IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

SHARON MONDRY,

Plaintiff, MEMORANDUM AND ORDER

v. 06-C-320-S

AMERICAN FAMILY MUTUAL INSURANCE COMPANY and AMERIPREFERRED PPO PLAN,

Defendants.

Plaintiff Sharon Mondry commenced this civil action against defendants American Family Mutual Insurance Company and AmeriPreferred PPO Plan alleging violations of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, and seeking civil forfeitures and reimbursement of benefits allegedly due under an employee benefit plan governed by ERISA.[1] Jurisdiction is based on 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e). The matter is presently before the Court on defendants' motion for summary judgment. The following facts are either undisputed or those most favorable to plaintiff.

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[1]Plaintiff also commenced this action against Connecticut General Life Insurance Company. However, on September 26, 2006 the Court entered an order granting Connecticut General's motion to dismiss. Accordingly, the Court dismissed said party from the action. Additionally, on said date the Court granted defendant American Family Mutual Insurance Company's motion to dismiss counts three through six of plaintiff's complaint. As such, only counts one and two of plaintiff's complaint remain which allege ERISA violations.

FACTS

Defendant AmeriPreferred PPO Plan (hereinafter the Plan) is a self-insured group health insurance plan offered by defendant American Family Mutual Insurance Company (hereinafter American Family) to its employees. Plaintiff Sharon Mondry was an employee of defendant American Family and participated in the Plan. At all times relevant to this action, defendant American Family was designated as the Plan Administrator while Connecticut General Life Insurance Company (hereinafter CGLIC) served as the Plan's Claims Administrator. CGLIC is an affiliate of CIGNA Corporation and CIGNA Health Care Group (hereinafter collectively referred to as CIGNA.) CGLIC was granted discretionary authority for making claim determinations. Defendant American Family did not actively participate in the claims determination process.

In the year 2003, plaintiff's son Zevee Mondry received speech therapy services from Communication Development Center. Accordingly, plaintiff submitted a claim in which she requested that the Plan cover her son's speech therapy services. On June 15, 2003 CIGNA (by letter) notified both plaintiff and Communication Development Center of its decision to deny coverage for Zevee Mondry's speech therapy services as not medically necessary. Said letter provides in relevant part as follows:

> ...Your plan provides coverage for specified Covered Services which are medically necessary. After a review of the information submitted, we have determined that the requested services are not covered under the terms of

> your plan. This coverage decision was made based on the following:
>
> The information provided does not meet plan language for speech therapy per CIGNA guidelines....Speech therapy is not restorative. Based on CIGNA's Benefit Resource Tools Guidelines - Speech Therapy....

On June 30, 2003 plaintiff (by letter) notified both CIGNA and defendant American Family of her decision to appeal CIGNA's claim denial. Said letter provides in relevant part as follows:

> ...I am attaching a copy of a denial letter I recently got from CIGNA for speech therapy for my son.
>
> I want to appeal the denial, and am requesting a complete copy of my Plan Documents. The document I was told to pull off the American Family Intranet site is a Summary Plan Description, and is incomplete.

On July 23, 2003 CIGNA notified plaintiff by letter of its decision to uphold its initial adverse benefit determination. Said letter provides in relevant part as follows:

> ...we have decided to uphold the original decision to maintain denial of Zev's Speech therapy as not medically necessary.
>
> The decision was based on the following:
>
> ...Speech therapy, which is not restorative, is not a covered expense per the patient's specific plan provisions.
> Reference CIGNA Clinical resource tool for Speech Therapy.
>
> ...You are entitled to receive free of charge, upon request, copies of all documents, records and other information relevant to your appeal for benefits....

Accordingly, CIGNA's letter demonstrates that it based its decision to uphold the original denial of plaintiff's claim on its Clinical

Resource Tool for Speech Therapy. As such, this information was relevant to both plaintiff's claim and to any second-level appeal for benefits.

On July 28, 2003 plaintiff submitted an additional written request for documents to both CIGNA and defendant American Family. Her letter provides in relevant part as follows:

> ...I first wrote on June 30, 2003 requesting a complete copy of my CIGNA plan documents. Your response of July 11, 2003 unfortunately does not respond to my request. All copies are attached.
>
> I am again requesting the total and complete copy of my Plan Documents.

Additionally, plaintiff's submission included copies of all prior communication occurring between her, CIGNA, and defendant American Family.

