IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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ANNA EDWARDS,

Plaintiff,

v.

KOHLER CO.,

Defendant.

OPINION AND ORDER

11-cv-781-bbc

- -

Plaintiff Anna Edwards is suing defendant Kohler Co. under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461, contending that defendant violated ERISA when it refused to pay her long term disability benefits under its disability insurance policy. The case is before the court on the parties' cross motions for summary judgment. Dkts. ##13, 17. Jurisdiction is present under 28 U.S.C. § 1331.

I conclude that defendant's decision to deny plaintiff's benefits claim was arbitrary and capricious because it did not substantially comply with the requirements of 29 U.S.C. § 1133. Defendant did not give plaintiff notice of the actual grounds on which it denied her claim until it decided her final appeal. Furthermore, defendant did not notify plaintiff of the information necessary to perfect her claim or have two independent decision makers evaluate whether she met the plan's definition of total disability. By deciding plaintiff's appeal on grounds different from those it used to justify denial of her initial claim without

giving her the opportunity to appeal on those new grounds, defendant deprived plaintiff of the two levels of decision to which she is entitled under ERISA and defendant's plan. Remand to the plan's administrator is appropriate to restore plaintiff to the position she was in before defendant applied its defective procedures.

From the findings of fact proposed by the parties, I find that the following facts are undisputed and material.

UNDISPUTED FACTS

A. Parties

On February 26, 2007, defendant Kohler Co. hired plaintiff Anna Edwards as a systems project leader. In that role, she led teams for information technology projects relating to data warehousing and analysis and worked with management, end users and other project teams. Physically, plaintiff's job required her to work at a desk, as well as walk to meetings. It is unclear when plaintiff's employment with defendant ended or if it did.

Around 1986, plaintiff was given a diagnosis of rheumatoid arthritis and system lupus erythematosus. During plaintiff's employment with defendant, her physician Dr. Hohenwarter found that she still suffered from rheumatoid arthritis in her hands, knees and neck. He noted subjective symptoms of severe pain and stiffness. In a February 28, 2009 "disability appeal" to defendant, plaintiff wrote that having to work "long, hard hours" as a result of a staff shortage at Kohler worsened her symptoms. AR 62. She took a medical leave of absence from October 27, 2007 to January 8, 2008 and another one from March

24, 2008 to approximately July 6, 2008.

B. Payment Protection Plan

During plaintiff's employment, defendant maintained and sponsored a "Pay Protection Plan." The summary plan description of the plan functions as the written plan document. Under the plan, certain employees are eligible for up to 26 weeks of disability benefits under the "Salary Continuation Plan." Admin. Rec., dkt. #16-1, at 9. After 26 weeks of salary continuation, employees who have been employed for at least one year and meet the plan's definition of total disability are eligible for long term disability benefits, which replace up to 60% of the employee's pre-disability pay. AR 11. The plan makes the following provision for total disability:

> During the first 24 months of disability, you must be totally disabled from performing any and every duty of your occupation or similar job. After 24 months, you must be totally disabled from performing any occupation or employment. You must always be under the care of a licensed physician during your disability.

AR 12.

The plan offers some guidance as to how to file a claim for benefits. In its "How to File a Claim" section, it states that an ill or injured employee should notify her supervisor as soon as possible that she will be absent from work. AR 15. It then says that the employee's supervisor will notify defendant of the employee's disability and payroll will process the employee's short term salary continuation benefits under the plan. Id. If "it is obvious that [the employee's] disability will continue," "Kohler Konnect will send [the

employee] the application form for Long-Term Disability benefits before payments under the Short-Term or Salary Continuation Plans end." Id. The employee and her doctor then are to complete the long term disability application form and submit it to the company. Id.

The plan also provides for an appeals process. "[A]n appeal of an adverse benefit decision is filed when a claimant (or authorized representative) submits a written request for review to the claim administrator." AR 28. This appeal includes a right to "a review that does not defer to the initial adverse benefit determination and that is conducted by a named fiduciary of the Plan that is neither the individual who made the adverse determination nor that person's subordinate." AR 34.

