

12-370-cv(L)

Thurber v. Aetna Life Ins. Co.

1
2 UNITED STATES COURT OF APPEALS

3
4 FOR THE SECOND CIRCUIT
5
6

7
8 August Term, 2012
9

10 (Argued: December 14, 2012

Decided: March 13, 2013)

11
12 Docket Nos. 12-370-cv (Lead), 12-521-cv (XAP)
13

14
15 SHARON THURBER,
16

17 *Plaintiff-Counter-Defendant-Appellant-Cross-Appellee,*
18

19 -v.-
20

21 AETNA LIFE INSURANCE COMPANY,
22

23 *Defendant-Counter-Claimant-Appellee-Cross-Appellant,*
24

25 QUEST DIAGNOSTICS, INCORPORATED WELFARE PLAN,
26 AKA THE QUEST DIAGNOSTICS' AETNA LONGTERM
27 DISABILITY BENEFIT PLAN, AKA THE QUEST
28 DIAGNOSTICS' MANAGED DISABILITY BENEFITS
29 PLAN, THE QUEST EMPLOYEE BENEFITS
30 ADMINISTRATION COMMITTEE, AS PLAN ADMINISTRATOR,
31

32 *Defendants-Appellees-Cross-Appellants.*
33
34

35
36
37 Before:

38 WESLEY, HALL, LYNCH, *Circuit Judges.*
39

40 Plaintiff-Counter-Defendant-Appellant-Cross-Appellee
41 Sharon Thurber appeals from a January 6, 2012 Decision and
42 Order by the United States District Court for the Western
43 District of New York (Skretny, J.) granting Defendant-
44 Counter-Claimant-Appellee-Cross-Appellant Aetna Life

1 Insurance Company's motion for summary judgment on the issue
2 of whether the insurer improperly denied Thurber long-term
3 disability benefits under ERISA. Thurber argues that the
4 district court used the wrong standard of review and further
5 erred by upholding Aetna's decision denying her long-term
6 disability benefits. Because Aetna's reservation of
7 discretion was sufficient to compel use of the arbitrary and
8 capricious standard of review, we AFFIRM the district
9 court's grant of summary judgment to Aetna on its denial of
10 benefits.

11 Aetna cross-appeals the portion of the district court's
12 Decision and Order denying Aetna's motion for summary
13 judgment on its counterclaim for equitable restitution of
14 overpaid short-term disability benefits. Aetna argues that
15 the plan language gave it the right to seek reimbursement of
16 overpaid benefits pursuant to 29 U.S.C. § 1132(a)(3). What
17 qualifies as "appropriate equitable relief" under ERISA is
18 an open question in this Circuit. We now hold that Aetna's
19 action seeking return of overpaid benefits was properly
20 brought under 29 U.S.C. § 1132(a)(3) as an equitable
21 counterclaim. We REVERSE the district court's denial of
22 summary judgment on the counterclaim.

23 AFFIRMED IN PART AND REVERSED IN PART.

24
25
26
27 LISA BALL (Christen Archer Pierrot, Andrew P.
28 Fleming, *on the brief*) Chiacchia & Fleming,
29 Hamburg, NY, *for Plaintiff-Counter-Defendant-*
30 *Appellant-Cross-Appellee.*

31
32 MICHAEL H. BERNSTEIN (John T. Seyberg, *on the*
33 *brief*), Sedgwick LLP, New York, NY, *for*
34 *Defendant-Counter-Claimant-Appellee-Cross-*
35 *Appellant and Defendants-Appellees-Cross-*
36 *Appellants.*

1 WESLEY, *Circuit Judge*:

2 **Background**

3 Sharon Thurber worked at Quest Diagnostics ("Quest") as
4 a client services representative from 1993 through August
5 15, 2007. As a full-time Quest employee, Thurber was
6 enrolled in Quest's Employee Retirement Income Security Act
7 (ERISA) disability benefits plan, administered by Aetna Life
8 Insurance Company ("Aetna"). Under the plan, Thurber was
9 entitled to long-term disability benefits if a disabling
10 condition rendered her unable to perform the material and
11 substantial duties of her occupation. According to
12 Thurber's supervisor, her position as a client services
13 representative consisted of sitting for approximately 80% of
14 her shift and alternately standing and walking a short
15 distance for the remaining 20% of the time.

16 In 1983, Thurber broke both of her legs in a car
17 accident; her right leg is shorter than her left leg as a
18 result. On or about August 17, 2007, Thurber was involved
19 in another car accident, in which she hit a cement barrier
20 twice while driving on the New York State Thruway. She has
21 not worked since that accident. Aetna approved Thurber's
22 initial claim for short-term disability benefits for

1 "traumatic arthritis in both knees." She received short-
2 term disability benefits for six months, ending on February
3 20, 2008.

