IN THE SUPREME COURT OF FLORIDA
TALLAHASSEE, FLORIDA

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CASE NO. 82,933

BARBARA A. SAVONA,

Plaintiff-Appellant-Petitioner,

vs.

PRUDENTIAL INSURANCE CO.,

Defendant-Appellee-Respondent.

_____/

CERTIFIED QUESTION FROM THE UNITED STATES COURT OF APPEALS ELEVENTH CIRCUIT, CASE NO. 93-2281 BASED ON APPEAL FROM ORDER ENTERED FEBRUARY 11, 1993, BY MAGISTRATE D.P. DIETRICH, JUDGE FOR THE UNITED STATES DISTRICT COURT, MIDDLE DISTRICT OF FLORIDA, ORLANDO DIVISION, D.C. NO. 91-00462-CIV-ORL-19

ANSWER BRIEF OF RESPONDENT, PRUDENTIAL

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STATEMENT OF THE CASE

Course of Proceedings and Dispositions Below

Plaintiff-Appellant's summation of the course of proceedings in this case is accurate, and will be adopted by appellee, Prudential Insurance Company of America, for the purposes of this answer brief. In addition, the Memorandum Opinion and Judgment entered by the court on February 12, 1993, (R2-43, R2-44) for the Defendant and against the Plaintiff (see Appendix, Exhibits "A2" and "B".

However, Defendant-Appellee, Prudential, believes that Plaintiff-Appellant, Savona, omitted a very significant factor when referring to the Eleventh Circuit's per curiam opinion, transferring this case for review to the Supreme Court of Florida. On Page 7 of its per curiam opinion, the Eleventh Circuit clearly stated its intent not to limit the Supreme Court of Florida in its consideration of the problem posed by the case, and transferred the entire record, along with the briefs of the parties, to the Supreme Court of Florida. It is Prudential's position that the Supreme Court of Florida is not limited to considering the application of Florida law to the problem posed by the case, but may, if it deems it appropriate, analyze the problem posed by the case by applying ERISA principles, as well. See the Eleventh Circuit per curiam opinion, transferring this case to the Supreme Court of Florida (see Appendix, Exhibit "A1").

Statement of the Facts

Defendant-Appellee, Prudential, disagrees with Plaintiff's-Appellant's, Savona's, statement of the facts. Specifically, Prudential disagrees with Plaintiff's-Appellant's assertion that Prudential did not timely furnish copies of the policy, or timely apprise Plaintiff-Appellant of the policy terms, conditions, and rates. In addition, Plaintiff's-Appellant's Statement of the Facts is woefully lacking in detail as to the nature of the benefit plan in which Barbara Savona was enrolled, upon which she relies to support her claim and her appeal. It is Prudential's position that, in order for this Court to adequately formulate a response to the Certified Question posed by the Eleventh Circuit, as well as to assess whether the Honorable Magistrate Dietrich, Judge for the United States District Court, Middle District of Florida, correctly ruled in favor of Prudential, giving rise to this appeal, this Court must be fully apprised of the exact nature of the benefit plan in Barbara Savona was enrolled, as well as all of the applicable laws governing the implementation of that benefit plan. Therefore, Prudential has supplemented Plaintiff-Appellant Savona's Statement of the Facts by incorporating the following Statement of the Facts into its Answer Brief for this Court's consideration.

Plaintiff-Appellant, Barbara A. Savona, was employed at the Hotel Royal Plaza in Orlando, Florida. Her employer provided a major medical expense benefit plan entitled "Your Employee Benefit Plan" provided by the SKF Group Benefit Plans Trust through a self-funded program. The Prudential Insurance Company of America

provided certain administrative services in connection with the plan. The employee benefit plan included an option to convert to an individual policy of health care benefits. Policy No. I1079511 was the Individual Conversion Policy issued by Prudential in accordance with the option to convert provided as a benefit of the plan. The benefits and provisions of the Individual Conversion Policy differed from those of the plan.

On January 29, 1986, Plaintiff-Appellant, Barbara A. Savona, was involved in an accident which rendered her totally disabled. Her employment was terminated on May 8, 1986 and her employee benefits under the "Your Employee Benefit Plan" were extended from May 8, 1986 to May 8, 1987. On May 9, 1987 she applied to Prudential for an Individual Conversion Policy in accordance with the employee benefit plan. She converted from the "Your Employee Benefit Plan" to a major medical Individual Conversion Policy effective May 9, 1987. The Plaintiff was admitted to the Beechwood Residential Facility on May 13, 1987 and Prudential accepted the Beechwood Residential Facility as a facility eligible for benefits under the Individual Conversion Policy.

Prudential ceased paying benefits to Plaintiff-Appellant, Barbara A. Savona, under the Individual Conversion Policy because Prudential maintained that Savona's aggregate benefit limit was two hundred fifty thousand dollars ($250,000) as a lifetime maximum. The aggregate benefit limit of two hundred fifty thousand dollars ($250,000) was completely exhausted by May 31, 1991.

When Plaintiff-Appellant, Barbara A. Savona, was employed by the Hotel Royal Plaza and participated in the employee benefit plan provided by her employer, she originally was enrolled in a plan which provided group health benefits with one million dollars ($1,000,000) maximum lifetime benefits. See "Your Employee Benefit Plan" No. 59967 (see Appendix, Exhibit "C"). After her motor vehicle accident in which she was rendered disabled, she terminated from the benefit plan pursuant to the terms of that plan. Employees of the Hotel Royal Plaza were offered the privilege by their employer to convert from the above mentioned group plan to an Individual Conversion Policy, pursuant to the terms of the employee benefit plan. Barbara A. Savona took advantage of that opportunity and converted to an Individual Conversion Policy which provided a policy maximum limit of two hundred fifty thousand dollars ($250,000). See Individual Conversion Policy, Appendix, Exhibit "D". It was Prudential's position that Plaintiff-Appellant's employer was wholly within its right to draft an employee benefit plan however it wished as long as it did not violate the law, and that the courts were prohibited from rewriting any of the terms of such benefit plan to accommodate an individual who was unhappy with the terms or who needed more benefits from the program than the program they have selected provides.

The "Your Employee Benefit Plan" at issue specifically, unequivocally and unambiguously stated that:

> CHANGE TO AN INDIVIDUAL EXPENSE INSURANCE POLICY
>
> An employee whose health care expense coverage is terminated for any reason other than discontinuation of

> the plan if replaced by a similar plan within 31 days or the employee's failure to make any required contribution may, subject to established rules, obtain a Prudential individual policy of health care benefits. The benefits and provision of the individual policy differ from those of the plan. (Emphasis supplied.)