C. Plaintiff's Benefits under the Plan

When plaintiff took her leaves of absence in 2007 and 2008, she received and exhausted 26 weeks of salary continuation benefits through defendant's plan. On June 11, 2008, shortly after she had exhausted her short term benefits under the plan, she emailed Geralyn Pekarski, a human resource generalist for defendant, saying that "I would like to know what I should do to qualify for the long-term disability as described in the benefits summary." AR 93. On June 23, 2008, a disability examiner working for defendant, Joanne Tasche, responded to plaintiff's inquiry, telling her that as of January 8, 2008, when she completed her first medical leave of absence, she did not qualify for long term disability because she "did not have the length of service required for this benefit." AR 70. She added that

> [a] single instance of a continuous period of disability occurs when you are absent from work and your absence is not separated by at least three months of full-time employment. Since you were again on a medical leave of absence beginning March 18, 2008, this would be a continuing claim and all eligibility would be based on the dates that your medical leave initially began. Therefore, you are not eligible for long-term disability for your current leave of absence.

Id.

On February 28, 2009, plaintiff submitted a letter titled "disability appeal" to James Jost, R.N., defendant's supervisor of nursing administration. AR 60. She summarized her medical condition, described the stressful conditions at work that she thought aggravated her symptoms and included medical documents. AR 60-66.

On June 27, 2008, Tasche emailed Daniel Velicer, defendant's Director of Global Benefits, asking him whether it was appropriate to send plaintiff a letter advising her of her ineligibility for long term disability benefits because she had not worked for defendant for one year and because she did not return to work for three months between her two medical leaves. AR 90. Tasche requested the same advice from Velicer on July 14, 2008. Id. She sent copies of both requests to Jost.

On July 17, 2008, Jost informed plaintiff that he had "received her appeal letter," AR 69, that her case had been reviewed and that defendant had determined that she was not eligible for benefits. He explained that

> [a] single instance of a continuous period of disability occurs when you are absent from work and your absence is not separated by at least three consecutive months of active full-time employment as indicated on Page 7 of the Pay Protection section of the Summary Plan Description.

Jost informed plaintiff that she was entitled to a second appeal and that her appeal should be

addressed to Dan Velicer. Id.

On November 20, 2011, plaintiff submitted an application for long term disability benefits on a standard Kohler form. AR 71. Less than a month later, on December 9, 2008, Tasche wrote plaintiff, citing the June 23, 2008 and July 17, 2008 letters and informing plaintiff again that she was ineligible for long term disability benefits. AR 68. She advised plaintiff that she was entitled to submit a secondary appeal to Daniel Velicer. Id.

On December 31, 2008, Jeffrey Oullet, plaintiff's attorney, wrote Velicer to ask him to reevaluate the denial of benefits. AR 55-58. Oullet pointed out that the language of the long term disability plan did not support defendant's decision because it said nothing about the need for a continuous period of disability. He added that he had found no reference to a service requirement preceding an award of long term disability payments. AR 57. On February 25, 2009, Velicer responded to Oullet, acknowledging that the plan's language regarding continuing disabilities was not clear and agreeing to reevaluate plaintiff's claim and make a determination on the merits of the medical documentation within 60 days. He gave plaintiff the opportunity to submit additional medical documentation if she wished.

On March 17, 2009, Mary Dekker, R.N., reviewed plaintiff's medical documentation on behalf of defendant. In a report to Velicer, she wrote that she had found no objective evidence to support plaintiff's claims that her employment accelerated her arthritis or that her condition required her to be off work for an extended period of time. Dekker listed several sources of information that would have been useful in making these determinations, such as a standing MRI, flat x-rays, documentation of changes in treatment and records from

a hospitalization in Peglerae, South Africa. AR 88. She concluded by saying that "if this claim was initiated now it would be denied until objective medical documentation was supplied." Id.

