UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

BRITTANY TYTHCOTT on behalf of herself and all others similarly situated,	:	**3:03CV1732 (WWE)**
Plaintiff,	:	
	:	
v.	:	
	:	
AETNA LIFE INSURANCE,	:	
Defendant.	:	

RULING ON MOTION FOR SUMMARY JUDGMENT

The plaintiff, Brittany Tythcott, brought this class action on behalf of herself and all similarly situated adult participants and/or beneficiaries in health plans administered by the defendant, Aetna Life Insurance. She alleges that defendant violated the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. Sections 1001, et seq., when she was denied coverage for a proposed treatment to remove an extensive port-wine stain on her body. In count one, plaintiff seeks to recover benefits due under the plan pursuant to Section 502(a)(1)(B) of ERISA. In count two, plaintiff seeks an injunction pursuant to Section 502(a)(3) that prevents Aetna from determining that removal of a port-wine stain on an adult is cosmetic and therefore excluded under the terms of the plan. Plaintiff has attached as exhibits to her complaint the relevant 2002 summary plan description and correspondence regarding Aetna's refusal to authorize her treatment.

Defendant moved to dismiss the complaint in its entirety, and this court converted that motion to dismiss into a motion for summary

judgment on the issue of whether Aetna was a proper defendant. For the following reasons, the Court finds that Aetna is not the proper defendant, and the Court will grant the defendant's motion for summary judgment.

BACKGROUND

According to the evidence submitted, the following factual background is undisputed. Plaintiff, who is a beneficiary under a self-funded health benefits plan procured through her father's employer Cooper Industries, was born with extensive port-wine stain on approximately 25% of her body. Staining is present on her right eye, right breast, upper back, and right arm. In 2002, she sought coverage under the plan for laser removal of a port-wine stain birthmark that allegedly affects 25% of her body.

In January, 2003, Aetna informed plaintiff that her request for coverage had been denied. The denial letter stated:

> Aetna considers the treatment of port wine stains in adults to be cosmetic. The documentation does not support that there is functional impairment from the abnormality in question. Therefore, the Plan will not cover this service.

On February 26, 2003, plaintiff appealed Aetna's denial. In a letter dated April 14, 2003, Aetna upheld its denial of coverage. The letter explained:

> Based upon review of the documentation, we are upholding the original denial. However, the ultimate responsibility for the final review of denied claims and certification decisions under the health benefit plan is Cooper Industries, Inc. If you wish to pursue this appeal further, you may direct your request to

the benefits department at Cooper Industries, Inc. for further consideration. Alternatively, you may first request an external review of coverage denials that are based on our determination that the requested service or treatment is not medically necessary or is experimental/investigational, and the cost

> of the service or treatment for which you would be financially responsible exceeds $500.
>
> External reviews are conducted by independent physicians with appropriate expertise in the area at issue. If the denial of coverage or certification is upheld on external review, you may then exercise your right to appeal the coverage or certification denial to Cooper Industries, Inc.

Plaintiff proceeded to exercise her right to an external review of Aetna's coverage denial. By letter dated July 21, 2003, Aetna informed plaintiff that the external review had affirmed Aetna's denial of coverage.

On October 9, 2003, plaintiff filed this action asserting her rights pursuant to ERISA.

DISCUSSION

A motion for summary judgment will be granted where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to judgment as a matter of law. Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). "Only when reasonable minds could not differ as to the import of the evidence is summary judgment proper." Bryant v. Maffucci, 923 F. 2d 979, 982 (2d Cir.), cert. denied, 502 U.S. 849 (1991).

The burden is on the moving party to demonstrate the absence of any material factual issue genuinely in dispute. American International Group, Inc. v. London American International Corp., 664 F. 2d 348, 351 (2d Cir. 1981). In determining whether a genuine factual issue exists, the court must resolve all ambiguities and draw

all reasonable inferences against the moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). If a nonmoving party has failed to make a sufficient showing on an essential element of his or her case with respect to which he or she has the burden of proof, then summary judgment is appropriate. Celotex Corp., 477 U.S. at 323. If the nonmoving party submits evidence which is "merely colorable," legally sufficient opposition to the motion for summary judgment is not met. Anderson, 477 U.S. at 249.

In a civil enforcement action pursuant to ERISA Section 502(a), 29 U.S.C. Section 1132(a), "only the plan and the administrators and trustees of the plan in their capacity as such may be held liable." Crocco v. Xerox Corp., 137 F. 3d 105, 107 (2d Cir. 1998). ERISA defines the term "administrator" as 1) "the person specifically so designated by the terms of the instrument under which the plan is operated;" 2) "if an administrator is not so designated, the plan sponsor;" or 3) "in the case of a plan for which an administrator is not so designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe." 29 U.S.C. § 1002(16)(A). In Lee v. Burkhart, 991 F. 2d 1004, 1010 (2d Cir. 1993), the Second Circuit rejected a claim that an insurance, company which served under contract to provide case management in an employer’s self-funded employee benefits plan, was an unnamed plan administrator. In that case, the case management included

"discretionary authority regarding the processing of claims, determining the amounts owed, providing participants with notices

regarding claims denial, admission certification and authorization, and disbursement of benefit checks."