The document expressing the terms of the "Your Employee Benefit Plan" benefits under which Plaintiff-Appellant was originally enrolled clearly stated that the benefits provided for major medical expense benefits are the one million dollars ($1,000,000) lifetime maximum benefit. The Individual Conversion Policy to which Plaintiff-Appellant, Barbara A. Savona, converted after terminating her enrollment in the plan benefits, clearly stated the benefits provided for the major medical expenses benefits are the maximum aggregate limits of two hundred fifty thousand dollars ($250,000). The privilege to convert from the original plan benefit to the Individual Conversion Policy of health care benefits was provided by the employer as a benefit of the "Your Employee Benefit Plan", and is documented as same on Page SKF-36 of the "Your Employee Benefit Plan", Appendix, Exhibit "C".

It was undisputed that Plaintiff-Appellant, Barbara A. Savona, terminated from the original employee plan, "Your Employee Benefit Plan" pursuant to the terms of that policy and exercised her privilege to convert to an individual policy. It is also undisputed that Prudential issued an Individual Conversion Policy to Barbara A. Savona. The first page of the conversion policy states that "Prudential will pay the benefits shown in the contract for charges incurred on or after the affected date because of sickness or injury". The contract schedule indicates the policy

has a monthly premium of three hundred twenty eight and 05/100 dollars ($328.05), a deductible of five hundred dollars ($500.00) and an "aggregate benefit" of two hundred fifty thousand dollars ($250,000). See contract schedule of Individual Conversion Policy, Appendix, Exhibit "E". This conversion policy could only be interpreted to provide maximum benefits of two hundred fifty thousand dollars ($250,000). The conversion policy language is precise and the Aggregate Benefit limit is precise, and therefore, not ambiguous.

Prudential paid the two hundred fifty thousand dollars ($250,000) in benefits to which Plaintiff was entitled as coverage from the Individual Conversion Policy and therefore Prudential in good faith completely discharged its contractual coverage obligations to Plaintiff. Once the two hundred fifty thousand dollars ($250,000) in benefits were exhausted, the Plaintiff-Appellant filed a petition for declaratory relief seeking one million dollars ($1,000,000) in benefits originally afforded her under the group policy from which she converted to the Individual Conversion Policy. In its response to Barbara A. Savona's Petition for Declaratory Relief (R2-35), the Prudential Insurance Company of America argued that the Plaintiff's claims arising from her Individual Conversion Policy were covered by the Employment Retirement Income Security Act of 1974, (ERISA), and that Plaintiff was only able to apply for the Individual Conversion Policy because she had participated in the employee benefits plan offered by SKF, her employer. Prudential argued that the court was obligated under

the ERISA provisions to enforce the unambiguous, express terms and provisions of the ERISA employee benefit plan and the Individual Conversion Policy.

Prudential also argued, in the alternative that, if Florida Statutes applied, the aggregate benefit maximum of two hundred fifty thousand dollars ($250,000) provided in the pertinent Individual Conversion Policy which underlies the Plaintiff's claims in the instant case, complied with the Florida Statutory requirements as found in §627.6675(11)(a)1.b., Florida Statutes, (1990). (See Prudential's Response to Barbara Savona's Petition for Declaratory Relief and Supporting Memorandum of Law, (R2-35), Appendix, Exhibit "F".)

SUMMARY OF THE ARGUMENTS

I. The United States District Court for the Middle District of Florida was justified in deviating from the intermediate appellate court decisions in Blue Cross/Blue Shield of Florida, Inc. v. Shufelt, 487 So.2d 1085 (Fla. 5th DCA 1986), and Northbrook Life Ins. Co. v. Clark, 582 So.2d 1199 (Fla. 2nd DCA 1991), for they were not binding evidence of state law and were not good predictors of what the state supreme court would do given a similar case. The United States District Court for the Middle District of Florida was justified in its deviation from the Shufelt and Clark decisions that were published in conflict with the consistent legislative history of the pertinent statutory provisions found in §627.6675, Florida Statutes. The consistent statutory history evidenced clear legislative intent which allowed, at the option of the insurer, an individual policy providing a maximum benefit in the amount of two hundred fifty thousand dollars ($250,000), as was afforded to the Plaintiff/Appellant in the instant case. The United States Magistrate Judge Dietrich correctly construed §627.6675, Florida Statutes, and appropriately interpreted legislative intent when he ruled in favor of the Defendant-Appellee, that an Individual Conversion Policy need not provide benefits equal to that of the group policy from which conversion was made, and therefore final judgment in favor of the Defendant-Appellee should be affirmed.

II. In the alternative, should this court in a "de novo" review determine it should analyze Plaintiff's-Appellant's claims

by applying ERISA principles to the employer's self-funded plan at issue in this case, this court is obligated by ERISA to enforce the express provisions of an ERISA plan and is prohibited by ERISA from rewriting any of the terms of an ERISA plan. That plan specifically, unequivocally and unambiguously states that its terms are different from that of the Individual Conversion Policy provided as an option by the employer. Further, the Individual Conversion Policy upon which the Plaintiff's-Appellant's claim for one million dollars ($1,000,000) rests, specifically, unequivocally and unambiguously states that the maximum aggregate benefits are two hundred fifty thousand dollars ($250,000). Therefore, the United States Magistrate Judge Dietrich's ultimate decision, that Defendant-Appellee Prudential is not required to pay Plaintiff-Appellant in excess of two hundred fifty thousand dollars ($250,000) pursuant to the Plaintiff's-Appellant's Individual Conversion Policy, is also correct when applying federal ERISA principles to the facts of this case and therefore, the summary judgment in favor of Prudential should be affirmed.

ARGUMENT

I. THE UNITED STATES MAGISTRATE JUDGE DIETRICH CORRECTLY CONSTRUED §627.6675, FLORIDA STATUTES, AND APPROPRIATELY INTERPRETED LEGISLATIVE INTENT WHEN HE RULED IN FAVOR OF DEFENDANT-APPELLEE THAT AN INDIVIDUAL CONVERSION POLICY NEED NOT PROVIDE BENEFITS EQUAL TO THAT OF THE GROUP POLICY FROM WHICH CONVERSION WAS MADE.

Clearly the United States District Court for the Middle District of Florida was correct in applying the rationale used by the Seventh Circuit in Williams, McCarthy, Kinley, Rudy & Picha v. Northwestern National Insurance Group, 750 F.2d 619 (7th Cir. 1984), when it acknowledged that it is the Supreme Court of Florida which is the final authority on the meaning of Florida Statutes, and that an intermediate or appellate court decision is not binding evidence of state law and circumstances when it is not a good predictor of what the state's highest court would do in a similar case. See Williams at 624. See also West v. American Telephone and Telegraph Co., 311 U.S. 223, 237, 61 S.Ct. 179, 183, 85 L.Ed.2d 139 (1940); 19 Wright, Miller & Cooper Federal Practice and Procedure §4507, at p. 95 (1982).

