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United States District Court, E.D. Virginia,
Alexandria Division.

Heather COGDELL, Plaintiff,
v.
**RELIANCE STANDARD** LIFE INSURANCE COMPANY, Defendant.

Civil Action No. 1:23-cv-01343 (AJT/JFA)
|
Signed September 11, 2024

**Attorneys and Law Firms**

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## ORDER

Anthony J. Trenga, Senior United States District Judge

***1** In this ERISA governed benefits action, Defendant Reliance Insurance Co. has filed a Motion for Summary Judgment in its favor on Plaintiff's claim for long term disability benefits, [Doc. No. 14] ("Defendant's Motion"), and Plaintiff has filed a Motion for Judgment on the Administrative Record that she is entitled to such benefits, [Doc. No. 16] ("Plaintiff's Motion") (collectively, the "Motions"). For the reasons stated below, Plaintiff's Motion is **GRANTED** and Defendant's Motion is **DENIED**.

## I. FACTUAL BACKGROUND

The administrative record reflects the following:

Plaintiff Heather Cogdell ("Cogdell") is an engineer who received her bachelor's degree from the Massachusetts Institute of Technology and her two master's degrees from the University of Pennsylvania. [Doc. No. 17-2]. During the time relevant to the instant action, Cogdell worked for MITRE, where she had been employed since 2009, and was the Principal Business Process Engineer. AR-873. [1] MITRE publicly described the position as requiring "solving complex problems," "lead[ing] and work[ing] in project teams to apply business process reengineering, and process improvement to help solve complex sponsor problems," "manag[ing] critical sponsor relationships," and "mentor[ing] and develop[ing] staff." AR-870.

Friends, family, and colleagues reported Cogdell as being highly capable and highly energetic. AR-638; AR-646 (describing Cogdell as an "Energizer bunny"); AR-647 (describing Cogdell as having "high energy"); AR-649 (describing Cogdell as always being a "thoughtful, resilient person who meets life's challenges with grit ... she is a master of multitasking"); AR-642 (a work colleague of two decades describing Cogdell as "efficient, diligent, and tenacious."). However, in July 2021, Cogdell was infected with coronavirus ("**COVID-19**") and since then, she reports that she has suffered from long-**COVID**, with symptoms including intense fatigue and sporadic headaches, among other things. Cogdell went on Family Medical Leave Act ("FMLA") leave for the year following her **COVID-19** infection, although Cogdell worked part-time throughout her leave. *See* [Doc. No.

  

17] at 8 ("After treatment from a team of multi-disciplinary medical providers, she slowly progressed to the point where a year later she had been able to return to part-time work."); *see also* AR-299–327.

Although she had been reporting improvements in her health and was working part-time in June 2022, she had not returned to full-time work or full capacity work, and Cogdell suffered from a second **COVID-19** infection in July 2022. AR-652; *see also* AR-371-72; AR-887. The second infection disrupted her recovery, and Cogdell was unable to work at all following her second infection. Cogdell pursued testing and treatment with her primary care provider and various specialists, but was unable to identify a discrete cause of her symptoms, including tachycardia. *See* AR-234–39, 249, 915–20, 928 (primary care reports), 336–37, 979–80, 1010–21 (neuropsychological reports), 347–48, 921–24, 953–54 (cardiology reports), 930 (primary care reporting of pulmonology results). That said, there is no indication in the reports that any physician found an indication of malingering. *See generally id.* As a result of her continued condition, which extended beyond her short-term disability coverage, Cogdell filed for long-term disability under the MITRE policy (the "Policy") administered by Defendant Reliance Standard Insurance Company ("Reliance") in November 2022. She selected June 7, 2022 as her date of loss because that was the date that would allow for a seamless transition from her short-term disability benefits that she was already receiving through MITRE to long-term disability under the Policy. *See* AR-22 (explaining that all other benefits must be used prior to the Policy benefits).

***2** Reliance's case manager and agent, nurse Ana Celina T. Bergonio ("Bergonio"), rejected Cogdell's claim of long-term disability due to long-**COVID** in January 2023 without making any particular findings with respect to the material responsibilities of Cogdell's position at MITRE nor with respect to long-**COVID**. AR-54. Instead, Bergonio relied on the fact that Cogdell could "sit, stand, walk, and drive for 1-3 hours, [and was] able to do simple grasping, pushing/pulling and fine manipulation of both upper extremities .... And no restrictions to bend, squat, climb, reach above shoulder, kneel, crawl, use feet for foot controls and drive." *Id.* [2]

