IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

- -

BRIAN SPANGBERG,

Plaintiff,

OPINION AND ORDER

v.

05-C-703-C

THE PEPSI BOTTLING GROUP LONG TERM DISABILITY PLAN, PBG EMPLOYEE HEALTH CARE PROGRAM[1], PEPSICO, INC.

Defendants.

- -

This is a civil suit for monetary and declaratory relief arising under the Employee Income Retirement Security Act (ERISA), 29 U.S.C. §§ 1001-1461, in which plaintiff Brian Spangberg contends that (1) defendant Pepsi Bottling Group Long Term Disability Plan (the plan) wrongfully terminated his disability benefits under the disability benefits plan sponsored by his employer, Pepsi Bottling Group, Inc.; (2) defendant PBG Employee Health Care Program wrongfully terminated his medical benefits; and (3) defendant PepsiCo, Inc.,

[1] Plaintiff originally misnamed this party in the case caption as PepsiCo Employee Healthcare Program but later acknowledged that the correct name of the entity is PBG Employee Health Care Program.

violated 29 U.S.C. § 1132(c)(1) when it failed to provide plaintiff a copy of the disability plan documents in a timely manner. Subject matter jurisdiction is present. 28 U.S.C. § 1331.

This case was filed originally in the Circuit Court for Trempealeau County and the plan removed it to this court. The case is presently before the court on motions for summary judgment filed by plaintiff, the plan and PepsiCo. For the reasons stated below, I will deny plaintiff's motion and will grant the motions filed by the plan and PepsiCo. Also, I will dismiss PBG Employee Health Care Program from this lawsuit.

In a footnote in the defendant plan's reply brief, dkt. #50 at 2 n.1, the plan suggests that plaintiff's motion was not timely. I assume from the plan's failure to file a formal motion to strike the motion as untimely that it is not asking the court for any action.

The plan has also filed a motion to supplement the affidavit of Maryanne Barry with two pages from plaintiff's medical records that were omitted inadvertently from Barry's original affidavit. This motion will be denied as moot because these additional documents are not necessary to the decision.

From the parties' proposed findings of fact and the record, I find the following to be material and undisputed.

UNDISPUTED FACTS

A. Parties

Plaintiff Brian Spangberg is a forty-seven year old resident of Trempealeau County, Wisconsin and a former employee of Pepsi Bottling Group, Inc. (Pepsi). Defendants Pepsi Bottling Group Long Term Disability Plan (the plan) and PBG Employee Health Care Program are employee benefits plans subject to the provisions of the ERISA. Defendant PepsiCo, Inc., is an entity that administers certain benefits plans for Pepsi. PepsiCo's place of business is at 700 Anderson Hill Road, Purchase, NY 10577.

B. Disability Benefits

Pepsi provides disability benefits to certain employees and former employees pursuant to the terms of the plan. Aetna Life Insurance Company is the plan's underwriter and claims administrator and makes all decisions regarding eligibility for benefits. During discovery pertaining to this lawsuit, the plan advised plaintiff that PepsiCo was the plan's administrator (which is different from the plan's claims administrator, a function performed by Aetna). One day prior to the summary judgment deadline, the plan notified plaintiff that the plan administrator is Pepsi Bottling Group, Inc., not PepsiCo.

The plan's policy states that:

> This Plan will pay a Monthly Benefit for a period of total disability caused by a disease or accidental bodily injury. There is a waiting period. (This is the length of time during a period of total disability that must pass before benefits

start).

The policy defines "total disability" as follows:

> You are deemed to be totally disabled while either of the following applies to you:
>
> - In the first 24 months of a period of disability:
>   You are not able, solely because of injury or disease, to perform the material duties of your own occupation: except that if you start work at a reasonable occupation you will no longer be deemed totally disabled.
>
> - After the first 24 months of a period of disability:
>   You are not able, solely because of injury or disease, to work at any reasonable occupation.
>
> Under the policy, "reasonable occupation" means:
>
> any gainful activity in which you are or may reasonably become fitted by education, training or experience. It does not include work under an approved Rehabilitation Program or a Partial Disability Employment Program as defined later.

The plan also issued a "Summary Plan Description," briefly describing the plan. The summary stated:

> [The] plan administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the plans, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority will be upheld on judicial review, unless it is shown that the interpretation was an abuse of discretion.

* * *

> The contract administrator determines all benefits in accordance with the official plan documents and applicable contracts.
>
> * * *
>
> [T]he official documents remain the final authority and, in the event of a conflict with this book, shall govern in all cases.

C. Medical Benefits

Defendant PBG Employee Health Care Program provides medical benefits to certain Pepsi employees and former employees. Under the terms of the PBG Employee Health Care Program policy, former Pepsi employees are entitled to medical benefits only if they are receiving long-term disability benefits from the Pepsi Bottling Group Long Term Disability Plan (the plan).

D. Plaintiff's Employment Background

Plaintiff was employed by Pepsi as a route sales driver for 22 years beginning in October 1977 and ending in March 1999. His tasks as a route sales driver involved delivering Pepsi products and promoting the products to potential customers. The Dictionary of Occupation Titles categorizes the position of route sales driver as a "medium physical demand" job.

During his 22 years working as a sales route driver with Pepsi, plaintiff injured his

back on numerous occasions. His first back injury on the job occurred in 1982. Shortly thereafter, plaintiff consulted Dr. Tuenis Zondag, the doctor Pepsi had chosen as the company's physician. Beginning in 1985 plaintiff started seeing a chiropractor, Dr. Chris Hougen, for his work-related back injuries. He saw Dr. Hougen more regularly in 1998 and continued through September 2004. Dr. Hougen treated plaintiff 38 times in 1999, 26 times in 2000, 17 times in 2001, 12 times in 2002, 4 times in 2003 and 7 times in 2004.

