaintiff last saw her on November 9, 2021 and she complained of mental fog, fatigue, and low energy), 260–66 (documenting continued substantial brain fog, symptoms from [scleroderma](#), [Cushing syndrome](#), and [Graves' disease](#) in a follow-up gastroenterology appointment on September 19, 2022).

\*8 “Plan administrators ... may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician.” [Black & Decker, 538 U.S. at 834](#). Courts should neither require that administrators automatically give special weight to the opinions of a claimant's physician nor impose on plan administrators a burden of explanation “when they credit reliable evidence that conflicts with a treating physician's evaluation.” *Id.* The problem with Defendant's denial is not that it needed to give special weight to Plaintiff's physicians, but that it did not consider parts of Plaintiff's medical evidence and did not consider the evidence cumulatively. ERISA requires that an administrator must provide plan participants with a “full and fair review” of the participant's claim. *See Abatie, 458 F.3d at 974* (citing [29 U.S.C. § 1133\(2\)](#)). The Court finds that there is evidence on the record of Plaintiff's physical condition and symptoms that Defendant would have had to decide not to weigh or to disregard from its decision in order to conclude that “her condition was not of such severity to render her unable to physically perform the material duties of her Regular Occupation as of March 19, 2020.” Joint Admin. Rec. (33-1) at 197. Defendant's choice to find that there was “no indication of any physical restrictions and/or limitations precluding [Plaintiff's] ability to perform her Regular Occupation as of March 19, 2020 and ongoing” required a selective review of the evidence on the record. *Id.* The Court concludes that this irregularity of considering certain record evidence in the claim denial is a procedural irregularity that increases the level of skepticism given to Defendant's decision.

Reliance relied in part on independent physician reviewers after Plaintiff appealed the first claim denial and Plaintiff argues that Dr. Givens and Dr. Sonne “cherry-picked” evidence to find that she could work full time. Pl.'s Opening Br. at 14. Dr. Givens stated that Plaintiff's medical records documented complaints of depression, anxiety, mental fog, fatigue, and low energy. *See* Joint Admin. Rec. (Doc. 33-5) at 301. These observations led Dr. Givens to claim that Plaintiff was impaired from March 19, 2020, to September 14, 2022, and unable to work at her job. *Id.* at 302. Defendant argues that Dr. Givens' opinion persuaded it to partially reverse<sup>2</sup> the initial claim denial and award benefits to Plaintiff for the duration of the Policy's Mental or Nervous Disorders period. Def.'s Resp. Br. at 14–15.

A court's review of an administrator's decision is tempered by skepticism if “the administrator gave inconsistent reasons for a denial, failed to provide full review of a claim, or failed to follow proper procedures in denying the claim.” [Harlick](#), 686 F.3d at 707 (citations omitted). In Reliance's first denial of Plaintiff's claim, the applicability of the Policy's Mental or Nervous Disorders limitation on benefits was never mentioned. *See* Joint Admin. Rec. (Doc. 33-1) at 183–86. Reliance mentioned Plaintiff's mental status in its initial denial of benefits only to opine that her mental exams were “unremarkable.” *Id.* at 184–85. In Reliance's second review after Plaintiff appealed, Reliance relied on Dr. Givens' observations to find that Plaintiff was entitled to partial benefits for her mental nervous conditions. *Id.* at 202. Reliance's decisions are inconsistent given the stark difference in conclusions about Plaintiff's mental conditions.

Dr. Sonne reported that there was “no documentation of any internal medicine restriction, limitation or impairment that would preclude full-time work at [Plaintiff's] regular job.” Joint Admin. Rec. (Doc. 33-5) at 323. Plaintiff notes that this claim ignores her consistently reported complaints documented by her medical care providers, with which the Court agrees. Pl.'s Opening Br. at 16. Plaintiff's medical records show appointments after Plaintiff stopped working on March 15, 2020 that document her struggle with physical symptoms such as chronic fatigue, joint pain, and signs of [scleroderma](#). *See* Joint Admin. Rec. (Doc. 33-1) at 229–34. Defendant relied wrongfully on an implausible claim that there was no documentation on the record to demonstrate an internal medical issue that precluded Plaintiff from working.