In the instant case, on a page entitled "Plan Facts," the summary plan description specifically designates "The Plans Administration Committee" as the Plan Administrator. On that same page, the "Type of Administration" is described as "Self-insured; Administrative Services Contract with: Aetna Life Insurance Co."

However, elsewhere in the summary plan description are references to Aetna as a plan administrator. Under the heading, **"Why does Aetna, not the Company, determine what's an eligible expense?**" the summary plan description explains:

> While the Company sponsors the Medical Plan, we pay Aetna to administer it. So, in addition to paying claims and answering participants' questions about the Plan, it is Aetna who defines what an eligible expense is. In all circumstances, Aetna will condition coverage on its determination that the treatment provided meets the specific Plan requirements. In doing so, they have the full discretionary authority to rely on their own materials, expertise and procedures, especially in determining issues concerning the terms that are defined in this booklet and in the Glossary.

In a section entitled "Plan Administration," the summary plan description explains:

> Your Benefit Administrator, Aetna and the Plans Administration Committee all play a role in supervising the Aetna Managed Choice Medical Plan.
>
> # Your *Benefit Administrator* is responsible for routine Plan maintenance, such as collecting enrollment data; answering general questions about Plan eligibility, coverage and administration; and giving basic information about the

Plan.

- # As the Plan administrator, *Aetna* reviews all claims to determine their eligibility for benefits, and answers questions concerning Plan eligibility, coverage and administration. Upon written request, Aetna will review its initial claims determinations.

- # Cooper Benefit Administrators and Aetna serve under the authority of the *Plans Administration Committee*, which has final and complete discretionary authority to determine all questions concerning eligibility, elections, contributions, benefits and administration under the Plan. It is also up to the Committee to construe all terms under the Plan's principal documents and all other relevant documents, including any uncertain terms. Decisions made by the Committee shall be given full deference by any court of law.

Plaintiff argues that defendant Aetna is a proper defendant in light of the summary plan description's reference to it as a "Plan administrator" or its role as an administrator. Plaintiff invokes the rule that absent evidence indicating the intention of the parties, any ambiguity in the language used in an ERISA plan should be construed against the interests of the party that drafted the language." Perreca v. Gluck, 295 F. 3d 215, 223 (2d Cir. 2002). Plaintiff asserts further that Aetna is the plan administrator because it controlled benefit distributions or distribution of funds.

Defendant counters that the reference to Aetna as a "plan administrator" describes its role as a third-party entity under contract to perform various administrative responsibilities, rather than signifying that defendant is a designated Plan Administrator.

As evidence of the intent of the contract, defendant points to the Administrative Services Contract between defendant and Cooper Industries, which states, in relevant part:

> Aetna in performing its obligations under this Contract is acting only as agent for the Contractholder [CooperIndustries] and the rights and responsibilities of the parties shall be determined in accordance with the law of agency except as otherwise provided. The Contractholder hereby delegates to Aetna authority to make determinations on behalf of the Contractholder with respect to benefits, subject, however, to a right of the Contractholder to review and modify any such determination. For the purposes of the Federal "Employee Retirement Income Security Act of 1974" and any applicable state legislation of similar nature, the Contractholder shall, however, be deemed the administrator of the Plan.

The service contract clarifies the ambiguity present in the summary plan description relative to Aetna's role. The service contract coupled with the plan documents evidence that Aetna was not intended to serve as a designated plan administrator for purposes of ERISA.

Further, both summary plan description and the service contract provides for Aetna's discretion to be curtailed by review and modification by Cooper Industries, which provisions are fatal to plaintiff's argument that Aetna controlled the distribution of funds and benefit decisions. Accordingly, this case does not involve a factual dispute concerning which entity actually controls the distribution of funds and benefit decisions. See Am. Medical Ass'n v. United Healthcare Corp., 2003WL348963 (S.D.N.Y. 2003)(denying motion to dismiss against insurance companies where a factual dispute

existed as to which entities were the plan administrators and whether any of the insurance companies controlled the distribution of funds and decided whether or not to grant benefits).

Accordingly, the Court finds that defendant is not a designated plan administrator for purposes of ERISA and does not ultimately control the distribution of funds or benefit determinations. Accordingly, the Court will grant the motion for summary judgment in favor of the defendant.

CONCLUSION

Based on the foregoing, the motion for summary judgment [doc. 13] is GRANTED. The Clerk is directed to enter judgment in favor of the defendant and to close the file in this case.

____________________/s/________________________

Warren W. Eginton, Senior U.S District Judge

Dated this 21st day of September, 2004, at Bridgeport, Connecticut.