In the instance of interpreting state law, the goal of the federal courts is to try to get the same result that would be reached in the state courts. Where a statutory language in its amended form is plain, the federal court is entitled to resolve the conflict in interpretation of that law where the Supreme Court of Florida has not spoken on the interpretation of the particular statute in question. See Oliva v. Pan American Life Insurance Co., 448 F.2d 217, 221 (5th Cir. (Fla.) 1971). Plaintiff's-Appellant's reliance upon Flintkote Co. v. Dravo Corp., 678 F.2d 942 (11th Cir.

1982) is misplaced because Flintkote is factually distinguished in that it is a case where the federal jurisdiction is based on diversity citizenship, and a case in which there was no plain statute in direct conflict with the decision of the Georgia court of appeals under consideration.

In the instant case, the United States District Court for the Middle District of Florida was correct in its determination that it was not bound to adhere to decisions of the Florida intermediate appellate courts, specifically the Shufelt and Clark decisions[1], because there was very persuasive indication as evidenced by the plain language of §627.6675, Florida Statutes, that the Supreme Court of Florida would decide the issue otherwise. When there exists the plain language of a statute which clearly portrays legislative intent, this serves as a persuasive indication as to how the state's highest court would rule. In the instant case the United States District Court for the Middle District of Florida was justified in its deviation from the Shufelt and Clark decisions that were published in conflict with the consistent history of the pertinent statutory provisions found in §627.6675, Florida Statutes, evidencing clear legislative intent. A federal court applying state law is only bound to adhere to decisions of the state's intermediate appellate courts absent some persuasive indication that the state's highest court would decide the issue otherwise. Silverberg v. Paine, Webber, Jackson & Curtis, Inc.,

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[1] Blue Cross/Blue Shield v. Shufelt, 487 So.2d 1085 (Fla. 5th DCA 1986); Northbrook Life Insurance v. Clark, 582 So.2d 1199 (Fla. 2d DCA 1991).

710 F.2d 678, 690 (11th Cir. 1983) (Emphasis supplied.) See also Studstill v. Borg Warner Leasing, 806 F.2d 1005, 1007 (11th Cir. 1986); Provau v. State Farm Mutual Automobile Insurance Co., 772 F.2d 817, 820 (11th Cir. 1985). In addition, United States Magistrate Judge Dietrich clearly explained in a detailed analysis in his Memorandum Opinion dated February 11, 1993, why he deviated from reliance upon the intermediate state court Shufelt and Clark decisions.

In a well reasoned opinion, the Honorable Magistrate Dietrich details the flaws in the Shufelt and Clark decisions as well as outlines the statutory amendments to the pertinent conversion policy statute that have occurred since the Shufelt and Clark decisions were published. See Memorandum Opinion, Appendix, Exhibit "A2". Obviously, the analysis presented in the Memorandum Opinion by the Honorable Magistrate Dietrich reveals that there were great persuasive indications that the Supreme Court of Florida would decide the issue differently than did the intermediate appellate court in the Shufelt and Clark decisions, and as clearly, the District Court Opinion reveals that it was not simply based on the Honorable Magistrate Dietrich's disagreement with the state courts' reasoning or the outcome which the decisions dictated. Even a cursory review of the analysis in the Honorable Magistrate Dietrich's Memorandum Opinion reveals that he did not simply, unthinkingly deviate from the intermediate appellate court cases, but rather, carefully analyzed the pertinent Individual Conversion Policy statutory amendments, and the actions taken by the state

legislature since the intermediate state court decisions, which appeared to be an attempt to change those court decisions. See Oliva v. Pan American Life Insurance Co., 448 F.2d 217, 221 (5th Cir. 1971); Wright, Miller & Cooper Federal Practice and Procedure: Jurisdiction Sec. 4507 (1982).

In his Memorandum Opinion, the Honorable Magistrate Dietrich accurately outlined the history of amendments to the pertinent statute, and as Plaintiff-Appellant indicated in her Brief, there has been additional legislative activity on that statute since the publication of the district court's Memorandum Opinion. A review of the legislative history of §627.6675, Florida Statutes, reveals that the legislative intent regarding the insurer's obligation with respect to conversion policy benefits has been consistent and that, as the district court concluded in its Memorandum Opinion, p.9, the amendments to §627.6675, Florida Statutes, have made clear beyond any question what the unamended statute already had allowed: that a converted policy need not provide benefits equal to that of the group policy.[2]

The following outline of the legislative amendment to §627.6675, Florida Statutes, reveals that the United States District Magistrate Dietrich was justified in his belief that the

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[2]Defendant-Appellee Prudential, in discussing the legislature's intent regarding Fla. Stat. §627.6675, does not recede from its original position that the original benefit plan, upon which Plaintiff's-Appellant's claim and appeal is based, is not a group insurance policy, but rather is an employee benefit plan sponsored by the employer through a self-funded trust. (See "Summary Plan Description", p. SKF-45 of the "Your Employee Benefit Plan", Appendix, Exhibit "C".)

Supreme Court of Florida would not follow the decisions in Shufelt and Clark, at least not the Plaintiff's interpretation of §627.6675, Florida Statutes, as applied to the facts of this case. As indicated in Magistrate Dietrich's Memorandum Opinion, both the Shufelt and Clark opinions are unclear, particularly when contrasted with the very plain language of the pertinent statute, §627.6675, Florida Statutes. Thus Plaintiff's-Appellant's argument, that the Honorable Magistrate Dietrich erred in deviating from the intermediate state appellate court opinions, fails and is without merit. See Diesel Service Co. v. AMBAC International Corp., 961 F.2d 635, 639 (7th Cir. 1992).

A review of §627.6675, Florida Statutes, (1985) reveals that even as back as far as 1985, the pertinent policy provisions were as follows:

> (8) BENEFITS OFFERED - An insurer shall not be required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.
> ...
>
> (11) OPTIONAL COVERAGE: MAJOR MEDICAL - Subject to the provisions and conditions of this part, if the group insurance policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:
> (a) A maximum benefit at least equal to either, at the option of the insurer, the amount specified in subparagraph 1 or subparagraph 2.
> 1. The smaller of the following amounts:
> a. The maximum benefit provided under the group policy.
> b. A maximum payment of $250,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.
> 2. The smaller of the following amounts:
> a. The maximum benefit provided under the group policy.

b. A maximum payment of $250,000 for each unrelated injury or sickness. (Emphasis supplied.)