On September 23, 2003 plaintiff's attorney wrote a letter to both CIGNA and defendant American Family in which he again requested Plan documents.[2] Said letter provides in relevant part as follows:

> ...On June 30 and July 28, 2003 [plaintiff] requested the complete plan document used as the premise for denying coverage for her son Zev...
>
> ...Please immediately provide a copy of the plan document in effect at the time the coverage was denied for this claim...
>
> If you are not the Plan Administrator, please forward

[2]The letter from plaintiff's attorney is actually dated September 23, 2002. However, given the timing of events in this action the Court presumes said date should read September 23, 2003.

> this letter to that person and correspond to the undersigned with the name and contact information of that person.

On October 16, 2003 Ms. Stacy McDaniel, Benefits Specialist for defendant American Family, responded (by letter) to plaintiff's attorney's request. Said letter provides in relevant part as follows:

> American Family Insurance received communication from Jonathan Cope concerning a copy of the CIGNA Plan document. I have enclosed a copy of the AmeriPreferred Summary Plan Description. This Summary Plan Description is the Plan document; we do not have a separate plan document.
>
> This document was made available to you both in paper and electronically while you were an active employee. A paper copy was also provided to you based on an earlier request....

Plaintiff disputes that defendant American Family provided her with a paper copy of the Summary Plan Description based upon her earlier requests. However, plaintiff concedes that she received a paper copy during her term of employment with defendant American Family which ultimately terminated on October 2, 2003.

On October 30, 2003 plaintiff's attorney submitted a fourth written request for documents to CIGNA. Defendant American Family was copied into his letter. Said letter provides in relevant part as follows:

> On June 30 and July 28, 2003 [plaintiff] requested the complete plan document used for denying coverage to her son Zev....By way of response, she has been told several times to go to an online site where she can access the plan document electronically.

> The only document available to her is the AmeriPreferred PPO Summary Plan Description. As Jonathan M. Cope, Attorney-ABC for Health, Inc., requested the complete plan document again on September 23, 2003, and has received no response from CIGNA, we must conclude that the Summary Plan Description was the legally binding document used as the premise for denying coverage... American Family Insurance responded to Mr. Cope's request for a plan document on October 16, 2003, stating that there is no separate plan document. As of today, CIGNA has not responded to our request. Please advise us if this information about the plan document is incorrect, and if so, please immediately provide a copy of the legally binding plan document in effect at the time that coverage was denied for this claim. Please reference the specific language relied on in the plan document to deny coverage and forward a copy of that plan to the undersigned within 30 days....
>
> Prior to that request, a denial letter dated July 23, 2003, enclosed herein and addressed to [plaintiff,] referenced a CIGNA Clinical Resource Tool for Speech Therapy. This Clinical Resource Tool is not included in the AmeriPreferred PPO Summary Plan Description available to [plaintiff.] This letter, signed by Dr. Patricia J. Loudis, MD, states [plaintiff] is entitled to receive, free of charge, and upon request, copies of all documents, records, and other information relevant to her appeal for benefits. We are also requesting this Clinical Resource Tool, as well as any other information used to make your decision to deny these services, be sent to the undersigned....

On January 7, 2004 (approximately three months later) plaintiff's attorney again wrote to both CIGNA and defendant American Family concerning plaintiff's requests for Plan documents. Said letter provides in relevant part as follows:

> ...A summary of the health insurance contract in the form of a Summary Plan Description is not sufficient and is not what has been repeatedly requested....
>
> ...CIGNA has been made well aware of the fact that American Family Insurance has failed to provide the complete plan document, as CIGNA and American Family

> Insurance have both been contacted with each request made by ABC for Health and [plaintiff.] CIGNA also ignored several requests for the CIGNA Clinical Resource Tool for Speech Therapy and copies of all documents, records, and other information relevant to [plaintiff's] appeal for benefits....
>
> All correspondence dated October 30, 2003 and later is enclosed herein. All correspondence prior to October 2003 that is referenced in this...letter was enclosed in the October 30, 2003 letter sent to CIGNA and copied to American Family Insurance, except for the July 13, 2003 denial letter, which is enclosed herein.... Please immediately provide a copy of the legally binding plan document in effect at the time the coverage was denied for this claim, a copy of the above-mentioned Clinical Resource Tool, as well as any other information used to make the decision to deny these services....