Cogdell appealed on August 15, 2023. AR-394–414. Reliance assigned the appeal to an appeals team member over a month latter, on September 20, 2023. AR-45. On September 25, 2023, Reliance sought the review of Cogdell's medical records by independent medical examiners in connection with the appeal. AR-91. On September 29, 2023 and October 5, 2023, Reliance received the reports from the independent medical examiners. AR-1207–16, AR-1222–26. On October 25, 2023, Reliance provided the reports to Cogdell and indicated it would begin reviewing the appeal information in order to make its final determination of eligibility. AR-157. However, on October 3, 2023. Cogdell, believing Reliance to have violated the ERISA implementing regulation outlining the procedures for the appeal process by failing to issue a decision in her appeal within 45 days, filed this action for a benefits determination based on the administrative record. *See* [Doc. No. 1].

Now before the Court are Reliance's Motion for Summary Judgment, [Doc. No. 14], and Cogdell's Motion for Judgment on the Administrative Record, [Doc. No. 16]. The Parties also filed supplemental briefing, following oral argument, on the potential *Loper Bright* issue raised by Reliance during the hearing held on the Motions on July 17, 2024. *See* [Doc. Nos. 30, 31].

## II. LEGAL STANDARD

The parties dispute the applicable legal standard for a review of the denial of ERISA benefits, and by extension, the procedural mechanism for resolving it. Both parties agree that the Court reviews the plan documents *de novo* and if the plan confers discretionary authority on the fiduciary to determine eligibility, a decision denying benefits is reviewed for an abuse of discretion under Federal Rule of Civil Procedure 56. [3] The parties also appear to agree that under the applicable ERISA-implementing regulations and the prior decisions of this Court, if an administrator departs from ERISA's procedural requirements, the claim is considered administratively exhausted, a *de novo* standard of review applies instead of the abuse of discretion standard. [4] *See Rupprecht v. Reliance Standard Life Ins. Co.*, 623 F. Supp. 3d 683, 691 (E.D. Va. 2022) (collecting cases); *see also Fessenden v. Reliance Standard Life Ins. Co.*, 927 F.3d 998, 1004 (7th Cir. 2019) ("Because the administrator lacks discretion to take longer than the regulations allow, its tardy decision is not entitled deference"). However, the parties disagree as to (1) whether the

  

regulation imposing the 45-day timeline for claim appeals and the resulting divestment of discretion for failing to adhere to that timeline exceeds the Department of Labor's statutory authority and therefore violates the APA; [5] and (2) whether Reliance has in fact departed from the procedural requirements of ERISA and its implementing regulations. The Court addresses each of these issues before turning to the merits.

### A. The 45-Day Timeline for Review Regulation Is Consistent with the Broad Grant of Authority Given to the Department of Labor by the ERISA Statute.

***3** At oral argument and in its supplemental briefing, Reliance contends that the 45-day period imposed by a Department of Labor regulation on plan administrators for rendering an appeals decision is invalid because it exceeds the grant of authority delegated to the Secretary by statute to promulgate regulations and therefore any failure on its part to complete its review within that period should not destroy the deference to its decision that it would otherwise enjoy. *See generally* [Doc. No. 30]. In support of its position, Reliance relies on the recent Supreme Court opinion *Loper-Bright*, arguing that "it is an oversimplification" to say that *Loper-Bright* merely abrogated *Chevron* deference. Rather, according to Reliance, *Loper-Bright* "delineated the roles of federal agencies and the courts under the Administrative Procedure Act (APA)[,]" and that "under *Loper*, courts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires." *Id.* at 2. Although Reliance raises this issue within the context of this case, and does not, it appears, seek relief beyond this case, Reliance's contention is, in substance, a facial attack on the regulation under section 706(2)(c) of the APA, and as such, even setting aside the merits, the argument should be barred for the following procedural defects:

***First***, Reliance's challenge is untimely. Although *Loper-Bright* abrogated *Chevron* deference only recently, the relied upon pronouncement in *Loper-Bright* merely reiterates the long established APA mandate that Court's "hold unlawful and set aside agency action ... found to be ... in excess of statutory jurisdiction, authority, or limitations[.]" 5 U.S.C. § 706(2)(C). Reliance does not explain how *Loper-Bright* changed the landscape in such a way to permit Reliance now to bring a facial challenge that it could not have brought previously. [6] Without any applicable intervening change in law, Reliance's argument—raised for the first time at oral argument—is untimely.

