IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

LAWRENCE JONES

Plaintiff

v. **Civil Action No. 4:94CV007-D-O**

LUMBERMANS MUTUAL CASUALTY COMPANY

Defendant

MEMORANDUM OPINION

The court now comes to consider defendant Lumbermans Mutual Casualty Company's ("Lumbermans") motion for summary judgment. Plaintiff filed this non-jury suit seeking payment of total disability benefits due under employee benefit plan established by his employer, Kemper Insurance Company.[1] Lumbermans was the plan administrator of the Kemper National Benefit Plan under the Employee Retirement Income Security Act ("ERISA"). Having reviewed the record in this cause, the court is of the opinion the motion for summary judgment is well taken and should be granted.

FACTUAL BACKGROUND

Lawrence Jones was hired as a boiler inspector for Kemper on January 30, 1994. The record reflects that he participated in an employee benefit plan, Kemper National Benefit Plan ("the plan"), offered by his employer which provided benefits for certain losses which resulted from injury or sickness. Defendant Lumbermans was the plan administrator of the plan under ERISA. Under the terms of the plan, if a covered person becomes "totally disabled", then that person is to receive a monthly benefit of sixty percent (60%) of the covered person's basic monthly earning. "Total disability" is defined in the plan to mean that due to either injury or sickness:

[1] On May 2, 1994, Lumbermans was substituted in place of Kemper Insurance company and Kemper was dismissed as a defendant in this lawsuit.

1. For the first 24 months benefits are payable, the covered person is unable to perform each of the material and substantial duties of his work with the benefit sponsor; and

2. After the first 24 months that benefits are payable, the covered person is unable to perform each of the material and substantial duties of any employment for which the covered person is reasonably fitted by education, training and experience.

Long Term Disability Plan at p. 3, effective date 1-1-88.[2]

Jones, while an employee of Kemper Insurance Company, suffered a heart attack on March 7, 1984. He spent nine (9) days in the King's Daughter Hospital in Greenville, Mississippi, where he was diagnosed with acute myocardial infarction. Plaintiff was subsequently transferred to St. Dominic's Hospital in Jackson, Mississippi, for cardiac catheterization to determine the extent of the blockage and damage to his heart. During the catheterization, he suffered an allergic reaction to the contrast dye medication which was used in the procedure and became critically ill. Jones was diagnosed with a probable myocardial infarction at the time of the reaction to the dye and spent another nine (9) days in St. Dominic's. He was later discharged with a diagnosis of arterial sclerotic heart disease with angina pectoris and told not to return to work until further observation.

Plaintiff was considered "totally disabled" and placed under the care of Dr. Gaines L. Cook. Dr. Cook periodically performed treadmill stress test on plaintiff in an effort to monitor his condition. Jones tested positive for myocardial ischemia after tests were performed in May of 1985 and 1986. On July 1, 1986, he was diagnosed with advanced coronary ischemic disease on the basis of his continued positive testing results.

At the request of Kemper, Jones was evaluated by Dr. Robert E. Lee, a board certified specialist in internal medicine, on July 8, 1986. Dr. Lee determined that plaintiff had a significant

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[2] Some correspondence between Kemper and plaintiff have contained the language "for the first 104 weeks that benefits are payable" instead of "for the first 24 months benefits are payable". It appears that the former time limit was in place at the time of the disability in the present case and was amended to the latter at a later date. The change has no effect on the claims before this court.

coronary disease and that there was objective evidence of myocardial injury. He concluded that Jones was "totally disabled". Based on Dr. Lee's independent medical evaluation, Kemper continued to pay plaintiff disability benefits.

