UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

DENNIS DIAZ,

Plaintiff,

vs. Case No. 8:02-CV-1807-T-27MAP

JOHNSON CONTROLS, INC.,

Defendants.
_______________________________/

ORDER

BEFORE THE COURT is Defendant's Motion for Summary Judgment (Dkt. 25), Plaintiff's Response (Dkt. 32), and Defendant's Reply (Dkt. 33). Oral argument was heard on September 20, 2004. Upon consideration, Defendant's Motion for Summary Judgment is **GRANTED**.

Introduction

Plaintiff filed suit against Defendant Johnson Controls, Inc. ("JCI")[1] alleging violations of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1132 in Count I and seeking declaratory relief in Counts II, III and IV. (Dkt. 7). In Count I, Plaintiff alleges that he was wrongfully denied reimbursement of medical expenses by Defendant. In Counts II, III, and IV, Plaintiff seeks declaratory relief as to: (1) whether Plaintiff may rescind his Medicare coverage and resume coverage under Johnson Control's Production Employees Group Insurance Plan (the "Plan") (Count II); (2) whether Plaintiff's entitlement to Long Term Disability benefits under the Plan can be offset by his social security benefits (Count III) and (3) whether the Plan may apply a 5%

[1] Blue Cross/Blue Shield of Illinois, Inc. was dismissed without prejudice as a defendant. (Dkt. 31).

reduction factor when calculating Plaintiff's accrued retirement benefits. (Dkt. 7). Defendant has moved for summary judgment on all counts. (Dkt. 25).

Factual Background

Plaintiff was employed as a production worker at Defendant's battery manufacturing facility in Tampa, Florida. (Dkt. 26, p. 4). During his employment with Defendant, Plaintiff developed a work related injury and was eventually diagnosed with a permanent impairment. He stopped working in February 1996.[2]

When Plaintiff became disabled, he was covered by the Johnson Control's Production Employees Group Insurance Plan. The Plan is "sponsored by Johnson Controls, Inc. and administrated by: Employee Benefit Policy Committee, Johnson Controls, Inc." (Dkt. 7, Ex. A, p. 28). In relevant part, the Plan provides:

> Johnson Controls is self-insured (that is, makes contributions to the Johnson Controls Employee Benefits Trust for the purpose of paying certain medical, dental and short-term disability benefits). Although the claims are paid by the trust which is funded by the Company, the checks are issued by the plan administrators, ...

Id.

Effective January 1, 2000, Blue Cross/Blue Shield of Illinois, Inc. ("BC/BS") became a third party administrator for the Plan. (Dkt. 7, ¶¶ 17, 18). JCI remained the Plan sponsor and Plan administrator.[3] (Dkt. 7, Ex. A, p. 28).

---

[2] Because of Plaintiff's permanent injury, he was eligible for Long Term Disability benefits and medical coverage. Plaintiff was also approved for social security benefits. According to the Long Term Disability Benefits provision of the Plan, "Long term disability benefits are not payable if Social Security benefits are not payable." (Dkt. 7, Ex. A, p. 24). Additionally, Long Term Disability Benefits are "reduced by one-half (1/2) company-paid Social Security, disability pension and Workers Compensation." *Id.*

[3] At oral argument, the parties agreed that BC/BS merely performed a clerical function and that JCI remained the Plan administrator. This assertion is consistent with the plan language which provides:

Three provisions of the Plan are pertinent to a resolution of Defendant's motion for summary judgment. First, the Plan contains a "Coordination of Benefits" provision, which establishes primary and secondary payers of medical expenses. That provision provides, in relevant part:

> Coordination of benefits determines how much each plan should pay when there is more than one group plan. The following rules will be applied in determining order of payment.
>
> * * *
>
> Determination of which plan is "primary"
>
> If you are covered under a number of Health Care Plans or have any insurance coverage that pays health care costs, the plan or contract without a coordinating provision is always the primary payer. If all coverages have such a provision, the plan covering you as an employee is primary.
>
> * * *
>
> To receive maximum reimbursement, be sure to apply for benefits under all coverages.

(Dkt. 7, Ex. A, p. 4).