A review of §627.6675, Florida Statutes, (1987) reveals that the above pertinent policy provisions remain identical, reflecting consistent legislative intent allowing, at the option of the insurer, an individual policy providing a maximum benefit in the amount of two hundred fifty thousand dollars ($250,000), as was afforded to Plaintiff-Appellant in the instant case.

A review of §627.6675, Florida Statutes, (1989) contains the above identical provisions as found in subsections (8) and (11). A review of §627.6675, Florida Statutes (1991), also reveals that the above referenced provisions remain identical, evidencing the continuing intent of the legislature which clearly provides the insurer with the option of providing a maximum conversion policy benefit consisting of the smaller of two hundred fifty thousand dollars ($250,000), or the group policy limits.

Even in 1992, when there were significant amendments made to §627.6675, Florida Statutes, the above referenced provisions remained almost identical, however, the above referenced subsection (11) became subsection (10). In subsection (10) the legislature modified the required option for major medical coverage in pertinent part providing that the employee or member is entitled to obtain a converted policy providing major medical coverage under a plan meeting the following requirements:

a. A maximum benefit equal to <u>the lesser of the policy limit of the group policy</u> from which the individual converted, or $500,000 per covered person for all covered medical expenses incurred during the covered person's lifetime. (Emphasis supplied.)

Although by 1992, the legislature saw fit to raise the sum per covered person, the statutory language is plain in that the insurer still has the choice to provide a maximum benefit equal to the policy limit of the group policy, or five hundred thousand dollars ($500,000) per covered person, whichever is the lesser amount. Even in the 1992 supplement to the Florida Statutes, (1991), the legislature did not eliminate this provision, or add language to evidence an intent to require the insurer to provide a maximum benefit equal to the group policy limits from which the individual converted. Most significantly, in the 1992 supplement to the Florida Statutes (1991), the legislature added an additional provision as follows:

> (20) NOTHING IN THIS SECTION OR IN THE INCORPORATION OF IT INTO AN INSURANCE POLICY SHALL BE CONSTRUED TO REQUIRE INSURERS TO PROVIDE BENEFITS EQUAL TO THOSE PROVIDED IN THE GROUP POLICY FROM WHICH THE INDIVIDUAL CONVERTED, provided however, that comprehensive benefits are offered which shall be subject to approval by the insurance commissioner. (Emphasis supplied.)

As Plaintiff-Appellant indicates in its Brief, there was originally additional language in this provision which was deleted prior to the provision taking effect in October 1992. However, clearly for the purposes of this case, the most significant language, as emphasized above in subsection (20), remains as an amendment to the statute clarifying and specifying the legislative intent of this section that it does not require the issuance of conversion policies providing benefits equal to those provided in the group policy from which the individual converted.

In reviewing the history of the pertinent provisions outlined above, it cannot be disputed that the legislative intent has been clear as far back as 1985, and consistent, even through the amendments up to the present date, affording the insurer the option of providing a maximum conversion policy benefit of the smaller of two hundred fifty thousand dollars ($250,000) (or now five hundred thousand dollars ($500,000)), or the group policy limits. Nowhere in any of the pertinent policy provisions through the history of this statute since at least 1985, did the legislature evidence an intent to require insurers to provide benefits equal to those provided in the group policy from which the individual converted. Consequently, the Shufelt and Clark decisions relied upon by the Plaintiff-Appellant are not persuasive in light of the legislative history outlined above, and as analyzed by the United States District Court Magistrate Judge Dietrich in his Memorandum Opinion.

Further, a close look at both cases relied upon by Plaintiff-Appellant, Northbrook Life Ins. Co. v. Clark, 582 So.2d 1199 (Fla. 2nd DCA 1991), and Blue Cross/Blue Shield of Florida, Inc. v. Shufelt, 487 So.2d 1085 (Fla. 5th DCA 1986), reveal that these cases are distinguished from the facts in the instant case in a very significant manner. As explained in detail in Defendant-Appellee's Statement of the Facts, Barbara Savona was enrolled in a benefit plan through her employer, entitled "Your Employee Benefit", provided by the SKF Group Benefit Plans Trust through a self-funded program. The Prudential Insurance Company of America only provided certain administrative services in connection with

the plan. In Northbrook Life Ins. Co. v. Clark, the plaintiff was an insured under a group health insurance plan underwritten by Northbrook Life Insurance Company, in contrast to the employer's self-funded plan which is at issue in the instant case. Likewise, in Blue Cross/Blue Shield of Florida, Inc. v. Shufelt, the appellee-employee Shufelt was injured while covered under a health and accident policy issued by appellant's insurer, Blue Cross/Blue Shield, through employer. In the Shufelt case, as well as the Northbrook Life case, the plaintiffs' claims arose from a group insurance policy offered by an insurance company for delivery in the State of Florida. A close look at these cases reveals that neither case discusses, in any way, the implementation of a major medical expense benefit plan provided by a group benefit plans trust through the employer's self-funded program. Therefore, Plaintiff's-Appellant's emphasis on Northbrook Life Ins. Co. v. Clark and Blue Cross/Blue Shield of Florida, Inc. v. Shufelt to support her Appeal is misplaced. See Fla. Stat. §627.651(5), wherein in pertinent part, it states:

> (5) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974 ... (Emphasis Supplied).

Consequently, The United States District Court Magistrate Dietrich's denial of the Plaintiff's-Appellant's Petition for Declaratory Relief, and entry of judgment on behalf of the Defendant-Appellee, Prudential and against the Plaintiff-Appellant, Savona, should be affirmed.

ARGUMENT

II. THE UNITED STATES MAGISTRATE JUDGE DIETRICH'S ULTIMATE DECISION, THAT PRUDENTIAL WAS NOT REQUIRED TO PAY PLAINTIFF-APPELLANT IN EXCESS OF TWO HUNDRED FIFTY THOUSAND DOLLARS ($250,000) PURSUANT TO PLAINTIFF'S-APPELLANT'S INDIVIDUAL CONVERSION POLICY, IS ALSO CORRECT WHEN APPLYING FEDERAL ERISA PRINCIPLES TO THE FACTS OF THIS CASE.

Defendant-Appellee Prudential vehemently disagrees with Plaintiff-Appellant Savona's argument, found on Page 6 of its Brief, that "this case is not in any way connected with ERISA, and that the decision of the Magistrate and the submission of the Certified Question to the Supreme Court of Florida for its interpretation, puts the applicability of ERISA versus Florida law to rest." As previously stated in Defendant-Appellee Prudential's Statement of the Case, in its per curiam opinion, the Eleventh Circuit, in certifying its question, did not intend the particular phrasing of the question to limit the Supreme Court of Florida in its consideration of the problem posed by the case.

