IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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JAMES H. OATES,

OPINION AND ORDER

Plaintiff,

06-C-0139-C

v.

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND, and BOARD OF TRUSTEES as PLAN ADMINISTRATOR,

Defendants.

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Plaintiff James H. Oates sought benefits pursuant to the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461, from defendant Central States, Southeast and Southwest Areas Health and Welfare Fund. After defendant Board of Trustees denied plaintiff's application for benefits in its capacity as Plan Administrator, plaintiff brought this civil action against defendant Central States, Southeast and Southwest Areas Health and Welfare Fund and defendant Board of Trustees. Plaintiff contended that defendant Trustees' denial of the benefits was a breach of their fiduciary duty under 29 U.S.C. § 1104(a)(1) and a violation of 29 U.S.C. § 1132(a)(1)(B). In an order entered on June 1,

2006, I granted defendant Board of Trustees' motion to dismiss the fiduciary duty claim and to strike plaintiff's request for a jury trial and for compensatory damages. The case is before the court now on defendants' motion for summary judgment on plaintiff's remaining claim.

I conclude that defendants have failed to show that they are entitled to summary judgment. Although this court's review of their actions is deferential because defendants' plan documents vest defendant Board of Trustees with discretion to make final decisions on benefit applications, I cannot find that defendants acted reasonably in denying plaintiff his benefit request. The explanation that the Board offered does not correspond directly to plaintiff's request. Rather, it suggests that defendant misunderstood the precise terms of his request.

Plaintiff did not dispute any of the facts proposed by defendants. He proposed five additional facts of his own, three of which have been admitted by defendants and two of which I am not taking into consideration. I have not considered plaintiff's proposed fact that defendants ignored the documentation he submitted with his benefit request because it is not supported by any citation to the record. I have ignored the second proposal, that defendants had no documentation supporting their decisions, because plaintiff has not shown that he has personal knowledge of what documentation defendants had before them when they made their decisions. I find that the following facts are undisputed and material.

UNDISPUTED FACTS

A. The Parties

Plaintiff James H. Oates is an individual who resides in Browntown, Wisconsin. At all relevant times he has been a participant in the Central States, Southeast and Southwest Areas Health and Welfare Fund (which I will refer to hereafter as the Fund).

The Fund is subject to the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461, and is an Employee Welfare Benefit Plan as defined in 29 U.S.C. § 1002(1). It is administered by a board of trustees, with equal representation from management and labor. It is funded primarily by contributions remitted by multiple participating employers that are parties to negotiated collective bargaining agreements with local unions affiliated with the International Brotherhood of Teamsters.

The Fund provides benefits pursuant to the terms, conditions and limitations contained in the Fund's Plan Document and under the terms of the Fund's Trust Agreement.

B. Relevant Provisions of Governing Documents

The Trust Agreement gives defendant Trustees authority to control and manage the operation and administration of the Trust in accordance with applicable law. Art. VI, § 9 states that "[t]he Trustees are vested with discretionary and final authority in adopting rules and regulations for the administration of the Trust Fund." Art. IV, § 17 provides that the

"Trustees are vested with discretionary and final authority in construing plan documents of the Health and Welfare Fund."

Article IV, § 4.03 of the Fund's Plan Document provides that

> A Covered Individual shall not be entitled to payment on a claim for any charge incurred for any treatment or service for any illness or injury which is sustained as a result of any enterprise or occupation for wage or profit or is an illness or injury of the type covered by any applicable Worker's Compensation Act or similar law providing benefits to employees for on-the-job injuries.
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> In the event that a Covered Individual is awaiting disposition of a Worker's Compensation claim (or similar claim arising as a result of an on-the-job injury) and coverage for the illness or injury is disputed, the Covered Individual may be eligible to receive some benefits if the Covered Individual agrees to reimburse the Fund for any benefits advanced in the event he settles or receives an award from any Employer or insurance company relating to his on-the-job injury.
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> After a five (5) year period from the date of Disability, any complication arising from the illness or injury shall be deemed payable in accordance with the Plan provisions, unless it is still compensable under Worker's Compensation.

