2023 WL 491039
Only the Westlaw citation is currently available.
United States District Court, S.D. New York.

JESSICA ISRAEL, Plaintiff,
v.
UNUM LIFE INSURANCE COMPANY OF AMERICA, Defendant.

21-CV-4335 (GHW) (JLC)
|
January 27, 2023

REPORT AND RECOMMENDATION

JAMES L. COTT United States Magistrate Judge

***1 To the Honorable Gregory H. Woods, United States District Judge:**

Jessica Israel brought this suit against Unum Life Insurance Company of America to challenge its determination that she was no longer eligible for Long-Term Disability and Life benefits. The parties have cross-moved for summary judgment. In her motion, Israel argues that Unum, the administrator of her benefit plans, violated the Employee Retirement Income Security Act of 1974 ("**ERISA**") by failing to follow required appeals procedures after it determined that she was no longer eligible for Long-Term Disability benefits. Accordingly, she requests that her Long-Term Disability benefits determination be reviewed on the merits and reversed by this Court, or in the alternative be remanded for further proceedings. In its cross-motion, Unum counters that Israel never appealed her benefits determination, that she therefore has no legal basis to challenge it, and that even if this Court were to review the determination, it should uphold Unum's decision denying benefits.

For the reasons set forth below, Israel's communications with Unum following her adverse benefit determination were sufficient to constitute an appeal of her Long-Term Disability benefits and Unum should have treated them as such. Accordingly, Israel's Long-Term Disability benefits claim should be remanded for further review consistent with Unum's appeals procedures. Israel's motion should thus be granted in part. Unum's cross-motion should be denied with respect to the claim for Long-Term Disability benefits, and granted with respect to the claim for Life benefits, which Israel made no effort to appeal.

I. BACKGROUND

The following undisputed facts are taken from Unum's Response to Plaintiff's Statement Pursuant to Local Rule 56.1 ("Counter Statement"), Dkt. No. 45, [1] as well as exhibits submitted by the parties. [2]

Since at least 2016, Israel participated in both a Long-Term Disability Plan ("LTD Plan") and a Life and Accidental Death and Dismemberment Insurance Plan ("Life Plan"), provided through her employer and funded by the policies "issued and administered by Unum." Counter Statement at ¶¶ 3, 4, 6, 9, 20–24.

Israel's LTD Plan provides that if a Plan beneficiary receives an adverse benefit determination (one that wholly or partially denies requested benefits), the notice of that determination will:

- state the specific reason(s) for the determination;

- reference specific Plan provisions(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

***2** - describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of **ERISA** following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Id. at ¶ 15. The LTD Plan also provides Israel the following information about how to appeal an adverse benefit determination:

> Requests for appeals should be sent to the address specified in the claim denial.... You will have the opportunity to submit written comments, documents, or other information in support of your appeal.

Dkt. No. 39, Ex. 1 at 45; Dkt. No. 46, Ex. 1 at 46. It further provides:

> the notice of adverse benefit determination under the Plan will: ... describe Plan procedures and time limits for appealing the determination ....

Dkt. No. 39, Ex. 1 at 44–45; Dkt. No. 46, Ex. 1 at 45–46.

Between late 2016 and early 2017, Israel underwent two surgeries and a biopsy, and was consequently granted **Waiver** of **Premium** ("WOP") benefits under her Life Plan. Counter Statement at ¶¶ 41–46. In March 2017, Unum approved Israel's claim for LTD benefits, and requested additional medical records to determine continuing eligibility. Counter Statement at ¶ 19. Israel received assistance applying for benefits and communicating with Unum from a paralegal at a law firm she engaged to represent her named Maxine Riley ("Riley"). Plaintiff's Memorandum of Law in Support of Summary Judgment Motion ("Pl. Mem."), Dkt. No. 37 at 5; Defendant's Memorandum of Law in Support of Cross-Motion for Summary Judgment, Dkt. No. 43 ("Def. Mem.") at 11; *see also, e.g.*, Defendant's Local Rule 56.1(a) Statement of Undisputed Material Facts, Dkt. No. 44, ¶ 63, 104. [3]

In May 2017, Israel was admitted to the emergency room because of pain in her right flank and lower abdomen. Counter Statement at ¶ 58. In September of that year, she was again admitted to the emergency room, reporting that she "had been drinking" and "fell and hit her head at home." *Id.* at ¶ 63. A doctor performed a craniotomy surgery, and her "post-operative diagnosis was right acute subdural hematoma." *Id.* at ¶ 65–66. For the remainder of 2017, Israel experienced abdominal and low back pain, headaches, pain while urinating, fatigue, weakness, "poor exercise tolerance," and "inability to do usual activities," and she underwent a series of medical tests and examinations related to these symptoms. *Id.* at ¶¶ 67, 77–80, 82, 114, 122, 125, 128, 130, 133, 134, 154–57.

***3** In December 2017, Unum notified Riley that it would provide Israel with WOP benefits under her Life plan in the amount of $75,000. *Id.* at ¶ 177. It requested updated medical records be submitted in order to complete review of her benefits claim. *Id.* In early 2018, Israel continued to make frequent doctor visits, reporting "fatigue, weakness in the left upper extremity, poor exercise tolerance, inability to do usual activities, numbness and tingling in the left forearm and hand." *Id*. at ¶ 137. In May 2018, she visited the doctor again for "headache, neck pain, back pain, right flank pain, and memory problems." *Id.* at ¶ 139. From her 2018 visits, Israel was documented as being in a "good general state of health," but with a number of active

problems including "[a]nemia; [a]nxiety; [d]iabetes; [e]levated liver functions tests; [f]requent [h]eadaches; [kidney stones]; Hashimoto's Thyroiditis; [h]ypertension; [i]mpaired [m]emory; non-alcoholic fatty liver disease; [and] sub[d]ural hematoma." *Id.* at ¶¶ 137, 172.