On April 30, 2009, Velicer wrote plaintiff's counsel to say that defendant "d[id] not have sufficient medical documentation to support approving [plaintiff's] claim for LTD benefits." AR 47. He listed the medical documents upon which he had based his review and said that the documents confirmed "the diagnosis of Rheumatoid arthritis and overall degenerative changes often seen with aging." Id. He added that "there is nothing indicating that [plaintiff's] health status changed to the extent that her on-going treatment plan was changed during her employment at Kohler," and that "the documentation we have simply does not prove, to [defendant's] satisfaction, that [plaintiff] is incapable of performing any and every duty of her occupation or similar job." He stated that he had considered Oullet's letter "an appeal of a denied claim for benefits and this letter constitutes a denial of that appeal." Id. Therefore, Velicer said, plaintiff had exhausted her appeal rights under the plan. He ended by advising Oullet of plaintiff's rights under ERISA to bring a civil action under § 502(a).

OPINION

Plaintiff challenges defendant's denial of benefits on a number of grounds: it is arbitrary and capricious because defendant had a conflict of interest; defendant did not comply with the deadlines ERISA imposed; and defendant acted improperly when it relied

on the lack of change in plaintiff's treatment in denying her claim. However, her central argument is that defendant did not provide adequate notice of the reason for her claim's denial until the final decision and therefore denied her the opportunity to appeal its finding that she did not meet the plan's definition of total disability. I agree with plaintiff that defendant did not substantially comply with the procedural requirements of § 1133 and denied her adequate notice of an adverse benefit determination and the opportunity for a full and fair review. Therefore, it is not necessary to address her remaining arguments.

A. Standard of Review

Defendant has retained discretion under its plan to determine an individual's eligibility for benefits. Therefore, the court's review of the administrator's decision to deny plaintiff's claim for long term disability benefits proceeds under an arbitrary and capricious standard. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Love v. National City Corp. Welfare Benefits Plan, 574 F.3d 392, 396 (7th Cir. 2009). Plan administrators are required to afford a reasonable opportunity for a full and fair review of a claim denial; the elements of a full and fair review are spelled out in 29 U.S.C. § 1133 and accompanying regulations. A court "will reverse a plan's determination as arbitrary and capricious if it fails to substantially comply with these requirements." Love, 574 F.3d at 396 (citing Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003); Tate v. Long Term Disability Plan For Salaried Employees of Champion International Corp. # 506, 545 F.3d 555, 559 (7th Cir. 2008) (overruled on other grounds)).

B. Procedural Requirements

ERISA requires a plan to notify a claimant of the basis for its denial to "insure that when a claimant appeals a denial to the plan administrator, he will be able to address the determinative issues and have a fair chance to present his case." Halpin v. W.W. Grainger, Inc., 962 F.2d 685, 689 (7th Cir. 1992). Section 1133 provides that:

> In accordance with regulations of the Secretary, every employee benefit plan shall--
>
> > (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
> >
> > (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

The regulations provide more detailed information on the manner and content of the notification. In relevant part, they specify that

> The notification shall set forth, in a manner calculated to be understood by the claimant–
>
> > (i) The specific reason or reasons for the adverse determination;
> >
> > * * * * * *
> >
> > (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

29 C.F.R. § 2560.503-1(g).

"[S]ubstantial compliance" with these requirements is sufficient. Halpin, 962 F.2d at 690. However, a court will set aside the administrator's decision when it is arbitrary and

capricious, not supported by substantial evidence or relies on an erroneous interpretation of law. Id. (citing Wolfe v. J.C. Penney Co., 710 F.2d 388, 393 (7th Cir. 1983)). The core requirements of full and fair review include "'knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision.'" Brown v. Retirement Committee of Brings & Stratton Retirement Plan, 797 F.2d 521, 534 (7th Cir. 1986) (quoting Grossmuller v. International Union, United Automobile Aerospace & Agricultural Implement Workers of America, UAW, Local 813, 715 F.2d 853 (3d Cir. 1983)).