Article VIII, § 8.02 describes the powers of the Trustees:

> The Trustees shall have authority to jointly control and manage the operation and administration of the Fund and of this Plan, in accordance with the terms of the Trust Agreement and of this Plan . . . All questions or controversies, of whatsoever character, arising in any manner or between any parties or persons in connection with any claim for any benefits preferred by any Participant, beneficiary, or any other person, or whether as to the construction of the language or meaning of the rules and regulations contained in this Plan, shall be submitted to the Trustees, or to a Committee of the Trustees, and the decision of the Trustees or such Committee thereof shall be binding upon all persons dealing with the Fund or claiming any benefits under the terms of this Plan.

The Plan Document provides for a two-step administrative review procedure for

denied benefit claims. Art. X. During the administrative review process, the claimant is invited "to submit written comments, documents, record and other information relating to the claim for benefits," and shall be provided with "reasonable access to, and copies of, all documents, records or other information possessed by the Fund and relevant to the" claim. Art. X, § 10.01(b). "[A]ll adverse benefit determinations based upon . . . Section 11.15 (WORKER'S COMPENSATION SUBROGATION)" are "Trustee-Reviewable Determinations." Article X, § 10.05 provides that "[t]he Trustees are vested with discretionary and final authority in making any determination within the scope of this Article X." The plan provides also that "[t]he burden of proof in demonstrating any fact essential to the approval of any claim for benefits . . . shall at all times be the responsibility of the claimant."

Article XI, § 11.15 provides in part:

> If any Covered Individual has a claim denied pursuant to Section 4.03 of this Plan and the Covered Individual's claim for Worker's Compensation benefits is denied by the Worker's Compensation Carrier, the Fund may enter into an agreement with the Covered Individual to provide benefits during the appeal of the denial.

Article XII, § 12.02(a) provides in part:

> A Covered Participant shall receive from the Plan a weekly Loss of Time Benefit in the amount and for the maximum benefit period referenced under Section 20.01(a) during a single period of Disability . . . for loss of time from employment as a result of being unable to work because of illness, injury or pregnancy. To qualify for the Loss of Time Benefit a Covered Participant must:

> (1) Be absent from work because of a Disability, the treatment of which is compensable under the Plan . . .

Article XX, § 20.01(a) provides a Loss of Time benefit of $150 a week for a maximum of 26 weeks.

C. Plaintiff's Claim

On or about September 5, 2000, plaintiff injured his back while at work in his job as President of Local Union No. 754 of the International Brotherhood of Teamsters. Neither he nor Local 754 reported the injury to the Fund. Plaintiff continued to enjoy health and welfare coverage provided by the Fund and to work at his regular job until November 3, 2003, when he was declared disabled as a consequence of an onset of spondylolisthesis resulting from the September 5, 2000 injury. At that time, Local 754 removed him from its payroll. Plaintiff applied for worker's compensation benefits through the state of Illinois.

In November 2003, plaintiff telephoned the Fund to inform it for the first time of his 2000 back injury. He told defendant that he had not reported it when it first happened because his employer did not want his worker's compensation rates to rise. Instead, the employer had paid plaintiff's disability benefits, continued to submit contributions to the Fund on plaintiff's behalf as if he had never been injured on the job and allowed the Fund to cover medical expenses arising directly from an on-the-job injury.

D. Defendants' Handling of Plaintiff's Claim

On or about June 16, 2004, the Fund sent plaintiff a notice of his potential eligibility for benefits under Art. XI, § 11.15 of the Plan Document. Enclosed was a provisional "Agreement to Reimburse Central States Health and Welfare Fund," which stated in part that it was "subject to approval by the Central States Workers' Compensation Subrogation Committee" and added:

> Further note, this signed agreement is subject to review by the Central States Subrogation Committee. It is not a valid agreement until it is approved by the Subrogation Committee and signed by a Fund representative.