4 Thurber then submitted a claim for long-term disability
5 benefits. At this time, she informed Aetna that she had
6 received "other income" in the form of no-fault insurance
7 payments of \$1,202.32 per month while receiving short-term
8 disability benefits from Aetna. Under the plan, Aetna "may"
9 reduce short- or long-term disability benefits if a
10 beneficiary receives "Other Income Benefits," including no-
11 fault insurance payments. (AR 198.) In addition, any
12 "[i]ncome earned from a part-time return to work at Quest .
13 . . will result in a reduction" of benefits. (*Id.*) The
14 plan also authorizes Aetna to: (1) require the return of
15 overpayments; (2) cease paying benefits until overpayments
16 are recovered; (3) pursue legal action to recover
17 overpayments; or (4) "[p]lace a lien . . . in the amount of
18 the overpayment on the proceeds of any other income." (*Id.*
19 at 201.)

20 In support of Thurber's claim for long-term disability
21 benefits based on her "intermittent, unpredictable pain,"
22 Thurber's orthopedist, Dr. Michael T. Grant, completed a

1 Capabilities and Limitations Worksheet ("CLW") in November
2 2007. Dr. Grant indicated that Thurber could engage in
3 occasional sitting and occasional walking, but not in
4 standing, stooping, climbing, crawling, kneeling or
5 twisting, among other limitations. In January 2008, Dr.
6 Grant opined that Thurber "remains totally disabled" due to
7 being "persistently symptomatic in regards to severe post-
8 traumatic arthritis of her knees bilaterally." (*Id.* at
9 878.) Two months later, another of Thurber's physicians,
10 Dr. Anthony J. Bianchi, completed a second CLW and found
11 that Thurber could frequently (34%-66% of an eight-hour day)
12 sit, stand and walk. Dr. Bianchi noted that Thurber was
13 "still very symptomatic at times," but recommended that she
14 "slowly work up to an 8 hour work day." (*Id.* at 916.)

15 Based on this information, Aetna denied Thurber's claim
16 for long-term disability benefits on March 31, 2008.

17 Aetna's denial letter summarized the medical reports
18 provided by Thurber's doctors before concluding that the
19 information did not demonstrate that Thurber was unable to
20 perform the functions of her position as a client services
21 representative. Aetna informed Thurber that she could
22 submit any additional information she desired and gave a

1 list of the types of tests and records that might prove
2 helpful. Thurber appealed the denial of benefits in April
3 2008.

4 On April 28, 2008, Thurber underwent arthroscopic knee
5 surgery, as suggested by Dr. Grant. Aetna then forwarded
6 Thurber's claim file for an independent medical review by
7 Dr. Lawrence Blumberg, a Board Certified orthopedic surgeon.
8 Dr. Blumberg summarized the medical information provided by
9 Thurber's physicians, but his report wrongly attributed the
10 March 3, 2008 CLW to Dr. Grant, rather than to Dr. Bianchi.
11 Dr. Blumberg determined that "[i]n spite of claimant's
12 subjective complaints, she has an adequate range of motion
13 to perform sedentary activities," as required by her job,
14 because "[t]here is no evidence that she cannot stand, sit,
15 or ambulate." (*Id.* at 951.) In late May, Aetna denied
16 Thurber's claim on appeal and upheld its original decision.

17 Although the internal appeals process offers only one
18 level of review, Thurber requested reconsideration of her
19 appeal. She subsequently submitted medical information
20 regarding spinal problems in October 2008, specifically, the
21 results of a static EMG scan. Aetna forwarded Thurber's
22 claim file for two additional independent medical reviews,

1 both conducted by Board Certified orthopedic surgeons. The
2 second independent review physician, Dr. James Wallquist,
3 reviewed Thurber's medical reports and correctly attributed
4 the March 3, 2008 CLW to Dr. Bianchi. Both Dr. Wallquist
5 and Dr. Leela Rangaswamy, Aetna's third independent review
6 physician, concluded that Thurber was functionally impaired
7 from the date of her arthroscopic surgery and for six weeks
8 of recovery thereafter, but not during the periods prior or
9 subsequent. On December 6, 2008, Aetna completed the re-
10 review of its denial of Thurber's claim for benefits and re-
11 affirmed its initial denial.

12 Thurber filed a complaint in the United States District
13 Court for the Western District of New York (Skretny, J.)
14 challenging Aetna's denial of benefits under ERISA, 29
15 U.S.C. § 1132(a)(1)(B). Aetna counterclaimed for equitable
16 restitution of \$7,213.92 in overpaid plan benefits under 29
17 U.S.C. § 1132(a)(3). Aetna moved for summary judgment on
18 Thurber's claim and its counterclaim. On January 6, 2012,
19 the district court granted Aetna's motion for summary
20 judgment with respect to Thurber's claims but denied and
21 dismissed Aetna's counterclaim for lack of subject matter
22 jurisdiction under ERISA because it was legal, rather than
23 equitable, in nature.

Thurber appeals from the district court's grant of summary judgment to Aetna on Thurber's claim for disability benefits; Aetna cross-appeals from the district court's denial of its counterclaim.