Plaintiff thereafter received a packet of information from CIGNA which her attorney determined was an insufficient response to her requests. Accordingly, on January 28, 2004 plaintiff's counsel submitted a sixth written request for documents to CIGNA. Defendant American Family was again copied into his letter. Said letter provides in relevant part as follows:

> ...you have again failed to provide the information requested, which is the plan language used as the premise for CIGNA's denial of Zev Mondry's speech therapy. As you must know, this makes it impossible to prepare for a second level appeal....
>
> To remind you of the specific information requested, we are enclosing our prior three requests for this language, as well as CIGNA's denial letter dated July 23, 2003 and two CIGNA printable reports dated June 10, 2003 and July 23, 2003. These documents refer to a CIGNA Clinical resource tool for Speech Therapy and to CIGNA's specific plan provisions. The words "Expressive Language Delays" are not found in the Summary Plan Document, and so they must exist somewhere in plan documents that have been withheld from [plaintiff.]...

The next series of relevant communication occurring between plaintiff, CIGNA, and defendant American Family began on April 21, 2004 when Ms. Kathryn Kehoe, legal intern at ABC for Health, faxed another request for Plan documents to defendant American Family. Said transmission provides in relevant part as follows:

> ...I am also sending prior requests for information. We have not yet received a plan document from American Family or Cigna. We have been relying on a Summary Plan Description from an online site. We still require a plan document as well as the rules, guidelines, or protocols used as the premise for the denial of services....

Additionally, on said date, Ms. Kehoe left a telephone voice message for Ms. Rosalie Beck Detmer, Assistant General Counsel for defendant American Family, in which she requested a hard copy of the Clinical Resource Tool for Speech Therapy referenced in CIGNA's denial letter. Ms. Detmer responded by advising Ms. Kehoe that she would contact CIGNA and request that it provide plaintiff with a copy of the Clinical Resource Tool used to evaluate her claim. Additionally, Ms. Detmer indicated that the Summary Plan Description was the only Plan document and neither CIGNA nor defendant American Family had another Plan document.

On April 23, 2004 Ms. Kehoe again communicated with Ms. Detmer by telephone. Ms. Detmer advised Ms. Kehoe that she would contact CIGNA and attempt to obtain a copy of its Clinical Resource Tool for plaintiff. Indeed, Ms. Detmer contacted CIGNA on said date and requested that it provide plaintiff with a copy of its Clinical

Resource Tool for Evaluating Speech Therapy. However, CIGNA's representative Mr. Carl Peterson informed Ms. Detmer that its Resource Tool was proprietary and CIGNA would not release such information to either plaintiff or defendant American Family. Additionally, Mr. Peterson advised Ms. Detmer that CIGNA's Clinical Resource Tool was "too big to send anyway" and the Summary Plan Description was the only document either party was legally required to provide to plaintiff.

On May 20, 2004 Ms. Detmer informed Ms. Kehoe (by telephone) that CIGNA refused to release its Clinical Resource Tool to either plaintiff or defendant American Family. However, Ms. Detmer provided Ms. Kehoe with Mr. Peterson's name and telephone number. It is undisputed that defendant American Family never requested nor encouraged CIGNA to withhold such information from plaintiff. Additionally, it is undisputed that defendant American Family never possessed a copy of CIGNA's Clinical Resource Tool.

Subsequent to May 20, 2004 plaintiff ceased communications with defendant American Family and instead continued to communicate solely with CIGNA concerning documents related to her appeal. It is undisputed that defendant American Family provided only one written response to plaintiff's requests for Plan documents. Additionally, it is undisputed that the only Plan document defendant American Family provided to plaintiff was a copy of the Summary Plan Description.

On October 5, 2004 CIGNA provided plaintiff's attorney with a copy of its HealthCare Benefit Interpretation Resource Tool for GSA 2001 Requested Service: Speech Therapy (hereinafter BIRT document.) Said BIRT document provides that coverage for speech therapy services is governed in part by the standard benefit plan language defining medically necessary/medical necessity. The BIRT document defines medically necessary as follows:

> Medically necessary covered Services and Supplies are those Services and Supplies that are determined by the Healthplan Medical Director to be:
>
> No more than required to meet your basic needs; and
> Consistent with the diagnosis of the condition for which they are required; and
> Consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
> Required for purposes other than comfort and convenience of the patient or his Physician; and
> Rendered in the least intensive setting that is appropriate for the delivery of health care; and
> Of demonstrated medical value.