In this case, the administrative record shows that defendant (1) violated § 1133 by not providing plaintiff (1) the actual, specific reason for denying her claim until it denied her "final appeal;" (2) violated 29 C.F.R. § 2560.503-1(g)(iii)(2) because it did not describe to her the information necessary to perfect her claim; and (3) violated 29 C.F.R. § 2560.503-1(h)(3)(ii) and the terms of its own plan, AR 34, by not providing for a review of the decision conducted by an appropriate named fiduciary of the plan and who is not a subordinate of that individual who had decided her initial claim. The cumulative effect of these defective procedures was to deprive plaintiff of a full and fair review of her claim.

1. Characterization of mailings

The parties disagree about which emails and letters constituted a claim, denial, appeal and denial of the appeal. The characterization of these communications bears on the

question whether defendant provided plaintiff adequate notice of the denial and an independent administrative review. For the purposes of deciding this motion, I conclude that plaintiff's initial claim was the November 20, 2008 application she submitted on defendant's standard form. Although it could be argued that defendant treated her earlier correspondence as a claim (Jost told plaintiff she was entitled to a "second appeal" in his July 17, 2008 letter), I will not characterize it as a claim, for three reasons: first, because I am granting plaintiff's motion for summary judgment, I must grant all reasonable inferences in favor of the non-moving party, defendant. Kuhn v. Goodlow, 678 F.3d 552, 555 (7th Cir. 2012). Second, the plan gives defendant "the exclusive right to determine eligibility for benefits and to interpret the provisions of the Plan." AR 15, 35. Finally, I find defendant's characterizations more consistent with the plan's language in its "How to File a Claim" section.

The initial adverse benefit determination was Tasche's December 9, 2008 letter denying plaintiff's claim on the ground that she did "not meet the eligibility requirement for this benefit." Plaintiff appealed this decision in a December 31, 2008 letter from her counsel, requesting re-evaluation on the merits of plaintiff's medical documentation. Velicer denied that appeal in his April 30, 2009 letter, in which he stated that plaintiff had exhausted her administrative remedies. I conclude that this April 30, 2009 letter is a decision on plaintiff's appeal because it is a denial of her claim and a reversal of Tasche's initial rejection of plaintiff's claim, which was based on plaintiff's continuing disability. (In this instance, I cannot draw a reasonable inference in defendant's favor finding Velicer's February 25, 2009 letter a denial of plaintiff's claim. In this letter, he reversed Tasche's initial decision denying

plaintiff's claim because she did not meet the eligibility requirement for long term disability benefits and agreed to reevaluate plaintiff's claim on the basis of medical merit.)

2. Adequate notice of denial and full and fair review

When denying a claim for benefits, a plan administrator must give the claimant the specific reason for the adverse determination and cite the specific plan provisions on which the determination is based. 29 U.S.C. § 1133(1); 29 C.F.R. § 2560.503-1(g)(i)-(ii). Moreover, the plan administrator must "give [the plaintiff] *every reason* for its denial of benefits at the time of denial. . . . It may not add new reasons as litigation proceeds." Reich v. Ladish Co., 306 F.3d 519, 524 n.1 (7th Cir. 2002) (emphasis added). Allowing an administrator to proceed in such a "piecemeal" fashion would frustrate ERISA's purpose of insuring that employees can prepare for the full and fair review to which they are entitled under § 1133. Id.; Halpin, 962 F.2d at 693. An employee cannot be prepared for a review when that review will be based on a reason that the employee does not know and that has been communicated only vaguely to her.