In response to a request from plaintiff, the Fund sent a similar letter to plaintiff's attorney, along with requests for additional documentation.

On August 17, 2004, the Fund received plaintiff's signed Agreement to Reimburse, but did not execute or approve it immediately. On August 25, 2004, defendant rendered a provisional denial of plaintiff's request for a final Agreement to Reimburse based on plaintiff's failure to provide sufficient supporting documentation. On or about October 18, 2004, plaintiff's attorney submitted the requested documentation, which included a letter of retainer, a worker's compensation application, a copy of the worker's compensation carrier's denial letter and verification from the Illinois Industrial Commission that plaintiff's claim was pending. In addition, plaintiff submitted physicians' notes.

On or about October 27, 2004, the Fund informed plaintiff that it had not received

a completed "Loss of Time" claim form that was necessary to defendant's determination whether plaintiff was entitled to benefits under Art. IV, § 4.03 of the Plan Document. On or about October 29, 2004, plaintiff submitted an "Appellate Committee Review" form that stated in relevant part that plaintiff had received the required forms and was eligible for all benefits under the Plan. On or about November 12, 2004, the Fund received the requested "Loss of Time" claim form.

Once plaintiff had submitted all required supporting documentation to defendant Welfare Fund, the Workers' Compensation/Subrogation Committee met to review his request for Loss of Time benefits and for an "Agreement to Reimburse." The committee noted that the Fund had incurred $6,284.12 in medical expenses on plaintiff's behalf that were not compensable under the Plan Document because his injury had been incurred as a result of his employment and was not compensable under the Plan. The committee determined also that the Fund should not agree to an Agreement to Reimburse because plaintiff's September 2000 injury was not compensable under Art. IV, § 4.03 of the Plan Document.

In a letter dated December 1, 2004, the Fund informed plaintiff that the committee had decided to deny plaintiff's request for an Agreement to Reimburse because "it appears that your employer recognized that your injury of September 5, 2000 occurred on-the-job and continued to remit Health & Welfare contributions on your behalf." Defendant advised

plaintiff that it had already paid him benefits totaling $6,284.12 without realizing that the claims for those benefits were related to his employment. It added "[T]hese payments may be considered as an overpayment and a refund may also be requested . . . ." Defendant told plaintiff he had a right to appeal the committee's decision, pursuant to Art. X of the Plan Document.

On December 4, 2004, plaintiff appealed to defendant's Benefit Claims Appeals Committee, arguing that his employer's worker's compensation carrier had denied his claim as not being work-related and that he would be eligible for the Loss of Time benefit if he did not prevail on his worker's compensation claim. The Appeals Committee met on January 26, 2005, conducted a review of the relevant facts and plaintiff's documentation and determined that plaintiff was not eligible for the Loss of Time benefit he was seeking. It informed him of the decision in a letter dated February 2, 2005, stating that "the Plan specifically excludes the issuance of benefits for claims incurred for the treatment of a work-related injury for five years from the date of the occurrence." The Appeals Committee told plaintiff he had a right to appeal its decision to the Trustees.

On or about July 27, 2005, plaintiff submitted a final appeal to the Trustee Appellate Review Committee, contending that he should have been awarded benefits under Art. IV, § 4.03, because he was awaiting disposition of a worker's compensation claim that was disputed and he was willing to reimburse defendant for any benefits advanced if he should

settle or receive a worker's compensation award for his on-the-job injury. The Trustees met on September 13, 2005, reviewed the complete administrative record and concluded that plaintiff was not entitled to an "Agreement to Reimburse" or to Loss of Time benefits. They informed plaintiff of their decision on or about September 19, 2005, relying again on the Plan's specific exclusion of the issuance of benefits for claims incurred for the treatment of a work-related injury for five years after the date of occurrence. They added that they had agreed not to pursue the $6,284.12 overpayment created when defendant Fund provided benefits to plaintiff before learning that his injury was work-related.