On December 8, 1998, plaintiff was lifting the doors on the back of his delivery truck when he experienced an instant onset of low back pain that radiated into his hip. Plaintiff injured his back again on February 2, 1999, as he was lifting a door on his truck. Again, he had a sudden onset of severe low back pain that was intense at the belt line, shot into both buttocks and down to his right knee through his anterior thigh.

E. Initial Disability Period

Plaintiff began receiving disability benefits under the plan after his 1999 back injury. He received benefits from August 22, 1999 through February 21, 2001 because he was deemed unable "to perform the material duties of [his] own occupation." Plaintiff has not returned to work since February 2, 1999.

On February 2, 1999, plaintiff saw Dr. Zondag, who described his condition as "acute back strain or acute aggravation with underlying spondylolithesis and some degenerative

disc." Prior x-rays revealed grade I isthmic spondylolithesis at L5-S1 and an MRI scan from April 1998 revealed disc dessication at the lumbosacral level with a small herniation at L5-S1. A CT scan from May 1996 confirmed L5-S1 spondylolosthesis and disc protrusions.

On March 23, 1999, plaintiff and Dr. Zondag completed a form entitled Employee Claim for Self Insured Disability Benefits. Dr. Zondag wrote that plaintiff had been diagnosed with spondylolithesis isthmic symptomatic secondary to low back pain and was undergoing physical therapy and consulting a surgeon.

On March 29, 1999, plaintiff underwent an independent medical examination by Dr. John Whiffen at the request of Pepsi's worker's compensation insurer. Dr. Whiffen diagnosed plaintiff with "internal disc disruption L5-S1 with pre-existing spondylolithesis" and prohibited plaintiff from lifting more than 20 pounds. Later that month, plaintiff consulted a spinal surgeon, who recommended surgery. Plaintiff chose not to follow the recommendation. The surgeon's opinion was that "the issue of surgery is not an issue of return to work, but really an issue of the relationship of the symptomatic improvement of his life abilities."

On June 10, 1999, Dr. Zondag authorized plaintiff to return to work, but not in his former position as route sales driver. Dr. Zondag concluded that plaintiff could take a position requiring "medium job demand at this point." That day, Dr. Zondag completed two forms. In a Follow Up Report of Worker Illness/Injury, he wrote that plaintiff was

allowed to lift 20-25 pounds frequently and could occasionally lift up to 50 pounds. Dr. Zondag placed certain restrictions on plaintiff's movements, such as bending, squatting and twisting. In a Request for Extension of Self-Insured Disability Benefits, Dr. Zondag wrote that plaintiff would have to look for alternate work because he could not lift, reach, push or pull. That same day, Dr. Zondag wrote in plaintiff's medical chart that he had "reached his plateau of healing" and had elected not to have surgery.

After receiving Dr. Zondag's comments of June 10, the plan acknowledged that plaintiff was not able to meet the job demands of a route sales driver and asked plaintiff whether he was interested in rehabilitation services. Plaintiff expressed interest in rehabilitation or training, but the plan concluded that retraining would not be cost effective because plaintiff appeared to be employable as an airplane pilot.

On August 10, 1999, plaintiff received a letter from the plan notifying him that he had been deemed "totally disabled from your usual occupation according to the terms of your insurance coverage" and "eligible for monthly benefits starting August 22, 1999 and continuing for up to 18 months as long as you remain disabled from your usual occupation." The plan advised plaintiff that his eligibility would be re-evaluated periodically and if he were to become capable of performing his own job, benefits would be terminated. Morever, the letter stated:

If you are still eligible for long term disability benefits on February 21, 2001,

> the plan requires that you meet a more strict 'any occupation' definition of disability. To qualify for LTD [long-term disability] benefit eligibility, you must provide objective medical evidence that you are unable to perform any reasonable occupation for which you are qualified or could become qualified as a result of your education, training or experience.

In an interview with a counselor on September 9, 1999, plaintiff reported that he had been self-employed at Quixtar.com, an internet marketing company, since September 1, 1999. On September 20, 1999, during a vocational planning meeting, plaintiff reported that he had a high school diploma, a Wisconsin Class A commercial driver's license with air brake certification (which allowed him to drive semi trucks) and a pilot's license. He was certified as a flight instructor and had an aircraft instrument rating. In addition, plaintiff reported that his hobbies included hunting, fishing, golfing, biking and reading. Plaintiff stated that he wished to continue with his internet marketing business and wanted to pursue full-time conventional employment and that he searched the internet daily for jobs, although he was not interested in pursuing opportunities in air travel.

In December 1999, the plan concluded again that it would not be cost effective to retrain plaintiff because it found that he was employable as a pilot.

On June 15, 2000, plaintiff participated in a labor market survey at the plan's request. The survey showed that plaintiff was qualified to apply for an available flight instructor position. Plaintiff indicated that the $10 hourly rate did not meet his wage requirement.

On July 14, 2000, Dr. Zondag released plaintiff for "modified Light Medium work."

Dr. Zondag completed a Physical Capabilities Form, indicating that plaintiff could lift a maximum of 35 pounds occasionally, 15 pounds frequently and 7 pounds constantly. Dr. Zondag noted that plaintiff could climb steps, climb ladders, reach overhead and drive constantly, could squat, kneel and reach outward frequently and could bend forward and twist occasionally. However, plaintiff could not bend to the floor often. Dr. Zondag noted that these restrictions were permanent.

On July 24, 2000, Dr. Hougen concluded that plaintiff was limited to sedentary work and could lift no more than 10 pounds occasionally and could occasionally squat, reach outward and reach forward. Dr. Hougen concluded also that plaintiff could not return to his previous position with Pepsi.