Defendant-Appellee Prudential originally removed this case from the State Court to the United States District Court for the Middle District of Florida under the authority of 28 U.S.C. §1441 et seq., because Plaintiff-Appellant's Petition for Declaratory Relief set forth facts sounding in a federal cause of action seeking redress under an employee benefit plan, as defined in 29 U.S.C. §1001(1), which constituted a federal question sufficient for removal to the United States District Court for the Middle District of Florida. Although the United States district courts have original jurisdiction over civil actions arising under 29

U.S.C. §1132(a)(1)(B), state courts have concurrent jurisdiction pursuant to 29 U.S.C. §1132(e)(1). See Reineke v. Reineke, 627 So.2d 1182 (Fla. 1st DCA 1993); Shideler v. Connecticut General Life Ins. Co., 563 So.2d 1082 (Fla. 5th DCA 1990); and Neubauer v. Safeco Life Ins. Co., 532 So.2d 732 (Fla. 3rd DCA 1988). Further, Defendant-Appellee Prudential disagreed with the Eleventh Circuit Court's characterization that it was "an undisputed fact that the benefit plan in question was a group insurance policy issued for delivery in the State of Florida". The exact nature of the underlying benefit plan appears to be a disputed fact. A close review of the benefit plan in question will reveal it is not, as described in Fla. Stat. §627.6675, "a group policy delivered or issued for delivery in the State by an insurer ...", and therefore, whether Fla. Stat. §627.6675 even applies to the facts of this case, is also at issue. (See e.g., Fla. Stat. §627.651(5)).

Prudential has consistently argued to the Middle District Court of Florida and in its Answer Brief in response to Plaintiff-Appellant's Appeal to the Eleventh Circuit, that the "Your Employee Benefit Plan" was governed by the Employee Retirement Income Security Act in 1974, commonly known as ERISA, 29 U.S.C.S. §§1001 et seq. At no time was the employee benefit plan sponsored by Schimberg, Kennedy & Frost ("SKF") deemed by Prudential to be an insurance policy offered for delivery in the State of Florida, which could be regulated by the State insurance laws. It has been the position of Prudential at all times that, Plaintiff-Appellant's Petition for Declaratory Relief, which sought relief relating to

her employee welfare benefit plan, raised issues constituting a federal question sufficient for removal to the United States District Court for the Middle District of Florida. At no time has it been the position of Prudential that the plan in question was anything other than the employer's self-funded program under which Prudential Insurance Company of America only acted to provide certain administrative services in connection with the plan. The Florida district courts of appeal have acknowledged that ERISA regulates employee benefits plans, including ones providing for medical and hospital care, if the plan is established or maintained by an employer or employee organization, or both. ERISA, §4(a), 29 U.S.C. §1003(a); Blue Cross/Blue Shield of Florida, Inc. v. Weiner, 543 So.2d 794, 798 (Fla. 4th DCA 1989). In the Weiner case, the insurer, Blue Cross/Blue Shield of Maryland, asserted to the district court on appeal that it lacked jurisdiction on the subject matter, because the plaintiff's claim relating to insurance benefits was preempted by the Employee Retirement Income Security Act of 1974. The Fourth District Court of Appeal acknowledged that ERISA does regulate employee benefits plans, including ones providing for medical and hospital care, if the plan is established or maintained by an employer or employee organization, or both. However, the district court found in Weiner that the record did not support a conclusion that there was an employee plan. In Weiner, the Fourth District Court of Appeal found that, the plaintiff was the sole proprietor, who simply purchased a group policy for his family, and that there was no plan, or even an informal agreement,

established or maintained by an employer or employee organization. Based on that finding, the Fourth District Court of Appeal determined that ERISA did not apply to the facts of that case. Clearly, in contrast, the record herein reveals the existence of an employee plan sponsored by an employer through a self-funded trust, such that ERISA does regulate this employee benefit plan in which Mrs. Savona was enrolled, and which forms the basis of her appeal.

For some reason unknown to Prudential, the federal courts that have accepted jurisdiction in this case, have chosen only to focus on the application of Florida law, as if the plan in question was a typical group insurance policy, as addressed by Chapter 627, Florida Statutes. Although the Eleventh Circuit certified its question to the Supreme Court of Florida pursuant to Article 5, §3(b)(6) of the Florida Constitution, suggesting that the question of law is "determinative of the cause but unanswered by controlling precedent of the Supreme Court of Florida", it is Prudential's position that, the Supreme Court of Florida does not need to apply Florida law to establish controlling precedent to resolve the issues raised by the implementation of Plaintiff-Appellant's employee welfare benefit plan, but rather, once this Court fully understands the true nature of the underlying employee welfare benefit plan in question, this Court can and should resolve the issues arising from the employee welfare benefit plan, applying already existing ERISA principles, which govern the implementation of the type of employee benefit plan in question in this case.

Therefore, Defendant-Appellee Prudential has included in its Answer Brief the following argument also raised to the Middle District Court and the Eleventh Circuit Court of Appeal, which asserts that an analysis of Plaintiff-Appellant Savona's claims, by applying ERISA principles, reveals that Magistrate Judge Dietrich's ultimate decision, that Prudential was not required to pay Plaintiff-Appellant in excess of $250,000, should be affirmed.

In light of ERISA's "deemer clause", §514(6)(2)(B), 29 U.S.C. §1144(b)(2)(B) [29 U.S.C.S. §1144(b)(2)(B)], which states that a benefit plan shall not be deemed an "insurance company" for purposes of the insurance savings clause, any application of insurance industry regulations to benefit plans directly would be preempted by ERISA'S preemption clause, §514(a), 29 U.S.C. §1144(a) [29 U.S.C.S. §1144(a)]. See FMC Corporation v. Holliday, 498 U.S. 52, 63 (1990); and Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724, 737, N. 14 (1985). In FMC Corporation v. Holliday, 498 U.S. 52 (1990), the Supreme Court of the United States analyzed whether an application of a Pennsylvania state statute, prohibiting the exercise of subrogation rights on tort recovery to an employee welfare benefit plan, should be preempted by ERISA. The Supreme Court of the United States held that, ERISA preempted the application of the Pennsylvania statute to the employer's plan, because the Pennsylvania statute related to an employee benefit plan, within the meaning of §514(a) of ERISA. 498 U.S. at 58. Further, the Supreme Court of the United States held that, although the Pennsylvania statute fell within ERISA's saving

clause permitting states to regulate insurance except as provided by the deemer clause, the deemer clause, by forbidding states to deem an employee benefit plan to be an insurance company, an insurer, or engaged in the business of insurance, exempts self-funded ERISA plans from state laws regulating insurance. 498 U.S. at 61.