On May 8, 2018, Dr. Louise Banks, on behalf of Unum, reviewed Israel's claim for continued LTD benefits and concluded that "there is no evidence presented which change[s] my prior opinion that Ms. Israel is physically capable of performing her previous occupation." Dkt. No. 39, Ex. 8 at 53; Dkt. No. 46, Ex. 36 at 173. On May 11, 2018, Dr. Stephen Kirsch, on behalf of Unum, reviewed her claim for continued LTD benefits and concluded that "the medical record fails to support that [Israel] is currently precluded" from full-time work. Dkt. No. 46, Ex. 35 at 185. [4] In addition, on May 14, 2018, Dr. Jacqueline Crawford, on behalf of Unum, reviewed her claim for continued LTD benefits and reported that there was no evidence Israel "was referred to a neuropsychologist or neurologist for cognitive complaints as might be seen in an individual reporting an impairing degree of cognitive impairment" and that her "medication profile [did not] contain evidence of medicines used to augment alertness or cognition as might be seen in an individual seeking relief of impairing degree of cognitive impairment." Dkt. No. 39, Ex. 7 at 108–09; Dkt. No. 46, Ex. 35 at 186–87.

On May 15, 2018, Riley spoke on the phone with Angela Doiron ("Doiron"), a disability benefits specialist at Unum, with whom she had been communicating about Israel's claim. Dkt. No. 39, Ex. 7 at 117; *see also* Counter Statement at ¶ 216 (referring Court "to the cited record for the actual language"). In the call, according to Doiron's notes, she informed Riley that the "cl[ai]m [was] closed" as of May 15, 2018. *Id.* Doiron further noted:

> [Riley] said I don't understand, she had the brain procedure. She asked if we at least got the [medical records] from the hospital. [I] explained we did and those were reviewed and addressed in the letter. She said [Israel's] diabetes is out of control. She said the [medical records] are hard to get. [I] explained [the file transfer protocol] process and [that] the policy states info[rmation] is due [within] 45 days of our initial request.
>
> Info[rmation] was not [received] during that timeframe and an [additional] 30 days were provided. All of the [required] info[rmation] was not [received] and therefore, info[rmation] on [Israel's] file was [reviewed]. [The i]nfo[rmation] on file does not support ongoing benefits.
>
> ...
>
> [Riley] asked what [was] next and [I] stated [that] info[rmation] is forthcoming. [I e]xplained [that] she can send o/s [*sic*] and/or new info[rmation to me, the disability benefits specialist,] for review. [Riley] asked for the letter to be emailed to her.
>
> ...
>
> [Riley] said 'I swear I didn't get any of that' meaning the request for info[rmation]. [Previously, o]n [March 27, 2018,] [I] spoke [with Riley].... I [e]xplained we have not [received] all the [medical records] we [requested]. She said 'I have everything' ... As noted in our correspondence, info[rmation] was needed by the 75th day; however, this info[rmation] is not in by this timeframe. At this time, we will proceed with our review of it.

***4** *Id.* at 117–18.

Later on May 15, 2018, Riley received an adverse determination letter ("May 15 Determination") from Doiron informing her that Israel's LTD benefits would cease. Counter Statement at ¶ 214. The letter explained:

> The brain imaging on file documents improvement and stabilization of the residual subdural fluid with no new hemorrhage or stroke, consistent with the expected improvements. Her ammonia levels were not elevated as might be seen in an individual with impairing degree of liver disease. The most recent renal ultrasound is normal, without evidence of stone or obstruction to cause pain or delirium.

> There is no noted referral to a neuropsychologist or neurologist for cognitive complaints as might be seen in an individual reporting an impairing degree of cognitive impairment. Additionally, the medication profile does not contain evidence of medicines used to augment alertness or cognition as might be seen in an individual seeking relief of the same. It is acknowledged to include behavioral health medicines which can cause a sense of fatigue, however, the file reflects Ms. Israel is not claiming her behavioral health condition as impairing.
>
> Given these factors, the medical [evidence] on file fail[s] to support that Ms. Israel is currently precluded from performing the demands, as specified above.
>
> Based on our review, the information in the claim file indicates she is able to perform the duties of her own occupation and the claim has been closed effective May 15, 2018.

Id.

The May 15 Determination provided procedures and time limits for appealing the decision. Under the subheading "How do you request an Appeal?," it instructed:

> You will need to submit a written letter of appeal outlining the basis for your disagreement.... please include any additional information you would like considered....

Dkt. No. 39, Ex. 7 at 114; Dkt. No. 46, Ex. 35 at 207. Another subheading titled "What is an Appeal?" explained: "[a]n appeal is your written disagreement with our claim decision and a request for review of that decision." *Id.* Below that was another a subheading titled "How do you request an Appeal?," which read:

> You will need to submit a written letter of appeal outlining the basis for your disagreement.... please include any additional information you would like considered....

Id. Yet another subheading explained that to request an appeal, Israel "ha[d] 180 days from the date [she] receive[d] this letter." Dkt. No. 39, Ex. 7 at 115; Dkt. No. 46, Ex. 35 at 208. And below that: "Where do you mail or fax your written request for an Appeal?" followed by a PO Box addressed to "The Benefits Center / Appeals Unit." *Id.*

On May 21, 2018, Unum sent another letter to Riley notifying her that it was unable to approve Israel's WOP benefits because she had "not provided updated proof of continued disability." Counter Statement at ¶ 180.

On June 1, 2018, Riley sent a letter ("June 1 Letter") addressed to Doiron that stated: "Pursuant to your request, enclosed please find the following documentation in support of Ms. Israel's Disability claim." Dkt. No. 39, Ex. 7 at 119; Dkt. No. 46, Ex. 35 at 234. The letter enclosed 11 medical documents for review. Dkt. No. 39, Ex. 7 at 119–20; Dkt. No. 46, Ex. 35 at 234–35. There was no reference to Israel's WOP benefits under her Life Plan in the letter. *Id.* ("We represent Ms. Jessica Israel in connection with her claim for *long-term disability* benefits." (emphasis added)).