Discussion

I. Standard of Review

Thurber argues that the district court should have reviewed her claim *de novo* because she allegedly never received the plan documents that clearly reserved Aetna's discretion to assess her eligibility for long-term disability benefits. We disagree.

When an ERISA plan participant challenges a denial of benefits, the proper standard of review is *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority" to assess a participant's eligibility. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan does reserve discretion, the denial is subject to arbitrary and capricious review and will be overturned only if it is "'without reason, unsupported by substantial evidence or erroneous as a matter of law.'" *Kinstler v. First Reliance Standard Life Ins.*

1 Co., 181 F.3d 243, 249 (2d Cir. 1999) (quoting *Pagan v.*
2 *NYNEX Pension Plan*, 52 F.3d 438, 442 (2d Cir. 1995)).
3 Although we do not require the plan to employ any particular
4 language to reserve discretion, the chosen words must
5 clearly convey the administrator's intent. See *Nichols v.*
6 *Prudential Ins. Co. of Am.*, 406 F.3d 98, 108 (2d Cir. 2005);
7 *Kinstler*, 181 F.3d at 251-52.

8 Thurber conceded at oral argument that the plan itself
9 and the Summary Plan Description ("SPD") both include
10 language that is sufficient to reserve discretion to Aetna
11 to assess participants' eligibility for benefits.¹ Thurber
12 argues, however, that there is no evidence in the record
13 showing that she actually received either of these plan
14 documents and that, therefore, she cannot be bound by
15 language contained therein. According to Thurber, the only
16 plan document that she received (the "Booklet") does not
17 clearly reserve discretion to Aetna.²

¹ The plan provides Aetna with "discretionary authority to: determine whether and to what extent employees and beneficiaries are entitled to benefits." (AR 54.) Likewise, the SPD states that "[Aetna] has the discretionary authority to determine eligibility for benefits, decide claim appeals, and to interpret provisions of the plan." (*Id.* at 305.)

² The Booklet states that "[a] period of disability will be certified by Aetna if, and for only as long as, Aetna determines that you are disabled" (Doc. #40, Ex. A, 3.) Because we

1 Thurber relies on the Seventh Circuit's decision in
2 *Herzberger v. Standard Insurance Co.*, 205 F.3d 327 (7th Cir.
3 2000), for her assertion that she must have received actual
4 notice of Aetna's reservation of discretion before Aetna's
5 denial of benefits is entitled to deferential review. In
6 *Herzberger*, the Seventh Circuit reversed and remanded two
7 district court decisions granting summary judgment to plan
8 administrators after the lower courts reviewed eligibility
9 determinations under the arbitrary and capricious standard.
10 See *id.* at 333. The court held that neither plan at issue
11 clearly reserved discretion to the respective plan
12 administrators. *Id.* The court's analysis rested fully on
13 the language of the plan itself, and concluded that language
14 that simply provided that the administrator had to determine
15 eligibility did not imbue the administrator with discretion.
16 See *id.* In explicating this holding, the court further
17 noted that "[t]he employees are entitled to know what
18 they're getting into, and so if the employer is going to

find that the plan's reservation of discretion to Aetna was sufficient regardless of whether Thurber had actual notice of the plan's language, we need not decide the controversial question of whether use of the word "determines" in the Booklet is clear enough to reserve discretion under *Firestone*. See *Fay v. Oxford Health Plan*, 287 F.3d 96, 104 (2d Cir. 2002); *cf. Nichols*, 406 F.3d at 108-09.

1 reserve a broad, unchanneled discretion to deny claims, the
2 employees should be told about this, and told clearly." *Id.*

3 Contrary to Thurber's reading, the case did not in any
4 way involve, and the court's language did not address, a
5 situation in which the plan's language *did* unambiguously
6 provide for discretion (as did the SPD), but the employee
7 seeking benefits had not received a copy of either document.
8 That a court will review benefits determinations *de novo*
9 unless the plan documents clearly specify a reservation of
10 discretion does not imply that such a reservation must be
11 specifically conveyed to all members of the plan. In any
12 event, to the extent that the language in *Herzberger* could
13 be read to require actual notice of the insurer's purported
14 reservation of discretion, we cannot detect any basis in law
15 or the statute to support this position. Indeed, the
16 Supreme Court's decision in *Firestone* merely establishes
17 that review under the arbitrary and capricious standard will
18 be inappropriate "unless *the benefit plan* gives the
19 administrator or fiduciary discretionary authority to
20 determine eligibility." 489 U.S. at 115 (emphasis added).
21 *Firestone* says nothing about whether the SPD or other plan
22 documents must contain language clearly reserving discretion

1 - *Firestone* refers to the plan itself. Although plan
2 participants are entitled to receive copies of the SPD,
3 pursuant to 29 U.S.C. §§ 1021, 1022 and 1024, the
4 administrator of an ERISA plan has no obligation to ensure
5 that participants receive copies of the plan itself.