On February 14, 2001, the plan sent plaintiff a letter advising him that he had been approved beyond the "test change date" of February 21, 2001 and was therefore entitled to continuing disability benefits. The letter stated that "based on medical and other information available to us, we have determined that you are presently unable to work at any reasonable occupation."

F. Extended Disability Period

Plaintiff received long term disability benefits under the stricter test of "inability to

work at any reasonable occupation" from February 21, 2001 through October 1, 2004. From 2001 through October 2004, plaintiff continued to complain about low back pain that radiated into his lower extremities and he experienced episodes of acute pain that interfered with his daily living activities.

On July 3, 2001, Dr. Zondag completed a "disability statement" in which he wrote that although plaintiff's spondylolisthesis was stable, plaintiff's disability was ongoing. The "disability statement" included a list of different categories of work. Next to each category was a space in which the physician could indicate whether it was appropriate for his patient. The least demanding category was "sedentary work." Dr. Zondag did not check off any work categories on the list. Dr. Zondag noted that plaintiff's work restriction was permanent. That same day, Dr. Zondag made a note that plaintiff was in the process of determining what type of work he could do and was looking into alternative retraining. Dr. Zondag wrote that he considered plaintiff to be a "viable candidate for vocation rehabilitation."

On November 14, 2002, Dr. Hougen completed an Attending Physician's Statement, noting that plaintiff's condition was stable. Dr. Hougen imposed a permanent twenty-pound lift limit. He noted that plaintiff was unable to sit for longer than 30 minutes at a time and classified plaintiff's physical impairment as "Class 4- moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity."

In an Attending Physician's Statement dated May 22, 2003, Dr. Hougen wrote that

plaintiff was stable and recommended as much physical activity as plaintiff could tolerate. Again he classified plaintiff's physical impairment as "Class 4- moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity."

In October 2003, plaintiff fell out of a tree while deer hunting and fractured his left ankle. According to plaintiff, he used a four-wheeler when he hunted to move from tree to tree and was able to walk or stand for an hour at a time when he was not in pain. Dr. Todd Wright treated plaintiff's broken ankle, which required surgery but did not present any complications. (Dr. Wright released plaintiff as far as his ankle was concerned in September 2004.)

In an Attending Physician's Statement dated November 19, 2003, Dr. Hougen again wrote that plaintiff was stable. He indicated that plaintiff was capable of sedentary work activity four hours a day, three days a week and was capable of sitting for only 30 minutes at a time. Dr. Hougen wrote that plaintiff's spondylolisthesis was "grade II," even though the most recent x-rays in plaintiff's file were taken in 1999 and the only MRIs were from 1996 and showed that plaintiff's condition was "grade I." Dr. Hougen concluded that plaintiff was "a liability to any employer."

In December 2003, plaintiff reported that he was self-employed. On December 15, 2003, Dr. Hougen completed a Physical Capabilities Form, on which he noted that plaintiff could seldom climb steps or ladders, squat, kneel, twist, reach outward, bend forward, bend

to the floor or drive. He restricted plaintiff to sedentary work (lifting a maximum of ten pounds) on a permanent basis.

In a Physical Therapy Initial Evaluation (in connection with his broken ankle) dated December 24, 2003, plaintiff reported that he was generally very active and enjoyed walking, hunting and fishing. In a Claim Questionnaire dated January 15, 2004, plaintiff reported that he was unable to perform his occupation because "repetitive lifting results in extreme low back pain, sitting for long terms back and legs get sore." He stated also that he was not interested in seeking training in another line of work. He wrote that he drove an average of 5-10 miles per day and he enjoyed hunting, walking and outdoor activities. He reported that he was able to take care of all his personal needs, including cooking and shopping.

On August 24 and 30, 2004, plaintiff reported improvement in his symptoms, with a noticeable decrease in pain level, frequency and intensity. He rated his pain as "0 out of 10" for neck and leg pain, "1 out of 10" for mid back pain and "3 out of 10" for low back pain.

G. Termination of Benefits

Plaintiff received a letter from the plan dated October 1, 2004, notifying him that he no longer met the definition of "total disability" and that his benefits would cease immediately. The letter explained that because the first twenty-four months of his

entitlement to long term disability benefits had expired, in order to continue to receive disability benefits he needed to show that he was unable to engage in any reasonable occupation. The letter set forth in detail the plan's rationale for concluding that plaintiff had not shown that he was unable to engage in any reasonable occupation.

In the letter, the plan explained that plaintiff's medical file had been reviewed by medical consultant Maria I. Angelillo, a registered nurse. In her assessment, Angelillo took into account all records and notes of Dr. Hougen, Dr. Zondag, Dr. Wright, Patrick Roberts, Joan Roubal, Midlefort Clinic and Luther Hospital. Angelillo concluded that plaintiff's medical file lacked medical information to support a finding that plaintiff suffered from a physical functional impairment that prevented him from engaging in full-time sedentary work that allowed him to change positions frequently.