It is undisputed that the original coverage to Plaintiff-Appellant was provided to her by her employer and was evidenced by a document she received entitled "Your Employee Benefit Plan", benefits which were provided by the SKF Group Benefit Trust Plans through a self-funded program under which the Prudential Insurance Company of America only provided certain administrative services in connection with the Plan. See Appendix, Exhibit "C", particularly cover sheet and page 1. It cannot be disputed that the "Your Employee Benefit Plan" (Appendix, Exhibit "C") is governed by the Employee Retirement Income Security Act of 1974, commonly known as ERISA, 29 U.S.C. §1132(a)(1)(B). The Plaintiff's-Appellant's Petition for Declaratory Relief set forth facts sounding a federal cause of action by seeking redress under an employee benefit plan which includes the right to alleged benefits, "in the event of sickness, accident, disability, death or unemployment," as defined in 29 U.S.C. §1002(1) (which constituted a federal question sufficient for removal to United States District Court for the Middle District of Florida.) The "Your Employee Benefit Plan" itself provided to Plaintiff-Appellant in its Summary Plan Description, an explanation of her rights and protections as a

participant in the Plan. See Appendix, Exhibit "C", page SKF-47, wherein it states:

> RIGHTS AND PROTECTIONS:
> As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA)...

The Plan itself clearly informed Plaintiff-Appellant of the implementation of her employer's Employee Benefits Trust Plan and the rights and obligations arising therefrom as governed by ERISA.

When an employee participates in an ERISA plan, §502 of ERISA is the sole, civil enforcement provision available to him -- it provides that participant with his/her sole and exclusive remedies. See e.g., Drinkwater v. Metropolitan Life Insurance Co., 846 F.2d 821 (1st Cir.) cert. den. 488 U.S. 909, 109 S.Ct. 261, 102 L.Ed.2d 249 (1988). Section 514(a) of ERISA provides that ERISA supersedes any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. The Supreme Court of the United States has repeatedly stated that the preemptive effect of ERISA is extremely broad. See e.g., Ingersoll-Rand v. McClendon, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). In this recent pronouncement of preemption by the Supreme Court, it explained that state law claims are preempted even if their effect is only "indirect". The Court specifically noted that where there would be no cause of action if there were no Plan, then the cause of action is preempted. 112 L.Ed.2d at 485. In the instant case, if there had not been a Plan sponsored by employer, Shimberg, Kennedy and Frost, Inc., "SKF", there would be no cause of action against Prudential. But for Prudential's involvement as administrator

of certain claims of the "Your Employee Benefit Plan", it would not be a party to this suit. See also Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). It is obvious the Plaintiff's claims clearly relate to an ERISA plan, which is the "Your Employee Benefit Plan" (Appendix, Exhibit "C"), and, but for the existence of the ERISA plan, Plaintiff would have absolutely no relationship or cause of action against Prudential. In Ingersoll-Rand v. McClendon, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990), the Supreme Court of the United States said:

> §514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefit law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among states or between states in the federal government. Otherwise, the inefficiencies created could work to the detriment or plan beneficiaries. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement. 112 L.Ed. 2d at 486.

In Pilot Life Insurance Co. v. Dedeaux, 95 L.Ed.2d 39, 52 (1987), the Supreme Court of the United States held:

> In sum, the detailed provisions of 502(a) set forth a comprehensive, civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA...
>
> The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive...

Therefore, Plaintiff's determination of her rights as expressed in the Petition for Declaratory Relief which seek a determination and construction of the language in the "Your Employee Benefit Plan" and the Individual Conversion Policy to which she converted are clearly governed by ERISA provisions.

It is undisputed that Plaintiff-Appellant terminated from the original employee plan, "Your Employment Benefit Plan" pursuant to the terms of that policy and exercised her privilege to convert to an individual policy. (See Barbara A. Savona's Petition for Declaratory Relief, (R1-21).) It is also undisputed that Prudential issued an Individual Conversion Policy to Plaintiff-Appellant. The first page of the conversion policy states that "Prudential will pay the benefits shown in the contract for charges incurred on or after the effective date because of sickness or injury." The contract schedule indicates that the policy has a monthly premium of three hundred twenty eight and 05/100 dollars ($328.05), a deductible of five hundred thousand dollars ($500.00), and an "Aggregate Benefit" of two hundred fifty thousand dollars ($250,000). See Contract Schedule of Individual Conversion Policy (Appendix, Exhibit "D"). This conversion policy can only be interpreted to provide maximum benefits of two hundred fifty thousand dollars ($250,000). The conversion policy language is precise and the Aggregate Benefit limit is precise, and therefore, not ambiguous. Nowhere in this contract is there evidence, or even a suggestion, that the Aggregate Benefits equal one million dollars ($1,000,000), nor does this Individual

Conversion Contract incorporate by reference the Employee Benefit Plan language or coverage limits provided by the totally separate and distinct "Your Employee Benefit Plan" from which Plaintiff-Appellant terminated before she converted to the Individual Conversion Policy.

The application for conversion of insurance under the medical expense program, signed on behalf of the Plaintiff-Appellant, specifically seeks information regarding the "Your Employee Benefit Plan" from which the conversion is applied. See application (Appendix, Exhibit "G"). Question No. 6 seeks the name of the employer who had provided the program from which the conversion is applied, and in response is typed "Hotel Royal Plaza/Schimberg, Kennedy and Frost, Inc." with the #59967 reflecting the "Your Employee Benefit Plan" (Appendix, Exhibit "C"). Also, clearly stated is Question No. 6(b) wherein it queries "date coverage ends under the program", and in response, the date is written as 5/8/87. Further, also clearly queried is Question No. 6(c) "reason coverage ends", and in response is written "due to disability." Further down on the application is a paragraph which is a declaration to be read and under which the signature of the applicant or those signing on behalf of the applicant is placed. That declaration states as follows:

> I declare that, to the best of my knowledge and belief, the above statements are complete and true. I agree that no insurance will start unless Prudential approves this application. If that takes place, and the full first premium is paid, insurance under the contract issued will start, subject to its terms on the date stated in the contract...." (Emphasis supplied).

See Plaintiff's-Appellant's application for conversion of insurance (Appendix, Exhibit "G"). Clearly, right from the start involving the application for the Individual Conversion Policy, Plaintiff-Appellant, or those acting on her behalf, were on notice that the benefit under the employee benefit plan which was provided by her employer, Schimberg, Kennedy and Frost, Inc., ended, as revealed in Plaintiff's responses to Question Nos. 6(a), 6(b) and 6(c). Further, it is clear that Plaintiff-Appellant, or those acting on her behalf, having read the declaration and signed this application, were on notice and understood that if Prudential approved the application and the full first premium was paid, the insurance under the new Individual Conversion Policy with maximum Aggregate Benefits of two hundred fifty thousand dollars ($250,000) would start, subject to its terms on the date stated in the contract. There could have been no doubt, even at the very initiation of the conversion process, that Plaintiff-Appellant was applying for an Individual Conversion Policy which differed from the "Your Employee Benefit Plan" from which she terminated.

