

1 **Factual and Procedural History**

2 Plaintiff Alan Wright is sixty years old. (PSOF 1.)¹ He began working for Defendant
3 Raytheon² in 1984; his final position with Raytheon was titled Senior Industrial Security
4 Specialist for Defendant Raytheon. (DSOF 1; PRSOF 1; PSOF 1.) According to Plaintiff,
5 his job responsibilities included maintaining government procurement forms, managing
6 classified national security information and monitoring data affecting the national security
7 of the United States. (PSOF 2.) Plaintiff describes his job as 60-65% sedentary; Defendants
8 claim that Plaintiff spent most of his time sitting at a computer. (PSOF 2; DSOF 2; DRISOF
9 2.)

10 As a Raytheon employee, Plaintiff participated in the Raytheon Company Short Term
11 Disability Plan (“STD”). (DSOF 3; PRSOF 3.) The STD is funded through a group policy
12 of insurance issued to Raytheon by Defendants Metropolitan Life Insurance Company
13 (“MetLife”). (DSOF 4; PRSOF 4.) The STD is governed by the Employee Retirement
14 Income Security Act of 1974. (DSOF 5; PRSOF 5.) MetLife is the claims administrator for
15 the Raytheon Company Short-Term Disability Plan. (DSOF 6; PRSOF 6.) The Summary
16 Plan Description for the STD states, “[y]ou are considered disabled if, due to a non-work
17 related illness or injury, you are: under the regular care and attendance of a doctor and unable
18 to perform all of the essential elements of your regular job with reasonable accommodation.”
19 (DSOF 7; PRSOF 7.) The STD further provides that benefit payments end on the earliest
20 date the claimant: ceases to be disabled, as determined by the claims administrator; or
21 reaches the maximum duration of coverage under the plan (13 weeks). (DSOF 8; PRSOF
22

23 ¹ Citations to the Statements of Facts filed by the parties are abbreviated as follows:
24 Defendants’ Statement of Facts (Doc. No. 67), “DSOF;” Plaintiff’s Statement of Facts (Doc.
25 Nos. 64 & 77), “PSOF;” Plaintiff’s Response to Defendants’ Statement of Facts (Doc. No. 69),
26 “PRSOF;” Defendants’ Response to Plaintiff’s Statement of Facts (Doc. No. 73-3), “DRSOF.”
27 Citations to the Administrative Record (Doc. No. 74) are abbreviated as “AR.”

² The Complaint names as Defendants Raytheon Company Short Term Disability Plan
and Raytheon Company Long Term Disability Plan. (Doc. No. 1.) For convenience, these
Defendants are referred to collectively as “Raytheon.”

1 8.)

2 Plaintiff also participated in the Raytheon Company Long Term Disability Plan
3 (“LTD”). (DSOF 9; PRSOF 9.) The LTD protects a claimant’s income after the claimant
4 has received STD benefits for 13 consecutive weeks. (*Id.*) Unlike the STD, all benefits
5 under the LTD are paid from plan participants’ contributions and earnings on those
6 contributions. (*Id.*) For purposes of the LTD, a claimant is considered disabled for the first
7 15 months if he/she is unable to perform the essential elements of his/her job with reasonable
8 accomodation. (*Id.*) After this initial 15-month period, the claimant must be unable to work
9 at any job for which he/she is reasonably qualified by training, education or experience
10 through the maximum age for receiving benefits. (*Id.*) Because MetLife administers both
11 the STD and the LTD, a claimant is not required to submit a separate claim for LTD benefits.
12 (*Id.*)

13 Both the STD and the LTD provide that the plan administrator has the authority to
14 make the final decision with respect to paying claims. (DSOF 11; PRSOF 11.) The plans
15 further provide that the plan administrator has “broad discretion in interpreting the meaning
16 of plan provisions and in determining all questions arising under a plan, including, but not
17 limited to, eligibility for benefits.” (*Id.*)

18 In October, 1996, Plaintiff underwent heart bypass surgery. (DSOF 12; PRSOF 12.)
19 Plaintiff underwent a second heart bypass surgery in April, 2002. (DSOF 13; PRSOF 13.)
20 Following the 2002 heart surgery, Plaintiff’s sternum did not heal properly. (PSOF 11;
21 DRSOF 11.) Plaintiff suffers from a non-union of his sternum, 4-5 millimeters wide and
22 running the length of his sternum. (PSOF 11; DRSOF 11.)

23 Cardiologist Dr. Citron’s office ordered stress tests on Plaintiff on four occasions.
24 The first stress test, dated April 13, 2001, indicated that Plaintiff was able to exercise 6:26
25 minutes. (PSOF 15; DRSOF 15.) In March, 2002, another stress test was performed;
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1 Plaintiff was able to exercise for 4:43 minutes before experiencing dyspnea³ on exertion.
2 (PSOF 16; DRSOFF 16.) No arrhythmia was noted during the stress test. (DRSOFF 16.) On
3 June 21, 2002, Plaintiff was able to exercise for 4:29 minutes before experiencing
4 “moderate” dyspnea on exertion. (PSOF 17; DRSOFF 17.)

5 On September 10, 2002, Plaintiff reported to his treating physician, Dr. Barnett, that
6 he was “back to work and has done fairly well there.” (DSOF 14; PRSOF 14.)

7 On December 30, 2002, Dr. Citron examined Plaintiff regarding the non-union of his
8 sternum. Dr. Citron also observed that Plaintiff suffered from coronary artery disease. (AR
9 500.) Dr. Citron opined that a surgery to correct the non-union of the sternum carried a 2-3%
10 risk of death because of Plaintiff’s previous heart surgeries. (*Id.*) Dr. Citron also opined that
11 any repair of the sternum would be permanent. (*Id.*) Finally, Dr. Citron noted that he would
12 be willing to perform the operation but that it would present serious problems “for a
13 gentleman who weighs 300 lbs.” (*Id.*)

14 On April 1, 2003, Dr. Copeland authored a letter to Dr. Citron stating: “Alan Wright
15 has a sternal non union and we have been contemplating repair. We discussed it one more
16 time and we are still a little ‘on the fence.’ He is going to think about it for another month
17 and we will see him again at that time. Personally, I feel we could go either way. I have
18 warned him that it would be considerably painful and an interruption in his life to do it and
19 that he may do just as well without any operation at all.” (DRSOFF 13.)