E. Court Filing

Following receipt of the September letter of denial, plaintiff brought suit in the Circuit Court for Green County, Wisconsin. Defendants removed the case to this court in March 2006.

OPINION

Plaintiff does not deny that the language of the Plan Document provides discretionary authority to defendant Board of Trustees, as the plan administrator, or that the proper standard of review is the deferential one, in which a decision by defendant Trustees will not be overturned unless it is arbitrary and capricious. The parties' agreement is based upon

documents that grant authority to defendant Trustees to administer the Fund and make benefit decisions. In this situation, the court's reviewing role is limited to preventing abuses by the plan administrator. Firestone Tire & Rubber Corp. v. Bruch, 489 U.S. 101, 111 (1989) ("'Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion.'") (quoting Restatement (Second) of Trusts § 187 (1959)).

Defendants contend that the Trustees' decision had a reasonable basis in the facts and Plan Document and was not arbitrary or capricious. In their view, plaintiff is not entitled to the benefits he is seeking because his injuries were incurred on the job and are not compensable under the Plan Document. In responding to plaintiff's contention that because his injury was incurred on the job and he has a pending worker's compensation claim that has not been granted, he is entitled to enter into an Agreement to Reimburse with the Fund, defendants argue that nothing in the Plan Document requires the Fund to enter into such an agreement. The applicable language, Art. IV, § 4.03, says that a participant awaiting disposition of a worker's compensation claim "*may* be eligible to receive some benefits" and leaves it to the Fund's discretion to accept an Agreement to Reimburse. Defendants add that plaintiff was made aware of this arrangement when the Workers' Compensation/Subrogation Committee told him in July 2004 that any agreement would be subject to approval and would not be valid until approved and signed by the Fund.

If defendants are arguing that the court cannot review their decision to grant or deny plaintiff's request for an Agreement to Reimburse and Loss of Time funds because they have no obligation to grant such a request, they are wrong. Even apparently unfettered discretion must be exercised reasonably.

For his part, plaintiff seems to take the position that once he signed the Agreement to Reimburse, the Fund was obligated to do so as well and provide him Time of Loss benefits pending the disposition of his worker's compensation claim. He asserts that defendant's failure to comply with its obligations is demonstration of its bad faith and indicates that its true motivation for denying his request was its belief that plaintiff's worker's compensation claim was unfounded. It is not clear whether plaintiff believes that the Fund is obligated in every instance to enter into an Agreement to Reimburse and pay Loss of Time benefits when a worker's compensation claim is pending or whether he is arguing merely that the Fund is not permitted to base its refusal to enter into such an agreement on an opinion that his worker's compensation claim is meritless. If plaintiff believes that the Fund has an obligation to sign the Agreement to Reimburse, his belief is unfounded. The Plan Document makes it plain that the Fund has full discretion to refuse to enter into an Agreement to Reimburse.

If plaintiff believes that the Fund or the Trustees acted in bad faith, he must do more than make an assertion to that effect. The presumption is that "a fiduciary is acting

neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." Kobs v. United Wisconsin Insurance Co., 400 F.3d 1036, 1039 (7th Cir. 2005) (citing Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir. 1998)). Plaintiff has not adduced any specific evidence of actual bad faith. Schacht v. Wisconsin Dept. of Corrections, 175 F.3d 497, 504 (7th Cir. 1999) (summary judgment is "'put up or shut up" moment in a lawsuit, when a party must show what evidence it has that would convince a trier of fact to accept its version of events"). Therefore, he may not pursue this argument.