The plan noted the following facts in its October 1 letter: (a) on June 10, 1999, Dr. Zondag diagnosed plaintiff with symptomatic spondylolisthesis with degenerative disc. He wrote that plaintiff had reached maximum medical improvement and could meet "medium physical demands" for work; (b) on August 29, 2003, Dr. Hougen examined plaintiff and on November 29, 2003, he wrote that plaintiff could perform sedentary work activities 4 hours a day, 3 days a week, if sitting or standing for no more than thirty minutes at a time; (c) in October 2003, plaintiff went deer hunting, fell off a tree and broke his ankle; (d) in a statement dated January 15, 2004, plaintiff reported that his hobbies included hunting,

walking and outdoor activities; (e) on March 12, 2004, Dr. Hougen reported that plaintiff had suffered flare-ups in the cervical and thoracic regions; (f) in May 2004, plaintiff was released from treatment pertaining to his broken ankle; (g) on August 14, 2004, Dr. Hougen reported that plaintiff had presented with neck and back pain that increased after plaintiff did some traveling; and (h) on August 20, 2004, plaintiff reported pain at a level of "2-5 out of 10." On examination, spasms were noted in the thoracic and lumbar regions, with a limited range of motion. On August 24, 2004, plaintiff reported improvement, with a noticeable decrease in pain level, frequency and intensity. He rated the pain in his neck and right leg as "0 out of 10," in his mid back as "1 out of 10" and in his low back as "3 out of 10." On examination, he had tenderness in the thoracic and lumbar areas. Dr. Hougen wrote that plaintiff was progressing as expected and should return for treatment on an "as needed" basis.

Angelillo made the following findings from the preceding facts: (a) plaintiff's file lacked documentation that his physical condition had changed since he was seen by Dr. Zondag in June 1999, who reported that he had reached maximum medical improvement and could perform tasks that required "medium physical functional capacity"; (b) plaintiff was able to climb trees and hunt, activities that required frequent standing, walking and bending; and (c) plaintiff's file lacked evidence of a physical functional impairment that prevented plaintiff from performing sedentary work activity. Finally, the letter stated:

> Upon receipt of updated note from Dr. Hougen, in an addendum review dated September 29, 2004, Ms. Angelillo reports, "the file contains documentation of the claimant's level of activity; hunting, injured while climbing a tree, poked hand with used insulin syringe while emptying restaurant garbage for his wife, dropped a 2x4 board on top of his foot." She reports that recent office notes from Dr. Hougen ranging from August through September 2004, indicate that you have recent complaints of neck and back pain, which had gotten worse since doing some traveling. She notes that your subjectively reported level of pain increases with your activities of daily living. Dr. Hougen stated that you were tender in the cervical, thoracic and lumbar areas, and had decreased range of motion. Ms. Angelillo notes, "The file lacks mention of Mr. Spangberg's degree of range of motion limitations, there is no mention Mr. Spangberg is neurologically compromised or that he uses assistive devises [sic] to ambulate. The file lacks recent referrals to specialists or referrals for additional testing or invasive treatment to support impairment from a gainful employment.
>
> Ms. Angelillo concludes that, based on current medical information on file, your responsiveness to chiropractor treatment, the required frequency and level of treatment, the file lacks objective medical evidence to support a physical functional impairment to full time medium work activity with the ability to change positions as needed.
>
> When plaintiff's disability benefits ended, his medical benefits were terminated.

Plaintiff appealed the termination of his disability benefits. In support of his appeal, plaintiff submitted a letter from Dr. Hougen dated October 15, 2004, stating:

> It has been concluded that there is no clear cut solution to [plaintiff's] problem and that any type of repetitive activity will cause recurrent flare-ups and more intense disability. [Plaintiff] has a condition that is irreversible, progressive and makes him a liability to any employer. [Plaintiff] has been encouraged to maintain a life style that is as active as his spine will tolerate in order to retard the accelerated rate of osseous and neurological degeneration, as well as maintain reasonable core strength in cardiovascular fitness. [Plaintiff] has a bilateral pars defect of L5 causing anterior immigration of the

> body of L5 on S1. This causes sheering and degeneration of the L5-S1 disk, as well as, L4-L5. This results in accelerated degenerative joint disease probable IVF and canal stenosis and possible eventual lower extremity pain weakness and disability. He has constant pain of his paraspinal musculature of L4-5, with ROM universally painful in flexion, extension, right and left lateral flexion. [Plaintiff] is not fit for employment in any capacity.

The plan forwarded plaintiff's file to Dr. Oyebode A. Taiwo, an independent medical consultant. Dr. Taiwo concluded that there was no evidence in plaintiff's file to support a conclusion that plaintiff was physically unable to perform at least sedentary work that allowed him to change positions frequently.

On November 16, 2004, the plan discovered that plaintiff was teaching karate lessons. According to plaintiff, he taught primarily children and the classes involved stretching exercises and demonstrations. There were some classes when plaintiff could not do anything because his back flared up.

On December 2, 2004, plaintiff received a letter informing him of the plan's decision to uphold the termination of his benefits. The letter noted that in a telephone conversation between plaintiff and a plan representative on November 5, 2004, plaintiff described his hunting activities as involving carrying and climbing a ladder in order to reach platforms in trees. The letter stated, "these activities of deer hunting with climbing and carrying as well as karate instruction indicate that you are functioning above a sedentary physical level." (Plaintiff contests the plan's representation that he said he carries a ladder. Plaintiff's version is that he uses a four-wheeler to go from tree to tree and uses only a "light-weight

tree stand.")

On December 27, 2004, plaintiff sent the plan a vocational assessment report prepared by Kenneth E. Ogren. Ogren wrote that, "[i]n my opinion, [plaintiff] is disabled from competitive employment as a result of the medical limitations assigned. In my opinion no jobs exists in the national, regional or his local area he could perform." In the report, Ogren relied on the Independent Medical Evaluation performed by Dr. Whiffen in March 1999.

On February 7, 2005, the plan notified plaintiff that it was standing by its decision to terminate his long term disability benefits.