Subsequent to the evaluation of Dr. Lee, plaintiff came under the care of Dr. Ben Folk, a cardiologist in Greenville referred to plaintiff by Dr. Lee. In February of 1987, Folk conducted a physical capacity evaluation of the plaintiff. In the evaluation summary sheet, Dr. Folk indicated that, during a given work day, plaintiff could sit for four (4) hours, stand for three (3) hours or walk for one (1) or more hours. He was found able to use his hands for repetitive actions of grasping, pushing, pulling and fine manipulations. In addition, he could occasionally lift and carry up to ten (10) pounds and perform basic movements other than climbing. The doctor commented however that his physical activities were limited by easily induced angina (i.e. chest pain due to the heart not receiving adequate blood flow due to the coronary arteries) and that he likely suffered from critical coronary artery disease. He noted that this condition had not been definitely diagnosed due to the previously mentioned negative reaction to the dye during the attempted catheterization back in March of 1984. In any event, Dr. Folk concluded that plaintiff was a cardiac cripple for the indefinite future requiring aggressive medical therapy. See Dr. Folk's Physical Capacities Evaluation. Based on the evaluation, benefits continued.

On March 26, 1989, plaintiff suffered another heart attack and spent nine (9) days in the Delta Regional Medical Center Hospital in Greenville, Mississippi.

On February 26, 1991, in accordance with provisions in the plan, Jones was sent for another medical evaluation for disability redetermination.[3] Dr. Ray M. Allen reviewed plaintiff's history, conducted a physical exam, an exercise tolerance test on the treadmill and an echocardiogram. The record reflects that he found a significant discrepancy between the patient's description of activities which induced angina, as compared to his actual performance doing the exercises. Dr. Allen stated

[3] Defendant asserts that the evaluation was independent. Plaintiff claims that Dr. Allen was selected by the defendant and certainly biased in his observations.

that, based on the present evidence before him, Jones would fall under the American Heart Association functional Class II symptoms defined by Dr. Allen as "generally no symptoms with the activities of usual daily living, but provoked by more extremes of exertion or emotional stress." The doctor opined that, to a reasonable degree of medical probability, Jones could tolerate working an eight (8) hour day with minimal physical activity. He further found that plaintiff should be able to stand or sit most of the day and walk short distances at an average pace, carrying up to ten (10) pounds during parts of the day.

Dr. Allen completed an estimated functional capacity evaluation in which he determined that plaintiff could, in a working day, sit for eight (8) hours, stand for five (5) hours, or walk for three (3) hours with a rest break of ten (10) minutes twice a day. See Dr. Allen's Estimated Functional Capacities Evaluation. As such, he found that Jones did not fall into a high risk category for immediate cardiac or pulmonary decompensation. After an electrocardiographical and clinical examination, Dr. Allen found no significant evidence of angina and found fair exercise tolerance. He opined that plaintiff could now work a six (6) to eight (8) hour day. In response to his findings, plaintiff simply argues that the results were predictable given Dr. Allen's relationship with Kemper and that, because of the other evidence which supports plaintiff's claim of "total disability", benefits should continue. Although Kemper continued benefit payments, the company proceeded with further investigation.

Kemper wrote to Dr. Folk, plaintiff's treating physician, and informed him of Dr. Allen's new assessment which seemed to contradict Dr. Folk's disability report. The letter requested Dr. Folk to review his findings as to plaintiff's status. In a response letter, on April 22, 1991, Dr. Folk essentially agreed with Dr. Allen's evaluation stating that plaintiff's cardiac exam in the past had been normal. He indicated that he believed Jones should repeat the catheterization procedure in order to obtain a more accurate diagnosis. Although plaintiff had not repeated the catheterization, Dr. Folk elaborated that plaintiff had done well in his exercise treadmill test and commented that this improvement was

probably the result of ongoing medical therapy for ischemic heart disease. He stated that Jones was "capable of sedentary type activity".