20 Plaintiff decided against having the surgery to repair his sternal non-union. (PSOF
21 14; DRSOFF 14.)

22 On March 2, 2004, Dr. Barnett examined Plaintiff, who reported “severe chest wall
23 pain which is a result of nonunion of the sternum following ... surgery.” Dr. Barnett opined
24 that Plaintiff was “doing extremely poorly. Cannot do any form of exercise because of that
25 pain. As a result is battling weight gain and lethargy. The chest pain is worse when he is
26

27 ³ Dyspnea is defined as “difficult or labored breathing; shortness of breath.”
Webster’s New World Medical Dictionary (3rd edition 2008).

1 sitting at a desk or in front of a computer or when he tries to do anything physical. In
2 addition, he still has angina, gets [short-of-breath] with any exertion and has continued to be
3 depressed over the situation.” (AR 249.) Dr. Barnett noted that Plaintiff suffered from
4 “coronary artery disease/congestive heart failure/hypertension/severe chest wall
5 pain/depression.” (*Id.*) He recommended to Plaintiff that he apply for permanent medical
6 disability. (PSOF 20; DRSOFF 20.)

7 On August 13, 2004, Plaintiff reported to Dr. Barnett that he tired quickly and was
8 constantly worried about work. (AR 250.) Dr. Barnett noted that he did not think Plaintiff
9 could safely continue to work because the stress of work could shorten his life to within the
10 next year. (*Id.*)

11 During an appointment on September 10, 2004, Dr. Barnett opined that Plaintiff was
12 100% disabled and that his efforts to work were significantly impairing his long term health.
13 (PSOF 20; DRSOFF 20.)

14 On September 9, 2004, Plaintiff stoppped working. (DSOF 15; PRSOF 15.) On
15 September 10, 2004, Plaintiff filed for short-term disability benefits under the STD, claiming
16 that he was prevented from working due to “difficulty breathing, coronary artery disease and
17 depression.” (DSOF 16; PRSOF 16; AR 101.) MetLife obtained and reviewed Plaintiff’s
18 medical records. (DSOF 17; PRSOF 17.) MetLife also spoke with Plaintiff as part of its
19 review of his STD claim. (*Id.*)

20 On September 23, 2004, MetLife referred Plaintiff’s file to an independent physician
21 consultant, Dr. Amy Hopkins. (DSOF 18; PRSOF 18.) Plaintiff disputes Dr. Amy Hopkins
22 independence from MetLife, noting that the amounts paid by MetLife to Dr. Hopkins
23 increased from \$119,775 in 2001 to \$145,520.01 in 2004, and that Dr. Hopkins received total
24 payments of \$498,832.51 from MetLife between 2001 and 2004. (PSOF 43; DRSOFF 43.)
25 Dr. Hopkins reviewed Plaintiff’s file, including all of his medical records. (DSOF 19;
26 PRSOF 19.) She also interviewed Plaintiff’s treating physician, Dr. Barnett. (*Id.*) In her
27 report, Dr. Hopkins summarized Dr. Barnett’s notes regarding Plaintiff. Dr. Hopkins further

1 stated:

2 I spoke with Dr. Barnett on 10/8/04. He stated that EE [Plaintiff] reported
3 angina at rest at work, so he felt that EE's continuing to work would kill him.
4 He stated that EE had stress tests, but didn't know the most recent results. He
5 stated that the cardiologist would have that information. He stated that EE had
6 been through counseling for stress, but he did not know if EE was under the
7 care of a psychiatrist or in stress management classes. I pointed out to him that
8 work isn't the only source of stress in an individual's life, so it might be
9 lifesaving for EE to be in stress management if he really thought this would
10 kill him. I asked him what it was about EE's own job that EE felt was so
11 stressful, and he didn't know. I asked him if EE would work for another
12 employer, and he didn't know. He stated that EE had gone to the ED
13 [Emergency Department] with angina from work, but didn't know if actual
14 ischemia was documented. He stated that EE might need more surgical
15 procedures down the road. He stated that EE reported feeling betting [sic]
16 when he was working, and I reminded him that that was true of many people,
17 but that that did not imply that they couldn't work. There was no change in
18 treatment plan ...

19 No cardiology notes were provided to substantiate that EE has active angina.
20 Dr. Barnett stated that EE still got angina and SOB [Shortness of Breath] with
21 any exertion, but there were no stress tests in this record to determine if EE
22 had active ischemia. No pulmonary evaluation was documented. EE had a
23 CABG [Coronary Artery Bypass] in the past, and there was no evidence in this
24 file of any cardiac disease. Dr. Barnett stated that EE had a "little bit" of CHF
25 [Congestive Heart Failure], presumably based on ankle edema, but ankle
26 edema can be due to many causes and is not necessarily presumptive evidence
27 of CHF. EE reported chronic chest wall pain over his sternum since the
28 CABG, but there was no evidence in this file that this has changed recently. ...
29 While I cannot judge if EE is significantly impaired from a psychiatric
30 standpoint, there was no objective evidence in this file of any significant
31 physical impairment.

32 PSOF 19; DSOF 19.)

33 On October 13, 2004, Metlife informed Plaintiff that it was denying his claim for STD
34 benefits. (DSOF 20; PRSOF 20.) The decision stated:

35 There were no cardiology notes provided to substantiate that you have active
36 angina. Also no stress tests were submitted to determine if you have active
37 ischemia. It was also noted that Dr. Barnett recommended stress management
38 but there was no evidence that a formal program was recommended, that
39 medication was started, nor if you were referred for a mental health evaluation
40 or treatment. There was also no mention of what specifically at work was
41 giving so much anxiety and stress or if it could be remediated.

42 The information received lacks any recent cardiology notes and cardiac testing.
43 After our review of this information, and all other information obtained, it is
44 not clear how you are medically disabled from performing your regular job
45 functions.

46 (*Id.*)

1 On October 15, 2004, Plaintiff underwent a stress test at Dr. Citron's office. (PSOF
2 18; DRSOFF 18.) The test was concluded after 3:46 minutes because of labored and forced
3 breathing. Notes of the test indicate that Plaintiff was "quite dyspneic" at "peak and post
4 exercise," but did not experience any chest discomfort or arrhythmia. (PSOF 18; DRSOFF
5 18.)