***5** Throughout the summer of 2018, Israel met with at least three other doctors, reporting similar symptoms, and Riley continued to email records from these visits to Doiron. Counter Statement at ¶¶ 149, 152, 168–69, 170–72; Dkt. No. 39, Ex 8. at 4–14; Dkt. No. 46, Ex. 36 at 2–12. On July 25, Riley emailed Doiron: "Pursuant to our telephone conversation on July 25, 2018, enclosed please find the following documentation in support of Ms. Israel's disability claim," and attached notes from two recent visits with a different doctor. Dkt. No. 39, Ex 8 at 4; Dkt. No. 46, Ex. 36 at 2. A July 25, 2018 internal report from

Unum noted: "Please review the information received since 4/25/18 ... and please comment if this information changes your prior opinion;" it was followed by the entry: "there has been no change in my previously documented opinion." Dkt. No. 39, Ex. 8 at 18–19; Dkt. No. 46, Ex. 36 at 22–23.

On July 27, Riley emailed additional medical records to Doiron. Dkt. No. 39, Ex. 8 at 28–29; Dkt. No. 46, Ex. 36 at 137–38. On July 31, she sent more records to a different Unum employee: "Attached hereto is an updated disability status form. I'm in the process of obtaining additional medical records. Upon receipt thereof, I'll immediately forward you this information." Dkt. No. 39, Ex. 8 at 40–41; Dkt. No. 46, Ex. 36 at 156–57. The additional records were reviewed again by Dr. Kirsch, Dkt. No. 39, Ex. 8 at 35–36; Dkt. No. 46, Ex. 36 at 145–46; Dr. Banks, Dkt. No. 39, Ex. 8 at 53–54; Dkt. No. 46, Ex. 36 at 173–74; and Dr. Crawford. Dkt. No. 46, Ex. 36 at 150. [5]

On August 2, 2018, Unum sent a letter to Riley: "This letter is about the decision we made on the Long-Term Disability claim for Ms. Israel and to inform you the information you submitted would not change our prior decision." Dkt. No. 39, Ex. 8 at 47; Dkt. No. 46, Ex. 36 at 164. On the second page, the letter stated: "Decision/Reason: The new information received does not change our prior decision." Dkt. No. 39, Ex. 8 at 48; Dkt. No. 46, Ex. 36 at 165. It explained further:

> You were evaluated by Neurologist, Dr. Chen on June 20, 2018. On examination[,] orientation, attention, language and fund of knowledge were noted to be normal as well was the rest of the multi-system examination. There is no documentation th[at] states your need of assistance from others and it furthers states that you are able to care for your child. You reported short term memory loss, however, specifics of short term memory changes were not documented. Although a Neuropsychological consultation has been previously recommended, this has not yet occurred. No additional imaging has been recommended by Dr. Chen. Given this information, the medical record fails to support that ... you are currently precluded from performing your occupational demands as outlined in our attached letter.

Id. The section below explained: "When you submitted this additional information, you did not request an appeal of the claim decision. If you want to appeal this decision, please submit a request in writing by the timeframe outlined in the enclosed letter." *Id*. The record does not indicate whether Riley or Israel submitted additional medical records to Unum after the August 2 letter.

Almost three years later, in May 2021, another paralegal from the law office representing Israel sent a letter to Doiron requesting documents related to Israel's LTD plan, including all documents related to benefits determinations, records and medical opinions relied on, and communications, among other items. Dkt. No. 46, Ex. 36 at 264–66. [6] At this time, Israel's attorney and Unum representatives corresponded, disputing whether Israel had properly appealed her benefits determination and whether she had been adequately notified of the determination and of her rights to appeal. *See* Defendant's Rule 56.1 Statement, Dkt. No. 44 at ¶¶ 108–16. Israel's attorney wrote to Doiron on May 10, 2021:

> ***6** We urgently request that 1) Unum accept an appeal of the May 15, 2018 denial, and 2) toll the statute of limitations pending the appeal. Without Unum tolling the statute of limitations, we will be forced to file a lawsuit against Unum ... in order to preserve Ms. Israel's ongoing disability claim.

Dkt. No. 46, Ex. 36 at 281. He further explained that "Unum [had] addressed both the May 15, 2018 and August 2, 2018 letters to [the firm's] old address" and that Israel "therefore, did not receive adequate notice of her appeal rights." *Id*. He added that Riley "received the [May 15] letter," but "there is no reference to the second letter in our files." *Id.* On May 12, 2021, Unum sent a letter to Israel's counsel, noting that its "records document that someone was accessing the claim file via the Unum website,

including on May 15, 2018 and August 5, 2018" and "[t]he individual accessing the online account would have been able to view any letters that were sent." Dkt. No. 46, Ex. 37 at 10.

Israel brought this lawsuit on May 13, 2021, alleging that Unum had wrongfully terminated her WOP and LTD benefits and failed to follow appeal procedures required by **ERISA**. Complaint, Dkt. No. 1. [7] On May 15, 2021, this case was referred to me for general pretrial supervision and any dispositive motions. Dkt. No. 8. After an unsuccessful settlement conference, on March 15, 2022, Israel moved for summary judgment with respect to her claims for LTD and WOP benefits and on April 19, 2022, Unum cross-moved. *See* Dkt. Nos. 36, 42. On May 17, 2022, Israel filed a reply memorandum of law in support of her motion, Dkt. No. 48, and on June 14, 2022, Unum filed a reply memorandum of law in support of its motion. Dkt. No. 51. On June 16, 2022, Israel filed a letter notifying the Court of a recent Second Circuit decision, *McQuillin v. Hartford Life and Accident Insurance Co.*, 36 F.4th 416 (2022), arguing that it was applicable to her case. Dkt. No. 52. Unum did not respond to the letter.