As a result of the evaluations above, Kemper notified plaintiff that an employability evaluation would be performed. Kemper retained Crawford and Company ("C & C") to perform the evaluation. On June 21, 1991, Ms. Carol Gill, an investigator with C & C, met with Dr. Folk and Mr. Jones to gather information as to Jones' disability and prior work experience. On July 12, 1991, Dr. Folk signed a letter dated June 27, 1991, furnished by Ms. Gill which acknowledged that plaintiff could do "some type of sedentary work". On June 27, 1991, Ms. Gill prepared an Employability Evaluation which listed several jobs for which plaintiff was eligible for based on his skill level, educational level and current physical condition.[4] She developed her evaluation from a review of the two separate doctor's evaluations, plaintiff's past history and the personal interview of the plaintiff.

Kemper informed plaintiff of the above findings and that plaintiff was no longer "totally disabled" from gainful employment. Disability benefits were terminated on July 15, 1991. On August 8, 1991, apparently in response to a letter from plaintiff, Kathy Krautwurst, manager of the Kemper Employee Claims Department, sent a letter to Jones explaining why he was no longer eligible for long term disability benefits. Krautwurst stated in her letter that, after reviewing reports completed by Dr. Folk, Crawford and Company, and Dr. Allen, "it appears you are not totally disabled from gainful employment for which you are reasonably fitted by education, training or experience."

Plaintiff did not agree with the decision and plaintiff's present attorney, Jack R. Dodson, Jr., sent a letter to the Employee Group Claim Department Manager on behalf of plaintiff on June 9,

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[4] The following jobs were suggested as alternatives for Jones:

(1) Routing Clerk
Industry - Financial Institutions
(2) Work-Order Sorting Clerk
Industry - Light, heat and power
(3) Employment Agency Manager
Industry - Professional and kindred occupations
(4) Customer Service Manager
Industry - Business services

1992.[5] The letter was treated as a first level claim review and was responded to on June 30, 1992, by letter from George A. Dion, Jr., an Officer in the Health Claim Department.[6] The response reiterated the reasons for denial of payments stating that the decision was based on a review of all medical documentation and the employability evaluation which considered Jones' physical restrictions and limitations. Plaintiff's counsel was advised that if he was not satisfied with this response he could request a second level claim review on plaintiff's behalf.

On September 16, 1992, counsel for plaintiff responded with correspondence which was treated as a request for second level review. The second level claim review was referred to Ms. Sally Bullen, Kemper's Director of Compensation and Benefits, Corporate Human Resources.[7] Ms. Bullen found that, based on the information obtained from Dr. Folk and elsewhere, Mr. Jones could engage in "some sort of sedentary work" which takes into consideration his physical restrictions and limitations. She specifically mentioned vocational alternatives of Employment Agency Manager and Customer Service Manager. The letter stated that absent medical information from plaintiff's attending physician substantiating that he was under regular care of a physician and totally disabled, he remains ineligible for disability benefits.

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[5] The record also contains a letter dated March 5, 1992, from attorney Harold W. Duke to Krautwurst. See Exhibit 12 to Defendant's Motion for Summary Judgment. The letter, apparently written on behalf of plaintiff, suggests that the decision to terminate benefits was in error and should be reconsidered.

Evidently, attorney Duke is no longer involved in this litigation and, considering the date of his letter and subsequent responses by Kemper, it appears that Kemper was responding to present counsel Dodson and answering his inquiries.

[6] In connection with its response to the letter, Kemper also mailed a copy of the claim review procedures as outlined in the Profile of Benefits Manual. Although the Manual stated that a request for a first level review must be made within sixty (60) days from receipt of the decision to terminate disability payments, Kemper was treating the inquiry as a belated request for first level review.

[7] Defendant submitted as Exhibit 17 to this motion what appears to be Ms. Bullen's response letter to the request for second level review. The response letter is dated December 3, 1992. An identical letter apparently responding to the second level review was also submitted by plaintiff in his response as Exhibit V. The identical letter is dated November 5, 1992. Neither letter contains Ms. Bullen's signature. Despite the confusion that such discrepancies cause, the confusion does not prevent the court from addressing the present motion.