Plaintiff's-Appellant's contention, that now the Individual Conversion Policy whose benefits have been exhausted, should be reformed and rewritten to allow her one million dollars ($1,000,000) in benefits, is without merit.

ERISA is designed to promote the interest of employees and their beneficiaries in employee benefit plans as well as to protect contractually defined benefits. Shaw v. Delta Airlines. Inc., 463 U.S. 85, 90, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); Massachusetts

Mutual Life Insurance Company v. Russell, 473 U.S. 134, 148, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985). These interests are hardly promoted if deviations from the written plan are freely allowed. Modifications to a written plan that do not conform to the formal amendment procedures threaten the actuarial soundness of the plan and thereby undercut the ability of plan participants to rely on their expected stream of benefits. See, e.g., National Cos. Health Benefit Plan v. St. Joseph's Hospital of Atlanta, Inc., 929 F.2d 1558, 1571 (11th Cir. 1991). Strict adherence to a written plan also prevents a collusive agreement between an employer and a favorite employee that could operate to the detriment of all other plan participants' rights. In addition, if employer obligations could be casually created outside the written plan, a substantial disincentive to offering such plans would arise since employers would be potentially exposed to massive future liability for which they could not confidently plan. See Moore v. Metropolitan Life Insurance Company, 856 F.2d 488, 492 (2d Cir. 1988). This would undercut the public interest in encouraging employers to offer these plans. See Pilot Life Insurance Company v. Dedeaux, 481 U.S 41, 54 (1987). Finally, allowing informal modifications would invite costly, litigious, evidentiary disputes over what "promises" or "representations" were or were not made. In the instant case, the Plaintiff-Appellant can point to no formal written evidence that supports her contention that she is entitled to one million dollars ($1,000,000) in benefits under the Individual Conversion Plan, which clearly states Aggregate Benefit limits of two hundred

fifty thousand dollars ($250,000), to which she converted after terminating her enrollment in the "Your Employee Benefit Plan".

Although it is true that the "Your Employee Benefit Plan" provided a maximum lifetime payment of one million dollars ($1,000,000) to its participants (see "Your Employee Benefit Plan" (Appendix, Exhibit "C"), page SKF-12), it is clearly stated under the "Change To An Individual Expense Insurance Policy" provision of the "Your Employee Benefit Plan" that, "an employee... may, subject to established rules, obtain a Prudential individual policy of health care benefits, the benefits and provisions of which differ from those of the plan". See page SKF-36 of the "Your Employee Benefit Plan". Nowhere in either the "Your Employee Benefit Plan" or Plaintiff's-Appellant's individual health care benefit policy to which she converted, does it state that once you terminate from the "Your Employee Benefit Plan" and convert to an Individual Conversion Policy, you are entitled to the maximum lifetime benefits provided under the "Your Employee Benefit Plan" from which you terminated. To the contrary, the "Your Employee Benefit Plan" expressly states that, although a participant may terminate from the plan and exercise a privilege provided by the employer to obtain a Prudential individual policy of health care benefits, the benefits and provisions of the individual policy differ from those of the plan. It cannot be stated more clearly that the benefits and provisions of the individual policy are not identical to those of the employee benefit plan, nor are they required to be identical.

An employer is wholly within its right to draft an employee benefit plan however it wishes, provided it does not violate federal law (e.g., discrimination based upon race, religion, etc.). See Dzinglski v. Weirton Steel Corp., 875 F.2d 1075 (4th Cir.) cert. den. 493 U.S. 919, 110 S.Ct. 281, 107 L.Ed.2d 261 (1989); Moehle v. NL Industries, Inc., 646 F.Supp. 769 (E.D. Mo. 1986). See also, Amato v. Western Union Intern., Inc., 773 F.2d 1402 (2nd Cir. 1985); Bryant v. Food Lion, Inc., 774 F.Supp. 1484 (D.S.C. 1991).

Courts are obligated by ERISA to enforce the express provisions of an ERISA Plan and are prohibited by ERISA from rewriting any of the terms of an ERISA plan. United Mine Workers of America Health and Retirement Funds v. Robinson, 455 U.S. 562, 102 S.Ct. 1226, 71 L.Ed.2d 419, 430 (1982); Adams v. LTV Steel Mining Company, 936 F.2d 368 (8th Cir. 1991); Crews v. Central States Southeast and Southwest Areas Pension Fund, 788 F.2d 332, 336 fn. 1, (6th Cir. 1986); Dzinglski v. Weirton Steel Corp., 875 F.2d 1075 (4th Cir.) cert. den. 493 U.S. 919, 110 S.Ct. 281, 107 L.Ed.2d 261, (1989); Moore v. Reynolds Metals Company Retirement Program For Salaried Employees, 740 F.2d 454 (6th Cir. 1984); Blackmar v. Lichtenstein, 603 F.2d 1306 (8th Cir. 1979); Leigh v. Engle, 619 F.Supp. 154, 157-58, (N.D. Ill. 1985); Justice v. Bankers Trust Co., Inc., 607 F.Supp. 527, 534 (N.D. Ala. 1985); Helms v. Monsanto, 558 F.Supp. 928, 930 (N.D. Ala. 1982) rev'd on other grounds 728 F.2d 1416 (11th Cir. 1984); Flinchbaugh v. Chicago Pneumatic Tool Co., 531 F.Supp. 110 (W.D. Pa. 1982).

If courts could rewrite the plan to provide benefits not expressly provided in the plans, the prohibition against extracontractual and punitive damages, also addressed in ERISA, would be meaningless. Courts have not only held that they are prohibited from rewriting the plan, but they have also consistently held that in no event can the employer orally modify the ERISA plan. Cefalu v. B.F. Goodrich Co., 871 F.2d 1290 (5th Cir. 1989); Musto v. American General Corp., 861 F.2d 897 (6th Cir. 1988) cert. den. 490 U.S. 1020, 109 S.Ct. 1745, 104 L.Ed.2d 182 (1989); Nachwalter v. Christie, 805 F.2d 956 (11th Cir. 1986).

Put simply, a reviewing court must enforce the express terms of the "Your Employee Benefit Plan" and those of the Individual Conversion Policy. That Plan specifically, unequivocally, and unambiguously states that its terms differ from that of the Individual Conversion Policy provided as an option by the employer, and the Individual Conversion Policy upon which the Plaintiff's claim for one million dollars ($1,000,000) rests, specifically, unequivocally, and unambiguously states that the maximum Aggregate Benefits are two hundred fifty thousand dollars ($250,000).