II. DISCUSSION

In her motion papers, Israel contends that Unum's determination of her LTD benefits violated **ERISA's** implementing regulations, 29 C.F.R. §§ 2560.503-1(h)(2)(ii)–(iv), as well as the terms of the LTD plan itself, which entitle benefit holders to certain appeals processes when appealing adverse benefit determinations. Pl. Mem. at 4–5.

Unum responds that the appeals procedures required by 29 C.F.R. §§ 2560.503-1(h)(2)(ii)–(iv) and the LTD Plan were not applicable to Israel's claim because she never appealed her benefits determination, despite being provided with multiple notices of her right to do so. Def. Mem. at 11. According to Unum, Israel's failure to appeal her LTD determination means that she failed to exhaust her administrative remedies, and therefore she has no cause of action under **ERISA**. *Id.* at 17.

A. Legal Standards

1. Summary Judgment

***7** "[S]ummary judgment is proper only if there is no genuine dispute of material fact and the movant is entitled to judgment as a matter of law." *A & E Television Networks, LLC v. Pivot Point Ent., LLC*, No. 10-CV-09422 (AJN), 2013 WL 1245453, at *6 (S.D.N.Y. Mar. 27, 2013) (citing *Ramos v. Baldor Specialty Foods, Inc.*, 687 F.3d 554, 558 (2d Cir. 2012)). "When ruling on a summary judgment motion, the district court must construe the facts in the light most favorable to the non-moving party and must resolve all ambiguities and draw all reasonable inferences against the movant." *Landry v. Metro. Life Ins. Co.*, No. 19-CV-3385 (KPF), 2021 WL 848455, at *6 (S.D.N.Y. Mar. 5, 2021) (quoting *Dallas Aerospace, Inc. v. CIS Air Corp.*, 352 F.3d 775, 780 (2d Cir. 2003), *reconsideration denied*, 2021 WL 1731835 (May 3, 2021)).

On cross-motions for summary judgment, the "court must evaluate each party's motion on its own merits, taking care in each instance to draw all reasonable inferences against the party whose motion is under consideration." *A & E Television Networks*, 2013 WL 1245453, at *7 (citing *Schwabenbauer v. Bd. Of Ed. Of City Sch. Dist. Of City of Olean*, 667 F.2d 305, 314 (2d Cir. 1981)).

2. Exhaustion Under ERISA

Section 502 of **ERISA** entitles recipients of covered benefit plans "to enforce ... rights under the terms of the [applicable] plan." 29 U.S.C. § 1132(a)(1)(b). However, courts may only review **ERISA** claims brought by individuals who have exhausted the administrative remedies available. *See, e.g.*, *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 79 (2d Cir. 2009) ("[A]n **ERISA** action may not be brought in federal court until administrative remedies are exhausted."). If

a claimant does not exhaust administrative remedies available, then a court will dismiss an **ERISA** claim. *See, e.g., Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993).

A claimant is "deemed to have exhausted her administrative remedies if a plan fails to establish or follow claims procedures in compliance with **ERISA**." *McFarlane v. First Unum Life Ins. Co.*, 274 F. Supp. 3d 150, 155 (S.D.N.Y. 2017) (quoting 29 C.F.R. § 2560.503-1(*l*)(1) (internal quotations omitted)); 29 C.F.R. § 2560.503-1(*l*) ("[I]n the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of [§ 503-1], 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) ...."). [8] **ERISA's** implementing regulations governing procedures for the review of benefit claims, § 503-1 *et seq.*, require that plans "maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations" and may not be "administered in a way[ ] that unduly inhibits or hampers the initiation or processing of claims for benefits," including the appeals of adverse benefit determinations. 29 C.F.R. §§ 2560.503-1(b)–(b)(3). The regulations elsewhere provide procedural requirements for adverse benefit determinations and appeals of those determinations that plan administrators must follow. *See* 29 C.F.R. § 2560.503-1(g)–(j). For instance, 29 C.F.R. § 2560.503-1(h)(3)(ii) requires a "review" of the "initial adverse benefit determination" to be conducted by someone "who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;" 29 C.F.R. § 2560.503-1(h)(3)(v) requires that "the health care professional engaged for purposes of a consultation [of an adverse benefit determination] 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 29 C.F.R. § 2560.503-1(i)(1)(i) and (i)(3)(i) require (absent special circumstances not applicable here) that the plan administrator notify a disability claimant "of the plan's benefit determination on review" no later than 45 days "after receipt of the claimants request for review by the plan."

***8** The Court's decision is guided by the benefit plan at issue, along with the principles that "contractual limitations provisions ordinarily should be enforced as written," and that "**ERISA** puts the onus on the plan administrator to ... clearly inform plan participants of [appeals] procedures." *Landry*, 2021 WL 848455, at *7, 12 (citing *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. 99, 108 (2013) ("The plan, in short, is at the center of **ERISA**.")). To determine whether Israel appealed her denial of LTD benefits, the Court therefore begins by examining the instructions on how to take an appeal in the LTD Plan and in the May 15 Determination. [9]

The Court's decision is further guided by the requirement that plan administrators are obligated to "follow claims procedures consistent with the requirements of [§ 503-1]." § 2560.503-1(*l*). The Court must therefore ensure that the plan administrator "follow[ed] claims procedures consistent with the requirements of [§ 503-1]." § 2560.503-1(*l*). If Unum failed to do so, then Israel's claim "shall be deemed to have exhausted the administrative remedies available ... and shall be entitled to pursue any available remedies under section 502(a)." § 2560.503-1(*l*).

B. Analysis

1. Israel's Claim for LTD Benefits Should be Deemed Exhausted

Israel contends that the June 1 Letter constitutes an appeal. *See* Pl. Mem. at 4. Unum counters that the June 1 Letter is *not* an appeal. *See* Def. Mem. at 2. As the parties agree about the content of the June 1 Letter, whether the June 1 Letter constitutes an appeal is purely a question of law. *See, e.g., Landry*, 2021 WL 848455, at *12–13 (ruling as a matter of law on cross-motions for summary judgment on whether letter from benefit plan holder constituted appeal for **ERISA** purposes).

