No. 06-3708
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

GANDHI GUTTA,	)	
	)	
Plaintiff/Counter-Defendant,	)	**Appeal from the United States**
	)	**District Court for the Northern**
v.	)	**District of Illinois, Eastern Division**
	)	
STANDARD SELECT TRUST	)	**Hon. Blanche R. Manning**
INSURANCE PLANS,	)	**No. 04 C 5988**
	)	
Defendant/Counter-Plaintiff.	)	

BRIEF OF THE DEFENDANT / COUNTER-PLAINTIFF STANDARD SELECT TRUST INSURANCE PLANS

Warren von Schleicher
Smith, von Schleicher & Associates
39 S. LaSalle St., Suite 1005
Chicago, Illinois 60603
P: (312) 541-0300
F: (312) 541-0933

No. 06-3708
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

GANDHI GUTTA,	)	
	)	
Plaintiff/Counter-Defendant,	)	**Appeal from the United States**
	)	**District Court for the Northern**
v.	)	**District of Illinois, Eastern Division**
	)	
STANDARD SELECT TRUST	)	**Hon. Blanche R. Manning**
INSURANCE PLANS,	)	**No. 04 C 5988**
	)	
Defendant/Counter-Plaintiff.	)	

DEFENDANT'S CIRCUIT RULE 26.1 CORPORATE DISCLOSURE STATEMENT

The following information is submitted pursuant to Cir. R. 26.1 and Fed. R. App. P. 26.1:

1. Represented Parties: Standard Select Trust Insurance Plans.

2. Law firms whose partners or associates have appeared for the defendant / counter-plaintiff: Smith, von Schleicher & Associates.

3. Other persons known to have an interest in the outcome:

   (i) Standard Insurance Company (the insurer of Standard Select Trust Insurance Plans); Stancorp Financial Group, Inc. (parent corporation of Standard Insurance Company);

   (ii) Publicly held company that owns 10% or more of the defendant / counter-plaintiff's stock: None.

Signature of Counsel of Record:

_____

Warren von Schleicher
Smith, von Schleicher & Associates
39 S. LaSalle St., Suite 1005
Chicago, Illinois 60603
(312) 541-0300 / facsimile (312) 541-0933

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes and Regulations

Secondary Sources

JURISDICTIONAL STATEMENT

The Jurisdictional Statement of the plaintiff/counter-defendant, Gandhi Gutta, is incomplete and incorrect.

Gandhi Gutta, in the Complaint, asserts a claim against Standard Select Trust Insurance Plans to recover long-term disability benefits under §502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1132(a)(1)(B). (R. 1).[1] Jurisdiction is based on 28 U.S.C. §1331 and 29 U.S.C. §§1132(e)(1) and (f).

Standard Select Trust Insurance Plans filed a Counterclaim against Gandhi Gutta stating a claim for equitable restitution under §502(a)(3) of ERISA, 29 U.S.C. §1132(a)(3) and, alternatively, under the federal common law of ERISA. (R. 29, Ex. A). Jurisdiction over the §502(a)(3) claim is based on 28 U.S.C. §1331 and 29 U.S.C. §§1132(e)(1) and (f). Jurisdiction over the federal common law claim is based on 28 U.S.C. §1367(a).

On September 14, 2006, the Honorable Blanche R. Manning of the United States District Court for the Northern District of Illinois (hereafter, "district court") issued a Memorandum Opinion and Order granting summary judgment in favor of Standard Select Trust Insurance Plans with respect to the claims in the Complaint, and denying the motion for summary judgment filed by Gandhi Gutta. (R. 120). The district court also granted summary judgment in favor of Standard Select Trust Insurance Plans and against Gandhi Gutta on the §502(a)(3) claim asserted in the Counterclaim in the amount of $73,996.75. The district court's grant of summary judgment in favor of Standard Select Trust Insurance Plans with respect to the allegations of the Complaint and Counterclaim constitute a final judgment pursuant to Fed. R. Civ. P. 54(a). (R. 120-121). (R. 121).

[1] Citations to "R. _" are to the corresponding document numbers contained in the record on appeal.

On October 6, 2006, Gandhi Gutta filed a timely notice of appeal. (R. 122). The United States Court of Appeals for the Seventh Circuit has jurisdiction over this appeal pursuant to 28 U.S.C. §1291 and Fed. R. App. P. 3 and 4.

ISSUES PRESENTED FOR REVIEW

Whether the applicable standard of judicial review with respect to Gandhi Gutta's claim to recover benefits under 29 U.S.C. §1132(a)(1)(B) in the Complaint is the arbitrary and capricious standard, based on the "Allocation of Authority" provision in the Group Disability Insurance Policy.

Whether Standard Select Trust Insurance Plans' decision to decline to pay disability benefits to Gandhi Gutta after December 21, 2003, pursuant to the Group Disability Insurance Policy's "Any Gainful Occupation" definition of "Disability," was reasonable and not arbitrary and capricious.

Whether Standard Select Trust Insurance Plans is entitled to obtain restitution of overpaid disability benefits erroneously and mistakenly paid to Gandhi Gutta, in the amount of $73,996.75, based on the reimbursement provision of the Group Disability Insurance Policy, pursuant to 29 U.S.C. §1132(a)(3) or, alternatively, the federal common law of ERISA.

Whether the district court's finding that the parties did not agree to all material terms of a purported settlement was clearly erroneous.

STATEMENT OF THE CASE

Gandhi Gutta ("Gutta"), in the Complaint, asserted a claim against Standard Select Trust Insurance Plans (hereafter, "Plan") to recover long term disability benefits under §502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B), pursuant to a Group Disability Insurance Policy ("Group Policy") issued to Wells Fargo, N.A., as trustee for the Plan. The Group Policy and the

Summary Plan Description comprise the applicable Plan documents.[2] The Group Policy provides for an initial twenty-four month benefit period in the event a plan participant is disabled from working in his "own occupation." In order to qualify for benefits beyond twenty-four months, however, a plan participant must establish that he is unable to work in "any gainful occupation." The Group Policy provides that a participant whose claim for benefits has been overpaid must reimburse the Plan for the overpayment. The Plan's insurer and claims administrator, Standard Insurance Company ("Standard"), has discretionary authority to interpret the Group Policy and determine a claimant's eligibility for disability benefits.

On October 24, 2000, Gutta submitted a long-term disability claim to Standard, in which he claimed to be disabled from his occupation as a laparoscopic surgeon due to vision problems and various musculoskeletal complaints. (R. 88-8, Joint LR56.1, ¶ 10). Standard approved and paid Gutta's disability claim pursuant to the "own occupation" definition of disability. (R. 88-8, Joint LR56.1, ¶ 32).

After receiving benefits for twenty-four months, Gutta claimed to be disabled pursuant to the "any gainful occupation" definition of disability. Standard provided Gutta with a full and fair review of his disability claim, including two opportunities to appeal. Standard consulted three highly qualified physicians, all of whom concurred that Gutta has the functional capacity to perform sedentary to light level work and, therefore, that he is not disabled from "any gainful occupation." Standard reasonably exercised its discretionary authority by declining Gutta's "any gainful occupation" disability claim. As of September 14, 2004, Gutta exhausted his administrative remedies under the Plan. (R. 88-8, Joint LR56.1, ¶¶ 44, 68).

[2] The Group Policy is attached to the parties' Joint Appendix as Exhibit A. (R. 93-1, Ex. A, Group Policy). The Summary Plan Description is attached to the Complaint as Exhibit A. (R. 1, Ex. A).

The Plan asserted a Counterclaim against Gutta to recover $73,996.75 in overpaid benefits. (R. 29, Ex. A). Unbeknownst to the Plan, at the same time Gutta was collecting disability benefits under the Group Policy, Gutta also was collecting disability benefits under a separate group insurance policy that he had obtained from Sentry Life Insurance Company, through his membership in the American Medical Association. The Group Policy's offset provision, however, prohibits participants from obtaining full disability benefits from multiple group policies. The Plan, therefore, sought restitution of overpaid disability benefits from Gutta.

On June 29, 2006, the parties filed, and subsequently fully briefed, cross motions for summary judgment. (R. 99; R. 101; R. 110; R. 112). On September 14, 2006, the district court issued a Memorandum Opinion and Order finding, with respect to Gutta's claim to recover disability benefits under 29 U.S.C. §1132(a)(1)(B) in the Complaint, that the standard of review is the arbitrary and capricious standard, and granting summary judgment in favor of the Plan. (R. 120). In addition, the district court, applying the *de novo* standard of review, granted summary judgment in favor of the Plan on its Counterclaim, and entered judgment against Gutta in the amount of $73,996.75, representing the amount of overpaid disability benefits. (R. 120).

STATEMENT OF FACTS

Gutta worked as a general laparoscopic surgeon at Gandhi M. Gutta, M.D. S.C. ("Gutta Clinic") in Oak Brook, Illinois.[3] (R. 88-8, Joint LR56.1, ¶ 1). As a benefit of his employment, Gutta enrolled in the Gutta Clinic's ERISA Plan, which provides group long-term disability insurance coverage to employees of the Gutta Clinic pursuant to the terms of the Group Policy.

[3] Laparoscopic surgery is a minimally invasive procedure in which a fiber-optic video camera, inserted through a small incision, transmits images to a television monitor. The physician uses the image on the television monitor to guide the instruments and complete the surgical repair. *See* http://www.surgery.usc.edu/divisions/tumor/pancreasdiseases/web%20pages/laparoscopic%20surgery/WHAT%20IS%20LAP%20SURGERY.html.