6 On October 18, 2004, Dr. Barnett wrote a letter to MetLife stating:

7 I am gravely disturbed by your misrepresentation of the facts with regard to
8 my discussion with your independent physician consultant and your lack of
9 due diligence in collecting further medical information regarding Mr. Wright's
10 health condition. You indicate in your letter that "it was concluded that you
11 are out of work primarily due to work related stress." I spent over 30 minutes
12 on the phone with your independent physician consultant explaining that this
13 was definitely not the case. Indeed, this consultant seemed to have had a
14 preconceived notion that stress was why the patient was out of work and that
15 there was no cardiovascular disease contributing. I very clearly explained that
16 this was not the case. Indeed, Mr. Wright has ongoing cardiac disease
17 including ischemia and loss of function due to previous myocardial infarctions.
18 Each time I expressed the belief to your consultant, she would return to the fact
19 that she felt that stress must be the major issue that was keeping him out of
20 work.... Furthermore, I carefully explained to your physician that Mr. Wright
21 has nonunion of the sternum resulting in severe pain and contributing to his
22 disability, and yet you fail to mention that at all in your note.

23 (AR 157-158.) Dr. Barnett further noted that due to Plaintiff's inability to exercise for more
24 than 3 minutes during his October 15, 2004 stress test, the test was nondiagnostic with regard
25 to ischemia.

26 On October 20, 2004, Plaintiff wrote to MetLife and requested a review of the
27 decision to deny his claim for STD benefits. (DSOF 21; PRSOF 21.) On November 12,
2004, Plaintiff's counsel wrote to MetLife and withdrew the October 20, 2004 request.
(DSOF 22; PRSOF 22.) On April 5, 2005, Plaintiff formally appealed the October 13, 2004
denial of benefits. (DSOF 23; PRSOF 23.) In his appeal, Plaintiff argued that he was
permanently disabled due to obstructive airway disease and restrictive airway disease. (PSOF
29; DRSOFF 29.) The appeal argued that Plaintiff's pulmonary problems were exacerbated
by active cardiac disease. The appeal included a pulmonary function test completed by
Plaintiff on February 27, 2005, a letter from Dr. Barnett dated March 25, 2005, records from

1 Dr. Citron and Dr. Barnett and Plaintiff's summary of his occupational duties. (DSOF, Ex.
2 11, Part 1.) On May 10 and May 19, 2005, the appeal was supplemented with medical
3 records from April and May, 2005. (PRSOFF 23; AR 474-76, 480-82.)

4 The pulmonary function test conducted by Dr. Barnett on February 27, 2005 showed
5 that "moderate obstruction with [Plaintiffs'] forced vital capacity representing only 53% of
6 that predicted for him by the standard protocol. Even worse, his forced expiratory fraction
7 25/75 percent was only 37% of the predicted value. In other words, with regard to the
8 elasticity function of the lung, [Plaintiff] had a 63% reduction in function compared to a
9 normal individual." (PRSOFF 24.)

10 Dr. Barnett's March 25, 2005 letter stated that it was his "strong belief" that Plaintiff
11 is "completely and permanently disabled with regard to his or any other type of
12 employment." (AR 495-498.) He opined that if Plaintiff returned to any sort of work, he
13 would be at "serious risk of irreversible harm such as heart attack or stroke." (*Id.*) He noted
14 a 63% reduction in the elasticity function of Plaintiff's lungs caused by the pain in the
15 sternum, morbid obesity, sedentary status, deconditioning following several cardiac events,
16 chest surgery, chronic pain and a small degree of congestive heart failure. (*Id.*) Dr. Barnett
17 noted cardiac disease documented by Dr. Citron, including "extensive inferolateral wall
18 myocardial infarction" and pointed out that Plaintiff's stress tests indicated that Plaintiff's
19 exercise tolerance was steadily diminishing. (*Id.*) Dr. Barnett described a negative cycle in
20 which Plaintiff's illness decreases his ability to exercise, causing worsening obesity and
21 decreased lung function, which in turn further worsen his lung and cardiac output. (*Id.*) Dr.
22 Barnett further noted that Plaintiff was suffering from anxiety caused by his inability to work
23 and the denial of his disability claim. (*Id.*)

24 In his summary of his occupational duties, Plaintiff stated:

25 Unlike my triple bypass surgery in October 1996, I have never been able to
26 fully recover from my double by-pass surgery that I underwent in April of
27 2002. My sternum has failed to heal properly. I now live with what is known
as a non-union of the sternum. This causes me to live with a constant low
level of chest pain. As a natural pain response, I now take short breaths to

1 avoid causing further pain. Dr. Barnett referred me to Dr. Copeland, a
2 renowned heart surgeon at the University Medical Center. Dr. Copeland and
3 I discussed the possibility of having additional surgery to repair my sternum.
4 Based upon the inherent risk with this invasive surgery (2-3% fatality) and the
5 fact that any good achieved would be undone when and if I ever had to
6 undergo another bypass surgery, I opted out of having the surgery.
7 The very act of remaining in a sitting position for any length of time is painful.
8 Having to twist and turn at my desk as I answer the telephone, retrieve files
9 and work on my computer is also painful. Walking to and from the buildings
10 located on the facility, to attend meetings and conduct Security Education and
11 Training classes causes severe shortness of breath and unbearable chest pain.
12 I have noticed a continuing lack of energy, an inability to remain focused and
13 a steady decrease in my ability to recall facts pertinent to the proper handling,
14 storing, transmission and destruction of classified information. This has
15 caused me to question my decisions and therefore has shaken my belief in my
16 ability to quickly and accurately perform my job. I have become depressed by
17 the fact that no matter what I do, I am not going to get any better. The best I
18 can hope for is to relieve the stress and pain and hopefully delay the steady
19 deterioration of my health.

20 (AR 683-85.)

21 On April 27, 2005, pulmonary specialist Dr. Scott Bronnimann saw Plaintiff for a
22 pulmonary assessment. Dr. Bronnimann concluded that Plaintiff “has likely a mixed
23 obstructive and restrictive lung impairment and he may have underlying obstructive sleep
24 apnea as well. I think to quantify his lung function it is important to do formal pulmonary
25 function tests Based on these, I would be better able to comment on his underlying lung
26 function. The patient clearly has markedly reduced exercise capability due to his physical
27 size and the difficulty that the nonunion of the sternum creates for him.” (DSOF 24; PRSOF
28 24-25.) Dr. Bronnimann recommended a formal pulmonary function test and felt that it
29 would enable him to better comment on Plaintiff’s underlying lung function. (DSOF 24;
30 PRSOF 24.)