***Second***, there is an established procedure for facial challenges to federal regulations under the APA. Presenting the argument in this context rather than in a section 706 suit against the Secretary of the Department of Labor frustrates one of the intended legislative purposes of the APA, with its six-year statute of limitations that Reliance would otherwise face in bringing such a challenge. 28 U.S.C. § 2401(a); *see also Corner Post, Inc. v. Bd. of Governors of Fed. Rsrv. Sys.*, 144 S. Ct. 2440 (2024). Indeed, Reliance has frequently faced the consequences it now challenges from violating the regulation it now says is unconstitutional, including before July 2018, and as such, it would almost certainly be foreclosed from bringing a facial challenge under section 706. [7] *See, e.g., Coats v. Reliance Standard Life Ins. Pol'y*, No. 16-CV-233-TCK-TLW, 2017 WL 1536229, at *2 (N.D. Okla. Apr. 27, 2017) (holding that a *de novo* standard of review is appropriate where Reliance exceeded the 45 days to issue an appeal decision); *see also Buffkin v. Reliance Standard Life Ins. Co.*, No. 3:16-CV-21/MCR/CJK, 2017 WL 2903345, at *8 (N.D. Fla. Mar. 31, 2017) ("The ERISA deadlines offer a powerful tool for claimants to demand a decision from plan administrators who unreasonably drag out the process, depriving the claimant of a fair and timely review").

In any event, setting aside these procedural issues, Reliance's position fails on the merits of its contention that the challenged regulation, with its declaration that a claim has been administratively exhausted if no appeal decision has been rendered within 45 days (barring exceptions beyond the administrator's control), exceeds the Secretary's grant of statutory authority to promulgate regulations that ensure a "full and fair review" process, as provided for in 29 U.S.C. § 1133. [Doc. No. 30] at 3. In that regard, Reliance argues that because the regulation effectively nullifies the plan's discretion, it dictates the standard of review, which encroaches on the province of the courts. *Id.* at 4. But the grant of authority under ERISA is exceedingly broad, such that "ERISA empowers the Secretary of Labor to 'prescribe such regulations as he finds necessary or appropriate to carry out' the statutory provisions securing employee benefit rights." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003)

(quoting 29 U.S.C. § 1135). And, as a substantial majority of other courts have concluded, setting time limits for administrative claim exhaustion is both necessary and appropriate for a "full and fair review" of claim denials because without time limits for claim exhaustion, plan administrators would have *no* incentive to review and determine expeditiously the appeals brought to them, leaving vulnerable claimants in limbo indefinitely without judicial recourse. [8]

***4** Moreover, the regulation merely sets a time limit for claim exhaustion; it does not mandate or direct the courts to apply a particular standard of review as Reliance suggests. Rather, it is the courts that have determined whether the procedural violation of rendering a decision outside of the 45-day window still entitles a plan administrator to deference under the doctrine of substantial compliance—a determination that has produced different results in different jurisdictions. *Compare Fessenden*, 927 F.3d at 1005 ("This [substantial compliance] standard cannot be applied to an untimely decision because there is nothing to review at the time that administrative remedies are deemed exhausted."), *with Jebian v. Hewlett-Packard Co. Emp. Benefits Org. Income Prot. Plan*, 349 F.3d 1098, 1107 (9th Cir. 2003) ("[I]nconsequential violations of the [ERISA] deadlines ... would not entitle the claimant to de novo review in the context of an ongoing, good faith exchange of information between the administrator and the claimant"). With courts reaching different results on the standard of review issue, it is clear that the standard of review is neither expressly nor effectively controlled by the regulation, and the regulation does not run afoul *Loper-Bright*, as Reliance suggests.

For these reasons, Reliance's facial attack on the validity of the 45-day procedural requirement outlined in the ERISA implementing regulation, 29 C.F.R. § 2560.503-1(i)(1)(i), (i)(3) finds no support in the *Loper-Bright* decision.

### B. Reliance Departed from the Procedural Requirements of the Governing Regulations

In support of her argument that Reliance departed from the procedures mandated by ERISA and its implementing regulations, Cogdell contends that Reliance failed to give a valid reason for seeking an extension of the 45-day time limit on appeal determinations and that even if the reason given for the extension had been valid, the actual timeline of events shows that the extension was not actually necessary. *See* [Doc. No. 17] at 9 (citing 29 C.F.R. § 2560.503-1(l)). More specifically, Cogdell argues that (1) under the controlling regulation, Reliance was required to identify a "special circumstance" for the extension, and that the special circumstance offered by Reliance—review by an independent medical professional—is a standard requirement for all appeals, and such a reason is therefore neither "special" nor outside of the control of the administrator; and (2) even assuming the need for review by an independent medical professional, Reliance failed to timely act when it delayed sending her claim to its appeals department until September 20, 2023—36 days after she had applied—and did not send the claim for medical review until September 25, 2023—just four days shy of the regulatory deadline, the result of which was that a prompt independent medical review still exceeded the deadline. [Doc. No. 21] at 6–7.