Separately, Gutta also obtained disability insurance coverage under five insurance policies (one issued by Provident, one issued by Sentry Life, and three issued by New York Life). (R. 88-8, Joint LR56.1, ¶ 11). Gutta's coverage under all six disability insurance policies provide a combined maximum monthly benefit in the amount of $14,650.00 (excluding any applicable offsets). (R. 93-2, Joint Apdx., Admin. Rec. at STND 0382).

The Group Policy provides that a participant is "disabled" if, due to sickness or injury, he is "unable to perform with reasonable continuity the material duties of [his] own occupation." After benefits have been paid for twenty-four months, however, the definition of "disability" changes: the participant must establish that he is "unable to perform with reasonable continuity the material duties of *any gainful occupation* for which [he is] reasonably fitted by education, training, and experience." (R. 88-8, Joint LR56.1, ¶ 6) (emphasis added). The Plan approved and paid Gutta's disability claim under the "own occupation" definition of disability, and declined Gutta's disability claim under the "any gainful occupation" definition of disability.

The Plan's Evaluation of Gutta's "Own Occupation" Disability Claim

Gutta ceased performing laparoscopic surgery in August 2000, after overhearing a nurse advise a patient to find another surgeon due to Gutta's poor vision. (R. 88-8, Joint LR56.1, ¶ 1; R. 89, Def. Supp. LR56.1, ¶ 16). On October 24, 2000, Gutta submitted a long-term disability claim to the Plan's claims administrator, Standard. Gutta claimed to be unable to perform laparoscopic surgery due to a small blind spot (or "scotoma") in the peripheral vision of his left eye, and due to a progressive eye disease called macular degeneration.[4] (R. 88-8, Joint LR56.1, ¶ 10). Gutta also claimed to have various musculoskeletal conditions, including pain in his left

[4] Macular degeneration is characterized by deterioration of the retina. *See* American Macular Degeneration Foundation website, http://www.macular.org/disease.html.

thumb, right shoulder, both knees and cervical spine. Gutta, however, repeatedly emphasized the scotoma as his primary reason for claiming disability. (R. 89, Def. Supp. LR56.1, ¶¶ 4, 17).

As his "proof of claim," Gutta submitted four Attending Physician Statements ("APS") signed by various physicians, including an ophthalmologist (Motilal Raichand, M.D.), an orthopedist (Vikram Gandhi, M.D.), an endocrinologist (Luis F. Soruco, M.D.) and a neurologist (N. V. Joshi, M.D.). (R. 88-8, Joint LR56.1, ¶ 23). All four APS forms appear to have been prepared by Gutta rather than by the individual treating physicians who signed the forms. Indeed, the APS forms are essentially mirror images of Gutta's claim form: they contain the same phraseology and typewriter font, and cross-reference the same attachments. Each of the APS forms identifies restrictions and limitations only with respect to Gutta's ability to perform laparoscopic surgery. (R. 89, Def. Supp. LR56.1, ¶ 3). The APS forms do not list any restrictions or limitations with respect to Gutta's ability to work in "any gainful occupation."

On December 28, 2000, a registered nurse with Standard, Debby Sawyer, R.N., contacted Gutta's ophthalmologist, Dr. Raichand, to discuss Gutta's claimed visual impairment. Dr. Raichand informed Nurse Sawyer that Gutta has perfect 20/20 vision with corrective lenses, and that he "could not comment" as to whether the scotoma "would be significant enough to cause [Gutta] to cease work." (R. 89, Def. Supp. LR56.1, ¶ 6). In fact, Dr. Raichand was surprised to learn that Gutta even was claiming disability based on an ophthalmic condition. As stated by Nurse Sawyer:

> I informed [Dr. Raichand] the claimant stated he ceased work due to a blind spot in his visual field. Dr. Raichand stated he thought the claimant ceased work because of all of his other medical conditions. Dr. Raichand stated we might want the claimant evaluated by another ophthalmologist to determine the claimant's limitations.

(R. 89, Def. Supp. LR56.1, ¶ 7).

Standard, therefore, obtained an independent medical examination ("IME") of Gutta, which was performed by Aaron Weinberg, M.D., an ophthalmologist, on April 8, 2001. (R. 88-8, Joint LR56.1, ¶ 36). Dr. Weinberg found no pupillary defect, normal peripheral and arteriole retinas, and no evidence of macular degeneration in either eye. (R. 89, Def. Supp. LR56.1, ¶¶ 11-15). Dr. Weinberg concluded that Gutta "should have no restriction on his physical abilities based on the eye findings described above." (R. 89, Def. Supp. LR56.1, ¶ 13). Based on Dr. Weinberg's findings and other information in the administrative record, Standard determined that Gutta was not disabled by any ophthalmic condition.

In addition, Standard evaluated Gutta's various orthopedic conditions. Specifically, Standard determined that on January 10, 2001—approximately four months after claiming disability—Gutta underwent a laparoscopic procedure on his right shoulder (called a capsular release) to restore his range-of-motion. This procedure was performed by Gutta's treating orthopedist, Anthony Romeo, M.D. (R. 88-8, Joint LR56.1, ¶ 30). Standard consulted an in-house physician, Bradley Fancher, M.D., who opined that Gutta would be unable to perform laparoscopic surgery while recovering from the capsular release, and that his shoulder condition "was likely fairly limiting prior to surgery." (R. 88-8, Joint LR56.1, ¶ 20). On January 27, 2001, Standard approved Gutta's disability claim under the "own occupation" definition of disability, based on his shoulder condition. (R. 88-8, Joint LR56.1, ¶ 32).

From January 2001 to December 2002, while receiving disability benefits under the Plan, Gutta accepted an appointment and served as president of the medical staff at GlenOaks Hospital. (R. 88-8, Joint LR56.1, ¶ 34). During that period, Gutta restructured the Gutta Clinic, whereby he retained a 51% ownership interest in the business, continued to treat patients in the clinic, and hired a new physician to perform the laparoscopic procedures. (R. 89, Def. Supp.

LR56.1, ¶ 8). As part of the restructuring, Gutta contractually agreed not to accept any work earnings from the Gutta Clinic in exchange for retaining majority ownership and control. (R. 89, Def. Supp. LR56.1, ¶ 8). Although he continued to maintain office hours and treat patients at the Gutta Clinic, Gutta told Standard that he merely acted as a "greeter" for patients and as an "infrequent consult" for the Gutta Clinic's laparoscopic surgeon. (R. 89, Def. Supp. LR56.1, ¶ 17).

Notwithstanding his ongoing occupational activities, Gutta received monthly disability benefits from the Plan during the entire twenty-four month "own occupation" period (from November 22, 2000 to November 21, 2002). The Plan continued to pay disability benefits to Gutta through December 21, 2003, while evaluating his eligibility for benefits under the "any gainful occupation" definition of disability.

The Plan's Evaluation of Gutta's "Any Gainful Occupation" Disability Claim

On November 12, 2002, Standard notified Gutta of the commencement of its evaluation of his claim under the "any gainful occupation" definition of disability, and requested updated medical records and vocational information. (R. 88-8, Joint LR56.1, ¶ 37).

In response to Standard's request for information, Gutta again identified "eye problems" as his "primary disability." (R. 88-8, Joint LR56.1, ¶ 38). Despite this claim, Gutta's treating ophthalmologist (Dr. Raichand) informed Standard, on August 15, 2003, that Gutta's 20/20 vision has not changed.[5] (R. 88-8, Joint LR56.1, ¶ 42).

Gutta also submitted responses to a functional capacity questionnaire signed by orthopedist Dr. Vikram Gandhi on May 14, 2004. (R. 88-8, Joint LR56.1, ¶¶ 51, 55-56). On the

[5] Inconsistently, Mrs. Gutta told Standard on October 22, 2002 that Gutta's eye condition was worsening and that his physician stated that he would be surprised if Gutta was not completely blind by age 65 to 68. (R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 0787).

functional capacity questionnaire, Dr. Gandhi identified extreme limitations in Gutta's ability to sit (limited to 15 minutes), stand (limited to 10 minutes), and that Gutta can "rarely" turn his head up, down, left, right or even keep his head steady. Dr. Gandhi identified November 30, 1999 as the date Gutta's limitations purportedly began. (R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 0988).[6]

In contrast with the extreme limitations suggested by Dr. Gandhi, updated medical records from Gutta's orthopedic surgeon, Dr. Romeo, establish that by April 2001, Gutta had recovered fully from his shoulder surgery. In fact, on April 6, 2001, Dr. Romeo released Gutta to return to playing golf:

> He [Gutta] is having no pain at night, and he is able to use his arm for all his activities. He would like to return back to golf and I have no reservation in allowing him to do so.

(R. 88-8, Joint LR56.1, ¶ 35).

As part of its evaluation, Standard consulted two physicians who specialize in physiatry,[7] Hans Carlson, M.D. and Mark Shih, M.D., who reviewed all of Gutta's medical records. The first medical expert, Dr. Carlson, opined that the limitations identified by Dr. Vikram Gandhi in the May 14, 2004 functional capacities questionnaire were exaggerated and not supported by Gutta's medical records. (R. 88-8, Joint LR56.1, ¶ 63). Dr. Carlson opined that the medical records fail to substantiate "degenerative knee arthritis, or any significant limitations in relation to hip arthritis or lumbar spine degenerative abnormalities." (R. 88-8, Joint LR56.1, ¶¶ 61-62).

---

[6] Dr. Gandhi further opined that Gutta has "significant" limitations in his ability to grasp and twist objects due to thumb pain. An x-ray of Gutta's left thumb, obtained on January 16, 2003, however, demonstrated merely degenerative changes with no evidence of fracture or dislocation. (R. 88-8, Joint LR56.1, ¶¶ 40, 51, 55-56).