Additionally, the BIRT document provides that "[s]peech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature." Further, the BIRT document states that "[t]he Clinical Resource Tool presents more detailed information, background, and references regarding Speech Therapy." Finally, CIGNA's Clinical Resource Tool (provided to plaintiff during discovery) indicates what type of objective clinical information

may be required to support "the medical necessity of speech therapy." Such clinical information includes: diagnostic test results, complete speech therapy records, medical necessity narrative from an attending physician, and reports of standardized speech tests.

However, the Summary Plan Description defines "Medically Necessary" as follows:

> In addition to the reasonable and customary limits, to be eligible for Plan payment, medical services and supplies must be considered by CIGNA to be "Medically Necessary." For purposes of this plan, Medically Necessary means that services and supplies are provided by a hospital, doctor, or other licensed medical provider to treat a covered illness or injury. The treatment must be appropriate for the symptoms or diagnosis, within the standards of acceptable medical practice, the most appropriate supply or level safe for the patient, and not solely for the convenience of the patient, doctor, hospital, or other licensed professional.

Additionally, the Summary Plan Description provides that "[i]n general, the following medical services or supplies are covered by the Plan...[p]hysical, occupational or speech therapy if performed by a licensed or certified therapist and if referred by a doctor."

On April 13, 2005 CIGNA conducted a level-two appeal hearing on plaintiff's claim for benefits. After this hearing, CIGNA reversed both its initial denial and its level-one appellate decision and authorized reimbursement for speech therapy services provided to Zevee Mondry. Accordingly, plaintiff received checks from CIGNA reimbursing her in the amount of $3,056.11 for speech

therapy services provided to her son between January 1, 2003 and October 2, 2003.

On June 14, 2006 plaintiff commenced this action alleging that defendant American Family failed to provide her with a copy of the contract or other instrument under which the Plan was established or operated. Additionally, plaintiff alleges that defendant American Family breached its fiduciary duties by misrepresenting the terms and administration of the Plan and by withholding information necessary to defend her claim and perfect her appeal.

MEMORANDUM

Defendants acknowledge that plan administrators have a statutory obligation to provide their participants with copies of Summary Plan Descriptions, trust agreements, contracts, or other instruments under which an ERISA plan is established or operated. However, defendants assert the documents at issue, CIGNA's Resource Tools and the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA, are not statutorily defined Plan documents which defendant American Family was under an obligation to provide. Accordingly, defendants argue defendant American Family complied with its disclosure obligation when it provided plaintiff with a copy of the Summary Plan Description. As such, defendants argue their motion for summary judgment should be granted as it concerns count one. Additionally, defendants argue their motion for summary judgment should be granted as it concerns

count two because plaintiff is seeking purely legal remedies in this action where only equitable relief is available. Alternatively, defendants argue their motion for summary judgment should be granted as it concerns count two because defendant American Family did not breach any fiduciary duty.

Plaintiff asserts defendant American Family had an obligation to disclose CIGNA's Resource Tools and the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA because such documents are "similar in nature" to those specifically enumerated in 29 U.S.C. § 1024 as they assist Plan participants in understanding their rights. Accordingly, plaintiff argues defendants' motion for summary judgment should be denied as it concerns count one. Additionally, plaintiff asserts defendant American Family breached its fiduciary duty by failing to disclose complete and accurate information concerning her status as a Plan participant. Further, plaintiff asserts she is seeking equitable relief in this action such as retroactive reinstatement of coverage. Accordingly, plaintiff argues defendants' motion for summary judgment should be denied as it concerns count two.

A. Standard of Review

Summary judgment is appropriate where the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled

to a judgment as a matter of law." Fed. R. Civ. P. 56(c).

A fact is material only if it might affect the outcome of the suit under the governing law. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S.Ct. 2505, 2510, 91 L.Ed.2d 202 (1986). Disputes over unnecessary or irrelevant facts will not preclude summary judgment. Id. Further, a factual issue is genuine only if the evidence is such that a reasonable fact finder could return a verdict for the non-moving party. Id. A court's role in summary judgment is not to "weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." Id. at 249, 106 S.Ct. at 2511.