6 Thus, unless ERISA requires the SPD to contain language
7 setting the standard of review, we see no reason why a plan
8 administrator must actually notify a participant of its
9 reservation of discretion. ERISA contains no such edict.

10 See 29 U.S.C. § 1022(b); 29 C.F.R. § 2520.102-3.

11 Accordingly, to the extent that the Seventh Circuit has
12 articulated an *actual* notice requirement, we disagree that
13 ERISA imposes such an obligation on an insurer that
14 endeavors to reserve discretion.

15 Here, the language contained in Aetna's plan and the
16 SPD clearly reserves discretion to Aetna for determining
17 participants' eligibility for disability benefits. That
18 Thurber did not have actual notice of Aetna's reservation of
19 discretion is of no consequence. There may be strong
20 arguments that plan provisions that affect the basic terms
21 of the plan, or ones that affect what an applicant must do
22 to become eligible for benefits, should be conveyed directly

1 to plan beneficiaries and not buried in a lengthy and
2 technical contract. However, those arguments do not apply
3 to a provision that is effectively addressed not to the
4 beneficiary, but only to a reviewing court that must act
5 only after an application has been denied. Moreover, a
6 standard that focuses on the language of the plan raises a
7 purely legal standard of review for all participants in the
8 same plan. In contrast, an actual notice standard would
9 make the standard of review different for each individual
10 applicant, based on resolution by reviewing courts of
11 factual disputes - which will frequently pit a participant's
12 fallible and self-interested memory against a plan
13 administrator's reliance on evidence of standard practice -
14 about whether the particular participant received a copy of
15 the relevant documents.

16 As a result, we conclude that the district court
17 correctly utilized the arbitrary and capricious standard of
18 review. We review the district court's grant of summary
19 judgment to Aetna *de novo*, see *Pagan*, 52 F.3d at 441, and
20 thus will review Aetna's denial of long-term disability
21 benefits under the same arbitrary and capricious standard
22 properly used by the district court.

1 **II. The Merits of Thurber's Claim for Benefits**

2 Thurber makes several arguments on appeal for why Aetna
3 acted arbitrarily and capriciously in denying her long-term
4 disability benefits under the plan. Only some of these
5 arguments have sufficient merit to require discussion. We
6 agree with the district court that Aetna's determination of
7 Thurber's eligibility for long-term benefits was supported
8 by substantial evidence. Accordingly, we affirm the
9 district court's grant of summary judgment to Aetna.

10 First, Thurber argues that Aetna failed to give enough
11 weight to her subjective complaints of pain. Although
12 subjective complaints "if found credible . . . could [be]
13 legally sufficient evidence of disability," *Krizek v. Cigna*
14 *Group Insurance*, 345 F.3d 91, 102 (2d Cir. 2003), we agree
15 with the district court that Aetna gave sufficient attention
16 to Thurber's subjective complaints of pain before
17 determining that they were not supported by objective
18 evidence. In Aetna's first denial letter, the insurer
19 "noted that [Thurber] complain[ed] of recurrent discomfort
20 about the right knee." (AR 925.) In its May 2008 denial of
21 benefits on appeal, Aetna commented that "Dr. Blumberg found
22 that in spite of your subjective complaints, you had

adequate range of motion to perform sedentary activities.”
(*Id.* at 947.) Finally, in Aetna’s December 2008 final denial on re-review, the letter confirmed that “[t]he consultant noted that Ms. Thurber had had previous knee pain” and the consultant was aware that “[s]he claimed to have pain, stiffness, and ‘fatiguability’” on June 10, 2008. (*Id.* at 1118.) Aetna did not abuse its discretion in concluding either that Thurber’s subjective complaints of pain standing alone did not warrant finding her eligible for long-term disability benefits, or that objective evidence did not support finding otherwise.

Second, Thurber argues that Dr. Blumberg’s error attributing the March 3, 2008 CLW to Dr. Grant, instead of to Dr. Bianchi, is a “critical mistake” because Dr. Blumberg “believed that Dr. Grant found Ms. Thurber to have improved.” (Appellant’s Br. at 65.) Even if Dr. Blumberg erroneously believed that Dr. Grant had authored the March 2008 CLW, his recommendation to Aetna was based on the substance of the report – which was the most recent CLW available at the time of his review. Moreover, after Dr. Blumberg’s review and Aetna’s denial of Thurber’s appeal, Aetna retained two additional independent physicians to

1 review Thurber's file and subsequently affirmed its prior
2 denial based on their (correct) reports.