[7] Physiatrists specialize in the treatment of acute and chronic pain and musculoskeletal disorders. *See* http://www.aapmr.org/condtreat/what.htm.

Dr. Carlson concluded that Gutta is "capable of performing sedentary to light-level capacity work on a full time basis." (R. 88-8, Joint LR56.1, ¶¶ 61-62).

The second medical expert, Dr. Shih, concurred with Dr. Carlson's assessment:

> [Gutta's] primary complaint of visual impairment does not appear to be substantiated to a significant degree as his independent medical examiner had indicated restrictions only in monocular work activities. [S]ome arthritis/dislocation has involved his non-dominant left upper extremity. He, as well, does continue to have issues of arthritis and degenerative disc disease involving the right upper extremity and neck. This, however, will not preclude him from full-time work in a sedentary or light-level work capacity.

(R. 88-8, Joint LR56.1, ¶ 67).

Finally, Standard consulted a vocational analyst, Jeffery Smith, who concluded that Gutta has the education, training and experience to work as a medical director or assistant medical director overseeing the administration of medical services for a health plan. (R. 88-8, Joint LR56.1, ¶¶ 43, 64). Mr. Smith noted that, even while claiming to be disabled from "any gainful occupation," Gutta continued to perform administrative duties as chairman of the department of surgery for Oak Park / Rush Hospital, as president of medical staff at GlenOaks Hospital, and on numerous committees with the Chicago Medical Society. (R. 89, Def. Supp. LR56.1, ¶ 9; R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 0918-948). Mr. Smith further determined that during 2002 and 2003, Gutta applied for and obtained licenses to practice medicine in Hawaii, Florida and California. (R. 89, Def. Supp. LR56.1, ¶ 10). Jeffery Smith concluded that Gutta could receive annual compensation of $158,686.00 as a medical director, which qualifies as a "gainful occupation" under the Group Policy. (R. 88-8, Joint LR56.1, ¶ 64).

On December 1, 2003, Standard notified Gutta of its decision to decline his claim under the Group Policy's "any gainful occupation" definition of disability. On August 9, 2004, Standard upheld its decision on appeal. On September 14, 2004, after voluntarily permitting

Gutta a second round of appeals, Standard notified Gutta that its decision was final. (R. 88-8, Joint LR56.1, ¶¶ 44, 68).

SUMMARY OF THE ARGUMENT

Plan administrators have a duty to all plan participants "to investigate claims and make sure to avoid paying benefits to claimants who are not entitled to receive them." *Davis v. Unum Life Ins. Co. of America*, 444 F.3d 569, 575 (7th Cir.), *cert. denied*, 127 S.Ct. 234 (2006).

Gutta, in claiming to be disabled from "any gainful occupation," repeatedly emphasized vision problems as his "primary" disability. After Standard obtained objective medical evidence confirming that Gutta has no pupillary defect, normal retinas and 20/20 vision with glasses, Gutta tried to orchestrate a disability claim based on multiple orthopedic conditions in his neck, shoulders, hands, wrists and knees. Standard's decision to decline Gutta's claim, under the "any gainful occupation" definition of disability, is supported by the opinions of Standard's in-house physicians, Drs. Carlson and Shih, Standard's vocational consultant, Jeffery Smith, by the objective findings of Dr. Weinberg, and by Dr. Romeo's release of Gutta to return to playing golf. Standard evaluated all the medical and vocational evidence in depth, and reasonably determined that Gutta is not eligible to receive benefits under the "any gainful occupation" definition of disability.

Rather than address the medical evidence, Gutta devotes much of his Appellate Brief to criticizing Standard's vocational assessment. Gutta argues that he lacks the administrative experience and skills to engage in any occupational endeavor other than as a laparoscopic surgeon. The administrative record, however, is replete with evidence of Gutta's administrative qualifications, including his employment as president of the medical staff at GlenOaks Hospital,

his experience working with hospital administrators, and his knowledge of the managed care system, treatment protocols and third-party reimbursement methods.

Gutta also contends that his age might be a barrier to finding suitable employment, because potential employers might favor younger job candidates. Gutta fails to appreciate that the Group Policy provides disability insurance and not unemployment insurance or a retirement pension. Standard reasonably determined that Gutta has the ability to perform at least sedentary work and that he has the requisite educational background and experience to work as a medical administrator.

The Plan asserted a Counterclaim against Gutta to recover $73,996.75 in overpaid benefits. Unbeknownst to the Plan, at the same time Gutta was collecting disability benefits under the Group Policy, he also was collecting disability benefits under a group insurance policy issued by Sentry Life Insurance Company, through his membership in the American Medical Association. The Group Policy's reimbursement provision—which is designed to minimize the risk that plan participants might have a greater financial incentive to seek disability status than to continue working—prohibits Gutta from double-dipping and obtaining full disability benefits from multiple group policies. By retaining these identifiable funds, Gutta has been unjustly enriched. The Plan's claim for restitution arises under 29 U.S.C. §1132(a)(3) or, alternatively, the federal common law of ERISA.

ARGUMENT

I. Standard Of Appellate Review.

A district court's grant of summary judgment pursuant to Fed. R. Civ. P. 56 is reviewed by the appellate court *de novo*. *Reich v. Ladish Company, Inc.*, 306 F.3d 519, 522 (7th Cir. 2002), *citing Anslett v. Eagle-Picher Indus., Inc*., 203 F.3d 501, 503 (7th Cir. 2000). A district

court's factual determination that the parties failed to reach a "meeting of the minds" as to the essential terms of a purported settlement should not be overturned on appeal unless clearly erroneous. *Baptist v. City of Kankakee*, No. 05-4034, 2007 WL 789583, at *3 (7th Cir. Mar. 19, 2007).

II. The Group Policy Contains Clear Language Granting Discretionary Authority To Standard.

Judicial review of an ERISA fiduciary's benefit determination is *de novo* unless the plan documents contain discretionary language. When the plan documents contain discretionary language, however, courts review the fiduciary's benefit determination by applying the "arbitrary and capricious" standard. *Hess v. Reg-Ellen Mach. Tool Corp.*, 423 F.3d 653, 658 (7th Cir. 2005); *Hackett v. Xerox Corp. Long Term Disability Plan*, 315 F.3d 771, 773 (7th Cir. 2003).

An ERISA plan adequately confers discretion when its language conveys that the fiduciary "has the latitude to shape the application, interpretation, and content of the rules in each case." *Diaz v. Prudential Ins. Co. of America*, 424 F.3d 635, 637-638 (7th Cir. 2005). Although the court has suggested certain "safe harbor" language as sufficient to confer discretion, the court has refused to make that language obligatory. *Id.*, at 637. *Accord, Patton v MFS/Sun Life Financial Distributors, Inc.*, No. 05-4765, 2007 WL 730577, at * n. 5 (7th Cir. Mar. 12, 2007). Indeed, the court has acknowledged that it "could imagine an almost infinite set of verbal formulations" that would be sufficient to confer discretionary authority. *Diaz*, 424 F.3d at 638. The absence of the word "discretion," therefore, "[d]oes not compel the conclusion that the administrator does *not* have discretion." *Id.*, at 637, *citing Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000).

The Group Policy's "Allocation of Authority" provision satisfies *Diaz* by providing that Standard has the complete and exclusive authority to shape the application, interpretation and content of the rules in evaluating a participant's claim for disability benefits:

> **ALLOCATION OF AUTHORITY**
> Except for those functions which the Group Policy specifically reserves to the Policyowner or Employer, we [Standard] have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.
>
> Our authority includes, but is not limited to:
>
> 1. The right to resolve all matters when a review had been requested;
>
> 2. The right to establish and enforce rules and procedures for the administration of the group Policy and any claim under it;
>
> 3. The right to determine:
>
> a. Eligibility for insurance;
> b. Entitlement to benefits;
> c. The amount of benefits payable; and
> d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.
>
> Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

(R. 93-1, Joint Apdx. Ex. A, Group Policy - Amendment 8). The district court appropriately determined that "[t]he full and exclusive ability to resolve any questions regarding the plan's administration, interpretation, and application when administering benefits is another way of saying that the plan administrator has discretion." (R. 120, pg. 23).

Gutta nevertheless persists in arguing that the "Allocation of Authority" provision fails to apprise Plan participants that discretionary review is envisioned. Gutta contends that the "Allocation of Authority" provision merely serves the routine function of identifying Standard (as opposed to some other entity) as the party responsible for deciding disability claims, as in

Ingram v. Martin Marietta Long Term Disability Plan, 244 F.3d 1109 (9th Cir. 2001). (Pl. App. Br., pg. 19).[8] The *Ingram* court held that the following language is insufficient to confer discretionary authority: "[t]he carrier solely is responsible for providing the benefits under this Plan." *Id*., at 1112. An allocation of general decision-making authority, Gutta maintains, is not the equivalent of a grant of discretionary authority.

In contrast with the plan language at issue in *Ingram*, the Group Policy's "Allocation of Authority" provision confers broad discretionary powers upon Standard, consistent with the requirements of *Diaz*. Standard has the "*full and exclusive authority*" to "*resolve all questions*" regarding the Plan's administration, interpretation, and application. Standard's authority includes the "*full and exclusive authority…to interpret* the Group Policy and *resolve all questions* arising in the administration, interpretation, and application of the Group Policy." Standard has the "*right to establish and enforce rules and procedures*," the "*right to resolve all matters* when a review has been requested," and the "*right to determine*" the "*sufficiency* and the *amount* of information" that Standard may reasonably require to determine a participant's "entitlement to benefits." (Def. R56, ¶ 9) (emphasis added). The "Allocation of Authority" provision, to be sure, is far more descriptive of Standard's broad discretionary powers than merely stating, in conclusory fashion, that Standard has "discretion."