In the December 9, 2008 initial determination letter, Tasche informed plaintiff that she did not qualify for benefits because she did not meet the eligibility requirement for long term benefits. This letter did not give plaintiff adequate information to allow her to prepare for an appeal. It neither says specifically why plaintiff did not meet the requirement nor tells plaintiff that defendant would be making its final decision on other grounds. Halpin, 962 F.2d at 689 (notice requirements of § 1133 "insure that when a claimant appeals a denial to

the plan administrator, he will be able to address the determinative issues and have a fair chance to present his case"). Tasche's letter does not communicate to plaintiff what she needed to know in order to take an informed appeal. It contained no warning that defendant was going to be deciding her appeal on a ground not relied upon for the initial determinations (whether she met the plan's definition of total disability). Without this information, she could not prepare properly for an appeal.

Defendant argues that Velicer's subsequent February 25, 2009 letter cures the defect in Tasche's December 9 letter. In the February 25 letter, Velicer agreed to reevaluate plaintiff's claim on the merits of medical documentation. He listed the documents in defendant's possession and invited plaintiff to submit any additional medical information she wished defendant to consider. Defendant contends that this letter gave plaintiff adequate notice of the new grounds on which the appeal would be based and therefore gave her the opportunity to adequately prepare for review. In fact, the letter is not adequate under either § 1133 or defendant's plan because it does not meet the requirement that defendant inform plaintiff that it is denying her claim and give the reasons for the denial.

It might seem peculiar that defendant should be required to give plaintiff this information when Velicer seemed to be giving a claimant a second chance to obtain long term disability benefits. The requirement derives from ERISA and the provisions in 29 C.F.R. § 2560.503-1(h)(3)(ii), which provides that plaintiff is entitled to two levels of administrative review: an initial determination and an administrative appeal.

On the question of eligibility for long term disability benefits, plaintiff received the

required two levels of review. Velicer reversed Tasche's initial decision that plaintiff was ineligible for long term disability benefits (after plaintiff's counsel pointed out the inadequacies of the plan's language). However, when he changed the question to whether plaintiff met the plan's definition of total disability, he did not give her two levels of review. Defendant denied plaintiff's claim but did not tell her it was doing so until Velicer wrote to her on April 30, 2009. This was the final letter she received on this point from defendant.

In the face of this serious procedural defect, defendant argues that Velicer's February 25, 2009 letter also served as an initial adverse determination based on medical merit. It concedes that the letter did not say that defendant was denying plaintiff's claim because it lacked medical merit, but argues that it was the "functional equivalent" of such an initial denial letter and provided enough information to allow plaintiff to prepare for appeal. Id. This is not a very persuasive argument. Granting a claimant review on new grounds does not constitute notice that the plan is simultaneously denying her claim on those new grounds. This is especially true in light of the requirement of § 1133(1) to communicate "in a manner calculated to be understood by the participant." Although § 1133(1) refers to communication regarding the reasons for the denial, it applies logically to the language the administrator uses to deny the claim in the first place. Velicer's letter did not inform plaintiff that it was denying her claim; it follows that the letter fails to comply with ERISA's requirement to communicate the specific reason for the denial. Velicer's February 25, 2009 letter was not the "functional equivalent" of a denial letter. Therefore, plaintiff received only one decision from defendant that gave her a chance to prepare for a determination based on medical merit.

Defendant argues that despite these procedural errors, it complied substantially with the requirements of ERISA. It cites this court's opinion in Winters v. Unum Life Insurance, 232 F. Supp. 2d 918 (W.D. Wis. 2002), for the proposition that the untimely addition of new reasons can constitute substantial compliance. In that case, the court found that defendant's addition of new reasons was substantial compliance with ERISA because the employee had an opportunity to appeal those new reasons. Id. at 930 ("because defendant informed plaintiff of his opportunity to appeal the additional reasons, defendant nevertheless substantially complie[d] with ERISA"). In this case, plaintiff had no opportunity to appeal the new reason for denial and received only one decision on the question whether she met the plan's definition of total disability. Because defendant did not provide an opportunity for review of the ultimate reason for the denial of plaintiff's claim, it did not comply substantially with ERISA.