In response to Plaintiff's position, Reliance simply maintains that review by an independent medical professional was necessary for a "full and fair review" mandated by 29 U.S.C. § 1133(2). [Doc. No. 15] at 25–26 ("It would be a hollow argument for Plaintiff to suggest that the initial 45 days was sufficient time for Reliance Standard to locate appropriate experts, send the records to them, have the experts prepare their reports and have those reports reviewed by the appeal examiner."). Consequently, Reliance does not explain why the need for an independent evaluation and review is a "special circumstance." However, at oral argument, Reliance suggested that new information provided by Cogdell with her appeal was the reason that the appeal process required more than 45 days.

The purported need for additional time beyond the 45 days is belied by Reliance's own factual submissions regarding the independent review process: the referral to the independent medical professionals was provided just five days after Reliance forwarded the appeal to the appropriate office (September 20, 2023) and, according to Reliance, the first independent neurological physician provided his report just four days after receiving the referral (September 29, 2023). Given this timeline, the relevant decisionmaker had the independent review information within nine days of initiating the process, [Doc. No. 15] ¶¶ 75–76; and the second independent physician—a psychiatrist—prepared his report six days later (October 5, 2023). *Id.* ¶

82. All told, if Reliance had forwarded the appeal to the appropriate office without delay, the decisionmaker would have had all of the relevant information to review within *15 days*, with a full month to review the information and render a decision within the regulatory deadline. Instead, it waited for nearly the entire initial 45-day time period to run before even referring the case. [9] And even after receiving the reports from the independent reviewers, Reliance concedes that it did not begin reviewing the reports until October 25, 2023—nearly three weeks after receiving the second report, *id.* ¶ 84, and was able to render a decision *one day* after beginning its October 25 review, on October 26, 2023. *Id.* ¶ 86. The actual timeline, therefore, that was needed for Reliance to come to its decision regarding the appeal was just 16 days. [10] For these reasons, Reliance has failed to show that the 45-day extension period was necessary in order to secure an independent review of the decision and to review the report of the independent physician.

***5** The Court also concludes, as many other courts have, that an independent medical review without more is not a "special circumstance" that would make a 45-day extension appropriate. [11] As Reliance itself argues, [Doc. No. 20] at 21, ERISA's implementing regulations *require* that "in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment ... the appropriate named fiduciary shall consult with a health care professional ...." 29 C.F.R. § 2560.503-1(h)(3)(iii), (4). Reading the regulatory mandate as a special circumstance that would justify an extension of the 45-day review period would effectively render meaningless the 45-day review period. [12]

For the above reasons, Reliance departed from the procedures required by the ERISA implementing regulations and therefore, in accordance with Part II.A, a *de novo* standard of review is appropriate. [13] Accordingly, the Court assesses the merits of the parties' respective positions based on the administrative record and makes the following findings of fact and conclusions of law under Rule 52. *See Tekmen v. Reliance Standard Life Ins. Co.*, 55 F.4th 951, 961 (4th Cir. 2022) ("In conducting *de novo* review of a denial of benefits under ERISA, the district court undertakes a careful examination of the often-voluminous administrative record to determine whether the claimant was entitled to benefits.").

## III. FINDINGS OF FACT

***6** 1. Cogdell is an accomplished engineer who served as the Principal Business Process Engineer for MITRE at the time of the claimed loss. *See generally* AR-167–71.

2. As determined by MITRE in backfilling her role, Cogdell's material responsibilities at the time of her claimed loss were (1) managing "critical" client relationships; (2) leading project teams to apply business process engineering including improvement methods "to help solve complex [client] problems"; (3) developing new opportunities with clients around intelligent process automation; (4) mentoring and developing staff "in the application of ... frameworks in the enterprise transformation space"; and (5) advancing MITRE's knowledge of research programs and thought leadership. AR-870.

3. Cogdell was required to show that she was unable to manage one or more of these responsibilities on even a part-time basis as a result of her claimed injury in order to be eligible for benefits under the Policy. AR-10.

4. Cogdell contracted **COVID-19** for the first time in late July 2021 and reported being unable to move for two weeks. AR-423. She reported being so fatigued that she "couldn't go to the bathroom without being out of breath." AR-424. In this initial phase of her illness, Cogdell was working 2-3 hours per day a few days per week, and used FMLA benefits to cover the remaining hours. *See, e.g.*, AR-312-313.