\*9 A recurring discussion in Dr. Sonne's report is Plaintiff's travel during the period of review and her use of telephonic medical appointments. Joint Admin. Rec. (Doc. 33-5) at 321–23. Dr. Sonne noted that “[Plaintiff] went out of state to take care of family members who had **COVID-19**” and “[c]learly, [Plaintiff] could have been doing her regular job at that point.” *Id.* at 322. Dr. Sonne does not point to what information on the record supports that conclusion, and neither did Reliance when it referred to Dr. Sonne's determinations in its final claim denial. *See id.*; Joint Admin. Rec. (Doc. 33-1) at 196. Defendant used an independent reviewer to provide an outside determination of Plaintiff's claim, but relying on Dr. Sonne's conclusions that were unsupported by facts on the record is conduct that should be viewed with a high level of skepticism given the conflict of interest.

### III. Inadequately Investigating Plaintiff's Claim

Plaintiff argues that Defendant's denial of her claim without conducting an independent medical examination was arbitrary and capricious. Pl.'s Opening Br. at 21. Plaintiff does not argue that it is an abuse of discretion in every case that a plan administrator fails to obtain an in-person examination, but claims that it is in this case. Pl.'s Reply Br. at 7. The Policy contains a provision for physical examinations that gives Reliance the right to have a claimant interviewed or examined physically, psychologically, or psychiatrically “to determine the existence of any Total Disability which is the basis for a claim.” Joint Admin. Rec. (33-1) at 18. In ERISA cases, “whether the plan administrator subjected the claimant to an in-person medical evaluation or relied instead on a paper review of the claimant's existing medical records” is frequently a factor. [Montour](#), 588 F.3d at 630. The choice to not conduct a physical exam by a non-treating physician may raise questions about the thoroughness and accuracy of a benefits determination in cases when “it is not clear the Plan presented [paper reviewers] with all of the relevant evidence.” *See* [Montour](#), 588 F.3d at 634 (quotations omitted).

“An insurance company may choose to avoid an independent medical examination because of the risk that the physicians it employs may conclude that the claimant is entitled to benefits.” [Salomaa](#), 642 F.3d at 676. The Court must consider this possibility given that the structural conflict present requires that the Court consider contributing factors for heightened skepticism. *See id.* The record before Reliance included a large amount of medical record evidence spanning many years. The Policy gives Reliance the discretion over whether a physical examination is conducted of the claimant and the choice not to conduct an examination is a factor to consider in determining how much skepticism to give Defendant's claim denial. An independent medical examination would have assisted in confirming information in evidence regarding Plaintiff's medical condition. Reliance's conclusion that Plaintiff's “work-up was unrevealing and her physical exam findings do not support her subjective physical complaints” runs contrary to the evidence in the record and brings into question the decision not to conduct an independent medical examination. Joint Admin. Rec. (33-1) at 197. The choice not to conduct an independent medical examination after Reliance purported a lack of objective evidence of physical disability contributes to the skepticism the Court considers in reviewing this claim denial.

#### IV. Missing Analysis of Plaintiff's Occupation

Plaintiff claims that Dr. Sonne's independent review made several substantial errors. Pl.'s Opening Br. at 23. Dr. Sonne described Plaintiff's occupation as a "sedentary job" involving administrative work that "is not working to lift patients or take care of patients." Joint Admin. Rec. (Doc. 33-5) at 321. Plaintiff's job description as a registered nurse at HonorHealth involved sedentary work, standing, walking, heavy physical effort of up to 50 pounds, lifting or moving patients, and performing treatments. Joint Admin. Rec. (Doc. 33-1) at 297. Dr. Sonne mischaracterized the requirements of Plaintiff's occupation and Reliance referred to this incorrect conclusion in its claim denial. *Id.* at 196 ("The patient has a sedentary job as an [sic] administrative work as an RN. She is not working to lift patients or take care of patients.").