F. Request for Documents

On May 18, 2005, plaintiff sent a letter to "Pepsi PBG Plan Administrator" at 1 Pepsi Way, Sommers, NY 10589, requesting further review of the plan's termination of his benefits. On June 8, 2005, plaintiff sent another letter to Pepsi PBG Plan Administrator at 1 Pepsi Way, requesting a copy of plaintiff's file and all plan documents. On June 16, 2005, a plan representative wrote plaintiff in response to the May 18 letter, stating that the plan's decision to terminate benefits was correct and attaching a copy of a PBG Long Term Disability Plan effective April 6, 1999. (It is undisputed that this PBG Long Term Disability Plan did not apply to plaintiff.) It was only on March 29, 2006, that the plan provided

plaintiff with a copy of the plan documents that applied to him.

OPINION

A. ERISA Standard of Review for Termination of Long Term Disability Benefits

The Employee Retirement Income Security Act applies to "any plan, fund or program which was heretofore and hereinafter established or maintained by an employer or employer organization or both." 29 U.S.C. § 1002(1). The parties agree that the plan is governed by ERISA. Under the statute, courts must apply a de novo standard of review to a plan's benefit denial unless the plan's plain language gives it discretionary authority to determine eligibility, in which case courts use the deferential "arbitrary and capricious" standard. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Militello v. Central States, Southeast & Southwest Areas Pension Fund, 360 F.3d 681, 685 (7th Cir. 2004). In the present case, it is undisputed that the plan's policy does not contain language granting the plan discretion to determine eligibility for benefits. However, the plan's summary description states that the "plan administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the plans, to decide all questions of eligibility for benefits and . . . [a]ny interpretation or determination made pursuant to such discretionary authority will be upheld on judicial review, unless it is shown that the interpretation was an abuse of discretion." (Defendant PepsiCo suggests that this summary description did not

pertain to the plan, but rather to some other benefit plan sponsored by Pepsi. PepsiCo's Resp. Plt.'s PFOF, dkt. #46, ¶ 7. Since neither plaintiff nor the plan raised this issue I will treat the summary as though it pertains to the plan, as plaintiff and the plan have done in their briefs.)

In determining which standard of review is appropriate, "the critical question is whether the plan gives the employee adequate notice that the plan administrator is to make a judgment within the confines of pre-set standards, or if it has the latitude to shape the application, interpretation, and content of the rules in each case." Diaz v. Prudential Insurance Co. of America, 424 F.3d 635, 639-40 (7th Cir. 2005). In Herzberger v. Standard Insurance Co., 205 F.3d 327, 331 (7th Cir. 2000), the court of appeals set out "safe harbor" language that would insure deferential review: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them." That language does not appear in the policy at issue in this case but its absence does not necessarily preclude deferential review. Id. (no "magic words" needed to trigger deferential judicial review of benefit determinations). As noted above, the focus of the inquiry is whether the employee has adequate notice: "[E]mployees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly." Id. at 333.

The plan argues that the arbitrary and capricious standard of review is appropriate

in this case because the summary plan description provides the requisite notice that defendant maintains discretion to determine eligibility for benefits. Plaintiff does not argue that the language in the summary does not give employees the notice required by Diaz. Instead, he argues that de novo review is appropriate because the language granting discretion to the plan appears in the summary plan description, not in the policy itself, and the absence of discretionary language in the policy trumps the language in the summary. This argument raises the question whether language in the summary description can have the same import as language in the actual text of the policy itself.

In light of the presumption that a denial of benefits is reviewed de novo when a policy is silent with respect to discretion, Herzberger, 205 F.3d at 330, plaintiff contends that the summary's discretionary language conflicts with the policy's silence and that the policy prevails, making de novo review appropriate. Health Cost Controls of Illinois, Inc. v. Washington, 187 F.3d 703 (7th Cir. 1999); see also Reinertsen v. Paul Revere Life Insurance Co., 127 F. Supp. 2d 1021, 1028-30 (N.D. Ill. 2001) (where summary plan description is unambiguous about giving discretion to plan administrator but policy on which summary is based is silent, terms of policy prevail). Morever, plaintiff argues, the summary states that "the official documents remain the final authority and, in the event of a conflict with this book, shall govern in all cases." However, this is not a classic case of conflicting provisions, where the policy says one thing and the summary states the opposite. Instead, the conflict

arises because the policy says nothing about the standard of review. The question, then, is whether the provisions of a summary can provide the plan the advantageous standard of review it seeks.

The parties are aware that this court addressed this issue recently in Olson v. Comfort Systems USA Short Term Disability Plan, 407 F. Supp. 2d 995 (W.D. Wis. 2005). There, I noted that the Court of Appeals for the Seventh Circuit has not addressed the question whether discretionary language in a summary plan description can secure deferential judicial review when the policy itself is silent. My analysis of the relevant case law led me to the conclusion that de novo review was warranted in Olson, where, as here, the discretionary language appeared in a summary but not in the policy itself. For similar reasons, I reach the same conclusion in this case.

As I explained in Olson, there are cases supporting the plan's position that courts may look to the summary plan description and other plan documents for discretionary language. E.g., Cagle v. Bruner, 112 F.3d 1510, 1517 (11th Cir. 1997); see also James F. Jordan, et al., Handbook on ERISA Litigation § 4.04[C][2] (2d ed. Supp. 2005) ("The requisite grant of discretion . . . may be derived . . . from any number of plan documents, including the plan itself, insurance contacts, summary plan descriptions, trust instruments, and internal plan memoranda or guidelines."). The plan relies on Fritcher v. Health Care Service Corp., 301 F.3d 811 (7th Cir. 2002), in particular. In Fritcher, the benefit plan reduced a beneficiary's