Therefore, the threshold—and dispositive—issue presented here is whether Israel exhausted the administrative remedies available to her. If Israel adequately appealed the May 15 Determination that she was no longer eligible for LTD benefits, then she was entitled to the Plan's appeals procedures, as also required by **ERISA's** implementing regulations. *See* 29 C.F.R. §§

2560.503-1(h) *et seq*. If Unum failed to "establish or follow claims procedures consistent with the requirements of" § 503-1, then her claim is deemed exhausted. § 2560.503-1(*l*). The resolution of this issue hinges on an assessment of the actions taken by both parties: 1) the June 1 Letter, which Israel characterizes as an appeal, and which Unum argues is plainly not an appeal because it did not follow the instructions for taking appeals clearly specified in the May 15 Determination, Pl. Mem. at 5; Def. Mem. at 3, 12; and 2) Unum's treatment of the additional medical information that Israel submitted following the May 15 Determination.

To take an appeal, the May 15 Determination explained, Israel would have to send a "written letter of appeal outlining the basis for [her] disagreement ... with any additional information [she] would like considered." Counter Statement at ¶ 216; Dkt. No. 39, Ex. 7 at 114. Further along, the letter described an "appeal" as a "written disagreement with [Unum's] claim decision and a request for a review of that decision," and provided an address for the Benefits Center, Appeals Unit, where a "request for an Appeal" should be sent. Dkt. No. 39, Ex. 7 at 115.

The June 1 Letter was mailed to Doiron, with whom Riley had been communicating on her behalf, and stated that it had enclosed "documentation in support of Ms. Israel's Disability claim." Dkt. No. 39, Ex. 7 at 119; Dkt. No. 46, Ex. 35 at 234. It did not include the word "appeal." *Id.* In *Landry v. Metropolitan Life Insurance Company*, a benefit claimant's letter to his insurer following an adverse benefit determination was found to constitute an appeal even though it did not use the word "appeal." 2021 WL 848455, at *12. The court in *Landry* opined that there is no "magic word" requirement unless the plan at issue makes clear that there is one. *Id.* That the June 1 Letter does not use the word "appeal" is therefore not fatal to Israel's claim, as the May 15 Determination's description of the appeals process does not require it.

***9** Beyond dismissing the notion of a "magic word" requirement, the court in *Landry* emphasized that the "burden" is not on the claimant to timely appeal because of the insurer's "lack of clarity" about the appeals process. *Id.* at 12. There, the insurer's Plan required that a claimant submit an appeal in writing, "providing the employee name, name of the LTD plan, reference to the initial decision, an explanation of the reason(s) for the appeal, and additional documentation in support of the request." *Id.* Landry's letter provided his "name and claim number, refer[red] to [his employer], state[d] that [he] believe[d] he [was] not being paid the full amount of LTD benefits to which he [was] entitled, [and] ask[ed his insurer] to 'review [his] monthly benefit amount, reinstate the correct ongoing amount, and forward the resulting back-payments.' " *Id.* Landry's letter was considered sufficient because **ERISA** "puts the onus on the plan administrator to establish and maintain reasonable procedures governing appeals and to clearly inform plan participants of those procedures," and so the Court declined to construe any ambiguity in the insurer's favor. *Landry*, 2021 WL 848455, at *12 (citing 29 C.F.R. § 2560.503-1(b)).

Although conceding that it need not have included the word "appeal," Unum maintains that the June 1 Letter does not constitute an appeal because in it, Riley did not "articulate any reason for her disagreement." Def. Mem. at 21–22; Def. Reply at 2. The Court disagrees with this assessment and with the notion of superimposing additional hurdles for appeal onto Unum's stated instructions. The June 1 Letter provided "documentation in support of Ms. Israel's Disability claim," in response to a determination that listed "[i]nformation ... outstanding beyond the timeframe ..." as the "Decision/Reason." Dkt. No. 39, Ex. 7 at 119; Dkt. No. 46, Ex. 35 at 234. The additional documentation Riley submitted provided a substantive basis for disagreement with the determination, and was plainly submitted as a "request for review." In fact, the June 1 Letter stated explicitly that Doiron should "please find the following documentation," and that it was sent "[p]ursuant to [Doiron's] request," language indicating that Doiron was supposed to read it in consideration of Israel's claim. *Id*.

In sum, the "disagreement" and "request for review" is apparent when reading the letter in the context of Riley's correspondence with Doiron, and the "burden" is not on the claimant to be more explicit when the insurer failed to provide clear instructions about what specific words an appeal should include. *Landry,* 2021 WL 848455, at *12; *cf. Saladin v. Prudential Ins. Co. of Am.*, 337 F. App'x 78, 79 (2d Cir. 2009) (where claimant had not met requirements for appeal specified in Plan, **ERISA** claim dismissed). Construing ambiguities in Israel's favor, the Court considers the "written disagreement" and "request for appeal" requirements to have been met in the June 1 Letter. *See Landry,* 2021 WL 848455, at *12 (letter to insurer constituted appeal because "a fair reading of the document ... satisfie[d] the [insurer's] content requirements of a written appeal").

Separately, Unum contends that Israel's June 1 Letter is not an appeal because it was not sent to Unum's Appeals Unit, as was instructed on page six of the May 15 Determination. Def. Mem. at 19–20. Instead, Riley sent the letter to Doiron, the sender of the May 15 Determination, the person with whom Riley had been communicating about Israel's claim, and to whom she had spoken on the phone that day about a "forthcoming" letter and the opportunity to send "o/s [*sic*] and/or new info[rmation to her, the disability benefits specialist,] for review." Dkt. No. 39, Ex. 7 at 117; Dkt. No. 46, Ex. 35 at 211. After this phone conversation, it was reasonable for Riley to believe that she should submit documentation to Doiron, and nothing in Doiron's detailed notes of their phone conversation on May 15, 2022 suggests she told Riley to send any information to the Appeals Unit, rather than to her. *Id.* To rely on this technicality to deny Israel her opportunity to appeal would "unduly inhibit[ ]or hamper[ ]the initiation or processing of claims for benefits." *See* 29 C.F.R. § 2560.503-1(b)(3).