31 On May 11, 2005, Dr. Bronnimann issued a pulmonary function report. He stated:

32 These values [spirometry, lung volume and diffusion levels] indicate a
33 moderate restrictive lung impairment. There is also a very mild degree of
34 airflow obstruction at the level of small airways. After administration of
35 bronchodilator, there is no improvement in airflow. Examination of the flow
36 volume loops indicate some flattening of the expiratory and inspiratory limbs.
37 This pattern can indicate intrathoracic airway obstruction. Lung volumes
confirm a significant restrictive lung impairment with a total lung capacity of
52% of predicted and the residual volume 26% of predicted. Diffusion is
markedly reduced but it does correct for alveolar volume. This indicates that

1 the decrease in diffusion is directly related to the reduced alveolar volume
2 within the thorax. In summary, there is a moderate severity in restrictive lung
3 impairment and a very mild airflow obstruction present on pulmonary function
tests. In addition, consideration should be given to a fixed intrathoracic airway
obstructive given the shape of a flow volume curve.

4 (DSOF 25; PRSOF 25.)

5 On May 24, 2005, MetLife conducted an initial internal assessment of Plaintiff's
6 appeal. (AR 119.) MetLife's claim log notes that current medical records were submitted
7 with the appeal that reflect "moderate severity in restrictive lung impairment and a very mild
8 airflow obstruction present on pulmonary function tests." (*Id.*) MetLife initially decided to
9 refer the appeal to a cardiologist and a psychiatrist for independent consult. (*Id.*) On May
10 31, 2005, MetLife decided to refer the appeal to a cardiologist only. (AR 120.)

11 On May 31, 2005, as part of its consideration of Plaintiff's appeal, MetLife referred
12 his file to independent physician consultant cardiologist Dr. Michael J. Rosenberg. (DSOF
13 26; PRSOF 26.) Dr. Rosenberg is Board Certified in Internal Medicine, Cardiology and
14 Interventional Cardiology. (DSOF 26; PRSOF 26.) Plaintiff disputes Dr. Rosenberg's
15 independence. Dr. Rosenberg's review was obtained through Elite Physicians, a trade name
16 for Network Medical Review ("NMR"), which markets its services to insurance companies.
17 (PRSOF 26.) In 2001, MetLife paid NMR \$79,410 in annual revenues; by 2005 MetLife's
18 annual payments to NMR had increased to \$2,063,890. (PRSOF 26.) According to
19 Defendants, Dr. Rosenberg reviewed Plaintiff's entire file, including new medical
20 information submitted as part of his appeal, and spoke by telephone to Dr. Barnett and Dr.
21 Citron. (PSOF 28.) Plaintiff notes that Dr. Rosenberg did not speak to Dr. Bronnimann and
22 does not appear to have considered Plaintiff's summary of his occupational duties. (PRSOF
23 28.) On June 14, 2005, Dr. Rosenberg issued a report to MetLife stating that:

24 Objective information is sparse in these records. ... The most recent medical
25 record available is that of Mr. Wright's pulmonary specialist, Dr. Scott
26 Bronnimann. Dr. Bronnimann ordered pulmonary function studies, which
27 were performed on 5/11/05. These showed moderate severity restrictive lung
impairment and very mild airflow obstruction on pulmonary function testing.
The diffusion capacity was reduced but corrected normally for alveolar
volume. Bronchodilators did not improve airflow; thus indicating the findings

1 were consistent with moderate restrictive lung impairments due to Plaintiff's
2 physical size, who also 'has marked reduced exercise capability due to his
3 clinical size....' A diagnosis of sleep apnea was being obtained but has not
4 been confirmed.

5 On the basis of the information provided, records suggest Mr. Wright to have
6 limitations in exercise capacity that are largely related to deconditioning and
7 morbid obesity; the degree to which moderate restrictive lung disease plays a
8 role relates to the morbid obesity. There is no evidence of congestive heart
9 failure in the record, no evidence of myocardial ischemia, and no evidence of
10 rhythm disturbance or syncope. The chest discomfort that Mr. Wright
11 complains of is atypical, has never been demonstrated to be ischemic since the
12 time of the second bypass surgery, may relate to surgical nonunion, which
13 cannot limit exercise capacity in itself.

14 My Wright's occupation is described as sedentary. Mr. Wright had self-
15 described himself as becoming extremely tired at work, constantly worrying,
16 was observed to be anxious; this has been reinforced by his treating physician,
17 Dr. Barnett. Stress management has been recommended but has not been
18 noted or have been accomplished.

19 From a cardiovascular standpoint, Mr. Wright has minimal-to-no impairment
20 on the basis of objective findings. ... Therefore, from a purely cardiovascular
21 standpoint, there are no specific limitations of function related to Mr. Wright's
22 impairments. Morbid obesity, deconditioning, and severe anxiety/depression
23 with inability to handle stress may pose significant limitations for Mr. Wright,
24 but none of these are cardiovascular in nature.

25 (DSOF 29; PRSOF 29.) Dr. Rosenberg also summarized his conversation Dr. Citron, stating
26 that "on a cardiovascular basis, both Dr. Citron and I concluded that Mr. Wright, on the basis
27 of available objective medical information, cannot be stated to be totally unable to work."
(DSOF, Ex. 15.) Dr. Rosenberg further stated that he has spoken with Dr. Barnett, who had
opined that "Mr. Wright does have a mild ischemic cardiomyopathy," but that Dr. Barnett
"did not have any further information that would qualify it as disabling," and that Drs.
Rosenberg and Barnett had discussed the possibility that "if Mr. Wright still feels unable to
work, pulmonary/restrictive lung disease or anxiety/depression perspectives may be more
relevant than cardiovascular issues." (DSOF, Ex. 15.) Finally, Dr. Rosenberg concluded that
"from a cardiovascular standpoint/perspective," Plaintiff could perform medium work, did
not suffer from impairments substantiated by objective clinical findings, had no significant
functional limitations that would support his inability to perform sedentary job duties, and
that Plaintiff's limitations were predominantly related to morbid obesity, anxiety, and

1 depression, which were beyond the scope of Dr. Rosenberg's review. (DSOF, Ex. 15.)