3 Third, Thurber claims that Aetna did not give
4 sufficient consideration to the total impact of the medical
5 evidence she submitted to support her claim for disability
6 benefits. As the district court correctly determined, the
7 facts prove otherwise. Each of Aetna's three denial
8 letters, along with the reports from three independent Board
9 Certified physicians, explained why Aetna found Thurber's
10 submissions to be insufficient. In addition, Thurber's
11 claim that Aetna failed to credit the objective medical
12 evidence she submitted regarding her neck and spinal
13 problems also fails. Thurber's initial disability claim and
14 all of the supporting documentation from her care providers
15 up until the fall of 2008 focused on injuries to her knees
16 caused by her August 2007 car accident in conjunction with
17 her 1983 car accident. But, even if Thurber's claim
18 extended beyond disabling knee pain, the third independent
19 physician's review and Aetna's subsequent final denial
20 letter both discuss the tests performed on Thurber's spine,
21 demonstrating that Aetna did not arbitrarily ignore this
22 evidence for purposes of assessing her eligibility for
23 benefits.

1 We have considered Thurber's additional arguments that
2 the rejection of her claim was arbitrary and capricious and
3 find them without merit. We affirm the district court's
4 conclusion that Aetna's eligibility determination was
5 supported by substantial evidence.

6 7 **III. Aetna's Counterclaim**

8 Aetna brought a counterclaim seeking the return of
9 overpaid short-term benefits pursuant to ERISA, 29 U.S.C. §
10 1132(a)(3), which authorizes civil actions brought "by a
11 participant, beneficiary, or fiduciary . . . to obtain . . .
12 appropriate equitable relief . . . to enforce any provisions
13 of this subchapter or the terms of the plan." 29 U.S.C. §
14 1132(a)(3). What qualifies as "appropriate equitable
15 relief" is an issue that continues to perplex courts despite
16 efforts by the Supreme Court during the past decade to shed
17 some light on the matter. *See Sereboff v. Mid Atl. Med.*
18 *Servs., Inc.*, 547 U.S. 356 (2006); *Great-West Life & Annuity*
19 *Ins. Co. v. Knudson*, 534 U.S. 204 (2002). Here, the
20 district court determined that it did not have subject
21 matter jurisdiction over Aetna's counterclaim because Aetna
22 sought legal, rather than equitable, relief. Because we are
23 convinced that Aetna's counterclaim seeking the return of

1 overpaid benefits constituted an action for “appropriate
2 equitable relief,” we reverse.

3 The Supreme Court first tackled the question of whether
4 29 U.S.C. § 1132(a)(3) authorizes subrogation-like actions
5 by insurers under an ERISA plan in *Great-West Life & Annuity*
6 *Insurance Company v. Knudson*. There, the insurer paid
7 approximately \$350,000 for the participant’s medical
8 expenses under her husband’s ERISA plan after a car
9 accident. See *Knudson*, 534 U.S. at 207. The Knudsons
10 subsequently settled their state court tort suit against the
11 car manufacturer and other tortfeasors. *Id.* The state
12 court approved the settlement and directed the distribution
13 of approximately \$250,000 into a Special Needs Trust that,
14 under California law, would provide for medical care. In
15 addition, the state court allotted nearly \$375,000 for
16 attorney’s fees and costs; \$5,000 to reimburse the
17 California Medicaid program; and approximately \$14,000 “to
18 satisfy” Great-West’s claim. *Id.* at 207-08. Great-West
19 received notice of the proposed settlement and, “calling
20 itself a defendant,” unsuccessfully attempted to remove the
21 state action to federal court on the grounds that the state
22 action “involved federal claims related to ERISA.” *Id.* at
23 208.

1 Great-West simultaneously sought to block the state
2 court settlement in federal court under 29 U.S.C. §
3 1132(a)(3), claiming that the plan's subrogation provision
4 required the Knudsons to reimburse Great-West from any
5 third-party payments for plan-covered expenses and precluded
6 the state court from limiting Great-West's recovery to the
7 past medical expenses portion of the settlement. The
8 district court denied Great-West's request for a temporary
9 restraining order and Great-West did not appeal. *Id.* The
10 district court ultimately dismissed Great-West's action
11 after the state court approved the settlement. *See id.*

12 The Ninth Circuit affirmed the dismissal of Great-
13 West's claim, holding "that judicially decreed reimbursement
14 for payments made to a beneficiary of an insurance plan by a
15 third party is not equitable relief and is therefore not
16 authorized" by the statute. *Id.* at 209. On appeal, the
17 Supreme Court explained that it had previously determined
18 that the statute provided only equitable and not legal
19 remedies to plan administrators to redress violations of the
20 plan or to seek enforcement of plan provisions. *Id.* The
21 Knudsons had not retained any moneys recovered in the state
22 action as those funds were sequestered in the Special Needs
23 Trust pursuant to the state court order. Consequently,

1 Great-West was really trying to enforce its plan provision
2 authorizing the imposition of personal liability if a
3 beneficiary failed to reimburse the insurer after receiving
4 a third-party settlement. See *id.* at 207, 210-12. The
5 Supreme Court saw this as an action at law, for breach of
6 contract, rather than an action at equity, to enjoin the
7 Knudsons from violating the terms of the plan by failing to
8 reimburse Great-West. “[F]or restitution to lie in equity,
9 the action generally must seek not to impose personal
10 liability on the defendant, but to restore to the plaintiff
11 particular funds or property in the defendant’s possession.”
12 *Id.* at 214.