***10** Finally, Unum argues that the August 2 Letter left no ambiguity as to the steps she would need to take an appeal. Def. Mem. at 15. Indeed, the August 2 Letter informed Israel: "[w]hen you submitted this additional information, you did not request an appeal of the claim decision. If you want to appeal this decision, please submit a request in writing by the timeframe outlined in the enclosed letter." Dkt. No. 39, Ex. 8 at 47; Dkt. No. 46, Ex. 36 at 164. [10] However, the Court does not agree that the August 2 Letter was unambiguous. The first page explained that Unum had *already reviewed* the materials Israel submitted following the May 15 Determination, and informed her that it "would not change [its] prior decision." *Id*. Thus, the reader should not be faulted for thinking that a review of Israel's claim had already occurred.

Indeed, a review had occurred—one that is not provided for in § 503-1, which requires the review of the initial benefit determination to be conducted by someone "who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual," 29 C.F.R. § 2560.503-1(h)(3)(ii), and that "the health care professional engaged for purposes of a consultation [for a review] of a benefit determination 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." § 2560.503-1(h)(3)(v).

Here, Doiron reviewed the additional information Riley submitted during June and July of 2018 after sharing it with the same doctors who had participated in the May 15 Determination and "ask[ing] them to advise if these additional medical records changed their opinions." Def. Mem. at 12; *see also* Dkt. No. 39, Ex. 8 at 35–36; Dkt. No. 46, Ex. 36 at 145–46 (Dr. Kirsch); Dkt. No. 39, Ex. 8 at 53–54; Dkt. No. 46, Ex. 36 at 173–74 (Dr. Banks); Dkt. No. 46, Ex. 36 at 150 (Dr. Crawford). Unum contends that this review was permissible, because § 2560.503-1(h) *et seq.* only applies to the formal appeals process, which they argue was not triggered. Def. Mem. at 20–21; Def. Reply at 5.

Regardless of whether the formal appeals process was triggered, Unum's *ad hoc* review of documents submitted is not provided for in the regulations at all, and the onus is on Unum, as the plan administrator, to comply with § 503-1. *See, e.g. McQuillin*, 36 F.4th at 421–22 (§ 503-1 does not lay out benefit claims process "that narrowly corrects certain errors and then remands for further consideration;" it "assumes a final decision on appeal"); *Spears v. Liberty Life Assurance Co. of Bos.*, No. 11-CV-1807 (VLB), 2015 WL 1505844, at *31 (D. Conn. Mar. 31, 2015) (plan administrator's practice of "provid[ing claimant] with additional time to submit further records" after issuing benefit determination on review triggered exhaustion); § 503-1(*l*) ("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." (emphasis added)). [11] If Israel's benefit determination was to be reviewed, then it could only have permissibly been done so in accordance with the requirements for appeal set forth in **ERISA**. Thus, Israel's claim could alternatively be deemed exhausted on the grounds that Unum's extra-regulatory review of her submissions following the initial May 15 Determination triggered exhaustion of Israel's claim.

***11** It is concerning that Israel's attorneys later requested that Unum "accept an appeal of the May 15, 2018 denial" and maintain that they never received the August 2 letter despite evidence to the contrary. Pl. Reply at 18; Dkt. No. 46, Ex. 37 at 10. This request in 2021 would seem to undermine, at least in part, the arguments now made on summary judgment. It is also concerning that Israel's counsel waited three years after she was denied benefits to pursue a further review of her adverse

benefit determination. *But see Landry*, 2021 WL 848455 at *12 ("While the Court is conscious of Plaintiff's lack of diligence in pursuing his appeal, **ERISA** puts the onus on the plan administrator to establish and maintain reasonable procedures governing appeals and to clearly inform plan participants of those procedures.").

Nonetheless, whatever mistakes were made, Riley, a paralegal, made diligent attempts to submit documentation and advocate for a reinstatement of Israel's disability benefits immediately following the May 15 Determination. A more skilled or experienced advocate might have understood the need to send those documents in a communication denominated as an "appeal" to the appeals department, but **ERISA** "puts the onus on the plan administrator to establish and maintain reasonable procedures governing appeals and to clearly inform plan participants of those procedures." *Landry*, 2021 WL 848455, at *12 (citing 29 C.F.R. § 2560.503-1(b)). If there is a "lack of clarity" about whether submissions of additional documentation "could be pursued through [an] appeal[s]" process or simply by submitting more records, the Court is duty-bound to construe it in Israel's favor, and Unum is duty-bound to comply with **ERISA's** mandated procedures. *Id.*; § 503-1(*l*) (plan administrator must "establish or follow claims procedures consistent with the requirements of [§ 503-1]."). Indeed, as § 503-1 contemplates an initial benefit determination and an appeal of that determination—it does not contemplate reconsideration of an initial benefit decision—there was nothing that prevented Unum from construing the June 1 letter as an appeal, and doing so would have ensured its actions were consistent with § 503-1. Israel should not be denied her "full and fair review" because her representative used the wrong language or mailed her records to the wrong Unum employee as a result of confusion caused by Unum, or, at a minimum, unwillingness to afford her appellate review when it could have. Israel deserved to have her claim reviewed on the merits under the proper appellate procedures.

In sum, the June 1 Letter should be deemed to have constituted an appeal and Unum should have treated it as such. Indeed, neither Unum's Plan nor the regulations contemplate review of additional information after an adverse benefit determination —they only permit an appeal. As Unum instead reviewed Israel's June 1 Letter (and other later submissions) in a manner inconsistent with the procedures set forth in § 503-1, Israel's claim should be deemed exhausted pursuant to § 503-1(*l*), and thus reviewable in federal court.