2 On June 23, 2005, MetLife wrote to Drs. Barnett and Citron and asked them to
3 comment on Dr. Rosenberg's report. (DSOF 30; PRSOF 30.)

4 On June 30, 2005, MetLife wrote to Plaintiff's counsel and stated that it was
5 upholding the denial of Plaintiff's claim for STD benefits:

6 Based on our review of the information contained in Mr. Wright's claim file,
7 we have determined that the information does not support the severity of a
8 condition that would render Mr. Wright unable to perform his job duties. The
9 medical documentation indicates that Mr. Wright retains nearly normal left
10 ventricular function, no evidence of myocardial ischemia and has no
11 significant rhythm disturbances and has not been shown unable to work. Mr.
12 Wright's limitations are predominantly related to morbid obesity, anxiety and
13 depression. Furthermore, Mr. Wright has been treated for anxiety and
14 depression, however, has not had ongoing psychiatric care. From a
15 cardiovascular standpoint, symptoms and impairments are not substantiated by
16 objective clinical findings.

17 In summary, the medical information provided does not support the severity
18 of impairment that would render Mr. Wright totally disabled and unable to
19 perform the essential elements of his job.

20 (DSOF 31; PRSOF 31.)

21 On June 25, 2006, Dr. Bronnimann authored a letter to Plaintiff's counsel in which
22 he stated that

23 Dr. Rosenberg focused on cardiovascular issues and did not fully consider the
24 pulmonary aspects of the patient's health. I believe he underemphasized some
25 of the pulmonary information that was available to him. For example, my
26 interpretation of the diffusion capacity on pulmonary function tests was that
27 the diffusion was markedly reduced, whereas Dr. Rosenberg says that the
diffusion capacity was 'reduced.' Mentioning that the diffusion corrects for
alveolar volume means only that there is no underlying scarring in the lungs.
It does not imply that the limited diffusion is not significant. Dr. Rosenberg
emphasized the patient's obesity, but did not specifically comment on how
nonunion of the sternum and the abdominal ventral hernia might also
contribute to the patient's limited lung function.... Due to all of the above-
listed factors, it is my opinion that Dr. Rosenberg did not fully consider the
patient's pulmonary limitations in his conclusion that Mr. Wright was not
disabled.

28 (PSOF, Ex. 4.)

29 On October 12, 2005, Plaintiff filed this action in federal court, asserting claims
30 against Defendants for breach of fiduciary duty, breach of contract and declaratory relief.
31 (Doc. No. 1.) Plaintiff claims he is entitled to benefits under both the STD and the LTD.

1
2 **Legal Standard**

3 Plaintiff brings this case pursuant to the Employment Retirement Income Security Act
4 of 1974 (“ERISA”) seeking disability benefits under Raytheon’s short and long-term
5 disability plans. The purpose of ERISA is “to protect ... the interests of participants in
6 employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to
7 participants and beneficiaries of financial and other information with respect thereto, by
8 establishing standards of conduct, responsibility, and obligation for fiduciaries of employee
9 benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the
10 Federal courts.” 29 U.S.C. §1001(b). 29 U.S.C. §1132(a)(1)(B) provides that a participant
11 in an employee benefit plan may bring a civil action “to recover benefits due to him under
12 the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights
13 to future benefits under the terms of the plan.”

14 **A. Abuse of Discretion Standard of Review**

15 In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the United States
16 Supreme Court addressed “the appropriate standard of judicial review of benefit
17 determinations by fiduciaries or plan administrators under” 29 U.S.C. § 1132(a)(1)(B). *Id.*
18 at 105, 108. Principles of trust law require courts to review a denial of plan benefits “under
19 a *de novo* standard” unless the plan provides to the contrary. *Id.* at 115. Where the plan
20 provides to the contrary by granting “the administrator or fiduciary discretionary authority
21 to determine eligibility for benefits,” *id.* at 115, “[t]rust principles make a deferential
22 standard of review appropriate,” *id.*, at 111. In the present case, the STD Plan grants MetLife
23 “broad discretion” to interpret “the meaning of plan provisions and [to determine] all
24 questions under a plan, including but not limited to, eligibility for benefits.” (DSOF 11;
25 PRSOF 11.) Thus, the abuse of discretion standard applies.⁴ A plan administrator abuses

26
27 ⁴ Where the decision to grant or deny benefits is reviewed for abuse of discretion, a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material

1 its discretion if it renders a decision without any explanation, construes provisions of the
2 plan in a way that conflicts with the plain language of the plan, or relies on clearly erroneous
3 findings of fact in making benefit determinations. *See Bendixen v. Standard Ins. Co.*, 185
4 F.3d 939, 944 (9th Cir. 1999).

5 **B. Consideration of Plan Administrator’s Conflict of Interest**

6 *Firestone* further provides that if “a benefit plan gives discretion to an administrator
7 or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a
8 ‘factor in determining whether there is an abuse of discretion.’” *Id.* at 115. The United States
9 Supreme Court recently held that “the kind of ‘conflict of interest’ to which [*Firestone*]
10 refers” includes cases in which “a plan administrator both evaluates claims for benefits and
11 pays benefits claims.” *See Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, *5 (June 19,
12 2008).⁵ This is true even if (as here) the plan administrator is not the employer itself but
13 rather a professional insurance company. *Id.* at *6. In this case, MetLife both evaluates the
14 claims for benefits and pays the benefit claims. (DSOF 4, 6; PRSOF 4, 6.) Thus, pursuant
15 to *Glenn*, MetLife operates under an inherent conflict of interest in administering Raytheon’s
16 Short Term Disability Plan.

17 *Glenn* also “elucidate[s] what this Court set forth in *Firestone*, namely, that a conflict
18 should ‘be weighed as a factor in determining whether there is an abuse of discretion.’” *Id.*
19 at 2350. According to *Glenn*, *Firestone’s* statement does not imply a change in the standard
20 of review, from deferential to *de novo*. *Id.* “*Firestone* means what the word ‘factor’ implies,

21 _____
22 fact exists, do not apply. *See Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 942 (9th Cir. 1999).