Secondly, the Plan provides that participants must satisfy an annual deductible of $200.00 per person ($400 per family). (Dkt. 7, Ex. A., p. 1). Finally, with respect to administration of the Plan, the Plan provides: "If any plan provision is unclear or ambiguous, the Plan administrator [ ] determine[s] how it should be applied in any given circumstance." (Dkt. 7, Ex. A, p. 27). If a participant disagrees with the administrator's denial of benefits or interpretation of the Plan, the Plan's "Application Review Procedures" affords the participant three levels of review. (Dkt. 7, Ex. A, p. 29).

On November 13, 2000, Defendant notified Plaintiff that the terms of the Plan required Plaintiff to apply for Medicare benefits. (Dkt. 7, Ex. E). Defendant also provided Plaintiff with a

---

The Plans are sponsored by Johnson Controls, Inc., and administrated by:
Employee Benefits Policy Committee
Johnson Controls, Inc.

(Dkt. 7, Ex. A, p. 28).

"Notice to Long Term Disability Plan Participants", which stated in relevant part: "Once you become eligible for Medicare coverage, all claims must be submitted to Medicare first. [Defendant] will only pay claims after Medicare has paid its part of the bill . . . ." *Id.*

Plaintiff subsequently enrolled in Medicare. In 2001 and 2002, he submitted claims for reimbursement of medical expenses that were partially paid by Medicare. (Dkt. 7). Plaintiff's claims were denied. BC/BS's letter denying Plaintiff's claims explained that Medicare had paid 80% of the fee but that Plaintiff had not yet reached his $200.00 deductible. The letter further explained:

> Under the terms and conditions of your health care policy, eligible services are covered at 80% of the usual and customary fee. If Medicare, being the primary payer, makes a payment of 80% or greater, then Blue Cross Blue Shield will make no additional payment until your out of pocket expense has been satisfied.

(Dkt. 7, Ex. H)

On review, BC/BS affirmed the administrator's denial of Plaintiff's claims. Plaintiff appealed BC/BS's decision to the JCI Employee Benefits Administrative Committee (the "Administrative Committee"). The Administrative Committee affirmed BC/BS's denial. Plaintiff then invoked the final level of review under the Plan to the JCI Employee Benefits Policy Committee (the "Policy Committee"). The Policy Committee affirmed the administrator's denial of Plaintiff's request for additional reimbursement. (Dkt. 7, Ex. L). In relevant part, the Policy Committee's denial letter provided:

> Your request for additional payment does not meet the plan coverage described in the Summary Plan Description (SPD). Page 1 of the SPD states that you must first pay the annual deductible of $200 per person ($400 per family). After meeting the deductible, the claims are paid at 10% over what Medicare paid. After $30,000 of claims per calendar year, 100% will be paid by the plan.

> Your submitted claims exceeded the $5000 out of pocket maximum for calendar year 2001. Thereafter, for the remaining claims of 2001, Blue Cross/Blue Shield has already paid 10% over what Medicare paid. Your claims did not exceed $5000 for calendar year 2000. Your claims did not exceed $30,000 in either calendar year.
>
> In addition, benefits are coordinated so that there is non-duplication of benefits. Medicare is your primary plan. As stated on page 4 of the SPD, 'If our plan is secondary and the primary plan pays as much or more than our plan would provide, there is no payment from our plan.'

(Dkt. 7, Ex. L).

While Plaintiff exhausted the Plan's review process with respect to the administrator's denial of his medical expense reimbursement claim, he did not submit a claim and therefore has not exhausted the Plan's appeal process with regard to his claims for declaratory judgment, namely that (1) he should be permitted to rescind his Medicare coverage, (2) his Long Term Disability benefits should not be offset by his social security benefits, and (3) the Plan should not apply a 5% reduction when calculating his future retirement benefits.

Summary Judgment Standard

Summary judgment is proper if following discovery, the pleadings, depositions, answers to interrogatories, affidavits and admissions on file show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986); Fed. R. Civ. P. 56. The Court must view all evidence and all factual inferences reasonably drawn from the evidence in the light most favorable to the nonmoving party. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144 (1970); *Stewart v. Happy Herman's Cheshire Bridge, Inc.*, 117 F.3d 1278, 1285 (11th Cir. 1997).

Discussion

1. *Standard of Review under ERISA*

ERISA does not provide a standard of review of decisions by a plan administrator in actions challenging benefit determinations under § 1132(a)(1)(B). *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 108-09 (1989); *Paramore v. Delta Air Lines*, 129 F.3d 1446, 1449 (11th Cir. 1997). The Supreme Court has determined that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Bruch*, 489 U.S. at 115.