\*10 Defendant claims that "Dr. Sonne was under the mistaken belief that Plaintiff worked in a sedentary capacity" and that the mistake was not material to the outcome. Def.'s Resp. Br. at 28, n.10. The Court disagrees. The Policy's definition of "Totally Disabled" and "Total Disability" requires knowing whether the insured can perform the material duties of their regular occupation. *See* Joint Admin. Rec. (Doc. 33-1) at 14. Correctly understanding the material duties of Plaintiff's occupation is crucial to adequately determining whether Plaintiff can recover benefits under the Policy. Dr. Sonne's report makes assumptions about Plaintiff and her ability to return to work and Defendant relied on that opinion in the claim denial. *Id.* at 196. The Court must view this choice by Defendant with increased skepticism.

Defendant also argues that it is not required to perform a vocational assessment. Def.'s Resp. Br. at 28 (citing [Woolsey v. Aetna Life Ins. Co.](#) ("Woolsey"), 457 F. Supp 3d 757, 774 (D. Ariz. 2020)). Given that Defendant relied on an inaccurate assessment of Plaintiff's occupation, a vocational assessment would have been beneficial in this case. Relying on inaccurate information and failing to rectify the mistake is a procedural irregularity that goes toward an administrator's duty to provide a "full and fair" review of the claim. *See* [Abatie](#), 458 F.3d at 973; 29 U.S.C. § 1133(2). Reliance did not afford Plaintiff a full and fair review of her claim by relying on inaccurate information in determining that she could not recover benefits under the Policy.

#### V. Social Security Administration's Disability Determination

Plaintiff supplemented the record after appealing Defendant's denial with the Social Security Administration's decision on her disability claim. Joint Admin. Rec. (Doc. 33-5) at 333–47. Social Security disability awards are not binding on plan administrators, but are evidence of disability. [Salomaa](#), 642 F.3d at 679. "Evidence of a Social Security award of disability benefits is of sufficient significance that failure to address it offers support that the plan administrator's denial was arbitrary, an abuse of discretion." *Id.* "Weighty evidence may ultimately be unpersuasive, but it cannot be ignored." *Id.* Defendant did acknowledge the Social Security Administration's results in Plaintiff's case. Joint Admin. Rec. (Doc. 33-1) at 197. Little weight was given to the decision because the Social Security Administration "did not have the results of [Reliance's] independent physician's report or other medical and vocational information [Reliance] may have developed in [Plaintiff's] file[.]" *Id.* The Social Security Administration determined that Plaintiff became disabled on August 1, 2020 and has continued to be disabled through the date of the decision, March 13, 2023. *See* Joint Admin. Rec. (Doc. 33-5) at 347.

Defendant's acknowledgement of the Social Security Administration's decision was brief, and Defendant used the independent physician's reports to suggest that the Social Security Administration's decision was less complete than Reliance's records. Joint Admin. Rec. (Doc. 33-1) at 197. This comparison is not convincing now that the Court has identified several issues with Reliance's independent physician reports. The Social Security Administration's decision was the result of testimony, medical records, and affidavits from Plaintiff's family members. Joint Admin. Rec. (Doc. 35-5) at 348–55. Defendant gave little consideration to the Social Security Administration's disability decision, though it was substantive information that Plaintiff submitted for review. Defendant's decision is not as complete as it could have been without a more meaningful review and explanation of why Defendant did or did not find the decision worth including in its claim denial. The Court concludes that Defendant ignored evidence submitted of Plaintiff's Social Security disability award without sufficient explanation which warrants reviewing Defendant's claim denial with heightened skepticism.