To determine whether there is a genuine issue of material fact for trial courts construe all facts in the light most favorable to the non-moving party. Heft v. Moore, 351 F.3d 278, 282 (7th Cir. 2003)(citation omitted). Additionally, a court draws all reasonable inferences in favor of that party. Id. However, the non-movant must set forth "specific facts showing that there is a genuine issue for trial" which requires more than "just speculation or conclusory statements." Id. at 283 (citations omitted). If a court determines that the material facts are not in dispute then the "sole question is whether the moving party is entitled to judgment as a matter of law." Santaella v. Metro. Life Ins. Co., 123 F.3d 456, 461 (7th Cir. 1997)(citation omitted).

B. Count One - Violation of 29 U.S.C. § 1024(b)(4) - Failure to Provide Required Information

Count one of plaintiff's complaint is governed by 29 U.S.C. § 1024(b)(4) which provides in relevant part as follows:

> The administrator shall, upon written request of any participant[3] or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated....

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[3]Participant in the context of ERISA is defined as (as is relevant to this action) "former employees who have a reasonable expectation of returning to covered employment or who have a colorable claim to vested benefits." Winchester v. Pension Comm. of Michael Reese Health Plan, Inc. Pension Plan, 942 F.2d 1190, 1192-1193 (7th Cir. 1991)(citation omitted). It is undisputed that plaintiff is no longer employed by defendant American Family and there is no suggestion that she has a reasonable expectation of returning to covered employment. Additionally, plaintiff is not seeking a benefit from an employee benefit plan under count one. Rather, she is seeking damages under a penalty provision. Accordingly, at first glance it appears that plaintiff does not have standing to bring her cause of action under Section 1024(b)(4). However, the Seventh Circuit has stated that there is some merit in allowing former employees to bring actions against an administrator for failure to provide information within a reasonable amount of time after receiving vested benefits. Id. at 1193. Plaintiff was reimbursed for her son's speech therapy services on March 2, 2006 and she commenced this action on June 14, 2006. The Court finds this is a reasonable amount of time for plaintiff to commence an action under Section 1024 especially in light of the fact that plaintiff made numerous requests for information both before terminating her employment with defendant American Family and before her claim was ultimately approved. Accordingly, the Court finds that plaintiff has standing to bring this action. In any event, defendants failed to object to plaintiff's standing in their motion for summary judgment. As such, they have waived any argument they may have had on this issue. Milwaukee Area Joint Apprenticeship Training Comm. for the Elec. Indus. v. Howell, 67 F.3d 1333, 1337 (7th Cir. 1995)(citation omitted).

Penalties for violations of Section 1024(b)(4) are imposed pursuant to 29 U.S.C. § 1132(c)(1)(B) which provides in relevant part as follows:

> Any administrator...(B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant...by mailing the material requested to the last known address of the requesting participant...within 30 days after such request may in the court's discretion be personally liable to such participant...in the amount of up to $100 a day from the date of such failure or refusal...

Once a participant submits a written request for documents under Section 1024(b)(4) a plan administrator must respond so long as the participant's request provides clear notice of what information he or she desires. Anderson v. Flexel, Inc., 47 F.3d 243, 248 (7th Cir. 1995)(citations omitted). However, while a participant's request for information must be clear, an administrator's knowledge of either the surrounding circumstances or the information being requested may require a response to an otherwise general request. Id. (citations omitted). Additionally, a participant need not ask for specific documents by name and an administrator cannot use such "technical considerations as an excuse for its failure to respond." Id. at 250 (citation omitted).

As previously stated, pursuant to Section 1132(c)(1)(B), a plan administrator has thirty-days to respond to a participant's written request for information and a court (in its discretion) may impose penalties of up to $100 a day from the date on which the

administrator either failed or refused to respond. The underlying purpose of Section 1132(c)(1)(B) "is not so much to penalize as to induce plan administrators to respond in a timely manner to a participant's request for information." Winchester, at 1193. Accordingly, when determining whether to award a penalty for disclosure violations courts should consider both the "conduct and intent of the [plan] administrator in not providing the relevant information" and "the harm or prejudice suffered by the participant." Hess v. Hartford Life and Acc. Ins. Co., 91 F.Supp.2d 1215, 1224 (C.D.Ill. 2000)(citation omitted), *aff'd*, 274 F.3d 456 (7th Cir. 2001).

In this action, the documents at issue are CIGNA's Resource Tools (both its Clinical Resource Tool and its BIRT document) and the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA. Defendants argue that none of these documents fall within the disclosure requirements of Section 1024(b)(4). However, all parties agree that defendants are liable for statutory penalties only if the Court finds that these three documents fall within the "other instruments under which the plan is established or operated" language of 29 U.S.C. § 1024(b)(4).