2. Israel's Claim Should be Remanded to Unum for a "Full and Fair Review"

For a remedy, Israel requests *de novo* review or, in the alternative, a remand to Unum's appeals department for a review of her claim consistent with its appeals procedures. Pl. Mem. at 29–30. Considering that the crux of this matter is not substantive but procedural—that is, Unum failed to offer Israel the appeals procedures she was due—the appropriate course of action is to remand Israel's claim for Unum to review her claim consistent with its own appeals procedures.

"Courts broadly agree that after review of an **ERISA** benefits determination, remand to a Plan Administrator ... is an available remedy." *Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Health Plan*, 217 F. Supp. 3d 608, 633 (N.D.N.Y. 2016) (collecting cases). It is, in fact, "the typical remedy" where the **ERISA** claim "concerns a beneficiary's procedural rights." *Martin v. Hartford Life & Acc. Ins. Co.*, 478 F App'x 695, 698 (2d Cir. 2012) (quoting *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 630 (2d Cir. 2008)); *see also Meidl v. Aetna, Inc.*, 346 F. Supp. 3d 223, 242 (D. Conn. 2018) (courts are to opt for remand "unless there is no possible evidence that could support a denial of benefits").

***12** On the other hand, courts have elected to review insurers' benefit decisions *de novo* where a benefit "plan's compliance failures adversely affected the development of the administrative record," *Halo v. Yale Health Plan, Dir. of Benefits & Recs. Yale Univ.,* 819 F.3d 42, 60 (2d Cir. 2016), or "where the difficulty is not that the administrative record was incomplete but that a denial of benefits based on the record was unreasonable." *Zervos v. Verizon New York, Inc.*, 277 F.3d 635, 648 (2d Cir. 2002) (citing *Zuckerbrod v. Phoenix Mut. Life Ins. Co.*, 78 F.3d 46, 51 n.4 (2d Cir. 1996)). But neither of these scenarios applies here.

The cause for the Court's disagreement with Unum's decision is procedural rather than substantive, as the records that Israel submitted following the May 15 Determination were not reviewed in accordance with Unum's appeals procedures. Because there

is no reason to believe the initial adverse benefit decision itself was unreasonable nor to believe that the procedures provided for in Unum's LTD Plan are out of compliance with **ERISA**, the appropriate course of action is to remand the claim. *See, e.g., Martin*, 478 F. App'x at 698 (remanding **ERISA** challenge because insurer's determination prevented claimant from developing administrative record); *Miller v. United Welfare Fund*, 72 F.3d 1066, 1073 (2d Cir. 1995) (remanding **ERISA** challenge because more evidence presented after initial determination); *Landry*, 2021 WL 848455, at *13 (remanding **ERISA** challenge because more evidence presented after initial determination); *Viglietta v. Metro. Life Ins.,* No. 04-CV-3874 (LAK), 2005 WL 5253336, at *13 (S.D.N.Y. Sept. 2, 2005) (remanding with instructions to review claim in compliance with **ERISA's** claims procedure requirements).

Because Israel did not receive the appeals procedures to which she was entitled, it is appropriate to remand her benefits determination to the insurer "to provide a 'full and fair review' of [the claimant's] appeal in the first instance" consistent with 29 C.F.R. § 2560.503-1(h). Israel's claim should therefore be reviewed consistent with 29 C.F.R. § 2560.503-1(h). [12]

3. Israel Failed to Exhaust her Claim for WOP Benefits

Israel moved for summary judgment with respect to her WOP benefits in addition to her LTD benefits. *See* Dkt. No. 36 (notice of motion sought order awarding judgment against Unum "including long term disability benefits and life insurance **waiver** of **premium** benefits"). But a federal court may only review a benefit claim under **ERISA** Section 502(a) if the claim has been deemed exhausted. S*ee, e.g.*, *McFarlane*, 274 F. Supp. 3d at 154 (quoting *Burke*, 572 F.3d at 79 ("[A]n **ERISA** action may not be brought in federal court until administrative remedies are exhausted.")). While she has argued extensively about her LTD benefits, Israel does not offer any argument as to why her claim for WOP benefits should be deemed exhausted and thus reviewable, or any suggestion that she appealed or attempted to appeal Unum's May 21 Determination with respect to those benefits. *See* Pl. Mem. at 1 (summarizing arguments in support of summary judgment motion, both related solely to disability benefits claim); Pl. Reply at 2–3 (same, discussing "benefits" generally but referring only to LTD Plan). [13] Nothing in the record suggests that Israel or Riley attempted to appeal the May 21 decision with respect to WOP benefits. Unum contends that Israel's claim for WOP benefits should be dismissed for failure to exhaust, as Israel never appealed the May 21 Determination. Def. Mem. at 1; Def. Reply at 6. The Court agrees. Unum's cross-motion for summary judgment should therefore be granted with respect to Israel's WOP benefits.

III. CONCLUSION

***13** For the foregoing reasons, Israel's motion for summary judgment should be granted in part, and her LTD benefits claim remanded to Unum for a full and fair review. Unum's cross-motion for summary judgment should be granted with respect to the WOP benefits claim and otherwise denied. [14]

PROCEDURE FOR FILING OBJECTIONS

Pursuant to 28 U.S.C. § 636(b)(1) and Rule 72(b) of the Federal Rules of Civil Procedure, the parties have fourteen (14) days (including weekends and holidays) from service of this Report and Recommendation to file any objections. *See* Fed. R. Civ. P. 6(a), (b), (d). A party may respond to any objections within fourteen (14) days after being served. Such objections, and any responses to objections, shall be filed with the Clerk of Court, with courtesy copies delivered to the chambers of the Honorable Gregory H. Woods and the undersigned, United States Courthouse, 500 Pearl Street, New York, New York 10007. Any requests for an extension of time for filing objections must be directed to Judge Woods.