3. Information necessary to perfect claim

In addition to denying plaintiff the opportunity to appeal the finding that she did not meet the plan's definition of total disability, defendant did not provide an adequate description of the additional material necessary to perfect her claim on such an appeal, as required under 29 C.F.R. § 2560.503-1(g)(1)(iii). Halpin, 962 F.2d at 691 ("[c]learly, a blanket request for 'additional medical information' [does] not satisf[y] the regulatory requirements"; a plan administrator must "specify *the kind* of additional medical information needed"). Id. (emphasis added). In his February 25, 2009 letter, Velicer listed the

documents in defendant's possession and invited plaintiff to submit any additional medical documentation she wanted. This is the kind of blanket request for more medical information the court of appeals found insufficient in Halpin.

Defendant points out correctly that this procedural rule applies only "when more information is needed for a plan administrator to review the denial of a claim." Brehmer v. Inland Steel Industries Pension Plan, 114 F.3d 656, 661 (7th Cir. 1997) (administrator did not need additional information to find that company's letter clearly communicated to plaintiff that she was not guaranteed her old job back after leave of absence). However, the rule applies in this case. The March 17, 2009 report from defendant's medical reviewer shows that there was documentation plaintiff could have provided on appeal to perfect her claim (standing MRI, flat x-rays, documentation of changes in treatment, records from hospitalization in Peglerae, South Africa, and objective documentation that plaintiff needed to be off work). The reviewer added that plaintiff's claim should be denied *until* this objective medical documentation is supplied. Id. This implies that if plaintiff had supplied the objective medical documentation, her claim might have been approved. It does not demonstrate, as defendant argues, that plaintiff had no evidence she could have submitted that would have caused the administrator to approve her claim.

As part of the same theory, defendant argues that it did not need additional medical information, particularly objective medical documentation of work restrictions, because plaintiff's own doctor had concluded that she did not have any. Defendant argues that by listing plaintiff's symptoms instead of specifying work restrictions on the attending

physician's statement, Dr. Hohenwarter meant to communicate that plaintiff did not have any such restrictions, but this argument reads too much into the doctor's statement. His documentation of symptoms does not prove one way or the other whether plaintiff had work restrictions because he did not answer the question in the correct manner. Had defendant complied with 29 C.F.R. § 2560.503-1(g)(iii) and notified plaintiff of this deficiency, she could have addressed it on appeal.

4. Independent review

Defendant violated 29 C.F.R. § 2560(h)(3)(ii) and its own plan when it allowed Velicer to be the only individual to decide whether plaintiff met the plan's definition of total disability. An administrator must provide a claimant with a review of an initial adverse benefit determination that does not defer to that initial decision and that is conducted by a named fiduciary of the plan that is neither the individual who made the adverse determination nor that person's subordinate. In order to show compliance with the regulations, defendant would have to prove that two individuals independently evaluated whether plaintiff supplied sufficient medical documentation of her disability. It has not done this.

Plaintiff argues that Velicer was not an independent evaluator because the emails he received in the summer of 2008 from Tasche concerning the initial reason for the denial (plaintiff had a continuing disability), infected Velicer with Tasche's view of the claim, destroying his independence. In response, defendant argues that plaintiff received an

independent review because Tasche and Velicer did not communicate about the claim until after Tasche sent plaintiff the June 23, 2008 letter denying her claim on the ground that she had a continuing disability. These arguments miss the point: it does not matter that Tasche, not Velicer, denied plaintiff's claim on December 9, 2008 on the ground that plaintiff did not meet the eligibility requirements for long term benefits because that was not the ground on which defendant ultimately denied the claim.