The Seventh Circuit has determined that the "catch-all" part of 29 U.S.C. § 1024(b)(4) which requires disclosure of "other instruments under which the plan is established or operated" is to be narrowly construed. Ames v. Am. Nat'l Can Co., 170 F.3d 751,

758-759 (7th Cir. 1999). Accordingly, a plan administrator is not required to produce all documents relevant to a plan. Id. Rather, a plan administrator has an obligation to disclose only those formal documents that establish or govern a plan. Id. at 758.

When determining whether certain documents establish or govern a plan courts consider whether such documents "allow the individual participant [to] know [] exactly where [s]he stands with respect to the plan - what benefits [s]he may be entitled to, what circumstances may preclude [her] from obtaining benefits, what procedures [she] must follow to obtain benefits, and who are the persons to whom the management and investment of [her] plan funds have been entrusted." Hess, at 1226 (citation and internal quotation marks omitted). Accordingly, with the legal framework in place, the Court will determine whether the three documents at issue were subject to disclosure under Section 1024(b)(4) beginning with the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA.

Plaintiff argues that she was entitled to the 1996 Claims Administration Agreement by and between defendant American Family and CIGNA (hereinafter the 1996 agreement) because it is a plan document containing information relevant to her appeal for benefits. The Court does not agree. The 1996 agreement defines the terms whereby CIGNA agreed to furnish claims administration services to defendant American Family. Specifically, the 1996

agreement: (1) provides the amount CIGNA charges defendant American Family for its services, (2) outlines the length of time it is to remain in effect; and (3) defines what laws govern its operation. However, what is most important to the Court's determination is not what is actually contained within the language of the 1996 agreement. Rather, the factor the Court finds dispositive is what is absent from the language of the 1996 agreement as it fails to define what rights or benefits are available to the Plan's participants and beneficiaries. Accordingly, while the 1996 agreement may be relevant to the Plan it does not fall within the Seventh Circuit's narrow reading of Section 1024(b)(4)'s "other instruments" language. As such, defendant American Family had no obligation to disclose the 1996 agreement under 29 U.S.C. § 1024(b)(4). Ames, at 758-759.

Additionally, plaintiff argues that she was entitled to both CIGNA's Clinical Resource Tool for Speech Therapy and its BIRT document because such documents are similar in nature to documents expressly subject to Section 1024(b)(4)'s disclosure requirements. Defendants argue these documents are not organic documents underpinning the Plan. Rather, they argue these documents are internal rules and guidelines which are not subject to disclosure under Section 1024(b)(4). This is a close question. However, the Court finds that even under the Seventh Circuit's narrow reading of Section 1024(b)(4) these documents are the type of formal documents under which the plan is operated.

CIGNA's Clinical Resource Tool indicates what type of objective clinical information may be required to support "the medical necessity of speech therapy." Such clinical information includes: diagnostic test results, complete speech therapy records, medical necessity narrative from an attending physician, and reports of standardized speech tests. Additionally, the BIRT document not only defines medically necessary/medical necessity but it also provides that "[s]peech therapy is not covered when (a) used to improve skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature." Accordingly, these documents allowed plaintiff to know: (1) what circumstances precluded her from obtaining benefits under the plan; and (2) what procedures she needed to follow to obtain benefits under the plan i.e. what type of objective clinical information she needed to submit in support of the "medical necessity" element of her claim. Hess, at 1226.

Additionally, CIGNA denied plaintiff's claim for benefits based on these documents not only initially but also at the appellate level. For example, CIGNA's June 15, 2003 denial letter provides that plaintiff's claim was denied because Zevee's "[s]peech therapy [wa]s not restorative. Based on CIGNA's Benefit Resource Tools Guidelines - Speech Therapy." Additionally, CIGNA's July 23, 2003 letter provides that its decision to uphold its

initial adverse benefit determination was based on the following: "[s]peech therapy, which is not restorative, is not a covered expense per the patient's specific plan provisions. Reference CIGNA Clinical resource tool for Speech Therapy." However, the Summary Plan Description fails to specifically provide that speech therapy is not a covered expense when it is not restorative. Rather, the Summary Plan Description provides that "[i]n general, the following medical services or supplies are covered by the Plan...[p]hysical, occupational or speech therapy if performed by a licensed or certified therapist and if referred by a doctor." Accordingly, it is clear that both CIGNA's Clinical Resource Tool for Speech Therapy and its BIRT document (and not solely the Summary Plan Description) govern when speech therapy claims are approved under the Plan. As such, these documents govern plan operation and were subject to disclosure under Section 1024(b)(4).