Gutta represents to the court that two district court cases from the Ninth Circuit, *Bode v. St. Joseph's Health Sys. Home Health Agency Long Term Disability Plan*, 298 F.Supp.2d 918 (C.D. Cal. 2003) and *Reilly v. Standard Ins. Co.*, No. 03 C 5423, 2004 WL 2002434 (N.D. Cal. Sep. 8, 2004), considered the exact same "Allocation of Authority" language at issue in the present case and found it insufficient to confer discretion. (Pl. App. Br., pg. 18). These two district court decisions, however, conflict with the Ninth Circuit's holding in *Bendixen v.*

[8] Citations to "Pl. App. Br." are to the Brief and Appendix for Plaintiff-Appellant.

Standard Ins. Co., 185 F.3d 939, 943 (9th Cir. 1999), which also considered the exact same "Allocation of Authority" provision *sub judice* and held that it unambiguously confers discretion. *See also Abatie v. Alta Health & Life Ins. Co*., 458 F.3d 955 (9th Cir. 2006); *Twomey v. Delta Airlines Pilots Pension Plan*, 328 F.3d 27, 31 (1st Cir. 2003); *McElroy v. Smithkline Beecham Health & Welfare Benefits Trust Plan*, 340 F.3d 139, 141 (3rd Cir. 2003) (all of which hold that plan documents granting to the administrator the authority to interpret the plan and make final and binding benefit eligibility determinations constitutes a grant of discretionary authority).

Because the "Allocation of Authority" provision clearly states that Standard has the full and exclusive authority to resolve all questions regarding the Group Policy's administration, interpretation, and application, including the final authority to decide the amount and sufficiency of the evidence submitted, Standard has discretionary authority under ERISA. The district court, therefore, correctly applied the arbitrary and capricious standard of review.

III. Standard Had A Reasonable Basis To Decline Gutta's Disability Claim Under The "Any Gainful Occupation" Definition Of Disability.

Under the arbitrary and capricious standard of review, the administrator's decision should be upheld by the court as long as "it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome…." *Houston v. Provident Life And Accident Ins. Co.*, 390 F.3d 990, 995 (7th Cir. 2004), *quoting Exbom v. Central States, Southeast & Southwest Areas Health & Welfare Fund*, 900 F.2d 1138, 1142-43 (7th Cir. 1990). Questions of judgment, including the weight and sufficiency of the medical and vocational evidence, are left to the discretion of the administrator. *Dougherty v. Indiana Bell Telephone Co*., 440 F.3d 910, 917 (7th Cir. 2006). "Put simply, an administrator's decision will not be overturned unless it is 'downright unreasonable.'" *Davis*, 444 F.3d at 576, *quoting Sisto v. Ameritech Sickness &*

Accident Disability Benefit Plan, 429 F.3d 698, 700 (7th Cir. 2005), *quoting Tegtmeier v. Midwest Operating Engineers' Pension Fund*, 390 F.3d 1040, 1045 (7th Cir. 2004).

Standard evaluated all of Gutta's medical records in depth, consulted three well qualified physicians and a vocational expert, and articulated a reasonable basis for its decision to decline his claim under the "any gainful occupation" definition of disability.

A. Standard reasonably determined that Gutta was not disabled from "any gainful occupation" due to an ophthalmologic or orthopedic condition.

When Gutta submitted his disability claim to Standard under the "any gainful occupation" definitions of disability, he emphasized vision problems as his primary impairment, namely, a scotoma in his peripheral field of vision and macular degeneration. After Standard obtained objective medical evidence establishing that Gutta has 20/20 vision, his scotoma is minor and non-limiting, and that he does not have macular degeneration at all, Gutta changed course and attempted to cobble together a disability claim based on a litany of minor orthopedic conditions.

In declining Gutta's "any gainful occupation" disability claim based on purported vision impairments, Standard reasonably relied on the medical opinions of Dr. Weinberg, an ophthalmologist who performed an IME of Gutta. Dr. Weinberg detected absolutely no pupillary defect, no evidence of macular degeneration, normal peripheral and arteriole retinas and 20/20 vision in both eyes. (R. 89, Def. Supp. LR56.1, ¶¶ 11-15). Dr. Weinberg concluded that Gutta has "*no restriction* on his physical abilities" whatsoever due to any ophthalmologic condition. (R. 89, Def. Supp. LR56.1, ¶ 17) (emphasis added).

Even Gutta's treating ophthalmologist, Dr. Raichand, was unable to identify any clinical evidence to substantiate Gutta's claim of a disabling ophthalmologic impairment. To the

contrary, Dr. Raichand was surprised to learn that Gutta was claiming to be disabled by an eye condition. (R. 89, Def. Supp. LR56.1, ¶¶ 6-7).

Standard clearly has rational support for its decision to decline Gutta's disability claim based on a purported ophthalmologic condition, in light of the objective medical evidence and the clinical opinions of Dr. Weinberg. *See, e.g., Chionis v. Group Long Term Disability Plan for Edward Health Services Corp*., No. 04 C 4120, 2006 WL 1895951 (N.D. Ill. July 7, 2006) (holding that it was reasonable for the administrator to decline an ophthalmologic disability claim submitted by the plaintiff, based on the opinion of an ophthalmologist who reviewed the plaintiff's medical records).

Even though Gutta emphasized vision problems as his primary disability, he switched course during his administrative appeal and emphasized multiple orthopedic conditions in his neck, wrists, knees and shoulders as his primary basis for seeking disability benefits. He attempted to garner after-the-fact support for an orthopedic disability by submitting (on May 14, 2004) responses from Dr. Vikram Gandhi to questions on a functional capacity questionnaire. (R. 88-8, Joint LR56.1, ¶ 50). On the questionnaire, Dr. Gandhi identified extreme limitations in Gutta's ability to walk (limited to ½ to 1 block), stand (limited to 10 minutes), and move his head in any direction (he can "rarely" turn his head right, left, up, down or even hold his head steady). Dr. Gandhi opined that these limitations began as early as November 30, 1999. (R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 0988). Gutta relies on Dr. Gandhi's questionnaire as the principal, if not exclusive, evidence of orthopedic restrictions and limitations.

The documents in the administrative record, however, raise serious doubts about the reliability of Dr. Gandhi's conclusions. On his APS dated September 15, 2000, Dr. Gandhi noted "dislocated left thumb" as Gutta's sole orthopedic problem. Dr. Gandhi identified

restrictions and limitations only with respect to Gutta's ability to wear sterile gloves for prolonged periods. But on the functional capacity questionnaire, Dr. Gandhi identified extreme limitations in Gutta's ability to walk, stand, and move his head. (R. 88-8, Joint LR56.1, ¶ 55-56). Dr. Gandhi somehow opined that these extreme limitations began as early as November 30, 1999, which predates Dr. Gandhi's APS and is long before Gutta even claimed to be disabled. (R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 0988). Dr. Gandhi's opinions in the functional capacity questionnaire, therefore, are inconsistent with his opinions in the APS.

The extreme orthopedic limitations noted in Dr. Gandhi's functional capacity questionnaire also conflict with the opinions of Gutta's orthopedic surgeon, Dr. Romeo. Despite Dr. Gandhi's opinion that Gutta's orthopedic limitations began as of November 30, 1999, Dr. Romeo opined, on April 5, 2001, that Gutta was able to return to playing golf without any restrictions or limitations whatsoever. (R. 88-8, Joint LR56.1, ¶ 35). Gutta's golf activities clearly require prolonged standing, walking, head and neck movements, as well as substantial flexibility of the shoulders, wrists and knees, far in excess of Dr. Gandhi's exaggerated restrictions and limitations.

Standard, moreover, consulted two physiatrists who specialize in orthopedic conditions, Dr. Carlson and Dr. Shih. Dr. Carlson opined that Dr. Gandhi's restrictions and limitations in the functional capacity form are exaggerated and unsupported by clinical findings. (R. 88-8, Joint LR56.1, ¶ 63). Dr. Carlson opined that the medical records (i) fail to substantiate the existence of "an active cervical or lumbosacral radiculopathy or any significant impairment related to the radiculopathy," and (ii) fail to substantiate "degenerative knee arthritis, or any significant limitations in relation to hip arthritis or lumbar spine degenerative abnormalities."

Dr. Carlson concluded that Gutta is "capable of performing sedentary to light-level capacity work on a full time basis." (R. 88-8, Joint LR56.1, ¶¶ 61-63).

Dr. Shih, based on his evaluation of the medical records, opined that Gutta would be able to perform sedentary to light level work activities, and that reasonable restrictions would be for Gutta simply to alternate positions every 30 to 60 minutes. (R. 88-8, Joint LR56.1, ¶¶ 66-67).

Gutta, in his Appellate Brief, distorts Dr. Shih's reasonable restrictions. Gutta argues that in order to comply with Dr. Shih's restrictions, he would need to alternately sit for 30 to 60 minutes and then stand for 30 to 60 minutes, rendering him incapable of sedentary activity for half of the working day. (Pl. App. Br., pg. 23). But that is not what Dr. Shih's reasonable restrictions envision. Dr. Shih recommended that Gutta shift positions, and clearly did not prohibit Gutta from sitting for half of the working day. To the contrary, Dr. Shih specifically opined that his restrictions "will not preclude [Gutta] from full-time work in a sedentary or light-level capacity." (R. 88-8, Joint LR56.1, ¶¶ 66-67; R. 89, Def. Supp. LR56.1, ¶ 20).