13 By contrast, in *Sereboff v. Mid Atlantic Medical*
14 *Services, Inc.*, the insurer sought “specifically
15 identifiable funds that were within the possession and
16 control of the Sereboffs.” 547 U.S. at 362-63 (internal
17 quotation marks omitted). Like in *Knudson*, the plan
18 participants in *Sereboff* were injured in a car accident and
19 the insurer paid a sum of money, approximately \$75,000, to
20 cover medical expenses under their ERISA plan. *Id.* at 360.
21 Subsequently, the Sereboffs settled a tort suit arising out
22 of their accident. *Id.* Mid Atlantic brought an action
23 under ERISA to enforce a plan provision requiring the

1 beneficiary to reimburse the insurer from third-party
2 recoveries. *Id.* The Sereboffs agreed to set aside a sum of
3 money from their settlement and put it into an investment
4 account until the case had been decided. *Id.*

5 First, the Court determined that the *nature* of the
6 relief desired in *Sereboff* was equitable because Mid
7 Atlantic sought a specific portion (approximately \$75,000)
8 of specifically identified funds (the third-party recovery).
9 See *id.* at 362-63. Second, the Court concluded that Mid
10 Atlantic established that the *basis* for its claim was
11 equitable. See *id.* at 363. The Court discussed the 1914
12 case (from the time of the divided bench) of *Barnes v.*
13 *Alexander*, 232 U.S. 117 (1914), in which Justice Holmes
14 described

15 the familiar rul[e] of equity that a
16 contract to convey a specific object even
17 before it is acquired will make the
18 contractor a trustee as soon as he gets a
19 title to the thing.

20
21 *Sereboff*, 547 U.S. at 363-64 (quoting *Barnes*, 232 U.S. at
22 121).

23 Because the Sereboffs' ERISA plan specifically
24 identified a particular share of particular funds subject to
25 return, Mid Atlantic "could rely on [this] familiar rul[e]
26 of equity to collect for the medical bills it had paid."

1 *Id.* at 364 (internal quotation marks omitted). “This rule
2 allowed them to ‘follow’ a portion of the recovery ‘into the
3 [Sereboffs’] hands’ ‘as soon as [the settlement fund] was
4 identified,’ and impose on that portion a constructive trust
5 or equitable lien.” *Id.* (quoting *Barnes*, 232 U.S. at 123)
6 (alterations in original). Moreover, the Supreme Court
7 rebuffed the Sereboffs’ contention that Mid Atlantic needed
8 to satisfy “strict tracing rules” before equitable relief
9 was appropriate. *Id.* at 364-65. Instead, the Court
10 confirmed that tracing rules have no import in the context
11 of an equitable lien *by agreement*. *Id.* at 365.

12 The Court reached different results in *Knudson* and
13 *Sereboff* because Great-West could not assert an equitable
14 lien on settlement funds contained in a separate entity –
15 the restrictive trust – while Mid Atlantic did not face a
16 similar obstacle. The Sereboffs had possession and control
17 over the specific funds sought by their insurer. As a
18 result, the Court found that the Sereboffs held these funds
19 in constructive trust for Mid Atlantic.

20 Here, the nature of Aetna’s claim is equitable: the
21 insurer seeks specific funds (overpayments resulting from
22 Thurber’s simultaneous receipt of no-fault insurance
23 benefits and short-term disability benefits) in a specific

1 amount (the total overpayment, \$7,213.92) as authorized by
2 the plan. These funds were entrusted to Thurber.

3 However, this case differs from *Sereboff* in two ways.
4 First, the “particular fund” (from which Aetna seeks a
5 specific portion of money) is not the actual third-party
6 income Thurber received; instead, it is the benefits
7 rendered overpayments as a result of Thurber’s receipt of
8 no-fault insurance benefits. Second, these overpayments
9 have since dissipated. We do not believe either of these
10 distinctions requires labeling Aetna’s claim as one in law,
11 though we recognize the existence of a Circuit split on the
12 issue. Compare *Funk v. CIGNA Grp. Ins.*, 648 F.3d 182, 194-
13 95 (3d Cir. 2011) (finding that “dissipation of the funds
14 [is] immaterial” if an equitable lien by agreement is in
15 place), and *Cusson v. Liberty Life Assurance Co. of Boston*,
16 592 F.3d 215, 231 (1st Cir. 2010) (determining that an
17 insurer need not identify a “specific account in which the
18 funds are kept or prove[] that they are still in [the
19 beneficiary’s] possession”), with *Bilyeu v. Morgan Stanley*
20 *Long Term Disability Plan*, 683 F.3d 1083, 1093-95 (9th Cir.
21 2012) (holding that “fiduciar[ies] must recover from
22 specifically identified funds *in the beneficiary’s*
23 *possession*” (emphasis in original)).