This leaves plaintiff's argument that defendants' refusal to enter into an Agreement to Reimburse does not pass judicial scrutiny even under the arbitrary and capricious standard of review. Although this argument is not articulated as clearly as it might have been, plaintiff does cite Lister v. Stark, 942 F.2d 1183 (7th Cir. 1991), for the proposition that a decision is unreasonable if the Trustees "entirely failed to consider an important aspect of the problem, offered an explanation for [their] decision that runs counter to the evidence before [them] or is so implausible that it could not ascribed to a difference in view or the product of [their] expertise." Id. at 1189 (quoting Reilly v. Blue Cross and Blue Shield United of Wisconsin, 846 F.2d 416, 420 (7th Cir. 1988) (quoting in turn Motor Vehicle Mfg. Ass'n v. State Farm Mutual Ins. Co., 463 U.S. 29, 42 (1983))).

In their denial of plaintiff's appeals from the initial denial of his request for an

Agreement to Reimburse and Loss of Time benefits, defendants offered an explanation that differed significantly from the explanation plaintiff received in response to his initial request. Both appellate decisions seem to be based upon a misapprehension of the basis for plaintiff's appeals. I cannot say that the explanations for the appellate decisions are "satisfactory in light of the relevant facts." Herman v. Central States, Southeast and Southwest Areas Pension Fund, 423 F.3d 684, 692-93 (7th Cir. 2005).

When plaintiff applied to the Workers' Compensation/Subrogation Committee for a Subrogation Agreement and Time of Loss benefits, the committee informed plaintiff that it was denying his request, "as it appears that your employer recognized that your injury of September 5, 2000 occurred on-the-job and continued to remit Health & Welfare contributions on your behalf . . . ." The committee added that defendant Fund had already paid plaintiff benefits of $6,284.12 and might have to ask for them back. It is arguable, but hardly explicit, that the committee was saying that because neither plaintiff nor his employer had advised defendants that plaintiff's claim for benefits arose out of a non-compensable injury (because it was work-related), the committee had concluded that plaintiff did not deserve the discretionary privilege of a subrogation agreement and Loss of Time benefits. Although this would have been a reasonable explanation had it been explicit, neither of the other two reviewing entities based their decision on this rationale. Both the Benefit Appeals Committee and the Trustee Appellate Review Committee told plaintiff that it was denying

his appeal because his September 2000 injury was an on-the-job injury and "the Plan specifically excludes the issuance of benefits for claims incurred for the treatment of a work-related injury for five years from the date of the occurrence . . . ." Neither appellate decision maker said anything about plaintiff's failure to advise defendants about his work-related injury at the time it incurred or referred to plaintiff's request in a way that would show that it considered the precise request that he made. In fact, neither seemed to appreciate the exact nature of plaintiff's request, but seemed to think that he was asking for benefits payable after five years to a person with a work-related disability whose worker's compensation benefits have expired. The record shows that plaintiff never requested benefits under the third paragraph of § 4.03, which covers payments of the kind referred to by the appellate decision makers. His request was made under the second paragraph of Art. IV, § 4.03 and Art. XI, § 11.15.

Under the circumstances, I cannot conclude that defendants have articulated a satisfactory explanation for their decision to deny plaintiff Loss of Time benefits. They have not shown that plaintiff is not entitled to a fresh review of his request. Although plaintiff has not moved for summary judgment, it is permissible to enter judgment for a non-moving party when there are no issues of material fact in dispute and application of the law to the undisputed facts shows that the non-movant is entitled to judgment in its favor. Jones v. Union Pacific R. Co., 302 F.3d 735, 740 (7th Cir. 2002).

ORDER

IT IS ORDERED that summary judgment is entered in favor of plaintiff James H. Oates and this matter is REMANDED to defendants Central States, Southwest and Southeast Areas Health and Welfare Fund and Board of Trustees, as Plan Administrator for the undertaking of a fresh review of plaintiff's request for an Agreement to Reimburse and Loss of Time benefits under the second paragraph of Art. IV, § 4.03 and Art. XI, § 11.15.

Entered this 27th day of September, 2006.

BY THE COURT:

/s/

BARBARA B. CRABB
District Judge