medical benefits because it concluded that the heightened benefits (eighteen hours a day of in-home health care) he had previously received were not medically necessary. Id. at 814. The first issue the court addressed was whether the language in the plan "bestowing upon the plan administrator the right to exercise 'reasonable judgment' in determining whether services are medically necessary is a sufficient grant of 'discretion' under the law of this circuit to trigger a milder standard of review." Id. at 816. The court found that it was not, because it was not a sufficiently broad reservation of rights. Id. The plan then pointed to language in a "Benefit Booklet" (the equivalent of the summary plan description in the present case), which stated that benefits would be provided for services only when they were, "in the reasonable judgment of the Claim Administrator, Medically Necessary." Id. The court held that the language in the booklet was not strong enough to "rebut the presumption of plenary review." Id. In the present case, the plan argues that in Fritcher, the court found the language in the benefits booklet insufficient because it was not clear enough, not because it appeared in a booklet rather than in the policy itself. The plan asks this court to conclude from Fritcher that language in a corollary document such as a booklet or summary can be a source of discretion. The plan believes that its position is bolstered by the fact that in Fritcher, the court rejected discretion-granting language in an "administrative services agreement" after it found that the agreement was not a "plan document." Id. at 817 ("a formal plan document is one which a plan participant could read to determine his or her

rights or obligations under the plan"). The plan concludes that because the court did not make this finding with respect to the booklet, the booklet and other summaries like it must be acceptable plan documents in which discretion-granting language may be placed. Absent an express holding from the court of appeals to that effect, I am not persuaded by the plan's argument.

In addition, most of the decisions that address situations in which discretionary language is found in the summary but not in the plan itself favor plaintiff's position. Wolff v. Continental Casualty Co., No. 03 C 4667, 2004 WL 2191579, at *10-11 (N.D. Ill. Sept. 28, 2004); Billings v. Continental Casualty Co., No. 02 C 3200, 2003 WL 145420, at *6 (N.D. Ill. Jan. 21, 2003); Flood v. Long Term Disability Plan for First Data Corp., Nos. 00 C 2568, 01 C 1610, 2002 WL 31155099, at *3 (N.D. Ill. Sept. 27, 2002); Akhtar v. Continental Casualty Co., No. 01 C 7109, 2002 WL 500544, at *4 (Apr. 1, 2002); Carter v. General Electric Co., No. 98 C 50239, 2001 WL 170464, at *5 (N.D. Ill. Feb. 20, 2001); Reinertsen, 127 F. Supp. 2d at 1028-30; Clark v. Bank of New York, 801 F. Supp. 1182 (S.D.N.Y. 1992). These decisions rely on the principle that the policy sets the terms of the relationship between the plan and the participants and the summary cannot expand the plan's authority. An unstated but important corollary is that ERISA was enacted "'to promote the interests of employees and their beneficiaries in employee benefit plans[.]'" Firestone, 489 U.S. at 113 (quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983)).

As a general matter, courts construe benefit plans in favor of beneficiaries and against plan administrators. Herzberger, 205 F.3d at 330. If a participant relies on a provision in a summary that conflicts with the terms of a benefit plan, it is reasonable to hold the plan to the terms in its summary. Helfrich, 328 F.3d at 917 ("Because ERISA requires plans to prepare summary plan descriptions, and because their content is within the plan's control, it makes sense to give these documents legal effect when relied on.") The present case presents the reverse situation: the provision in the summary favors the plan's administrator. In this instance, holding that the language in the summary prevails over the silence in the plan would undercut one of the public policy goals underlying ERISA and harm the class of persons the statute was intended to protect. As noted in Clark, 801 F. Supp. at 1190, "[a]lthough a plan summary may expand employees' rights when the summary conflicts with the plan itself, no court has found that a plan summary can expand the plan administrator's authority." In Reinertsen, 127 F. Supp. 2d at 1030, the court expressed the same idea in a different way:

> In the context of granting authority to a plan administrator, unless the policy affirmatively grants discretion, then de novo review applies, even if the [summary plan description] provides otherwise. This approach is consistent with the Seventh Circuit's rationale in Herzberger . . . , which held that, unless the plan affirmatively grants discretion, then the default rule of de novo review applies.

The plan analogizes the present case to Shyman v. UNUM Life Insurance Co., 427

F.3d 452 (7th Cir. 2005), a case in which the court of appeals ruled that deferential review was appropriate where a reservation of discretion was found in a certificate of insurance but not in the body of a disability benefits policy. In Shyman, however, the certificate of insurance at issue stated expressly that it was part of the disability policy. Id. at 455. The plan argues that the provision in the summary, which states, "the contract administrator determines all benefits in accordance with the official plan documents and applicable contracts," has the same effect as the language in the certificate of insurance in Shyman. The plan is incorrect. The language in the summary does not serve to incorporate the provisions of the summary into the terms of policy. On the contrary, it refers the user to the "official plan documents and applicable contracts" for the plan rules. Therefore, the ruling in Shyman does not apply to the facts of this case.

In his brief in support of his motion for summary judgment, plaintiff argued that the court should review the plan's decision de novo, but then went on to conduct an analysis using the arbitrary and capricious standard. Defendant urges the court to find that, because plaintiff applied the arbitrary and capricious standard to his discussion, he waived the argument that the de novo standard of review applies. The plan ignores the fact that plaintiff argued that even under the most deferential standard of review, the plan erred in its decision. He did not waive the argument that the court should conduct a de novo review. In fact, he argued that point vehemently in all of his briefs.

I conclude that the plan's decision to terminate plaintiff's long term disability benefits must be reviewed de novo.

B. Review of Termination of Long Term Disability Benefits

Under the de novo standard of review, I must determine whether the plan made the correct decision to terminate plaintiff's long term disability benefits. Wilczynski v. Kemper National Insurance Cos., 178 F.3d 933, 935 (7th Cir. 1999). To be eligible for benefits after the first twenty-four months of a period of disability, plaintiff had to show that he was not able to work at any reasonable occupation, meaning "any gainful activity in which you are or may reasonably become fitted by education, training or experience."