23
24 ⁵ The law governing Plaintiff’s ERISA claim has changed significantly while this case
25 has been pending. On April 20, 2006, the Magistrate issued an order regarding Plaintiff’s right
26 to conduct discovery on evidence outside the administrative record related to Defendants’
27 alleged conflict of interest. (Doc. No. 25.) That order relied on *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317 (9th Cir.1995), the governing legal standard at the time. The order was challenged by Defendants but affirmed by the district court on December 4, 2006 (Doc. No. 31); by then *Atwood* had been overruled by *Abatie v. Alta Health & Life Insurance Co.*, 458 F.3d 955 (9th Cir. 2006). Since then, the Supreme Court issued its decision in *Glenn*, which further clarifies the standard of review to be applied in ERISA cases involving conflicts of interest.

1 namely, that when judges review the lawfulness of benefit denials, they will often take
2 account of several different considerations of which a conflict of interest is one.” *Id.* at 2351.
3 “In such instances, any one factor will act as a tiebreaker when the other factors are closely
4 balanced, the degree of closeness necessary depending upon the tie-breaking factor's inherent
5 or case-specific importance.” *Id.* The conflict of interest should prove more important where
6 circumstances suggest a higher likelihood that it affected the benefits decision, including, but
7 not limited to, cases where an insurance company administrator has a history of biased claims
8 administration. *Id.* It should prove less important where the administrator has taken active
9 steps to reduce potential bias and to promote accuracy, for example, by walling off claims
10 administrators from those interested in firm finances. *Id.* Other factors relevant to the
11 Court’s review include: evidence of procedural unreasonableness; emphasis on medical
12 reports favoring denial coupled with de-emphasis of reports suggesting a contrary
13 conclusion; failure to provide independent vocational and medical experts with all of the
14 relevant evidence; and the ultimate adequacy of the record's support for the agency's factual
15 conclusion. *Id.* at 2351-52.

16 **C. Evidence That A Court May Consider**

17 Generally, the Court’s review of a plan administrator’s denial of disability benefits
18 under an abuse of discretion standard is limited to the administrative record. *See Abatie v.*
19 *Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006). However, the Court is permitted
20 to consider evidence outside the administrative record if such evidence relates to the
21 appropriate weight to accord the conflict of interest factor. *See Wilcox v. Wells Fargo and*
22 *Co. Long Term Disability Plan*, 2008 WL 2873735, *2 (9th Cir., July 23, 2008). Evidence
23 outside the record related to the merits of the administrator’s decision – *ie.* medical records
24 not presented to the administrator – are not admissible.⁶ *Abatie*, 458 F.3d at 970.

25
26 ⁶ Accordingly, the Court has not considered the letter written by Dr. Bronnimann to
27 Plaintiff’s counsel dated April 25, 2006 as it relates to the merits of MetLife’s decision to deny
benefits. (PSOF, Ex. 4.) The Court has considered Dr. Bronnimann’s letter to the extent it is
relevant to MetLife’s potential conflict of interest.

1 **Analysis**

2 **A. Defendants abused their discretion**

3 In determining whether a plan administrator abuses its discretion, the Court considers
4 three factors (apart from its conflict of interest inquiry): (1) whether the plan administrator
5 rendered a decision without any explanation; (2) whether the plan administrator construed
6 provisions of the plan in a way that conflicts with the plain language of the plan, and (3)
7 whether the plan administrator relied on clearly erroneous findings of fact in making benefit
8 determinations. *See Bendixen*, 185 F.3d at 944. In the present case, Plaintiff alleges only that
9 MetLife relied on clearly erroneous findings of fact in making its benefit determination.
10 Thus, in this case, the Court’s decision hinges on two factors: (1) the scope of MetLife’s
11 conflict of interest, and (2) whether MetLife’s findings were supported by fact. *See Glenn*,
12 128 S.Ct. at 2351 (conflict of interest is one factor to be considered in determining whether
13 plan administrator abused its discretion).

14 **1. Conflict of Interest**

15 In determining the scope of MetLife’s conflict of interest, the Court examines several
16 factors, including history of biased claims administration; evidence of procedural
17 unreasonableness; emphasis on medical reports favoring denial coupled with de-emphasis
18 of reports suggesting a contrary conclusion; failure to provide independent vocational and
19 medical experts with all of the relevant evidence, and the ultimate adequacy of the record’s
20 support for the agency’s factual conclusion *See Glenn*, 128 S.Ct. at 2351. If a plan
21 administrator who is also the funding source “repeatedly hire(s) particular physicians as
22 experts [such that] these experts have a clear incentive to make a finding of ‘not disabled’
23 in order to save their employers money and to preserve their own consulting arrangements,”
24 the court regards the arrangement as further evidence of a conflict of interest.

25 In the present case, Plaintiff has not alleged that MetLife has a history of biased
26 claims administration and this Court is not aware of any such history. *See Glenn*, 128 S. Ct.
27 at 2351-52 (finding evidence of history of biased claims administration in a law review

1 article summarizing one insurance company's history). Nor has Plaintiff alleged that
2 MetLife's administration of Plaintiff's claim was procedurally unreasonable.

3 Plaintiff has alleged, and the Court gives weight to, the remaining factors. As
4 explained in Section A(2), below, MetLife acted selectively in categorizing Plaintiff's
5 disability, its independent physicians de-emphasized medical evidence suggesting a contrary
6 conclusion, and the record as a whole did not support MetLife's denial of benefits. In
7 addition, MetLife's denial of Plaintiff's appeal relied on the opinion of Dr. Rosenberg.
8 MetLife increased its payments to NMR, a company that markets its services to insurance
9 companies and employs Dr. Rosenberg, from \$79,410 in 2001 to \$2,063,890 in 2005. This
10 marked increase in annual revenue supports the conclusion that MetLife had a close
11 relationship with NMR in which both entities stood to benefit from the denial of claims.
12 Such a relationship is considered evidence of bias.⁷ See *Caplan v. CNA Financial Corp.*, 544
13 F.Supp.2d 984, 991-92 (N.D.Cal., 2008) ("Hartford's structural conflict of interest is
14 accompanied by its reliance on UDC, a company which Hartford knows benefits financially
15 from doing repeat business with it, collecting more than thirteen million dollars from
16 Hartford since 2002. It follows that Hartford knows that UDC has an incentive to provide it
17 with reports that will increase the chances that Hartford will return to UDC in the future-in
18 other words, reports upon which Hartford may rely in justifying its decision to deny benefits
19 to a Plan participant.")