Plaintiff then proceeded to his third level review as provided for in the plan. Correspondence dated June 7, 1993, from Mr. Dodson was treated as the third a final appeal under the plan. Plaintiff based his third appeal on the evaluation and report of Dr. J. Ed Hill, who examined plaintiff on April 26, 1993. Dr. Hill found that plaintiff was totally and permanently disabled from a cardiac standpoint. See Exhibit 18 to Defendant's Motion for Summary Judgment. In response, Kemper noted that Dr. Hill first saw and treated Jones on April 26, 1993, without any documentation, other than Mr. Jones' medical history, to verify that he was totally disabled. Dr. Hill, in response to questions from Kemper, confirmed that he had not consulted plaintiff's treating physician concerning his disability. On November 9, 1993, after a review of the claim by the Welfare Benefit Trust Executive Committee, Ms. Bullen again denied the claim on the basis that "Dr. Hill could not substantiate that plaintiff was under the regular and continuous care of a physician and deemed totally disabled as of July 15, 1994".

Having appealed defendant's decision through all levels provided in the plan, on January 3, 1994, plaintiff filed suit alleging that Lumbermans abused its discretion by terminating disability benefits. Defendant argues that there is more than sufficient evidence to establish that the plaintiff was no longer totally disabled as defined under the terms of the plan and that, therefore, discontinuing benefits was appropriate.

Summary Judgment Standard

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. F.R.C.P. 56(c). The party seeking summary judgment carries the burden of demonstrating that there is an absence of evidence to support the non-moving party's case. Celotex Corp. v. Catrett, 477 U.S. 317, 325, 106 S. Ct. 2548, 2553, 91 L.Ed.2d 265 (1986). After a proper motion for summary judgment is made, the non-movant must set forth specific facts showing that there is a genuine issue for trial. Hanks v. Transcontinental Gas Pipe Line Corp., 953 F.2d 996, 997 (5th Cir. 1992). If the non-movant sets forth specific facts in support of allegations essential to his claim, a genuine issue is

presented. Celotex, 477 U.S. at 327, 106 S.Ct. at 2554. "Where the record, taken as a whole, could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial." Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587, 106 S. Ct. 1348, 89 L.Ed.2d 538 (1986); Federal Sav. and Loan Ins. v. Krajl, 968 F.2d 500, 503 (5th Cir. 1992). The facts are reviewed drawing all reasonable inferences in favor of the non-moving party. King v. Chide, 974 F.2d 653, 656 (5th Cir. 1992).

DISCUSSION

Plaintiff charges that Lumbermans selectively chose and developed evidence in furtherance of a scheme designed specifically to terminate disability payments to plaintiff to which he was entitled to under the subject insurance policy. He argues that the denial of benefits should be reviewed under a de novo standard. However, he claims that even if the court examines the decision for abuse of discretion, Lumbermans' conclusion was still in error. Lumbermans contests plaintiff's assertion and argues that it made factual determinations which should only be reviewed for abuse of discretion. Defendant maintains that its decision to deny benefits under the plan was justified and should be affirmed by the court.

Initially, this court must determine whether this matter should be reviewed under a de novo or "abuse of discretion" standard. "Under the de novo standard, the court would hear the matter for a second time in the same manner as the matter was originally heard by the plan administrator, while under the arbitrary and capricious standard courts review the plan administrator's findings for any abuse of discretion." Freeman v. Sickness and Accident Disability Plan of AT & T Technologies, Inc., 823 F.Supp. 404, 410 (S.D. Miss. 1993).[8] Plaintiff argues that the plan contains no language granting the plan administrator discretionary authority to construe the meaning of the policy provision

[8] The Fifth Circuit has recognized that different courts in this circuit have referred to both the "arbitrary and capricious" and the "abuse of discretion" standard when describing the more deferential alternative to de novo review. See Wildbur v. Arco Chemical Co., 974 F.2d 631, 635 n. 7 (5th Cir. 1992). As found in Wildbur, although there may appear to be a difference in application, the difference is only semantic, not substantive. Id.