Plaintiff is mistaken if he believes that the plan terminated his benefits in October 2004 because it concluded that he was capable of returning to his position at Pepsi as a route sales driver. Plt.'s Br., dkt. #39 at 23. The plan made it clear in its letter of October 1, 2004 that it was terminating plaintiff's benefits because plaintiff had failed to show that he was unable to engage in any reasonable occupation. Examining the plan's decision under a de novo standard of review, I conclude that its decision was correct. The voluminous factual record contains evidence favorable to both parties. However, scrutiny of the record in its entirety reveals that the evidence favoring the plan's position is stronger. The record contains adequate support by a preponderance of the evidence for the plan's conclusion that

plaintiff did not provide evidence sufficient to show that he was unable to engage in any reasonable occupation.

The plan based its decision to terminate plaintiff's benefits on the evidence that plaintiff participated in fairly demanding physical activities. In light of that evidence, the plan declined to take seriously medical opinions that plaintiff was unable to engage in sedentary work. The plan cites Black & Decker Disability Plan v. Nord, 538 U.S. 822, 825 (2003), for the proposition that "plan administrators are not obliged to accord special deference to the opinions of treating physicians." "ERISA and the Secretary of Labor's regulations under the Act require 'full and fair' assessment of claims and clear communication to the claimant of the 'specific reasons' for benefit denials . . . [b]ut these measures do not command plan administrators to credit the opinions of treating physicians over other evidence relevant to the claimant's medical condition." Id. Where, as here, there is other evidence of plaintiff's physical capabilities, a benefits plan does not have to accept the opinion of a treating physician over other contradictory evidence.

In terminating plaintiff's benefits, the plan focused on the nature of plaintiff's hobbies (deer hunting, walking, fishing and other outdoor activities) and on plaintiff's report that he could drive and handle all of his own shopping and cooking. The plan focused also on the facts that plaintiff poked his hand with a used insulin syringe while emptying restaurant garbage for his wife and he dropped a 2x4 board on his foot. Although these two facts do

not bolster the plan's position, because a single instance of removing garbage and carrying a 2x4 board do not reveal much about plaintiff's activity level, the plan reasonably concluded that plaintiff's contention of inability to work was belied by the fact that on more than one occasion since his back injury in 1999 plaintiff reported that he was active in outdoor and self-care activities. It is inconsequential that the parties do not agree whether plaintiff walked or used a four-wheeler when hunting. The hunting clearly involved climbing, standing, sitting and at least some walking, giving the plan sufficient evidence that plaintiff was able to engage in significant physical activities. Also, in denying plaintiff's appeal, the plan noted its discovery of plaintiff's karate teaching, another indicator that he remained fairly active.

Besides plaintiff's high level of physical activity, the plan had good reason to be unpersuaded by the doctors' and other providers' opinions. In June 1999, Dr. Zondag said plaintiff could meet "medium job demand" and in November 2002 and May 2003, Dr. Hougen said plaintiff was capable of sedentary work. The plan concluded that Dr. Hougen's sudden declaration in November 2003 that plaintiff could work only 4 hours a day, 3 days a week did not make sense and had no factual basis. The plan was also skeptical of Dr. Hougen's decision to change plaintiff's spondylolithesis diagnosis from "grade I" to "grade II" without citing any objective evidence for doing so. Although Dr. Hougen mentioned objective findings in x-rays and MRIs to support his new diagnosis, he did not list the dates

of these tests. The only tests in the file are MRIs in 1996 and back x-rays from 1999. Moreover, the plan noted that throughout 2002 and 2003, Dr. Hougen "increasingly limited the range of activities that [plaintiff] could engage in" (for example, in November 2003, Dr. Hougen said plaintiff could sit or stand for only 30 minutes at a time) even though at the same time his records reflected that plaintiff's "reports of pain and need for chiropractic treatment significantly decreased over time." Dft.'s Rep. Br., dkt. #58 at 2. Therefore, the plan found no basis for Dr. Hougen's opinion on October 15, 2004, that plaintiff was "not fit for employment in any capacity." The plan looked instead to plaintiff's activity level as an indicator of what plaintiff was capable of doing.

Also, the plan discounted Kenneth Ogren's conclusion that "no jobs exist in the national, regional or his local area [plaintiff] could perform" because Ogren relied on an examination conducted in March 1999 by Dr. Whiffen, one month after plaintiff's injury. Dr. Whiffen stated in his March 1999 report that it was too early to tell whether plaintiff had a permanent partial disability. In explaining why it was disregarding Ogren's remarks, the plan stated that "Mr. Ogren arbitrarily and without explanation selected the earlier and more severe limitations recommended by Dr. Whiffen." Dft.'s Br., dkt. #26 at 18 n.4.

Plaintiff objected to the plan's analysis, arguing that it ignored key pieces of evidence. According to plaintiff, the plan should have given greater weight to the fact that in July 2001, Dr. Zondag did not release him even for sedentary work and that Dr. Hougen said he

was a "a liability to any employer" and "not fit for employment in any capacity." The plan did not ignore these statements, as plaintiff contends. Rather, it chose to give them little weight, as it has the discretion to do, in light of plaintiff's active lifestyle. Plaintiff argues that his activities were limited in nature, that he was advised by his doctors to remain as active as possible and that it was wrong for the plan to terminate his benefits because he was able to "periodically engage in recreational activities." Plt.'s Br., dkt. #39 at 24. Plaintiff argues also that the plan "completely failed to consider" the fact that more than one doctor stated that he needed spinal surgery. Id. However, as defendant notes, a doctor's opinion that a patient needs surgery is not conclusive evidence that he cannot perform any occupation. Moreover, plaintiff elected not to have surgery and was capable of remaining fairly active nonetheless. I find that the record contains enough evidence to support the plan's position and that its interpretation of the evidence is not an unreasonable one. Therefore, the plan's motion for summary judgment will be granted and plaintiff's motion for summary judgment on its claims against the plan will be denied.