The relevant inquiry is whether two independent individuals decided whether plaintiff met the plan's definition of total disability. They did not; only Velicer made a determination on the basis of medical merit. Velicer wrote the April 30, 2009 letter, which was the only notice plaintiff received that her claim was denied because she had not provided sufficient medical documentation. Even if I agreed with defendant that the February 25, 2009 letter constituted the "functional equivalent" of an initial denial on medical merit, plaintiff still did not receive an independent review because Velicer wrote that letter as well. Defendant cannot interpret the December 9, 2008 and February 25, 2009 letters as the initial denials for some purposes (complying with ERISA's deadlines and providing a decision on plaintiff's appeal) and Tasche's June 23, 2008 letter as the initial denial for another (providing an independent review). Just as the law required defendant to afford plaintiff an opportunity to challenge the reasons for which her claim was denied, it also required defendant to insure that two different individuals evaluated the ultimate reason for denying plaintiff's claim.

In summary, defendant failed to provide plaintiff with adequate notice of its denial and the opportunity for a full and fair review. It waited until its final letter to inform her of

the reason for the denial of her claim and then provided no opportunity for her to appeal the denial on that ground or supply the additional information necessary to perfect her claim. Throughout the process, only one decision maker evaluated her claim on its medical merits. These combined procedural defects do not achieve substantial compliance with the requirements of ERISA and render defendant's decision arbitrary and capricious.

Plaintiff was not provided an opportunity to appeal defendant's decision that her medical documentation was insufficient to show that her medical condition did not meet the plan's definition of total disability. Defendant never gave her notice of the specific reason for denial until it informed her that she had exhausted her administrative rights; it never provided her with notice of the kind of information necessary to perfect her claim; and it had only one decision maker evaluate the claim on its medical merits.

C. Remedy

Once it has been determined that defendant's decision was arbitrary and capricious, it is necessary to decide the appropriate remedy. In cases in which the plan administrator did not provide adequate procedures in its initial determination, "the appropriate remedy respecting the status quo and correcting for the defective procedures is to provide the claimant with the procedures that she sought in the first place." Schneider v. Sentry Group Long Term Disability Plan, 422 F.3d 621, 629 (7th Cir. 2005); Hackett v. Xerox Corp., 315 F.3d 771, 776 (7th Cir. 2003) (citing Wolfe, 710 F.2d at 394). This remedy is consistent with ERISA's policy that plan administrators should be allowed to decide a

claimant's eligibility for benefits. Halpin, 962 F.2d at 697. A court will order a defendant to pay benefits only when the employee was receiving benefits before she encountered the defective procedure. Hackett, 315 F.3d at 776.

In arguing that the court should order the payment of benefits rather than remand, plaintiff fails to cite a single case involving the denial of a claim for benefits in which the court awarded benefits rather than remanded. In fact, the cases she cites support the distinction between cases in which defendants deny a claim and those in which defendants terminate benefits. Weitzenkamp v. Unum Life Insurance Co. of America, 661 F.3d 323 (7th Cir. 2011); Holmstrom v. Metropolitan Life Insurance Co., 615 F.3d 758 (7th Cir. 2010). Therefore I will remand the case to defendant for further proceedings.

Defendant argues that regardless of its noncompliance with procedural regulations, it is clear that plaintiff does not meet the plan's definition of total disability, so it should not be required to reconsider her claim. Without giving plaintiff the opportunity to supply the kind of objective medical documentation defendant found lacking in 2008 or an opportunity to present an appeal to independent decision maker, defendant has no way of knowing whether the result on the merits would change. Defendant erred in applying § 1133 and its accompanying regulations, and fairness requires this court to set aside the plan administrator's decision and remand for further proceedings consistent with this opinion.

Plaintiff has asked for attorney fees and costs to be determined after judgment is entered. At the present time, plaintiff has not shown that attorney fees should be awarded but she is free to file a motion to that effect.

ORDER

IT IS ORDERED THAT plaintiff Anna Edwards's motion for summary judgment is GRANTED and plaintiff's claim is REMANDED to defendant for proceedings consistent with this opinion. Defendant Kohler Co.'s cross motion for summary judgment is DENIED.

Entered this 14th day of November, 2012.

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