5. In order to qualify for short-term disability or FMLA leave through MITRE, Cogdell's treating physicians completed forms to substantiate her condition to MITRE and to communicate her capacity for work. Although the physicians both reported that there was no "single continuous period of time" during which Cogdell would be incapacitated on a forward-looking basis, they also indicated that Cogdell would require a reduced schedule of up to four hours per day of work, which was continually

extended *and resulted in* a "single continuous period" of reduced work from the end of July 2021 through June 6, 2022. *See* AR-277–97. [14] The form does not provide enough context to determine whether the physicians were aware of the material responsibilities of Cogdell's position, and if so, whether they concluded that Cogdell could complete all material aspects of her position on a part-time basis, or only some. *See id.*

6. Cogdell herself reported that she had to minimize client interaction because she suffered from frequent headaches and was not able to step away from client meetings with the sudden onset of symptoms. AR-429.

7. Cogdell further reported that her employer temporarily "moved [her] into a job" in which she "could go to whatever meetings [she] could" and without any client interaction, which was a central (material) part of her normal role as the Principal Business Process Engineer. AR-425.

8. During this period, Cogdell also credibly reported that she experienced shortness of breath, dizziness, and fatigue. Cogdell explained that she had to sit down while showering and had to "work up the energy" to brush her teeth. AR-574. In the fall of 2021, Cogdell enrolled in a clinic for long **COVID** patients at INOVA, which included a pulmonary rehabilitation program that required weekly in-person visits, and she completed the program in December 2021. AR-423.

***7** 9. Cogdell's family and friends reported significant changes in her energy and personality following her **COVID** diagnoses. AR-642–50. For example, a longtime work colleague reported that she witnessed Cogdell—who was previously a high performer in her characterization—"struggling" at work with fatigue and headaches. AR-642–43.

10. Cogdell's treating physician reported that her condition was steadily improving throughout the spring of 2022. *See* AR-202, 212. However, these improvements were not so significant as to enable Cogdell to full-time work. *See* AR-298–325.

11. Cogdell again contracted **COVID** in July 2022, which significantly disrupted her long **COVID** recovery. AR-652; *see also* AR371-72; AR-887. She took Paxlovid, which helped to mitigate the acute symptoms, but once again suffered from shortness of breath and nausea, AR-887, as well as fatigue and memory recall difficulties. [Doc. No. 17-2] at 2.

12. Even with the assistance of Paxlovid, Cogdell could not work at all after her second **COVID** infection. In fact, her employer recommended that she take 100% leave after the setback. AR-887; AR-240. This recommendation is probative of the fact that Cogdell could not complete the material aspects of her position.

13. After her second **COVID** infection, Cogdell continued her seeing her primary care provider as well as various specialists in an effort to better understand her long-**COVID** symptoms and to develop a treatment path. The reports from these physicians largely indicate that no physical abnormalities were identified through testing, with the exception of tachycardia identified by a cardiologist as "likely due to her **COVID-19** infection." *See* AR-234–39, 249, 915–20, 928 (primary care reports), 336–37, 979–80, 1010–21 (neuropsychological reports), 347–48, 921–24, 953–54 (cardiology reports), 930 (primary care reporting of pulmonology results). [15]

14. Cogdell's primary care provider observed in January 2023 that she "agree[s] that a dysautonomia is part of her post-**Covid** syndrome." AR-933. She reported that she discussed with Cogdell that "symptomatic treatment and time are likely our only options," and that she considered prescribing a beta blocker but was "concerned that this could exacerbate fatigue." *Id.*

15. Additionally, a neurologist reported that "Cogdell became visibly exacerbated ... on some tasks. She needed to take a break from testing after about 90 minutes .... By part 2 of this test, she had become tearful and began breathing very heavily." AR-1012. Nevertheless, the neurologist categorized her functioning as "WN" or "within normal." AR-1013.

16. Research has shown that long **COVID** is difficult to diagnose and assess using traditional diagnostic tests, and that there is significant skepticism about false claims because the most common symptoms are "trouble concentrating" and fatigue. AR-631–

32. Indeed, in a report assessing the workplace impact of long-**COVID**, medical researchers state that "[s]ome providers report feeling hard-pressed to make a diagnosis, as some *symptoms are perceived as subjective.*" AR-632 (emphasis added). As such, the absence of a clinical diagnosis relating to long-**COVID** should not preclude eligible persons such as Cogdell from being designated as Totally Disabled when their self-reported symptoms, observed and documented by physicians, AR-1010–21, indicate an inability to complete the material tasks of their job.