20 Because four of the six factors by which a conflict of interest is evaluated support a
21 finding that MetLife's denial of benefits was influenced by its conflict of interest, the Court
22 concludes that the conflict of interest factor weighs in favor of Plaintiff in this case.

23 **2. Factual Support for Findings**

24 Raytheon's STD plan provides that Plaintiff is entitled to short-term disability benefits

26 ⁷ The Court is less troubled by MetLife's payment history with respect to Dr. Amy
27 Hopkins, whose MetLife revenues increased from \$119,775 in 2001 to \$145,520.01 in 2004 but
decreased to \$1,920 in 2005. (DRSOF 43.)

1 if he (1) suffers from a non-work related illness or injury, (2) is under the regular care of a
2 doctor, and (3) unable to perform all of the essential elements of his regular job with
3 reasonable accommodation. MetLife concluded that Plaintiff did not meet this burden
4 because Plaintiff failed to demonstrate that his heart condition was so severe that he was
5 unable to perform all of the essential elements of his regular job. MetLife also concluded
6 that Plaintiff was not under the regular care of a physician for treatment of his anxiety and
7 depression.

8 MetLife relied on clearly erroneous findings of fact in making its benefit
9 determination. MetLife's review of Plaintiff's appeal consistently omitted or misrepresented
10 relevant information in several ways. First, MetLife decided to refer Plaintiff's appeal to a
11 cardiologist and a psychiatrist for independent consult when the thrust of Plaintiff's appeal
12 was that he was permanently disabled due to obstructive airway disease and restrictive
13 airway disease.⁸ (PSOF 29; DRSOFF 29.) The only mention of a cardiac illness in Plaintiff's
14 appeal is his claim that his pulmonary problems were exacerbated by active cardiac disease.
15 Furthermore, at no time did Plaintiff contend that mental health issues prevented him from
16 working.⁹ Thus, from the outset, MetLife structured its review of Plaintiff's appeal in such
17 a way that Plaintiff's most serious health concern – pulmonary restrictions – were not
18 considered.

19 Second, Dr. Rosenberg's review of Plaintiff's medical file was unfairly selective. Dr.
20 Rosenberg repeatedly limited his opinion of Plaintiff's medical condition to a "purely
21 cardiovascular standpoint," using the phrase as a qualifier *eight* times in a three page opinion.
22 Dr. Rosenberg participated in telephone conferences with Dr. Citron and Dr. Barnett, but did
23 not contact Plaintiff's pulmonary specialist, Dr. Bronnimann. In summarizing Dr.

24
25 ⁸ In fact, MetLife's claim log noted that Plaintiff submitted his appeal with current
26 medical records noting "moderate severity in restrictive lung impairment and a very mild airflow
27 obstruction present on pulmonary function tests," which makes it even more troubling that
MetLife did not refer Plaintiff's claim to an pulmonary expert for review. (AR 119.)

⁹ As stated on page 10, MetLife later decided to refer the appeal to a cardiologist only.

1 Bronnimann's treatment notes, Dr. Rosenberg downplayed the severity of Plaintiff's
2 pulmonary limitations. He concluded that Plaintiff's diffusion capacity was "reduced." (AR
3 444.) Dr. Bronnimann actually opined that Plaintiff's diffusion capacity was "markedly
4 reduced." (AR 431.) Dr. Bronnimann also opined that Plaintiff's lung diffusion "does
5 correct for alveolar volume."¹⁰ (AR 431.) When Dr. Rosenberg summarized this statement
6 he inserted the word "normal" to minimize the finding of reduced diffusion capacity: "the
7 diffusion capacity was reduced but corrected normally for alveolar volume." (AR 444.) Dr.
8 Bronnimann wrote to MetLife to express his concern that Dr. Rosenberg had
9 underemphasized the pulmonary information available to him. In addition, Dr. Rosenberg
10 found "no evidence of congestive heart failure in the record," despite the fact that Dr. Barnett
11 had noted congestive heart failure in Plaintiff's file on March 2, 2004. In fact, Dr. Barnett
12 wrote to MetLife on October 18, 2004, to take issue with Dr. Hopkins findings and re-affirm
13 his diagnosis of Plaintiff's cardiac disease. Dr. Barnett also wrote to MetLife on March 25,
14 2005, stating that both he and Dr. Citron had diagnosed Plaintiff with congestive heart
15 failure/cardiac disease. Finally, Dr. Rosenberg stated that there was no evidence of ischemia
16 in Plaintiff's medical records, but failed to mention that Plaintiff's inability to exercise for
17 more than 3 minutes during his October 15, 2004 stress test precluded an ischemia diagnosis.
18 (AR 157-158.)

19 Third, Drs. Hopkins and Rosenberg both demonstrated a bias against Plaintiff on the
20 basis of his obesity and anxiety, suggesting that Plaintiff's medical problems were the result
21 of his refusal to lose weight or otherwise improve his health. Dr. Barnett expressed concern
22 that Dr. Hopkins "had a preconceived notion that stress was why the patient was out of
23 work" and that "each time I expressed the belief [in Plaintiff's cardiac disease] to [Dr.
24 Hopkins] she would return to the fact that stress must be the major issue." Dr. Rosenberg
25

26 ¹⁰ According to Dr. Bronnimann, when diffusion corrects for alveolar volume, it means
27 that there is no underlying scarring of the lungs. It does not mean that the diffusion is not
significant. (PSOF, Ex. 4.)

1 stated that “records suggest Mr. Wright to have limitations in exercise capacity that are
2 largely related to deconditioning and morbid obesity,” and that “morbid obesity,
3 deconditioning, and severe anxiety/depression with inability to handle stress may pose
4 significant limitations for Mr. Wright.” The record does not support this conclusion.
5 Plaintiff’s obesity and anxiety were exacerbated by the non-union of his sternum and the
6 pulmonary limitations it caused, not the other way around. Dr. Barnett stated in March, 2004
7 and March, 2005 that Plaintiff could not exercise due to severe chest pain caused by his
8 sternum non-union. Dr. Barnett also consistently noted that Plaintiff’s anxiety was related
9 to his inability to work due to his illness.