FAILURE TO FILE OBJECTIONS WITHIN FOURTEEN (14) DAYS WILL RESULT IN A WAIVER OF OBJECTIONS AND WILL PRECLUDE APPELLATE REVIEW. 28 U.S.C. § 636(b)(1); Fed. R. Civ. P. 72. *See Thomas v. Arn*, 474 U.S. 140 (1985); *Wagner & Wagner, LLP v. Atkinson, Haskins, Nellis, Brittingham, Gladd & Carwile, P.C.*, 596 F.3d 84, 92 (2d Cir. 2010).

All Citations

Slip Copy, 2023 WL 491039

Footnotes

1 The Court has reviewed both statements submitted by the parties pursuant to Local Rule 56.1, *see* Dkt. Nos. 38, 44, and, except where noted, chooses to rely on the Counter Statement, as it clearly articulates the facts that are undisputed by the parties.

2 When citing to the parties' documentary materials submitted with Bates numbering, this report and recommendation refers to pagination created by ECF.

3 **ERISA's** implementing regulations and Unum's benefit plans permit authorized representatives to act on behalf of individuals claiming benefits. *See* 29 C.F.R. § 2560.503-1(b)(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."); Dkt. No. 46, Ex. 1 at 45 ("To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative ..."). The parties do not dispute that Riley was Israel's authorized representative.

4 This record appears to be missing from the exhibits submitted by Israel.

5 This record appears to be missing from the exhibits submitted by Israel.

6 Israel cites to these documents (by Bates number) in her papers but does not include them in her exhibits. *See, e.g.,* Pl. Reply at 6. As both parties cite and refer to the correspondence that occurred between Israel's and Unum's representatives during May 2021, the Court considers them to be undisputed.

7 Israel originally sued First Unum Life Insurance Company as well, but dismissed this defendant and removed it from the caption by stipulation on July 30, 2021. Dkt. No. 20.

8 As Israel was initially approved disability benefits on February 3, 2017, Counter Statement ¶ at 19, her claim is not subject to § 503-1's amendments that apply to claims filed on or after April 1, 2018. *See, e.g., Mayer v. Ringler Assocs. Inc. & Affiliates Long Term Disability Plan*, No. 18-CV-2789 (VB), 2020 WL 1467374, at *6 (S.D.N.Y. Mar. 26, 2020) ("The current version of Section 503-1 applies to claims filed on or after April 1, 2018.").

9 The LTD Plan provides that adverse benefit determinations will "describe [the] Plan procedures and time limits for appealing the determination." Counter Statement at ¶ 15.

10 Israel maintains that she never saw the August 2 Letter. Dkt. No. 46, Ex. 36 at 281; Pl. Reply at 6. Unum reports that "someone was accessing the claim file via the Unum website ... [on] August 5, 2018" and "[would have been able to view any letters that were sent." Dkt. No. 46, Ex. 37 at 10. For the purposes of this analysis, the Court assumes Israel or her representative saw the August 2 letter.

11 The Second Circuit's recent decision in *McQuillin* provides further support for this conclusion. In *McQuillin*, after a claimant appealed an adverse determination with respect to his disability benefits, his plan administrator sent him a letter informing him that it had " 'overturned the original decision to deny the claim' and ... had 'forwarded the claim to the claim department to determine if disability is supported' "—creating an additional level of review. 36 F.4th at 418 (citations omitted). The court held that a "benefit determination" as described in § 503-1 is, by definition, a final decision and so a plan administrator may not conduct a determination on review that is not final. *Id.* at 419–20. Further, the purpose of § 503-1 is "to prevent plans from imposing an unlimited number of levels of administrative appeals and denied claims." *Id.* at 422 (citation omitted). Unum's secondary review of Israel's benefit determination, conducted by the same experts and decisionmakers, impermissibly imposed an additional level of review onto Israel's claim.

12 Moreover, the August 2 Letter did not address the lengthy submissions made by Riley following the May 15 Determination. *See* Dkt. No. 39, Ex. 8 at 5–14, 48; Dkt. No. 46, Ex. 36 at 3–12, 165; Counter Statement at ¶¶ 149, 154, 156, 157, 159–63, 165, 167–69, 172 (August 2 Letter only mentioned evaluation from Dr. Chen, even though Riley submitted documentation of evaluations from at least three different doctors after the May 15 Determination). A remand will allow for a proper development of an appellate record.

13 In addition, "federal courts may deem a claim abandoned when a party moves for summary judgment on one ground and the party opposing summary judgment fails to address the argument in any way." *See, e.g.*, *Moore v. City of New York*, No. 15-CV-6600 (GBD) (JLC), 2018 WL 3491286, at *14 (S.D.N.Y. July 20, 2018) (") (quoting *Quintero v. Rite Aid of N.Y., Inc.*, No. 09-CV-6084 (JLC), 2011 WL 5529818, at *19 (S.D.N.Y. Nov. 10, 2011), *reconsideration denied* 2012 WL 10401 (Jan. 3, 2012)), *adopted by* 2018 WL 4043145 (Aug. 7, 2018). Israel appears to have effectively abandoned her WOP benefits claim.

14 In the conclusion of her Reply Memorandum, Israel for the first time mentions potential entitlement to fees (and argues that she has 14 days after the entry of judgment in her favor to file an application). Pl. Reply at 30. Such an application would, however, be premature. *See, e.g., Landry*, 2021 WL 848455, at *13 (premature to consider award of fees when court has remanded **ERISA** claim, as it has not yet shown "some degree of success"); *Spears*, 2015 WL 1505844, at *36 ("Courts within this Circuit typically decline to award fees and costs to a plaintiff following remand of a claim for benefits because such a request is 'premature,' given that the plaintiff 'is not yet the prevailing party in the truest sense of the term.' ") (citing cases).

End of Document