***8** 17. There is no basis on which to think that Cogdell's subjective complaints reflected malingering in any respect. *See* AR-234–39, 249, 915–20, 928 (primary care reports); *id.* at 336–37, 979–80, 1010–21 (neuropsychological reports); *id.* at 347–48, 921–24, 953–54 (cardiology reports), *id.* at 930 (primary care reporting of pulmonology results); *id.* at 642–50 (reports of family, friends, and a colleague). Her subjective complaints, and their associated effects upon her ability to perform the material duties of her job, were consistently reported throughout her disability and were in sharp contrast to her documented high-level of functioning before contracting **COVID**.

18. Due to her long-**COVID** symptoms, Cogdell was not able to complete all material aspects of her position beginning from August 2021 through at least spring of 2023. Accordingly, she was "Totally Disabled" under the Policy beginning on or before June 7, 2022.

19. Cogdell filed for long-term disability benefits under the Policy on November 10, 2022 and listed June 7, 2022 as the loss date. AR-40. While it was the technical date of the start of her Total Disability under the Policy, it was a continuation of her illness that had started in July 2021 and for which she had been under treatment, and therefore fully disabled within the meaning of the Policy, for a year. [16]

## IV. CONCLUSIONS OF LAW

20. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(f).

21. Although this case was brought in the Eastern District of Virginia where Cogdell resides and where her medical treatment was pursued and administered, the MITRE long-term disability insurance policy through Reliance, AR-1–38, is governed by Massachusetts law. AR-1.

22. Under Massachusetts law, the interpretation of the language in a contract is a question of law unless there is ambiguity, and the determination of whether ambiguity exists is also a question of law. *See Balles v. Babcock Power Inc.*, 476 Mass. 565, 571, 70 N.E.3d 905, 911 (2017).

23. Under the Policy, Cogdell would be entitled to benefits only after the completion of a 180-day elimination period (the "Elimination Period"). AR-7, 9.

24. Under the Policy, the Elimination Period begins on the first day that an eligible person covered by the Policy has a "Total Disability." AR-9. For the purposes of the Elimination Period, Total Disability is further defined by the policy as someone who cannot perform *all* of the material duties of their occupation. AR-10. [17]

25. Although the Elimination Period is generally required to be continuous, the Policy allows for interruptions (*i.e.*, a return to regular work) of 30 days or less. Although these days do not count towards the days in the Elimination Period, they also do not restart the clock. AR-9. A return to work means "Active Work," which is defined by the Policy is performing *all* of the material duties in the place and manner in which the job is normally performed. *Id.*

26. Additionally, an eligible person may elect to select a date after the date of "Total Disability" for the Elimination Period to begin running if the eligible person has alternative income benefits, such as under a short-term disability program funded by the

employer, because those income benefits would otherwise be deducted from the amount that the eligible person is otherwise entitled to under the Policy. AR-22.

***9** 27. To submit a claim for benefits under the Policy, a claimant must provide written proof of loss, including proof that: (1) the claimant is under the regular care of a physician; (2) the date the Total Disability began; (3) the cause of the Total Disability determined by "objective medical evidence, diagnostic studies, and examinations acceptable to the medical community"; (4) the nature of the Total Disability, including information regarding the limitations; (5) the name and address of all facilities where the claimant received any kind of treatment; (6) documentation of the covered monthly earnings; (7) documentation of any other applicable income benefits that the claimant may be eligible for; (8) authorization to allow Reliance to collect information about the claimant necessary to make an eligibility determination; and (9) tax returns that are necessary to determine the amount payable under the Policy. AR-14.

28. Although the Administrator may require, as the Plan expressly does, objective medical evidence, diagnostic studies, and examinations acceptable to the medical community, *see id.*, the Administrator cannot "simply dismiss ... subjective complaints ... out of hand." *DuPerry v. Life Ins. Co. of N. Am.*, 632 F.3d 860, 876 (4th Cir. 2011); *see also Montero v. Bank of Am. Long-Term Disability Plan*, No. 315CV00519RJCDSC, 2016 WL 7444957, at *4 (W.D.N.C. Dec. 27, 2016). [18] Accordingly, Cogdell's self-reported brain fog, headaches, and other symptoms preventing her from full-time work in her then-current role must be considered in evaluating her claim. *Id.*

29. Cogdell satisfied the proof of loss criteria as outlined by the Policy in AR-14 because she provided documentation that her treating physicians repeatedly determined that her symptoms were likely related to long-**COVID**, *see, e.g.*, AR-207–208, 770, and she also provided Reliance with medical studies about long-**COVID** and the difficulties in diagnosing it definitively, *see, e.g.*, AR-339–42.

30. During the relevant period, Cogdell was unable to perform all of the material aspects of her job as a result of her disability, particularly in the areas of "solving complex problems," "lead[ing] and work[ing] in project teams to apply business process reengineering, and process improvement to help solve complex sponsor problems," "manag[ing] critical sponsor relationships," and "mentor[ing] and develop[ing] staff." AR-870.