The undersigned will use both terms in this opinion to describe the deferential standard of review.

defining total disability, and thus, de novo review is appropriate. As found in Firestone Tire & Rubber Co. v. Burch, 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103 L.Ed.2d 80 (1989), an administrator's interpretation of the terms of the plan in connection with a denial of benefits is reviewed under a de novo standard unless the plan gives the administrator "discretionary authority to determine eligibility for benefits or to construe terms of the plan." The defendant argues that it determined the facts underlying the claim for benefits, as opposed to a legal interpretation of the terms of the plan, and, therefore, the court should review its findings under the abuse of discretion standard. The court agrees.

The Fifth Circuit, in applying Burch, has held "that for factual determinations under ERISA plans, the abuse of discretion standard of review is the appropriate standard; that is, federal courts owe due deference to an administrator's factual conclusions that reflect a reasonable and impartial judgment." Pierre v. Connecticut Gen. Life Ins. Co./Life Ins. Co. of North America, 932 F.2d 1552, 1562 (5th Cir.), cert. denied, 502 U.S. 973, 112 S.Ct. 453, 116 L.Ed.2d 470 (1991).[9] The court distinguished between administrator's determination of facts underlying the claim for benefits and a determination of whether those facts constitute a claim to be honored under the terms of the plan. Id. at 1557. After a thorough discussion supporting its reasoning, the court concluded "that a deferential standard for factual determinations [as opposed to plan term interpretations] is buttressed, if not compelled, by practical considerations", regardless of the authority given the administrator in the plan.[10] Id. at 1559. See Craft v. Northbrook Life Ins. Co., 813 F.Supp. 464, 472 n. 10 (S.D.

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[9] Interestingly, Justice White and Justice Blackmun dissented to the denial of the petition for writ of certiorari. The dissent discussed the disagreement that has developed in the Court of Appeals since Burch concerning the standard of review to be applied when a benefits decision turns on the facts of the case, rather than interpretation of the terms in the ERISA plan. Pierre, 116 L.Ed.2d at 470. The Third and Fourth Circuits have held that a decision of a plan administrator should be reviewed de novo. Justice White wrote that he would grant certiorari to resolve the conflict. Id. at 471.

[10] In Pierre, the court explained that an ERISA trustee (i.e. administrator), by its very nature, is granted some inherent discretion. The court found that this inherent discretion, although not extended in Burch to decisions that interpreted plan terms, extended to issues of fact that determined individual eligibility for benefits. Pierre, 932 F.2d at 1558.

Miss. 1993)(noting distinction above and recognizing use of abuse of discretion standard of plan administrator's factual determinations).

Here, Lumbermans, as plan administrator, made a factual determination as to whether plaintiff remained totally disabled as defined by the plan. Lumbermans determined that, based on the evidence before it, Jones could perform sedentary type work and therefore was no longer totally disabled. Plaintiff argues that the decision here involves interpretation of plan terms. In particular, he claims that the administrator had to interpret the meaning of "total disability" as defined in the plan to determine plaintiff's eligibility. The court, although intrigued by the argument, is of the opinion that the administrator here, as in Pierre, made a factual determination. As mentioned above, the Fifth Circuit held that an administrator has discretionary authority to make factual findings to determine eligibility for benefits, regardless of the authority given in the plan itself. Pierre, 932 F.2d at 1562. In Pierre, the insurer denied accidental death benefits under an ERISA plan based on a determination that deceased's shooting death was not "accidental" within the meaning of the policy. The court found the decision was a factual determination which should be reviewed under the abuse of discretion standard. Id. Clearly, one could argue that you must apply the facts to the plans definition of accidental in order to conclude that the death was not accidental. As such, one could argue that to conclude that a death was not accidental necessarily involves interpreting definitions in the plan. To hold that situations such as these involve interpretation of plan terms would effectively eliminate the distinctive categories of factual determinations and plan interpretations provided for in Pierre. The court will not so hold. Guided by the holding in Pierre, the court is of the opinion that the decision to terminate plaintiff's benefits was based on a factual determination that Jones was no longer totally disabled within the meaning of the policy. Accordingly, the court is of the opinion that an abuse of discretion standard of review is appropriate under these circumstances.[11]

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[11] The plan does not clothe the administrator with discretionary authority to interpret plan terms. Had this case involved interpretation of plan terms by the administrator, pursuant to Burch, the decision would be reviewed under a de novo standard.