Standard acted reasonably, therefore, in declining Gutta's "any gainful occupation" disability claim, based on the reliable medical opinions of Dr. Carlson, Dr. Shih, Dr. Weinberg, Dr. Raichand and Dr. Romeo, and in discounting the exaggerated limitations in Dr. Gandhi's functional capacity questionnaire. *See Davis*, 444 F.3d at 578 ("[r]eaching a decision amid such conflicting medical evidence is a question of judgment that should be left to [the administrator] under the arbitrary and capricious standard").

B. Standard reasonably determined that Gutta has the educational background and experience to work in "any gainful occupation" as a medical director.

ERISA does not require a "full-blown" investigation into an insured's vocational skills, though a plan administrator should have sufficient evidence to reach a reasonable decision. *O'Reilly v. Hartford Life & Accident Ins. Co*., 272 F.3d 955, 961 (7th Cir. 2001), *citing Quinn v.*

Blue Cross & Blue Shield Association, 161 F.3d 472, 476-477 (7th Cir. 1998). Questions about the thoroughness of a vocational evaluation become less relevant when the insured demonstrates his vocational skills by actually working. *See O'Reilly*, 272 F.3d at 962 (when the plaintiff demonstrated his vocational skills by working as an actuary on a part time basis, "[t]here was no necessity to inquire further about the transferability of [his] skills.").

Standard reasonably determined that Gutta has the educational background and experience to work as a medical director or assistant medical director of a health insurance plan, based on Gutta's extensive administrative experience, knowledge of the managed care system, and leadership role in several professional organizations.

According to the occupational description published in the Warren Surveys,[9] a medical director or assistant medical director must have an M.D. degree, knowledge of the managed care system, reimbursement methods, treatment protocols and may report to executive officers. (R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 1026). Standard reasonably determined that Gutta satisfies these requirements. Gutta was in private practice as a general surgeon/surgical oncologist from 1980-2000 with surgical privileges in seven hospitals. Gutta served as the Chairman of the Department of Surgery at Loretto Hospital from 1989 to 1992; as the President of the Medical Staff at Loretto Hospital from 1993 to 1995; as the Medical Director of Loretto Hospital from 1993 to 1995; as the Chairman of the Department of Surgery at Oak Park/Rush Hospital from April 2000 to December of 2001; and as the President of Glen Oaks Hospital from January 2001 to December of 2002. (R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND at 0946-948).

[9] The Warren Surveys, published by DeMarco Healthcare, provides occupational and salary information about health care professionals based on surveys of HMO, physician/hospital and university health systems. *See* http://www.demarcowarren.com/index.shtml and http://www.demarcowarren.com/brochures.shtml.

Gutta also assumed a leadership role within the Chicago Medical Society. He served as chairman of the Quality Control Committee, and as a member of the Health Care Delivery Committee, Physicians Advocacy Committee, Physician Review Committee, and Third Party Payment Processes Committee. (R. 106, Def. Response to Pl. Supp. LR56.1, ¶¶ 24, 30; R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 0980-985). As a member of these committees, Gutta was responsible for evaluating the quality and propriety of general physician care, developing and implementing medical policy, and evaluating third party payment procedures (*i.e.*, insurance and managed care). (R. 93-3, Joint Apdx. Ex. D, Admin. Rec. at STND 0946). Gutta, to be sure, touted his administrative experience in his Employee's Statement:

> I have responsibility to perform administrative job as a chairman of the department of surgery (Honorary) and chairman of the department quality improvement, member of executive committees at three different hospitals, member of cancer committees, and member of quality control committee.

(R. 106, Def. Response to Pl. Supp. LR56.1, ¶ 24).

Nevertheless, Gutta speculates that it might be difficult for him to secure a job, because employers might prefer to hire younger job applicants over older ones (though he lacks empirical data to support this assertion). Gutta contends that Standard should have evaluated his "employability" according to Social Security guidelines. In the Social Security context, the administrative law judge must consider factors such as the claimant's age and the general state of the economy.

There are "critical differences," however, between the Social Security disability program and voluntary disability benefit plans. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832-833 (2003). Unlike Social Security, ERISA plans are voluntary programs established as a matter of contract. Unless specifically required by the terms of an ERISA plan, administrators

are not obliged to consider an insured's age in evaluating disability. As stated by the court in *Hillery v. Metropolitan Life Ins. Co*., 453 F.3d 1087, 1092 (8th Cir. 2006):

> Hillery also asserts that MetLife breached its fiduciary duty when it did not consider her age and her length of unemployment. As she concedes, there is no Eighth Circuit or ERISA requirement that a plan administrator consider age, if not specifically required by the plan. And while she argues, without providing any evidence, that very few employers will hire a 54-year-old woman, the plan's plain language states that a person be able only to work a job for which she is, or can become, qualified. The plan does not speak to the difficulty of getting that job.

See also Block v. Pitney Bowes Inc., 952 F.2d 1450, 1455 (D.C. Cir. 1992) ("No provision required Pitney Bowes, as a condition of terminating Block's compensation, to 'ensure the availability of an alternative job.'"); *Couzens v. Equitable Life Assurance Society of the United States*, No. 98 C 527, 1998 WL 695425, at *4 (E.D. Pa. Oct. 2, 1998) ("The Court will not rewrite the clear and unambiguous definition of 'total disability' to mean that an applicant for long-term disability is totally disabled when that applicant is not able to find a job.").

Some ERISA plans specifically provide for consideration of the claimant's employability, including potential barriers to employment such as age. *See, e.g. Bacquie v. Liberty Mutual Ins. Co*., 435 F.Supp.2d 318, 324 n. 6 (S.D.N.Y. 2006); *Pannebecker v. Liberty Life Assurance Co. of Boston*, No. 01 CV 825, 2006 WL 2374845, at *1 (D.Ariz. Aug. 16, 2006). But that is not the type of coverage that the Gutta Clinic purchased. The focus of the Group Policy's definition of "disability" is on the claimant's functional capacities and vocational qualifications, not on whether the claimant actually can land a job.

It might be true that certain employers exhibit bias in their hiring practices and favor young job candidates, whether rightly or wrongly. There may be other barriers to employment, such as religion or national origin. But it is inappropriate for Gutta to attempt to use a privately funded ERISA plan as a panacea for every perceived obstacle in the employment marketplace.

Gutta has the education, training and experience to work as a medical director or assistant medical director. That Gutta theoretically might have difficulty securing employment may render him retired or unemployed, not disabled. *See Smith v. Business Men's Assurance Co. of America*, 971 F.Supp. 369 (C.D. Ill. 1997) ("The ERISA plan at issue is not unemployment insurance").

IV. The District Court Properly Granted Standard Select's Request For Restitution Of Overpaid Benefits.

Congress, in enacting ERISA, sought to ensure that employee benefits are administered equitably and that no party, not even plan participants, should unjustly profit. To achieve this goal, "courts should confine the benefits to the terms of the plans as written." *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Varco*, 338 F.3d 680, 692 (7th Cir. 2003), *cert. denied*, 542 U.S. 945 (2004), *citing Pohl v. National Benefits Consultants, Inc*., 956 F.2d 126, 128 (7th Cir. 1992). *See also Northcutt v. General Motors Hourly-Rate Employees Pension Plan*, 467 F.3d 1031, 1038 (7th Cir. 2006) (acknowledging "[t]he important role that reimbursement of overpaid plan benefits plays in the continuing viability of plans for all other beneficiaries….").

Consistent with Congress's objectives, the district court enforced the provision of the Group Policy that requires Gutta to reimburse the Plan for overpaid benefits. Specifically, the Group Policy provides an offset for "Income From Other Sources," which includes the amount of disability benefits received by Gutta under any group insurance coverage. (R. 88-8, Joint LR56.1, ¶ 7). The Group Policy's reimbursement provision prevents Plan participants from recovering full disability benefits from multiple group policies, thereby diminishing the risk that participants might have a greater financial incentive to seek disability status than to continue working.

There is no dispute that Gutta, while receiving monthly disability benefits totaling $75,846.75 under the Group Policy from November 22, 2000 to December 21, 2003, also was receiving monthly disability benefits totaling $129,500.00 during the same time period from Sentry Life Insurance Company, pursuant to group coverage he had obtained through membership in the American Medical Association. (R. 89, Def. Supp. LR56.1, ¶ 21). The benefits received by Gutta from Sentry Life offset the benefits he received from the Plan under the Group Policy.[10]

The Plan's right to recover overpaid benefits—totaling $73,996.75—is authorized by §502(a)(3), pursuant to *Sereboff v. Mid Atlantic Medical Services, Inc*., 126 S.Ct. 1869 (2006), or alternatively, by the federal common law of ERISA, pursuant to *Leipzig v. AIG Life Ins. Co*., 362 F.3d 406 (7th Cir. 2004).

A. Standard Select's right to restitution is authorized by §502(a)(3) or, alternatively, the federal common law of ERISA.

In the wake of *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), courts interpreted §502(a)(3) narrowly to allow claims for restitution only when specifically traceable funds are in the insured's possession. If the insured subsequently dissipated those funds or commingled them with his general assets, courts foreclosed plans from seeking restitution under §502(a)(3) on the basis that the claim sought primarily legal relief (*i.e*., monetary damages to be satisfied out of the insured's general assets) rather than equitable relief (*i.e*, the turn-over of specifically identifiable funds).