31. Under the Policy, the fiduciary has discretionary authority to make eligibility determinations, provided, however, that the fiduciary does so in accordance with the procedures required by ERISA and its implementing regulations. *Id.* at 15; 29 C.F.R. § 2560.503-1 ("[I]f the plan fails to strictly adhere to all the requirements of this section with respect to a claim, the claimant is deemed to have exhausted the administrative remedies available under the plan[,]" unless the departure is *de minimis*).

32. When the fiduciary does not act in accordance with the procedures required by ERISA and its implementing regulations, and the Court conducts a *de novo* review of the administrative record, the Court looks only to the evidence in the administrative record presented by the claimant at the time that the claim was administratively exhausted, absent exceptional circumstances. *See* 29 C.F.R. § 2560.503-1(h)(4)(i); *see also Wonsang v. Reliance Standard Ins. Co.*, No. 1:23-CV-1 (RDA/IDD), 2024 WL 1559292, at *9 (E.D. Va. Apr. 10, 2024) (limiting the record to the information before Reliance at the time the appeal window expired); *Donnell v. Metro. Life Ins. Co.*, 165 F. App'x 288, 297 (4th Cir. 2006) ("[I]n ERISA actions in which courts review the administrator's decision de novo, introduction of evidence outside the administrative record is permitted only in exceptional circumstances.").

***10** 33. The record before the Court does not include the independent medical reviews of Dr. Joseph Palermo, AR1207–16, and Dr. Reginald Givens, AR1222–26, because they were not made available to Cogdell with time to respond before the expiration of the appeal window. *See* 29 C.F.R. § 2560.503-1(h)(4)(i); *see also Wonsang*, No. 1:23-CV-1 (RDA/IDD), 2024 WL 1559292, at *9.

## V. CONCLUSION

For the foregoing findings of fact and conclusions of law, the Court finds in favor of the Plaintiff on her claim, and against Defendants; and it is hereby

**ORDERED** that the Plaintiff's Motion [Doc. No. 16] be, and the same hereby is, **GRANTED** and that Defendant retroactively award Plaintiff long-term disability benefits and pay past-due long-term disability benefits under the Plan with pre-and post-judgment interest; and it is further

**ORDERED** that the Parties submit a joint pleading within thirty (30) days from the entry of this Order detailing any agreed dollar amount of past-due benefits and pre-judgment interest. As to any aspects of the foregoing items on which the Parties cannot agree, Plaintiff's brief on the same subject is due forty-five (45) days from the entry of this Order, Defendant's response is due fourteen (14) days from the submission of Plaintiff's brief, and Plaintiff's reply is due seven (7) days from the submission of Defendant's response; and it is further

**ORDERED** that Defendant's Motion [Doc. No. 14] be, and the same hereby is, **DENIED.**

**All Citations**

--- F.Supp.3d ----, 2024 WL 4182589

## Footnotes

1 The Court cites to the administrative record for consistency because the Parties cite to the administrative record in their briefing.

2 Bergonio made these findings despite the fact that Cogdell has a job characterized as "sedentary." AR-333–35.

3 [Doc. No. 15] at 17–21; [Doc. No. 17] at 24.

4 [Doc. No. 15] at 17–21; [Doc. No. 17] at 9 (citing 29 C.F.R. § 2560.503-1(l)).

5 Reliance first raised this argument at the hearing on the Motions, relying on *Loper Bright Enters. v. Raimondo*, —— U.S. ——, 2024 WL 3208360 (2024), decided and published after the briefing concluded. *See* [Docs. 30, 31].

6 As Plaintiff explains in her supplemental briefing, *Loper-Bright* is applicable only insofar as there is statutory ambiguity, which is not present in this case. *See* [Doc. No. 31] at 2.

7 Even after the Supreme Court's decision in *Corner Post*, the statute of limitations would run from when Reliance had a "complete and present cause of action," which would (at minimum) have run from the time it faced its first argument that a claimant is entitled to *de novo* review because their claim was administratively exhausted after the expiry of the 45-day window. *Id.* at 2452.