C. Medical Benefits

The parties are in agreement that plaintiff is entitled to medical benefits from the PBG Employee Health Care Program only if the court finds first that plaintiff is entitled to

long term disability benefits. Because I have concluded that plaintiff is not entitled to long term disability benefits, it follows that plaintiff is not entitled to medical benefits. Plaintiff's motion for summary judgment on its claim that it is entitled to medical benefits will be denied and defendant PBG Employee Health Care Program will be dismissed from this lawsuit.

D. Plan Administrator Penalties

Plaintiff contends that it is entitled to receive $100 for each day that the plan administrator of the disability benefits plan delayed in providing him with a copy of applicable plan documents, pursuant to 29 U.S.C. § 1132(c)(1), which states that a plan administrator who fails to comply with a request for certain information within 30 days of such request may be liable to the plan participant in the amount of up to $100 a day. Pursuant to 29 U.S.C. § 1024(b)(4), requests for plan documents including summary plan descriptions are subject to the requirements of 29 U.S.C. § 1132(c)(1).

Plaintiff contends that he did not receive the applicable plan documents until March 2006, which was more than 30 days after he requested the documents in his letter of June 8, 2005. Plaintiff brought this claim against PepsiCo because the plan originally told him that PepsiCo was the plan administrator. Later, the plan notified plaintiff that the plan administrator was Pepsi Bottling Group, Inc. Also, PepsiCo denies that it is the plan

administrator. Even if plaintiff had shown that PepsiCo was the plan administrator, plaintiff's motion for summary judgment would have to be denied and PepsiCo's motion would be granted because plaintiff has not shown that he actually requested the plan documents from PepsiCo. When plaintiff wrote the June 8, 2005 letter requesting the plan documents, he neither addressed it to PepsiCo nor mailed to PepsiCo's address. Plaintiff has not shown that PepsiCo ever received its letter. If PepsiCo did not receive the request, it cannot be punished for not responding to it. See, e.g., Romero v. SmithKlein Beecham, 309 F.3d 113, 119-120 (3d Cir. 2002) (29 U.S.C. § 1132(c)(1) "requires actual receipt by the administrator").

In its response to PepsiCo's motion for summary judgment, dkt. #53 at 3, plaintiff argues that if Pepsi Bottling Group "is the proper Administrator, PepsiCo., Inc. may be substituted and replaced by the proper party, Pepsi Bottling Group." Substituting a party is not so simple. The court will not add a defendant to a lawsuit at this stage and make a ruling regarding it without giving the party a chance to defend itself. If plaintiff wishes to sue Pepsi Bottling Group, it must file a complaint against it. If plaintiff were to take such a step, it would have to support its claim against Pepsi Bottling Group with evidence that Pepsi Bottling Group received plaintiff's June 8, 2005, request for documents.

E. Attorney Fees

Plaintiff, the plan and PepsiCo have each asked the court for an award of attorney fees and costs. The court has the discretion to order such awards pursuant to 29 U.S.C. § 1132(g)(1). Under this provision, the court entertains a "modest presumption" that the prevailing parties are entitled to a reasonable attorney fee. Bittner v. Sadoff & Rudoy Industries, 728 F.2d 820, 830 (7th Cir. 1984). Different formulas have been used to determine whether a prevailing party is entitled to an award of costs and fees, but "the 'bottom-line question' is the same: was the losing party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent?" Little v. Cox's Supermarkets, 71 F.3d 637, 644 (7th Cir. 1995).

As the losing party, plaintiff will not be awarded attorney fees and costs. Also, because I conclude that plaintiff was not "simply out to harass" PepsiCo, I will not award attorney fees to PepsiCo. Plaintiff received mixed messages about who the plan administrator was and sued the party he believed was liable. Although ultimately he did not prevail on his claim, PepsiCo has produced no evidence that plaintiff acted in bad faith in pursing its claim against this defendant. Finally, I do not find that plaintiff acted in bad faith in pursuing its claims against the plan. Although I have concluded that the plan's denial of disability benefits was supported by a preponderance of the evidence, I do not find that this defendant is entitled to attorney fees and costs.

ORDER

IT IS ORDERED that

1. Defendant The Pepsi Bottling Group Long Term Disability Plan's motion to supplement Maryanne Barry's affidavit is DENIED as moot.

2. Defendant The Pepsi Bottling Group Long Term Disability Plan's motion for summary judgment is GRANTED and plaintiff's motion for summary judgment on its claims against The Pepsi Bottling Group Long Term Disability Plan is DENIED.

3. Plaintiff's motion for summary judgment on its claims against defendant PBG Employee Health Care Program is DENIED and defendant PBG Employee Health Care Program is dismissed from this lawsuit.

4. Defendant PepsiCo's motion for summary judgment on plaintiff's claim that plaintiff is entitled to damages from this defendant under 29 U.S.C. § 1132(c)(1) is GRANTED and plaintiff's motion for summary judgment on this claim is DENIED.

5. Plaintiff's request for attorney fees and costs is DENIED.

6. Defendant PepsiCo Inc.'s request for attorney fees and costs is DENIED.

7. Defendant The Pepsi Bottling Group Long Term Disability Plan's request for

attorney fees and costs is DENIED.

The clerk of court is directed to enter judgment for defendants and close this case.

Entered this 30th day of May, 2006.

BY THE COURT:
/s/
BARBARA B. CRABB
District Judge