1 With respect to the first distinction, Aetna seeks a
2 specific portion (all) of a particular fund (the subset of
3 disability benefits that became overpayments when Thurber
4 received no-fault insurance benefits). Not surprisingly,
5 these overpayments were not segregated from the total
6 disability payments. The Ninth Circuit recently held that
7 an action for the return of "overpaid long-term disability
8 benefits" does not seek "a particular *fund*, but a specific
9 amount of money encompassed *within* a particular fund – the
10 long-term disability benefits [the insurer] paid to [the
11 beneficiary]." *Bilyeu*, 683 F.3d at 1093 (emphases in
12 original). But the beneficiary's literal segregation of
13 funds is irrelevant when the terms of the ERISA plan "put
14 [the beneficiary] on notice that she would be required to
15 reimburse [the insurer] for an amount equal to what she
16 might get from" third-party sources. *Cusson*, 592 F.3d at
17 231.

18 We do not see a basis for distinguishing between
19 certain "funds" identified by ERISA plans – i.e., between
20 "third-party recoveries" and benefits that become
21 "overpayments" as a result of third-party recoveries. Both
22 constitute particular, identifiable sums over which an
23 insurer may assert an equitable lien authorized by its plan.

1 For this reason, we take issue with the Ninth Circuit's view
2 that the "particular fund" (overpayments) sought lacks
3 sufficient specificity by virtue of being an
4 "undifferentiated component of a larger fund" (total
5 benefits). *Bilyeu*, 683 F.3d at 1093.

6 Regarding the second distinction, Thurber argues that
7 Aetna may not seek return of the overpayments under 29
8 U.S.C. § 1132(a)(3) because Thurber has spent the no-fault
9 monies she was required under the plan to deliver to Aetna.
10 This, Thurber argues, makes Aetna akin to a general creditor
11 seeking a sum of money. The Third Circuit takes the
12 position that if "there was an equitable lien by agreement
13 that attached to the [third-party benefits] as soon as [the
14 beneficiary] received it, dissipation of the funds [is]
15 immaterial." *Funk*, 648 F.3d at 194. We believe that this
16 strikes the right balance, and we therefore reject the Ninth
17 Circuit's contrary view that insurers may not reach
18 specifically identified assets that have dissipated. See
19 *Bilyeu*, 683 F.3d at 1094-96. If the reason the insurer's
20 claim is equitable is because it is seeking return of
21 property over which it asserts a lien (the overpayments),
22 whether or not the beneficiary remains in possession of
23 those particular dollars is not relevant as long as she was

1 on notice that the funds under her control belonged to the
2 insurer; she held the money in a constructive trust.

3 When an ERISA plan creates an equitable lien by
4 agreement between the insurer and the beneficiary, the
5 insurer's ownership of the overpaid funds is established
6 regardless of whether the insurer can satisfy strict tracing
7 rules. See *Sereboff*, 547 U.S. at 364-65; *Bilyeu*, 683 F.3d
8 at 1102 (Rawlinson, J., dissenting). In the context of an
9 equitable lien by agreement, rather than an equitable lien
10 sought as a matter of restitution, all that matters is that
11 the beneficiary did, at some point, have possession and
12 control of the specific portion of the particular fund
13 sought by the insurer. See *Sereboff*, 547 U.S. at 364-65.
14 This is not a case like *Knudson*, in which the beneficiaries
15 never had possession or control of the funds identified for
16 recovery (the settlement). Here, Thurber had possession and
17 control of the overpaid benefits. That she spent the funds
18 over which Aetna exerted an equitable lien is insufficient
19 to void Aetna's right to enforce the plan's subrogation
20 provision and the resulting equitable lien by agreement that
21 Aetna entered into with Thurber.

22 The basis of Aetna's claim is equitable. The insurer
23 seeks to enforce an equitable lien by agreement on its

1 property – the overpaid funds that Thurber received. For
2 this reason, Thurber’s reliance on *Fehn v. Group Long Term*
3 *Disability Plan for Employees of JP Morgan Chase Bank*, No.
4 07 Civ. 8321(WCC), 2008 WL 2754069 (S.D.N.Y. June 30, 2008),
5 is misplaced. In *Fehn*, the plaintiff received disability
6 benefits that erroneously contained salary-continuation
7 payments, for which the plaintiff was not eligible,
8 resulting in a significant overpayment. 2008 WL 2754069, at
9 *1. Unlike the insurer in *Sereboff*, because JP Morgan Chase
10 paid the excess funds in error (believing that the plaintiff
11 was entitled to salary-continuation benefits when, in fact,
12 she was not), the company was asserting a contract claim for
13 money paid by the plan in excess of its terms. It was not
14 seeking recovery of funds held by the defendant that
15 replicated proper plan payments from third parties.³ *Id.* at
16 *4. Thus, the action was legal, rather than equitable.