8 On this point, the Court finds particularly instructive the Seventh Circuit's extensive discussion in *Fessenden*, 927 F.3d 998—notably, another case involving Reliance. There, the Seventh Circuit observed that

  

> Reliance's position that an administrator can change the standard of review with a late-breaking decision would ... be a novel application of the substantial compliance doctrine. And permitting that novelty would undercut the benefits of exhaustion for claimants. A claimant is entitled to sue as soon as a claim is deemed exhausted because the administrator has failed to make a timely decision. **But Reliance's position would leave such a claimant in an uncertain position. Should she wait a little bit longer just in case the administrator makes a decision? Or should she go ahead, attempting to frame her case in a way that is responsive to a decision that hasn't yet—but may still—come?** Moreover, an administrator who has more time may get an unfair advantage: it could sandbag a claimant who sues at the point of exhaustion by issuing a decision tailored to combat her complaint.

*Id.* at 1005 (emphasis added). This Court agrees: a time limit on the review process, with consequences for exceeding that time limit, is both necessary and appropriate for a fair review process.

9 This is not the first time that Reliance has had to deal with the consequences of an untimely appeal determination. In 2022, this Court determined that Reliance had scheduled an independent medical evaluation which "appears to have anticipated a decision beyond the 45-day window," and therefore squarely rejected Reliance's argument that the extension was necessary for completing the independent medical evaluation. *Rupprecht*, 623 F. Supp. 3d at 690.

10 Reliance also submitted at oral argument that the review could not have been completed during the 45-day window because Cogdell submitted "voluminous" additional documentation with her appeal on August 15; however, Reliance's records show that these voluminous records were apparently reviewed by the appeal agent, along with the new independent medical reviewer reports, in just one day.

11 *See Rhodes v. First Reliance Standard Life Ins. Co.*, 670 F. Supp. 3d 119, 125 (S.D.N.Y. 2023) (finding that a failure of the claims administrator to obtain independent medical examination could not be invoked to extend regulatory deadlines under ERISA on beneficiary's appeal of denial of the long-term disability claim); *see also Brewer v. Unum Grp. Corp.*, 622 F. Supp. 3d 1113, 1125 (N.D. Ala. 2022) ("Nor would [independent medical review] constitute a special circumstance, as virtually every appeal of the denial of a disability benefits claim will require physician and vocational review.") (internal quotations omitted); *Krysztofiak v. Bos. Mut. Life Ins. Co.*, No. CV DKC 19-0879, 2021 WL 5304011, at *3 n.5 (D. Md. Nov. 15, 2021) ("tolling is inapplicable [because the] burden to schedule and complete an IME within the 45-day decision window ... is on the claim administrator"); *Salisbury v. Prudential Ins. Co. of Am.*, 238 F. Supp. 3d 444, 449–50 (S.D.N.Y. 2017) (rejecting the defendant's offered "special circumstance" for seeking an extension because "[t]he only rationale for the extension provided in the company's written notice was that Prudential needed additional time to allow for review of the information in Ms. Salisbury's file which remains under physician and vocational review.") (internal quotations omitted); *but see Holmes v. Colorado Coal. for Homeless Long Term Disability Plan*, 762 F.3d 1195, 1206 (10th Cir. 2014) ("ERISA's regulations governing extensions of time and calculating time periods on review place with the plan administrator the sole discretion to determine whether special circumstances exist requiring an extension of time for decision").

12 The Court does not intend to suggest that the need for review by an independent medical expert could never, as a categorical matter, give rise to a "special circumstance" that warrants an extension of the 45-day window. For example, there may be an especially rare condition giving rise to the claim with limited availability of an appropriate medical expert, or a situation in which an expert timely selected failed to produce a report in a timely manner due to circumstances beyond the administrator's control.

13 In addition to these reasons, Reliance has also departed from the procedures required by ERISA implementing regulations by failing to provide Cogdell with documentation of its internal rules regarding benefit determinations, even after she made three requests for the rules. [Doc. No. 23] at 10 (citing 29 C.F.R. 2560.503-1(g)(vii)(C)).

14 Note that these forms are not in chronological order in the record.

  

15 Reliance also relies on other provider reports to support its position that Cogdell was well-adjusted and able to work, but they are providers who are wholly unrelated to Cogdell's post-**COVID** treatment, and whose observations of her affect and dress are cited without context. *See, e.g.*, AR-260, 266 (behavioral health reports), 892–99 (various reports on knee treatment).

16 Presumably Cogdell chose this date because she was approved for just six more months of short-term disability through her employer, and if that ran concurrent to the Elimination Period under the Policy, she would not have any gap in disability income by filing on June 7. Thus, the June 7 long-term disability claim essentially represented an extension of her short-term disability status.

17 However, entitlement to benefits following the Elimination Period is subject to a less stringent standard, such that an eligible person may qualify if they are only "Partially Disabled," which is also defined by the Policy. AR-10.

18 "A plan administrator may not require objective proof of disability if the plan does not contain such a requirement." *Tekmen*, 55 F.4th at 967.

**End of Document**