In addition to the clear schedule policy language of the Individual Conversion Policy, Prudential repeatedly made it clear to Plaintiff-Appellant Savona that she is only entitled to two hundred fifty thousand dollars ($250,000) maximum Aggregate Benefits just as the Individual Conversion Policy provides, therefore, Plaintiff-Appellant Savona knew she was not entitled to benefits in excess of two hundred fifty thousand dollars ($250,000)

and could not have relied on misrepresentation or information stating otherwise. See letters and health conversion package (Appendix, Composite Exhibit "H"). Prudential has acted totally in good faith in construing and implementing Plaintiff's-Appellant's rights, and placing Plaintiff-Appellant on notice regarding its obligations to provide her coverage benefits under the Individual Conversion Policy in which she participated and from which she now seeks more coverage benefits.

Further, the SKF benefit plan booklet unambiguously reserved to Plaintiff's employer the right to terminate the employee benefits under certain circumstances and to offer the employees an opportunity to change to an Individual Conversion Policy which differed from the employee benefit plan. Alday v. Container Corporation of America, 906 F.2d 660 (11th Cir.) cert. den. 111 S.Ct. 675, 112 L.Ed.2d 668 (1991). See also Moore v. Metropolitan Life Insurance Co., 856 F.2d 488 (2d Cir. 1988). It serves no interest other than that of actuarial chaos to have a court overturning or rewriting carefully crafted employee benefit plan provisions. Plaintiff's-Appellant's position, which seeks this Court to order disbursed to her the one million dollar ($1,000,000) benefits offered under the "Your Employee Benefit Plan" in which she was originally enrolled as an employee, would have the damaging effect of placing a duty on the employer to continue providing benefits even when the individual has terminated employment and the Employee Benefit Policy as to that individual has been terminated or canceled in accordance with its literal terms. See Rasmussan v.

Metropolitan Life Insurance Co., 675 F.Supp. 1497, 1504 (W.D. La. 1987). After the initial enrollment in the SKF benefit plan, Plaintiff's subsequent termination of participation in that plan acted to eliminate the existing coverage. Any contractual rights the Plaintiff had to the one million dollar ($1,000,000) fund she now seeks were relinquished in the application for the Individual Conversion Policy. Rosile v. Aetna Life Insurance Co., 777 F.Supp. 862, 870 (D. Kan. 1991).

The Individual Conversion Policy is part of an employee benefit plan governed by ERISA. All of Plaintiff's claims relate to the plan and are therefore preempted.[3] The right to convert to an individual policy was a benefit of the group plan, the resulting Individual Conversion Policy issued to Plaintiff is thus a benefit of the employment covered by ERISA. The Individual Conversion Plan entered into by Plaintiff-Appellant Savona after she terminated benefits with the "Your Employee Benefit Plan" solely exists for Savona as a benefit of her employment, and her opportunity to enroll in the Individual Conversion Plan was dependent upon benefits derived from the "Your Employment Benefit

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[3] Although plaintiff prefers to rely on Florida law citing, Blue Cross-Blue Shield of Florida, Inc. v. Shufelt, 487 So.2d 1085 (Fla. 5th DCA 1986) and §627.6675, Florida Statutes, it appears possible to interpret the statutes and case law such that those references do not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974. See §627.651(5), Florida Statutes 1990. Clearly the "Your Employee Benefit Plan" which is at issue in this case is a plan which is established or maintained by an individual employer in accordance with the Employment Retirement Income Security Act of 1974. (Emphasis supplied.)

Plan." Therefore, Plaintiff's claims arising from her Individual Conversion Policy are also covered by ERISA and the fact that the Individual Conversion Policy is a separate document from the "Your Employee Benefit Plan" makes no difference. See Silverman v. Barbizon School of Modeling and Fashion, Inc., 720 F.Supp. 966 (S.D. Fla. 1989).

Finally, even if this Court disagrees with the reasoning of the Honorable Magistrate Judge Dietrich in his Memorandum Opinion, a judgment which is correct in ultimate effect will not be disturbed on appeal even if the lower court relied on the wrong ground or gave an untenable reason for its decision. See American Family Life Assurance Co. of Columbus v. Blue Cross of Florida, Inc., 486 F.2d 225 (5th Cir. 1973); Davis v. Liberty Mutual Insurance Co., 525 F.2d 1204 (5th Cir. 1976); Stuart v. State, 360 So.2d 406 (Fla. 1978) (A proper ruling, even if based on the wrong reason, should be affirmed); In re Estate of Yohn, 238 So.2d 290 (Fla. 1970) (If a trial court's ruling is correct for any reason that appears in the record, its judgment will be affirmed). Further, a court of appeals on review of a district court decision is not restricted to the reasons given by the district court if the judgment of the district court is correct. See Murray v. Ford Motor Co., 770 F.2d 461 (5th Cir. 1985). See also T. Harris Young v. Marquette Electronics, Inc., 931 F.2d 816 (11th Cir.) cert. den. 112 S.Ct. 658, 116 L.Ed.2d 749 (1991) and Jonathan's Landing, Inc. v. Townsend, 960 F.2d 1538 (11th Cir. 1992).

CONCLUSION

The Honorable United States Magistrate Dietrich did not err as a matter of law in his deviation from reliance upon intermediate state court opinions which were unclear and which conflicted with unambiguous state statutory language to the contrary, where such language clearly supports the Magistrate's finding that the provision of a two hundred fifty thousand dollar ($250,000) lifetime major medical benefit was all that was required to be offered by Prudential under the plain language of subsections (8) and (11) of §627.6675, Florida Statutes (1990).

Whether this court, after its de novo review, determines that the United States Magistrate Judge Dietrich correctly applied and construed §627.6675, Florida Statutes, and appropriately interpreted legislative intent in ruling in favor of the Defendant-Appellee that an Individual Conversion Policy need not provide benefits equal to that of the group policy from which conversion was made, or whether this court determines that Plaintiff's-Appellant's claim should be analyzed applying federal ERISA principles to the facts of this case, Prudential contends the United States Magistrate Judge Dietrich's ultimate decision, that Prudential was not required to pay Plaintiff-Appellant in excess of two hundred fifty thousand dollars ($250,000) pursuant to Plaintiff's-Appellant's Individual Conversion Policy, should be affirmed.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished this 19th day of APRIL, 1994, to Charles E. Davis, Esquire, Pitts, Davis & Morris, P.A., 201 East Pine Street, Suite 425, Post Office Box 512, Orlando, Florida 32802.

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