17 The district court’s conclusion that it lacked subject
18 matter jurisdiction over Aetna’s counterclaim rested in part
19 on its belief that the language contained in Aetna’s SPD

³ To the extent that the district court in *Fehn* rested its decision on the insurer’s inability to “identify segregated funds in plaintiff’s possession,” 2008 WL 2754069, at *4, we disagree. See *supra* our discussion of *Cusson*, 592 F.3d at 230, and *Funk*, 648 F.3d at 194-95.

1 substantively differed from language in the plans at issue
2 in *Sereboff* and *Cusson*. Aetna's SPD provides that the
3 insurer "may" reduce benefits if a beneficiary receives
4 other income, and "may" require the beneficiary to return
5 any benefits subsequently rendered overpayments. The
6 district court emphasized that the SPD's use of the word
7 "may" "implies a discretionary act, not a conclusive right
8 to the funds." According to the court, this converts
9 Aetna's right to restitution of overpaid benefits into a
10 contractual and legal right, rather than an equitable one.
11 This strikes us as being overly formalistic.

12 In *Sereboff*, the plan's subrogation language specified
13 the insurer's "right to recover any payments made to you or
14 your dependent by a third party." *Mid Atl. Med. Servs.,*
15 *Inc. v. Sereboff*, 303 F. Supp. 2d 691, 698 (D. Md. 2004).
16 In *Cusson*, the plan gave the insurer "the right to recovery
17 of such overpayments" if a participant received an
18 overpayment on her claim from any source. *Cusson*, 592 F.3d
19 at 230. The district court here cited to these plans as
20 "requir[ing]" beneficiaries to reimburse overpayments to
21 their insurers. But whether the plan "requires" a
22 participant to reimburse an insurer or "may[] [r]equire [the
23 beneficiary] to return the overpayment," as one of four

1 options the insurer "may" pursue, is an immaterial
2 distinction. Under either scenario, reimbursement remains
3 dependent on an act committed to the insurer's discretion,
4 namely, requesting or suing for the return of its property.
5 The insurer must still elect to assert its "right to
6 recover." Or, it *may* opt not to pursue this right.

7 Likewise, a plan that "may" reduce payments if the
8 beneficiary receives income from other sources adequately
9 reserves the insurer's right to lessen the beneficiary's
10 entitlement to benefits. Here, had Aetna been aware that
11 Thurber was receiving no-fault insurance income while Aetna
12 was still paying short-term disability benefits, the insurer
13 would have had the right to reduce its payments to Thurber,
14 just as it now has the authority to seek return of those
15 overpayments.

16 We are not persuaded that a different result is
17 compelled by language in Aetna's SPD distinguishing between
18 benefits that "may" be reduced following receipt of "Other
19 Income Benefits" and benefits that "will" be reduced
20 following receipt of income from a part-time return to work.
21 Although we note that Aetna's decision to use two different
22 phrases could signify a meaningful difference, we believe
23 that the insurer's election here is sensible in light of the

1 purpose behind disability benefits: supporting individuals
2 who are unable to work by reason of their impairment.
3 Receiving income from a part-time return to work undermines
4 the very basis for receiving disability benefits; the
5 benefits should never have been paid. Benefits that are
6 overpaid by virtue of the beneficiary receiving additional
7 payments from a third party simply render some portion of
8 the ERISA benefits unnecessary after the fact. Because
9 Aetna had the right to reduce Thurber's short-term
10 disability benefits at the time she received them, Aetna now
11 retains the right under its subrogation provision to compel
12 return of the overpayments.

13 Thus, the language in Aetna's plan puts a beneficiary
14 on notice that any overpayments she receives belong to Aetna
15 by virtue of an equitable lien by agreement.⁴ That the
16 participant takes immediate possession of the overpayments
17 (and perhaps even keeps possession for a certain period of
18 time) has no bearing on Aetna's right to the property nor on
19 its ability to seek return of the overpayments. We note in

⁴ Although Thurber did not raise this point in connection with Aetna's counterclaim, even if she never received the SPD, Thurber admitted to possessing the Booklet containing the following language: "[o]ther income benefits . . . will reduce the benefit actually payable." (Doc. #40, Ex. A, 5.)

1 closing that the distinction between claims based in law and
2 those sounding in equity is often fine. In close cases, our
3 inclination is to favor judicial efficiency by allowing
4 ERISA insurers to bring responsive claims in ongoing federal
5 actions, rather than forcing the parties to litigate two
6 actions, one in federal court and one in state court,
7 unnecessarily. Here, because we find that Aetna's plan
8 established an equitable lien by agreement, we hold that
9 Aetna presented a claim for "appropriate equitable relief"
10 under 29 U.S.C. § 1132(a)(3) over which the district court
11 had subject matter jurisdiction. We therefore reverse the
12 district court's dismissal of Aetna's counterclaim and
13 remand to the district court with instructions to enter
14 judgment in favor of Aetna.

15 16 **Conclusion**

17 For the foregoing reasons, the order of the district
18 court is hereby AFFIRMED IN PART and REVERSED IN PART.