Consistent with the Court's directive in *Bruch*, the Eleventh Circuit has adopted three standards of review for plan interpretations: (1) *de novo*, applicable where the plan administrator is not afforded discretion; (2) arbitrary and capricious, applicable when the plan grants the administrator discretion; and (3) heightened arbitrary and capricious, applicable when the plan grants discretion, but the administrator operates under a conflict of interest. *Buckley v. Metropolitan Life*, 115 F.3d 936, 939 (11th Cir. 1997) (citations omitted).

Here, the Plan provides: "[i]f any provision is unclear or ambiguous, the Plan administrator will determine how it should be applied in any given circumstance." (Dkt. 7, Ex. A, p. 27). The initial issue presented is whether this language vests in the Plan administrator discretion in interpreting and applying its provisions. If so, the arbitrary and capricious standard of review applies, absent any conflict of interest.

Defendant contends the above quoted language of the Plan expressly grants the Plan administrator discretionary authority to determine eligibility for benefits and to construe the terms

of the Plan, arguing that this language is "nearly identical" to the language in the plans discussed in *Lee v. Blue Cross & Blue Shield of Alabama*, 10 F.3d 1547, 1550 (11th Cir. 1994) and *Jett v. Blue Cross & Blue Shield of Alabama*, 890 F.2d 1137, 1139 (11th Cir. 1989), in which the arbitrary and capricious standard of review was applied.

While the language of the instant Plan is similar in context to the plan language discussed in *Lee* and *Jett*, it is not identical. The language in the plans discussed in *Lee* and *Jett* is distinguishable to some extent, as the *Lee* and *Jett* plans provide that the administrator "has the *exclusive right* to interpret the provisions of the Plan, so its decision is *conclusive and binding*." *Lee*, 10 F.3d at 1550 (emphasis added); *Jett*, 890 F.2d at 1139 (emphasis added). This language ordinarily justifies the deferential arbitrary and capricious standard of review. *See Shaw v. Connecticut General Life Ins. Co.*, 353 F.3d 1276 (11th Cir. 2003) (citing *Buce v. Allianz Life Ins. Co.*, 247 F.3d 1133, 1138-39 (11th Cir. 2001)).

The instant Plan's language does, however, as did the language in the *Lee* and *Jett* plans, vest discretion in the Plan's administrator to interpret and construe the Plan's terms, notwithstanding that it does not expressly provide that the administrator's decision is conclusive and binding. Indeed, the Eleventh Circuit has applied the arbitrary and capricious standard of review where, as here, the plan language confers discretion on the administrator to interpret the plan but does not expressly provide that the administrator's interpretation is final or binding. *See Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 38 (11th Cir. 1989) (applying arbitrary and capricious standard of review where plan conferred on trustees the exclusive "authority to determine all questions of coverage and eligibility" and "full power to construe the provisions of [the] Trust . . .").[4]

[4] Plaintiff cites no case in which similar plan language has been held insufficient to warrant the arbitrary and capricious standard of review.

Accordingly, this Court concludes that the language of the instant Plan confers discretionary authority on the administrator to construe the terms of the Plan.

When a plan administrator operates under a conflict of interest, such as where the administrator pays benefits directly out of its operating expenses, a "heightened" arbitrary and capricious standard of review must be applied. *See Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001). Under the heightened arbitrary and capricious standard of review, the interpretation of the administrator is deemed arbitrary and capricious if it advances the conflicting interest of the administrator at the expense of the affected beneficiary, unless the administrator justifies the interpretation on the ground that it benefits the class of all participants and beneficiaries. *Id.* However, "[i]t is fundamental that the fiduciary's interpretation first must be 'wrong' from the perspective of *de novo* review before a reviewing court is concerned with the self-interest of the fiduciary". *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990). For the reasons discussed below, this Court concludes, after a *de novo* review, that Defendant's interpretation of the Plan as requiring Plaintiff to apply for Medicare and Defendant's application of the Coordination of Benefits provision once Plaintiff received Medicare benefits was not "wrong" in light of the unambiguous Plan language. It is, therefore, unnecessary to determine whether Defendant acted under a conflict of interest.[5]