The court is of the opinion that, even had the administrator's decision to terminate disability benefits been reviewed de novo, the result may well have been the same. The defendant

In applying the abuse of discretion standard to factual determinations of an administrator, the court will not disturb the decision unless its factual conclusions do not "reflect a reasonable and impartial judgment." Pierre, 932 F.2d at 1562.[12]

Our review of whether an administrator abused its discretion in making a factual determination (as opposed to a legal interpretation of plan terms) "must focus on the evidence that was before the... [administrator] when the final benefit determination was made." Denton v. First National Bank, 765 F.2d 1295, 1304 (5th Cir. 1985). See Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 102 (5th Cir. 1993)(district court should evaluate administrator's fact findings regarding eligibility of claimant on evidence before administrator). Furthermore, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, as plaintiff claims here, that conflict must be weighed as a factor in determining whether there is an abuse of discretion. Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1014 (5th Cir. 1992). However, the alleged conflict does not change the standard of review. Id. Rather, the conflict is weighed as a factor in determining whether there is an abuse of discretion, with the court conducting a more penetrating review the greater the suspicion of partiality. Id.

In the case sub judice, Lumbermans made a factual determination that Jones could perform sedentary type work and, therefore, was no longer totally disabled. The decision was based on two separate medical evaluations which concluded that plaintiff was capable of performing sedentary type work and a subsequent employability evaluation which listed jobs available to plaintiff for which he

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re-evaluated plaintiff to determine if he remained eligible for disability benefits. After reviewing two separate medical evaluations and an employability evaluation which found that plaintiff was no longer totally disabled, defendant stopped benefit payments. There can be no question that the decision was supported by a majority of the evidence.

[12] Had the court found that (1) the administrator's decision was one of interpretation of plan terms and (2) that the plan provided the administrator with discretionary authority to construe plan terms, the court would examine whether Lumbermans incorrectly interpreted the terms of the plan and then abused its discretion in applying the interpretation to the facts before it. Wildbur v. ARCO Chemical Co., 974 F.2d at 637-38 (5th Cir. 1992)(citing Jordan v. Cameron Iron Works, Inc., 900 F.2d 53, 56 (5th Cir.), cert. denied, __ U.S. __, 111 S.Ct. 344, 112 L.Ed.2d 308 (1990)).

was "reasonably fitted by education, training and experience." In support of his position, plaintiff relies primarily on Dr. J. Ed Hill's conclusion that he was totally and permanently disabled from a cardiac standpoint. Dr. Hill reached his conclusion after examining plaintiff on April 26, 1993. The record reflects that this was his only examination of Jones. As discussed in the factual summary above, defendant considered Dr. Hill's conclusions as part of his third level review. However, based on the other medical evaluations performed by Dr. Allen and Dr. Folk, his treating physician since 1987, and the employability evaluation of Ms. Gill, the defendant discontinued disability benefits. Reliance on the substantial evidence before it that indicated plaintiff was no longer totally disabled was reasonable and defendant did not abuse discretion in reaching its conclusion.

Plaintiff also argues that defendant should have given more weight to the Social Security Administration's ("SSA") conclusion, on January 14, 1988, that he was totally and permanently disabled. Under the plan, plaintiff must be:

> "unable to perform each of the material and substantial duties of any employment for which the covered person is reasonably fitted by education, training, and experience."