[10] The disability benefits payable to Gutta under the Group Policy from November 22, 2000 to December 21, 2003 should have been $50.00 per month (or a total of $1,850.00), which is the Group Policy's minimum monthly benefit amount, rather than the $75,846.75 in fact paid to Gutta during that period. (R. 89, Def. Supp. LR56.1, ¶ 31).

In some federal circuits, therefore, ERISA plans largely have been left without any avenue to obtain reimbursement under ERISA. *See, e.g., Qualchoice, Inc. v. Rowland*, 367 F.3d 638 (6th Cir. 2004), *cert. denied*, 544 U.S. 942 (2005); *Cooperative Benefit Administrators, Inc. v. Ogden*, 367 F.3d 323, 332 (5th Cir. 2004). In other federal circuits (including the Seventh Circuit), however, courts have recognized a right to seek legal relief under the federal common law of ERISA. *See, e.g., Leipzig*, 362 F.3d at 410 (acknowledging the existence of a federal common law restitution claim, over which there is no federal question jurisdiction).

The traceability requirement judicially grafted onto restitution claims in the wake of *Great-West* essentially turned §502(a)(3) into an empty promise, as least for plans and plan fiduciaries seeking restitution of overpaid benefits. The Supreme Court took corrective action in *Sereboff*. Pursuant to *Sereboff*, the Plan's Counterclaim for restitution properly seeks equitable relief under §502(a)(3), because it is indistinguishable from an action to enforce an equitable lien by agreement. *See Sereboff*, 126 S.Ct. at 1875 (holding that the plan's third-party reimbursement provision "specifically identified a particular fund, distinct from the [beneficiaries'] general assets—'[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)'—and a particular share of that fund to which [the administrator] was entitled—'that portion of the total recovery which is due [the plan fiduciary] for benefits paid.'").[11]

As a Plan participant, Gutta agreed to reimburse the Plan in the event his disability claim was overpaid as a result of his receipt of "Income From Other Sources." (R. 93-1, Joint Apdx. Ex. A, Group Policy, pg. 28). During each month in which Gutta received benefits from Sentry Life, an equitable lien attached upon the disability benefits that Gutta received from the Plan for

[11] *Sereboff* clarified that equitable relief was unavailable in *Great-West* simply because the sought-after funds had *never been* in the possession of the insured (the funds were in a trust account controlled by the State of California), and not because the funds could not be specifically traced. *Sereboff*, 126 S.Ct. at 1876, *citing Great-West Life & Annuity Ins. Co.*, 534 U.S. at 214.

the corresponding month, in the amount of the offset. Like the administrator in *Sereboff*, the Plan seeks specifically identified funds distinct from Gutta's general assets (the amount of benefits paid by the Plan to Gutta each month) and a particular share of those funds to which the Plan was entitled (all overpayments during the period from November 22, 2000 to December 21, 2003 resulting from Gutta's receipt of benefits from Sentry Life for the corresponding period).

The amount of overpaid disability benefits received by Gutta each month are specifically identifiable funds in Gutta's possession. By retaining those funds, Gutta has been unjustly enriched. That Gutta subsequently disbursed or commingled the Plan's funds—thereby thwarting strict traceability—does not defeat the Plan's claim for equitable relief. *See Sereboff*, 126 S.Ct. at 1876.

Pursuant to *Sereboff*, the Eight Circuit Court of Appeals, in *Dillard's Inc. v. Liberty Life Assurance Co. of Boston*, 456 F.3d 894 (8th Cir. 2006), held that an action for reimbursement of overpaid benefits based on the insured's receipt of Social Security benefits (which are an offset under the plan) properly arises under §502(a)(3). As stated in *Dillard's*:

> The present case is analogous to *Sereboff* in that Liberty seeks reimbursement for amounts paid to [the insured] from a third-party source, the Social Security Administration. [L]iberty seeks a particular share of a specifically identified fund—all overpayments resulting from the payment of social security benefits. Accordingly, Liberty's complaint constitutes a request for equitable relief [.]

Id. at 901.

The Eleventh Circuit Court of Appeals, on the other hand, in *Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006), interpreted *Sereboff* too narrowly. The *Popowski* court held that, in order to create an equitable lien by agreement, the plan's reimbursement language not only must identify a specific fund in the insured's possession that properly belongs to the plan fiduciary,

but also must expressly state that the insured must satisfy his reimbursement obligation utilizing specific monies "out of" that particular fund. *Id*., at 1373-1374.

According to *Sereboff*, however, when an insured promises to reimburse the plan in the event his claim is overpaid, an equitable lien properly attaches to the funds upon the insured's receipt of the overpayment. The equitable lien attaches because the insured receives specifically identifiable monies that properly belong to the plan, which the insured promised to reimburse. Nothing in *Sereboff* requires that the plan must contain precise language requiring the insured to satisfy his reimbursement obligation using only monies "out of" that particular fund.

In *Barnes v. Alexander*, 232 U.S. 117 (1914), on which the *Sereboff* Court relied in discussing the origins of equitable liens by agreement, attorney Barnes orally agreed to pay attorneys Street and Alexander one-third of any fees obtained in representing Barnes's client. Barnes's promise created an equitable lien by agreement on a specifically identifiable fund. Barnes, however, did not promise to satisfy her payment obligation exclusively "out of" specific monies from that fund, yet that did not foreclose Street and Alexander from seeking equitable relief. It was sufficient to obtain equitable relief that Barnes obtained possession of an identifiable fund that properly belonged to Street and Alexander.

Even if the Plan's Counterclaim were to be construed as seeking primarily legal relief, the Plan is entitled to recover overpaid benefits pursuant to the federal common law of ERISA. Although Gutta somehow disputes this, the authority of federal courts to develop a federal common law of ERISA is well established. The Supreme Court has emphasized that Congress intended for federal courts to develop a federal common law of ERISA, in order to fill the gaps left by Congress in ERISA's statutory scheme. *Firestone Tire & Rubber Co. v. Bruch,* 849 U.S. 101, 110 (1989) ("[w]e have held that courts are to develop a 'federal common law of rights and

obligations under ERISA-regulated plans.'"), *quoting Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). *See also Senkier v. Hartford Life and Accident Ins. Co.*, 948 F.2d 1050, 1051 (7th Cir. 1991) (acknowledging the judiciary's authority to develop a federal common law of ERISA).

Prior to *Sereboff*, the court in *Leipzig* acknowledged that AIG, as a fiduciary of the plan, may pursue a legal claim for restitution under the federal common law of ERISA. Although the court in *Leipzig* ultimately dismissed AIG's restitution claim, it did so solely on jurisdictional grounds, because AIG failed to invoke federal jurisdiction under 28 U.S.C. §1367(a). The court nonetheless recognized that AIG could pursue its legal claim for restitution as a federal common law claim in state court:

> State courts were, and remain, empowered to entertain claims arising under federal law. Although today almost every federal claim can be heard in federal court under §1331, *Great-West* shows that there are still lacunae. AIG can pursue its claim in state court without encountering a defense of preemption; ERISA preempts state-law theories, not claims arising under federal law.

Leipzig, 362 F.3d at 410.

The holding in *Leipzig* is consistent with prior Seventh Circuit authority incorporating principles of unjust enrichment and restitution into the common law of ERISA. *See, e.g., Operating Engineers Local 139 Health Benefit Fund v. Gustafson Construction Corp*., 258 F.3d 645, 651 (7th Cir. 2001) ("The payor's rights are governed by the principles of the law of restitution. The propriety of the court's incorporating those principles [of restitution] into the common law of ERISA cannot be doubted") (citations omitted); *Harris Trust and Savings Bank v. Provident Life and Accident Ins. Co*., 57 F.3d 608, 615 (7th Cir. 1995) (recognizing the validity of the plaintiff's claim for restitution based on alternative theories of §502(a)(3) and the federal common law of ERISA). *See also Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985

(4th Cir.), *cert. denied*, 498 U.S. 982 (1990) ("[i]t is appropriate for a federal court to weave into the statutory fabric of ERISA the federal common law remedy of unjust enrichment").

Unlike the insurer's counterclaim in *Leipzig*, the Plan's Counterclaim expressly invokes §1367(a) as its jurisdictional basis. (R. 29, Ex. A, Counterclaim, ¶ 6). The Plan, therefore, has asserted in its Counterclaim precisely the type of federal common law restitution claim that the Seventh Circuit recognized in *Leipzig*.

B. The benefits received by Gutta under his Sentry Life coverage properly constitute "Income From Other Sources."

Gutta attempts to circumvent his reimbursement obligation by characterizing his Sentry Life coverage as "franchise insurance" and not group insurance, and thus outside of the ambit of the Group Policy's offset provision. Gutta incorrectly cites to *Hall v. Life Ins. Co. of North America*, 317 F.3d 773 (7th Cir. 2003) as authority that insurance coverage obtained by a member of a professional organization—in that case, the Society of Certified Public Accountants—always constitutes franchise insurance and not group insurance. (Pl. App. Br., pg. 33).

The court in *Hall* determined, however, that it was unnecessary to classify the plaintiff's coverage as either franchise insurance or group insurance, because the ERISA plan's offset provision applied to both types of coverage. *Id*. at 776. The holding in *Hall*, therefore, does not compel the conclusion that Gutta's Sentry Life coverage must be franchise insurance, as Gutta maintains.