10 Fourth, in denying Plaintiff’s claim, MetLife relied on the opinion of Dr. Rosenberg
11 and excluded considerable medical evidence of pulmonary disability from its review.¹¹
12 Plaintiff’s ability to breathe is restricted in two ways: first, his sternal non-union makes
13 breathing painful. (AR 249.) Second, his weakened heart and lungs cause him to suffer from
14 shortness of breath. (*Id.*) Dr. Barnett noted in March, 2004 that Plaintiff’s chest pain
15 prevented him from exerting himself or even sitting for long periods of time. Dr. Barnett
16 opined in March, August, September and October, 2004 and again in March, 2005 that
17 Plaintiff’s inability to perform even a sedentary task due to chest pain and shortness of breath
18 rendered him 100% disabled. Plaintiff’s February 27, 2005 pulmonary function test
19 documented that Plaintiff’s lung capacity was 63% reduced. Plaintiff also reported to
20 MetLife his inability to perform even the sedentary aspects of his job due to severe shortness
21 of breath and chest pain. Dr. Bronnimann performed a pulmonary function test in May, 2005
22 which showed that Plaintiff suffered from a moderate lung impairment. None of these
23 medical findings are discussed or mentioned in MetLife’s denial of Plaintiff’s appeal.

24 Accordingly, the Court concludes that both factors weigh in Plaintiff’s favor:
25

26 ¹¹ MetLife makes much of the fact that it provided Drs. Barnett and Citron with an
27 opportunity to comment on Dr. Rosenberg’s report. However, MetLife sent Dr. Rosenberg’s
report to Drs. Barnett and Citron only one week before it denied Plaintiff’s claim, affording the
doctors very little time to comment.

1 MetLife's denial of Plaintiff's claim was influenced by its conflict of interest and relied on
2 clearly erroneous findings of fact.

3 **B. The Court need not remand this case for a determination of Plaintiff's eligibility**
4 **for LTD benefits**

5 Plaintiff seeks an award of benefits under the STD and the LTD plans. Under the
6 terms of the LTD plan, a claimant becomes eligible for long-term disability relief after the
7 claimant has received STD benefits for 13 consecutive weeks. According to Defendants,
8 Plaintiff is not entitled to benefits under the LTD plan because he has not yet exhausted his
9 STD.

10 The Court disagrees. The definition of disability under the STD plan is identical to
11 the definition of disability under the first 15 months of the LTD plan. Thus, MetLife's
12 decision on Plaintiff's appeal was tantamount to a determination that he was not eligible for
13 phase 1 of the LTD benefits. *See Caplan*, 544 F.Supp.2d at 991-92 (N.D.Cal. 2008).
14 Furthermore, although federal courts have authority to enforce the exhaustion requirement
15 in ERISA actions, "and [] as a matter of sound policy they should usually do so," there are
16 exceptions to the general rule. *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir.1980).
17 "[D]espite the usual applicability of the exhaustion requirement, there are occasions when
18 a court is obliged to exercise its jurisdiction and is guilty of an abuse of discretion if it does
19 not, the most familiar examples perhaps being when resort to the administrative route is futile
20 or the remedy inadequate." *Id.*

21 Futility is demonstrated if it appears from the record that the plan administrator would
22 be certain to deny a subsequent claim for benefits. *Ruttenberg v. U.S. Life Ins. Co. in City of*
23 *New York*, 413 F.3d 652, 662 (7th Cir. 2005); *Moyle v. Golden Eagle Ins. Corp.*, 239
24 Fed.Appx. 362, 364 (9th Cir. 2007). In the present case, for the reasons discussed above,
25 MetLife demonstrated a bias toward unfairly denying Plaintiff's claim for STD benefits. The
26 STD plan requires a lesser degree of disability – claimant's inability to perform his own job
27 – than phase 2 of the LTD plan, which applies only if the claimant cannot perform any job

1 for which he/she is qualified. Given that MetLife rejected Plaintiff's claim that he was able
2 to perform his job, which MetLife described as sedentary, it seems certain that MetLife
3 would also reject a claim that Plaintiff's disability renders him unable to perform any job at
4 all.¹²

5 **C. Proper remedies**

6 Retroactive reinstatement of benefits is appropriate in ERISA cases where, as here,
7 "but for the insurer's arbitrary and capricious conduct, the insured would have continued to
8 receive the benefits." *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1163 (9th
9 Cir. 2001) (citation omitted). The Magistrate recommends that Defendants be ordered to pay
10 Plaintiff 13 weeks of STD benefits beginning on September 10, 2004, and 15 months of LTD
11 benefits, beginning on the date his short-term disability benefits would have expired if they
12 had been approved in the first instance. *See Caplan*, 544 F.Supp.2d at 994. The Magistrate
13 further recommends that Plaintiff's claim for additional long-term disability benefits be
14 remanded to Defendants for further proceedings consistent with this Court's final Order.
15 Finally, the Magistrate recommends that Plaintiff be awarded his reasonable attorneys' fees
16 incurred herein. *See* 29 U.S.C. § 1132(g)(1).

17 **Recommendation**

18 For the foregoing reasons, the Magistrate Judge recommends that the District Court,
19 after its independent review, enter an Order GRANTING Plaintiff's Motion for Summary
20 Judgment (Doc. No. 63) and DENYING Defendant's Cross-Motion for Summary Judgment
21 (Doc. No. 66).

22 Pursuant to 28 U.S.C. § 636(b), any party may file and serve written objections within
23 10 days after being served with a copy of this Report and Recommendation. If objections
24

25 ¹² In addition, the lengthy litigation history of this case weighs in favor of consideration
26 of Plaintiff's entitlement to long-term disability benefits now, rather than requiring remand.
27 Plaintiff has been unable to work due to his disability since September 9, 2004. If Defendants'
argument were adopted, Plaintiff would have spent the past *four years* litigating his right to 13
weeks of disability benefits.

1 are not timely filed, the party's right to de novo review may be waived. *See United States*
2 *v. Reyna-Tapia*, 328 F.3d 1114, 1121 (9th Cir. 2003) (en banc), *cert. denied*, 540 U.S. 900
3 (2003). If objections are filed, the parties should direct them to the District Court by using
4 the following case number: **CV 05-604-TUC-CKJ**.

5 The Clerk of the Court is directed to send a copy of this Report and Recommendation
6 to all parties.

7 DATED this 16th day of September, 2008.

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Jennifer C. Guerin
United States Magistrate Judge