[5] It appears from the Plan documents that JCI did not operate under a conflict of interest as the Plan provides that JCI makes "contributions to the Johnson Controls Employee Benefits Trust for the purpose of paying certain medical, dental and short term disability benefits", as opposed to paying benefits directly from JCI's operating expenses (Dkt. 7, Ex. A, p. 28). *See e.g. Williams v. Bellsouth Telecommunications, Inc.*, 373 F.3d 1132, 1135 n.4 (11th Cir. 2004) (conflict of interest exists where disability plan benefits were paid directly out of BellSouth's operating expenses, as opposed to being paid from a trust or otherwise self funded). However, neither party has presented evidence demonstrating how the trust was funded. Defendant failed to address whether it operated under a conflict of interest in its motion for summary judgment. Nonetheless, because this Court finds that Defendant's interpretation of the relevant Plan language is not "wrong" after a *de novo* review, it is unnecessary to determine whether Defendant acted under a conflict of interest.

2. *Count I - Denial of Reimbursement for Medical Expenses*

In Count I, Plaintiff alleges that Defendant wrongfully denied his request for additional reimbursement based on his Medicare eligibility. Plaintiff contends that since the Plan does not provide that Medicare would be a primary insurer and the Plan did not expressly require him to obtain Medicare coverage. Defendant's reliance on Medicare as a primary insurer pursuant to the Coordination of Benefits provision of the Plan violated "the express terms of the Plan's provisions giving long term and disability and medical benefits."

In denying Plaintiff's requests for reimbursement, Defendant relied on the Plan's Coordination of Benefits provision, which provides that if a participant is covered by other benefit coverage, the plan or contract without a coordination provision is the primary payer. (Dkt. 7, Ex. A, p. 4). According to Defendant, since Plaintiff was eligible for other coverage, namely Medicare, and in fact received Medicare benefits, Medicare was the primary payer pursuant to the Plan, thereby relieving Defendant of its payment responsibilities until Plaintiff met a specified minimum amount in claims.[6]

While Plaintiff correctly argues that the Plan does not expressly identify Medicare as a primary payer under the "Coordination of Benefits" provision, this Court cannot conclude that the Plan is ambiguous with respect to how the Coordination of Benefits provision would be applied if Plaintiff received Medicare benefits. The Plan explains that benefits are coordinated with *any other* coverage and that a plan without a coordinating provision is "always" the primary payer. While not specific with respect to Medicare, the "Coordination of Benefits" provision can reasonably be read to imply that Medicare, in addition to any other coverage provider, would be considered a primary payer if the participant was eligible to receive benefits and coverage for those benefits were not

[6] Neither party contends Medicare regulations contain a coordination of benefits provision.

subject to a coordinating provision. *See e.g. Maxa v. John Alden Life Ins. Co.*, 972 F.2d 980, 984 (8th Cir. 1992) (recognizing that Coordination of Benefits provision was not crystal clear in that it did not expressly state that only actual receipt of duplicative benefits was prohibited, but holding that provision reasonably implied that benefit coverage would be reduced by the amount of Medicare coverage for which participant was eligible).[7]

Plaintiff's contention that the Plan administrator wrongfully required Plaintiff to apply for Medicare is likewise unpersuasive. While the Plan does not expressly require Plaintiff to apply for Medicare, it does direct participants to "be sure to apply for benefits under *all* coverages". (Dkt. 7, Ex. A, p.5) (emphasis added). Moreover, the "Coordination of Benefits" provision provides that "*[i]f* [the participant is] covered under a number of Health Care Plans or *[has] any insurance coverage* that pays health care costs, the plan or contract without a coordinating provision is *always* the primary payer." (Dkt. 7, Ex. A, p. 4) (emphasis added). This language implies that eligibility for coverage is sufficient to trigger the primary payer status. Arguably, had Plaintiff not applied for Medicare, his benefits could have been reasonably reduced by the portion that Medicare would have paid had Plaintiff applied. *See e.g. Maxa*, 972 F.2d at 984 (upholding administrator's decision to reduce reimbursement for bills which Medicare would have covered if participant had enrolled for Medicare). There is no basis to conclude, therefore, as Plaintiff suggests, that Defendant misled him by notifying him that he was eligible for Medicare benefits and that he was required to apply for Medicare under the Coordination of Benefits provision.