As in *Hall*, the classification of Gutta's Sentry Life coverage as either group insurance or franchise insurance is neither necessary nor outcome determinative. The Group Policy broadly provides an offset for "[t]he amount you receive or are eligible to receive because of your disability under *any group insurance coverage*, other than group credit insurance or group mortgage disability insurance[.]" (R. 89, Def. LR56.1, ¶ 5) (emphasis added). The Group Policy

also identifies, as an exception to the offset provision, "[b]enefits from any individual disability insurance policy." (R. 93-1, Joint Apdx Ex. A, Group Policy, pg. 27, sec. 2(e)). Gutta's Sentry Life coverage clearly is not group credit or group mortgage insurance, nor is it an individual disability insurance policy (because Gutta received a Certificate of Insurance and not a stand-alone individual policy). *Hall* acknowledges that "[f]ranchise insurance is a variation on group insurance, in which all members of the group receive individual insurance policies." *Hall*, 317 F.3d at 776, *quoting* 1 *Couch on Insurance*, §1:29 (3rd ed. 2002). Even if Gutta's Sentry Life coverage reflects a franchise insurance relationship, franchise insurance, as a variation on group insurance, is subsumed within the Group Policy's broad category of *any group insurance coverage*, and does not fall within any of the Group Policy's exceptions to "Income From Other Sources."

Moreover, *Hall* actually suggests that coverage obtained through a professional organization like the Society of Certified Public Accountants qualifies as "group insurance coverage" as defined in *Couch on Insurance*. *Hall*, 317 F.3d at 776 ("It looks very much as if the [CPA] policy is 'group insurance' under this definition…."). *Couch on Insurance* distinguishes between group insurance and franchise insurance based on how the overall insurance relationship is structured. Group insurance entails three parties: the insurer, a central entity (to whom the policy is issued), and the group members (who typically receive certificates of insurance):

> Group insurance involves three parties: the employer or other "central entity," the insurer, and the insured group members. A group insurance policy is the contract between the insurer and an employer, association, creditor, or some other central entity, for the benefit of a group of people that have some relationship to the central entity, such as employees, association members, or debtors.

> [I]ndividual group members typically receive certificates proving they are insured and listing what coverage is provided. Thus, group insurance policies are "contracts for the benefit of third parties."

1A *Couch on Insurance*, §7:1.

Franchise insurance, on the other hand, avoids the tripartite relationship that is generally characteristic of group insurance. In franchise insurance, the insured contracts directly with the insurer and receives an individual insurance policy:

> Group insurance is an arrangement by which a single insurance policy is issued to a central entity—commonly an employer, association, or union—for coverage of the individual members of the group. *Franchise insurance is a variation on group insurance, in which all members of the group receive individual policies.* While franchise insurance avoids the 3-party relationship that complicates group insurance, it multiplies the administrative burden for insurers, and is not nearly as common as group insurance.

1 *Couch on Insurance*, §1:29 (emphasis added).

Gutta's Sentry Life coverage displays all the hallmarks of group insurance coverage. Gutta received a "Certificate of Insurance" from Sentry Life, the AMA group underwriter, rather than an individual insurance policy. The Certificate of Insurance expressly acknowledges that Gutta's coverage was obtained under "Group Policy No. 90-10613-47" and is "subject to all the provisions, definition, limitations and conditions of said policy…." Gutta's Sentry Life coverage reflects a three-party relationship between Sentry Life and the AMA as the contracting parties, and the AMA members (including Gutta) as third-party beneficiaries of Group Policy No. 90-10613-47. Gutta's Sentry Life coverage, therefore, fits exactly within the definition of group insurance described in *Couch on Insurance*.

C. Gutta may not obviate the Group Policy's reimbursement provision by application of the state law voluntary payment doctrine.

Gutta argues that the Plan's federal right to obtain restitution under ERISA should be barred by the state law voluntary payment doctrine. This state law doctrine provides that "a person who voluntarily pays another with *full knowledge* of the facts will not be entitled to restitution." *Randazzo v. Harris Bank Palatine, N.A.*, 262 F.3d 663, 667 (7th Cir. 2001) (emphasis added). Gutta, by characterizing the Plan's overpayment of benefits as "voluntary," contends that he should be entitled to retain the $73,996.75 windfall.

The Plan, however, did not voluntarily pay benefits to Gutta with *full knowledge* of the facts of his Sentry Life group insurance coverage. The Plan did not know, at the time it approved and paid Gutta's disability claim, that Gutta's Sentry Life coverage was group insurance coverage. Gutta admits as much by acknowledging that the Plan did not have a copy of the Sentry Life Certificate of Insurance, or even know that the Sentry Life coverage was established by a certificate and not an individual policy, until after the commencement of this litigation. (Pl. App. Br., pg. 30; R. 89, Def. Supp. LR56.1, ¶¶ 26-27; R. 100, Def. Supp. Apdx., Ex. A, Affidavit, ¶ 6; R. 93-1, Joint Apdx. Ex. B, Certificate).[12]

Although Gutta portrays his argument as a straightforward application of the voluntary payment doctrine, in actuality, he improperly seeks to expand this state law doctrine in a way that is inconsistent with ERISA. According to Gutta, restitution should be barred even when the erroneous overpayment was made *without* full knowledge of the facts, if the plan theoretically could have avoided making the overpayment through further investigation. Gutta, thus, wants to

[12] Although Gutta argues that the Plan failed to reserve (and therefore waived) its right to seek restitution (Pl. Appl Br., pgs. 29, 32, 35), his argument incorrectly assumes that the Plan knew that his Sentry Life benefits qualified as an offset at the time it paid benefits. The Plan, in short, did not intentionally relinquish a known right.

adjudicate the completeness of the Plan's pre-payment investigation, while sidestepping the crucial issue of his own unjust enrichment.

Nothing within ERISA allows a plan participant to retain a windfall simply because the fiduciary's investigation arguably might have been more searching. It would be absurd to suppose that if a plan owed one of its participants $1 and by mistake tendered payment for $1 million, the participant could keep the money on the basis that the plan should have avoided making the mistake. The law of ERISA should not be determined by the principle of finders-keepers.

Otherwise, disability claimants might be less forthcoming in their disclosure of information, in order to prevent the discovery of possible offsets or reductions. Plan fiduciaries, too, would be faced with the Hobson's choice of either incurring the administrative expense of conducting a relentless and exhaustive investigation, or simply accepting the financial risk of overpaying claims. Gutta's purported "voluntary payment" theory, therefore, would increase administrative costs and undermine the financial security of employee benefit plans, contrary to the goals of ERISA.

Gutta argues that employee benefit plans should bear the financial risk of making erroneous payments, citing *Trustmark Life Ins. Co. v. University of Chicago Hospitals*, 207 F.3d 876 (7th Cir. 2000). (Pl. App. Br., pg. 31). The plaintiff in *Trustmark*, a medical insurer, sought restitution of medical expenses paid to a third party medical provider (the University of Chicago Hospitals). UCH provided valuable medical services to the insured (a bone marrow transplant) in reliance on Trustmark's written promise to pay for those services:

> [W]e cannot say that UCH does not have an honest claim to the money. UCH provided services at the market rate, was paid for those services, and was not unjustly enriched.

Id. at 883-884. The Seventh Circuit held "that Trustmark is estopped" from seeking recovery of the medical payments based on ERISA estoppel. *Id.*

Unlike the hospital in *Trustmark*, Gutta did not perform a valuable service in exchange for the insurer's promise to pay. Indeed, Gutta does not even have a legitimate claim to the Plan's $73,996.75 overpayment, because he was not entitled to receive those monies in the first place. The overpayment is purely a windfall to Gutta.

Trustmark establishes, moreover, that the appropriate federal theory to bar enforcement of the plan's reimbursement provision would be ERISA estoppel, not the state law voluntary payment doctrine. Only extreme circumstances warrant the court to override the terms of the plan through the doctrine of ERISA estoppel. *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795, 797 (7th Cir. 2000). A party must establish an intentional misrepresentation, in writing, upon which the party reasonably relied to its detriment. *Trustmark Life Ins. Co.*, 207 F.3d at 883, *citing Coker v. Trans World Airlines, Inc.*, 165 F.3d 579, 585 (7th Cir. 1999). "Arguments that negligent misrepresentations 'estop' sponsors or administrators from enforcing the plans' written terms have been singularly unsuccessful." *Decatur Memorial Hospital v. Connecticut General Life Ins. Co.*, 990 F.2d 925, 926-927 (7th Cir. 1993) (citations omitted).

Gutta, however, fails to identify any intentional written misrepresentation by the Plan or its fiduciaries, much less that he detrimentally relied any such misrepresentation. *See Elmore v. Cone Mills Corp.*, 187 F.3d 442, 446 (4th Cir. 1999) ("The reliance must take the form of a definite and identifiable action"). *See also Brosted v. Unum Life Insurance Co. of America*, 521 F.3d 459 (7th Cir. 2005) (barring the plaintiff from trying to take advantage of the defendant's mathematical error in calculating benefits and seeking a higher level of benefits than authorized

by the plan's written terms, based on the plaintiff's failure to satisfy the elements of ERISA estoppel).

It is improper for Gutta to try to circumvent the rigorous requirements of ERISA estoppel—requirements that he cannot satisfy—by invoking what he erroneously calls the "voluntary payment doctrine." Gutta violated the terms of the Group Policy and ERISA by refusing to reimburse the Plan. The district court, therefore, appropriately granted the Plan's request for restitution.

D. The Plan was not required to "exhaust administrative remedies" prior to asserting its Counterclaim.

Finally, Gutta argues that the district court should have foreclosed the Plan from asserting its Counterclaim on the grounds that it failed "to administratively exhaust its reimbursement claim[.]" (Pl. App. Br., pg. 27).