## VI. Cumulative Consideration of Plaintiff's Claim

\*11 Plaintiff argues that Reliance's decision to deny benefits is not supported by the totality of the record. Pl.'s Opening Br. at 12–13. Plaintiff claims that Reliance examined her diagnoses and symptoms in pieces and minimized the severity of her physical conditions. *Id.* at 13. Had Reliance's paper reviewers considered Plaintiff's condition as a whole, Plaintiff argues the claim would not have been denied. *Id.* Courts have held that “a [d]efendant's review should address the cumulative effect of a [p]laintiff's symptoms and conditions when determining disability.” [Lewis v. Unum Life Ins. Co. of Am.](#) (“Lewis”), 569 F. Supp. 3d 983, 1012 (D. Ariz. 2021) (citing [Woolsey](#), 457 F. Supp. 3d at 772; [Lawrence v. Motorola Inc.](#), No. CV-04-1553-PHX-NVW, 2006 WL 2460921, at \*8, (D. Ariz. Aug. 24, 2006); [Nickola v. CNA Grp. Life Assurance, Co.](#), No. 03 C 8559, 2005 WL 1910905 at \*9, (N.D. Ill. Aug. 5, 2005)). The Court concludes that Reliance's failure to view Plaintiff's conditions and symptoms in the aggregate was a consequential factor that amounted to an abuse of discretion. Granting Plaintiff disability benefits from a mental nervous perspective, but finding that she had not shown that she suffered from physical disability required only looking at the symptoms and conditions present in the medical evidence singularly. This failure to view Plaintiff's medical conditions cumulatively to determine if she met the Policy's definition of total disability caused the claim denial to be without support from inferences that may be drawn from the record. The Court concludes that it was an abuse of discretion that Defendant failed to consider the possibility that the combined effect of Plaintiff's conditions was disabling. See [Woolsey](#), 457 F. Supp. 3d at 772; see also [Lewis](#), 569 F. Supp. 3d at 1013 (“The Court finds the failure of [d]efendant to consider [p]laintiff's conditions in the aggregate dispositive in this case ... As a result, much of [d]efendant's review shows a tendency to not see the forest for the trees.”). The Court concludes that Defendant abused its discretion and denial of Plaintiff's claim must be reversed.

## VII. Attorneys' Fees and Costs

Plaintiff seeks to recover her attorneys' fees and costs incurred pursuant to 29 U.S.C. § 1132(g). Compl. at ¶ 43. The Court may exercise its discretion to award reasonable attorneys' fees and costs of action to either party. See 29 U.S.C. § 1132(g)(1). The Court concludes that Plaintiff is entitled to her reasonable attorneys' fees and costs and orders that Plaintiff shall file a motion and supporting documentation in accordance with LRCiv. 54.1 and 54.2.

## CONCLUSION

Defendant abused its discretion in denying Plaintiff's claim for long-term-disability benefits under the Policy. The Court reviewed Reliance's decision with heightened skepticism given the conflict of interest and procedural irregularities. Plaintiff is entitled to judgment in her favor on the recovery of her benefits from Defendant's long-term disability policy. Accordingly, Plaintiff's claim for long-term disability benefits shall be remanded to Defendant with instructions to direct an award of benefits. Plaintiff shall file a motion and supporting documentation for attorneys' fees and costs in accordance with the local rules within thirty (30) days of this Opinion and Order.

**IT IS SO ORDERED** the Clerk of Court shall enter judgment accordingly.

**IT IS SO ORDERED** this 20th day of February, 2026.

## All Citations

Slip Copy, 2026 WL 539534

## Footnotes

\* Judge Jennifer Choe-Groves, of the United States Court of International Trade, sitting by designation.

- 1 From 2018 to 2019, medical records indicate that Plaintiff experienced papillary thyroid carcinoma, Graves' disease, goiter, chronic fatigue, post-surgical hypothyroidism, ACTH deficiency, vitamin D deficiency, pituitary gland disorder, adrenal adenoma, rheumatoid arthritis, type two diabetes, and chronic gastritis. See Joint Admin. Rec. (Doc. 33-1) at 310–22.
- 2 Defendant mentioned that it relied on internal clinical reviews in its first review of Plaintiff's claim where it denied all benefits claims. Def.'s Resp. Br. at 14, n.7. Once Plaintiff appealed and Defendant conducted a second review, Reliance used peer review reports and partially reversed the claim denial to allow for mental health benefits and “upheld the denial of the physical disability claim.” Id. Defendant argued that even if Reliance “abused its discretion when it relied on the clinical staff reviews – which it did not – then any perceived error was cured during the administrative appeal.” Id. at 14–15, n.7.

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