The SSA defines disability as:

> "[t]he inability to engage in any substantial gainful activity due to physical or mental impairment which can be expected to either result in death or last for a continuous period of not less than twelve months"

As argued by defendant the requirements of disability under the plan and the SSA are dissimilar. The fact the SSA reached a different conclusion, under another standard does not mean that the decision of the plan administrator here was incorrect or ill-considered. Freeman, 823 F.Supp. at 416. There is no problem with a conflict between the SSA's findings and those of the plan administrator, so long as the plan administrator had a well reasoned explanation for his findings. Id. (citing Pokratz v. Jones Dairy Farm, 771 F.2d 206, 209 (7th Cir. 1985)). Defendant concluded, after reviewing Jones' treating physician's evaluation and a separate doctor's evaluation, that plaintiff could perform sedentary type work. Subsequent to the above medical evaluations, defendant had Ms. Gill conduct an employment evaluation to ascertain if their were any jobs plaintiff could perform. Ms. Gill based on plaintiff's medical evaluations, education, training and experience concluded that he was capable

of performing the jobs listed in her evaluation. The record reflects that Ms. Gill has conducted similar evaluations in the past and that her job with C & C was essentially to make job possibility findings for disabled individuals. The court is of the opinion that defendant has relied on credible evidence and provided a well reasoned explanation for its decision to discontinue benefits. The SSA reached its conclusion in January of 1988, the evaluations relied on by defendant were all conducted after 1991. The more recent evaluations, with the exception of Dr. Hill's findings, have all stated that plaintiff is now capable of sedentary activity. The court is of the opinion that defendant's conclusion was reasonable under the circumstances.

The plaintiff next claims that he is not able to perform each of material and substantial duties of the jobs listed in Ms. Gill's employment evaluation and further argues that he is not "reasonably fitted by education, training and experience" for the positions suggested. Ms. Gill listed several jobs which she found plaintiff capable of performing based on his physical condition, education, training and experience. Plaintiff claims that the findings by Ms. Gill continue to overlook the fact that he has no training or experience in the fields listed in her evaluation and that he would certainly be unable to start any of the positions at the level suggested. In contrast, Ms. Gill has testified in her deposition and stated in the evaluation that she considered medical evaluations, past physical history, education, training and experience in reaching her conclusions. Based on Ms. Gill's testimony and previous experience in the field, the court is of the opinion that the administrator's reliance on her findings was reasonable and the decision that plaintiff was not totally disabled will not be disturbed on this ground.

In reaching this decision, the court has been careful to only test the reasonableness of the defendant's actions, and not to determine the manner in which it would have resolved the issue had it been the administrator. Furthermore, the court has taken into account the possible conflict of interest argued by plaintiff, but finds the conflict of negligible importance in this instance. Accordingly, under the circumstances presented, the court holds that the administrator did not abuse its discretion in finding that the plaintiff was no longer totally disabled under the subject plan.

CONCLUSION

In view of the foregoing, the court finds the motion for summary judgment submitted by defendant Lumbermans requesting this court to affirm its decision to discontinue plaintiff's disability benefits to be well taken and the same will be granted.

An order in accordance with this opinion shall issue this day.

THIS ___ day of February, 1995.

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United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

LAWRENCE JONES

Plaintiff

v. **Civil Action No. 4:94CV007-D-O**

LUMBERMANS MUTUAL CASUALTY COMPANY

Defendant

FINAL JUDGMENT

Pursuant to a memorandum opinion entered this day, it is hereby **ORDERED** that:

1) defendant Lumbermans Mutual Casualty Company's motion for summary judgment be, and it is hereby, **GRANTED;**

2) this case be, and it is hereby, **DISMISSED WITH PREJUDICE;**

3) All memoranda, depositions, affidavits and other materials considered by the court in granting defendant's motion for summary judgment are hereby incorporated into and made a part of the record in this cause.

SO ORDERED this __ day of February, 1995.

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United States District Judge