The exhaustion doctrine arises out of the requirements for a "full and fair" review under §503 of ERISA, 29 U.S.C. §1133. Section 503 requires every employee benefit plan to afford any participant or beneficiary whose claim for benefits has been denied with an opportunity for a "full and fair" review of that decision by the appropriate plan fiduciary. Section 503, by its terms, therefore, applies only to participants and beneficiaries who have received an adverse claim determination.

The Plan, however, is not a participant or beneficiary under ERISA, nor does its counterclaim for restitution qualify as an adverse claim determination. The exhaustion of administrative remedies, which typically is required when a plan participant or beneficiary seeks to recover benefits under §502(a)(1)(B), does not apply to claims for restitution under §502(a)(3) or the federal common law of ERISA, which are evaluated by the district court under a *de novo* standard. *See Reliance Standard Life Ins. Co. v. Smith*, No. 05 C 467, 2006 WL 2993054, at *3

(E.D. Tenn. Oct. 18, 2006) ("As Reliance is not a beneficiary/participant under the plan, it is not required to exhaust any administrative procedures on the overpayment claim").

The exhaustion doctrine, moreover, is a discretionary doctrine rather than a mandatory requirement of ERISA. *See, e.g., Wilczynski v. Lumbermens Mutual Casualty Co*., 93 F.3d 397, 401 (7th Cir. 1996) ("[T]he rule in this court is clear: [T]he decision to require exhaustion as a prerequisite to bringing suit is a matter within the discretion of the trial court and may be disturbed on appeal only when there has been a clear abuse of discretion."), *quoting Powell v. AT&T Communications, Inc*., 938 F.2d 823, 825 (7th Cir. 1991). The district court allowed the parties to conduct discovery with respect to the Plan's Counterclaim, so Gutta cannot legitimately contend that he was deprived of due process.[13]

V. Gutta Fails To Establish That The District Court's Denial Of His Motion To Enforce A Purported Settlement Was Clearly Erroneous.

Approximately one month after the Plan filed its Counterclaim, Gutta filed a motion to enforce a purported settlement agreement. The district court found that there was no meeting of the minds as to all essential terms of a settlement, and denied Gutta's motion. The district court's determination constitutes a finding of fact that should not be overturned unless clearly erroneous. *See, e.g., Baptist*, 2007 WL 789583, at *3. *See also Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust for Southern California*, 508 U.S. 602, 623 (1993) (Review under the clearly erroneous standard is "significantly deferential, requiring a definite and firm conviction that a mistake has been committed.").

[13] Gutta, in a footnote, incorrectly states that he was denied the opportunity to conduct discovery with respect to the Plan's Counterclaim. (Pl. App. Br., pg. 29 n. 3). The district court, however, expressly acknowledged the parties' right to conduct discovery in its August 30, 2005 Order: "The court's denial of discovery to Gutta relates to the claims asserted in Gutta's complaint (which are reviewed using an arbitrary and capricious standard of review), not Standard Select's counterclaim." (R. 40, pg. 2).

The Plan, in its Response to Plaintiff's Motion to Enforce an Alleged Settlement filed on July 28, 2005, detailed the early history of the parties' unsuccessful attempts to resolve this litigation. (R. 35). In summary, during the early stages of this lawsuit, Gutta steadfastly demanded a monetary payment as part of any settlement. The Plan, however, refused even to discuss settlement as long as Gutta continued to demand money, because Gutta's disability claim had been overpaid in the amount of $73,996.75. Due to the parties' fundamental dispute over who is indebted to whom, settlement discussions stalled in December 2004.

After several months of silence, on May 3, 2005, Gutta lowered his settlement demand to $25,000.00. The Plan, astonished by Gutta's insistence on making monetary demands, decided to file its Counterclaim and declined to respond to Gutta's latest demand. Consequently, on May 25, 2005, the Plan filed a Motion for Leave to File a Counterclaim against Gutta, which was set for hearing on June 2, 2005.

The day before that hearing, on June 1, 2005, Gutta's counsel sent an email to the Plan's counsel inquiring about his $25,000.00 settlement demand. (R. 65, Ex. A). The Plan's counsel, nonplussed by Gutta's continued monetary demands, responded that the Plan would be willing to "entertain" resolution of all disputes based on a "walk-away." (R. 65, Ex. A). The Plan thereby informed Gutta that it would resume negotiations *if* Gutta was willing to cease making monetary demands and *if* Gutta was willing to negotiate the terms of a broad release of claims.

Gutta's counsel, apparently eager to conclude a settlement on the narrowest possible terms, precipitously responded to the Plan's email within eight minutes, as follows: "Given the current posture of the case, your 'offer' is accepted." (R. 65, Ex. A). The following morning, during the June 2, 2005 hearing on the Plan's Motion for Leave to File its Counterclaim, the Plan's counsel specifically informed Gutta's counsel and the district court that there has been no

settlement. The district court, without objection from Gutta's counsel, granted leave for the Plan to file its Counterclaim. (R. 28).

The use of the word "entertain" in counsel for the Plan's June 1, 2005 email connotes the Plan's willingness to consider a non-monetary resolution *if* proposed by Gutta and to return to the negotiating table, and not a binding agreement to a dismiss all pending claims and containing no other terms. *See Random House Webster's Dictionary* (1991) (defining "entertain" in the present context as follows: "to admit into the mind; consider"). As the district court held in its August 12, 2005 Order:

> The court agrees with Standard Select that the statement that Standard Select would "entertain" the idea of a "walk-away" type settlement is not a binding agreement to enter into a settlement agreement containing no terms other than a mutual promise for the parties to dismiss their respective complaint and counter-claim. It is precisely what is says it is: an agreement to come to the table to talk about the parameters of an agreement which is premised on both sides walking away as opposed to one side paying the other side some amount of money. Simply put, there was no meeting of the minds as to an agreement whereby the parties would, without more, dismiss their claims.

(R. 39, pg. 2).

Gutta's continued effort to distort the parties' email exchange into a binding settlement agreement is particularly disturbing, because both counsel of record have handled a significant number of cases with each other. Consequently, Gutta's counsel is well aware that, as a condition of settlement *in every case*, the Plan and its counsel *always* require (i) a full and complete release of all claims (rather than merely the dismissal of the pending action), (ii) an agreement by the plaintiff never to apply for coverage from the plan's insurer, in order to prevent recidivism, (iii) an agreement by the plaintiff to surrender all coverage with the plan's insurer, and (iv) confidentiality. In the present case, Gutta has rejected each of these material terms.

After the hearing on June 2, 2005 in which the Plan obtained leave to file its Counterclaim, there were no further discussions about settlement for nearly three weeks. The Plan endeavored to break the stalemate on June 20, 2005, by proposing a settlement pursuant to a written Settlement Agreement and Release, which the Plan's co-counsel sent by email to Gutta's counsel. (R. 35, Ex. A). The proposed terms of the Settlement Agreement and Release mirror the terms that the Plan's counsel has insisted upon in the many cases they have settled with Gutta's counsel.

Gutta argues that the Plan's proposed Settlement Agreement and Release confirms that the parties had agreed to settle by reason of their June 1, 2005 email exchange. (Pl. App. Br., pg. 36). Gutta, however, fails to inform the court that (i) the Plan's counsel specifically rejected a settlement at the June 2, 2005 hearing before the district court, and (ii) Gutta's counsel specifically rejected the Plan's proposed Settlement Agreement and Release. On June 21, 2005, Gutta's counsel sent an email to the Plan's counsel, stating "[a]ttached is an annotation of the settlement agreement you tendered listing specific objections and comments." In his annotated comments, Gutta's counsel objected to the scope of the release, the confidentiality provision and the provision precluding Gutta from applying for coverage in the future. (R. 35, Ex. B). Gutta's written objections on the margins of the Plan's proposed Settlement Agreement underscores the fact that the parties do not have a "meeting of the minds" as to all the essential terms of a settlement. Accordingly, the district court's finding that the parties have not agreed to the essential terms of a settlement was appropriate and not clearly erroneous.

CONCLUSION

The Plan evaluated all of Gutta's medical records in depth, consulted qualified medical and vocational experts, and articulated a reasonable basis for its decision to decline Gutta's disability claim under the "any gainful occupation" definition of disability. The Plan's benefit determination, therefore, was reasonable, and not arbitrary and capricious. The Plan, moreover, is entitled to obtain reimbursement of overpaid benefits from Gutta. Whether the Plan's claim for restitution is characterized as an equitable claim under §502(a)(3) or a legal claim under the federal common law of ERISA, the Plan should prevail under either theory. *See Harris Trust and Savings Bank*, 57 F.3d at 615 ("We need not decide which of the two theories is applicable in the present case, however, for they are interrelated and [the Plan] would prevail under either."). Accordingly, the Plan respectfully requests that the court uphold the district court's grant of summary judgment in favor of the Plan.

Signature of Counsel of Record:

_____

Warren von Schleicher
Smith, von Schleicher & Associates
39 S. LaSalle St., Suite 1005
Chicago, Illinois 60603

CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for Defendant / Counter-Plaintiff, Standard Select Trust Insurance Plans, hereby certifies, pursuant to Fed. R. App. P. 32(a)(7)(C), that the Brief of the Defendant / Counter-Plaintiff complies with the type-volume provisions of Fed. R. App. P. 32(a)(7)(B) because this Brief contains 12,491 words excluding the parts of the Brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). In addition, this Brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this Brief has been prepared in a proportionally spaced typeface using Microsoft Word 2003, Times New Roman font in 12 point size, with footnotes in 11 point size.

Signature of Counsel of Record:

_____

Warren von Schleicher
Smith, von Schleicher & Associates
39 S. LaSalle St., Suite 1005
Chicago, Illinois 60603