While the instant Plan is not a model of clarity, this Court cannot conclude that an ambiguity

---

[7] In *Maxa*, the Plan expressly included Medicare within the Coordination of Benefits provision. The participant did not enroll in Medicare even though he was eligible. The administrator paid only some of the bills submitted on behalf of the participant, claiming that under the Coordination of Benefits provision of that plan, it was not liable for the bills which Medicare would have covered if the participant had enrolled in Medicare. *Id.* at 981-982.

exists or that Defendant's interpretation of the "Coordination of Benefits" provision, as applied to Plaintiff, was "wrong" under a *de novo* review. Where a court determines under a *de novo* standard that the administrator's benefits denial decision was not "wrong", that is, the court agrees with the administrator's decision, the court ends its inquiry and affirms the administrator's decision. *See Williams*, 373 F.3d at 1138. Accordingly, Defendant's motion for summary judgment on Count I is GRANTED.

3. *Counts II and III - Declaration that Plaintiff may rescind his Medicare coverage and that Plan may not offset his Long Term Disability benefits by his social security benefits*

Defendant seeks summary judgment on Counts II and III, arguing that Plaintiff failed to exhaust his administrative remedies. ERISA prescribes that every employee benefit plan must afford a reasonable opportunity for review of a claim for benefits. 29 U.S.C.A § 1133. Accordingly, every plan must establish a review procedure to examine employee claims and grievances. Although ERISA does not mandate exhaustion of administrative remedies as a condition precedent to filing an action, the Eleventh Circuit has expressly adopted an exhaustion requirement for ERISA claims. *See Mason v. Continental Group, Inc.*, 763 F.2d 1219 (11th Cir. 1985), *cert. denied*, 474 U.S. 1087 (1985). The compelling considerations which support the exhaustion requirement are: (1) administrative claim resolution reduces the amount of frivolous suits under ERISA; (2) it prevents premature judicial intervention; and (3) reduces the cost of dispute resolution. *Id.* at 1227.

Here, the Plan sets forth an appeals process establishing several levels of review. (Dkt. 7, Ex. A, p. 29). Plaintiff failed to submit the claims made in Counts II and III to the administrator for initial review and in turn, failed to exhaust the Plan appeal procedures before seeking declaratory relief from this Court.[8] The record establishes that Plaintiff exhausted his administrative remedies

[8] Notably, Plaintiff characterizes Count II not as a claim, but as a "remedy . . . for the wrong done him in Court [sic] One . . .". (Dkt. 32, p. 14).

only as to his claim for reimbursement of medical expenses partially paid by Medicare. His hand written letters of appeal do not refer to his request to discontinue Medicare coverage or his dispute regarding his Long Term Disability benefits. While exceptions to the exhaustion requirement exist, Plaintiff fails to argue that an exception is applicable. Furthermore, the record does not support application of an exception.[9] Accordingly, summary judgment on Counts II and III is GRANTED for failure to exhaust administrative remedies.

4. *Count IV - Declaration that the Plan may not apply a 5% reduction factor when calculating Plaintiff's accrued retirement benefits.*

In response to Defendant's motion for summary judgment, Plaintiff concedes that Count IV is not ripe for adjudication and requests leave to voluntarily dismiss the claim. (Dkt. 32, p. 16-17). Leave to dismiss is GRANTED. Count IV therefore, is dismissed. Accordingly, it is

ORDERED AND ADJUDGED that:

1. Defendant's Motion for Summary Judgment as to Counts I, II and III (Dkt. 25) is **GRANTED.**

2. Count IV is **DISMISSED.**

3. The Clerk is directed to enter judgment in favor of Defendant, deny any pending motions as moot and close this case.

DONE AND ORDERED in chambers this 4th day of November, 2004.

/s/James D. Whittemore
JAMES D. WHITTEMORE
United States District Judge

Copies to:
Counsel of Record

---

[9] "Exhaustion of administrative remedies is not required (1) where it would prove futile; (2) where the claimant was wrongfully denied access to the review procedures; (3) where irreparable harm would result by requiring exhaustion; (4) where administrative remedies are inadequate; or (5) where the issue involves statutory interpretation." *Foster v. Cordis Corporation*, 707 F.Supp. 517, 519 (S.D. Fla. 1989) (citations omitted).