The facts of this action are distinguishable from the situation in Hess where plaintiff claimed that she was entitled to (among other items) a copy of her LTD data form. Id. at 1227. The Court in Hess determined that plaintiff's claim failed because the LTD data form was used simply to transmit information pertinent to her particular claim such as her name and social security number, her level of insurance benefits, and her yearly salary. Id. However, the facts of this action demonstrate that the Clinical Resource Tool and the BIRT document are used by CIGNA to evaluate

all speech therapy claims submitted to the Plan. Accordingly, both documents were formal legal instruments governing the plan's operation or management. Id. As such, plaintiff was entitled to these documents within thirty-days of her first clear request which the Court finds was her initial request made on June 30, 2003.

In her June 30, 2003 letter plaintiff advised both defendant American Family and CIGNA that she was requesting a complete copy of her Plan Documents which includes both CIGNA's Clinical Resource Tool and its BIRT document. Additionally, plaintiff attached a copy of CIGNA's June 15, 2003 denial letter which specifically referenced CIGNA's BIRT document. While plaintiff's June 30, 2003 letter failed to request either the Clinical Resource Tool or the BIRT document by name, an administrator cannot use such "technical considerations as an excuse for its failure to respond." Anderson, at 250 (citation omitted). Additionally, imposing a burden upon plaintiff to ask for documents by name rather than by description would be "contrary to the spirit of § 1024(b)(4)." Id. Accordingly, the Court finds that plaintiff's June 30, 2003 letter provided defendant American Family with notice of which documents she desired. As such, this letter triggered the thirty-day limitations period to respond pursuant to 29 U.S.C. § 1132(c)(1)(B).

Defendants argue they should not be held liable for violations of 29 U.S.C. § 1024(b)(4) as they relate to these documents because

defendant American Family never possessed them and it would be impossible to disclose documents it never had. It is undisputed that defendant American Family never possessed these documents. However, 29 U.S.C. § 1024(b)(4) does not contain any language which suggests that a plan administrator's statutory obligation to furnish documents is limited to furnishing only those documents which are actually in its possession. Rather, the language of the statute provides that:

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated....

29 U.S.C. § 1024(b)(4). Accordingly, said statute imposes a mandatory obligation on plan administrators to disclose documents that fall within the statutory language regardless of whether the administrator actually possesses such documents. As such, the Court must find defendants liable for violating 29 U.S.C. § 1024(b)(4). Accordingly, defendants' motion for summary judgment is denied as it concerns count one of plaintiff's complaint. Both CIGNA's Clinical Resource Tool and its BIRT document are Plan documents which defendant American Family had an obligation to disclose under 29 U.S.C. § 1024(b)(4).

Courts can in appropriate cases "grant summary judgment for the non-moving party even though it made no formal cross-motion

under Rule 56." Lett v. Magnant, 965 F.2d 251, 261 (7th Cir. 1992)(citations omitted). However, the Court finds that it is not appropriate to do so in this action. While the Court found that both CIGNA's Clinical Resource Tool and its BIRT document are Plan documents subject to the disclosure requirements of 29 U.S.C. § 1024(b)(4) issues of material fact remain concerning when plaintiff received CIGNA's Clinical Resource Tool. It is undisputed that plaintiff received the BIRT document from CIGNA on October 5, 2004. However, the only information submitted to the Court concerning the Clinical Resource Tool is that plaintiff received it during discovery. An exact date was not provided.

Additionally, issues of material fact remain concerning what harm or prejudice (if any) plaintiff suffered as a result of defendant American Family's failure to disclose. Hess, at 1224 (citations omitted). On March 2, 2006 plaintiff was reimbursed for expenses associated with her son's speech therapy services. While plaintiff alleges a balance of $303.89 remains outstanding, the Court does not know whether plaintiff is entitled to this allegedly outstanding balance or why she has not received this balance if she is entitled to it. Accordingly, issues of material fact remain concerning whether a penalty should be awarded to plaintiff for defendant American Family's disclosure violations. As such, the Court cannot grant summary judgment in plaintiff's favor as it

concerns count one of her complaint.[4]

C. Count Two - Violation of 29 U.S.C. § 1104(a)(1) - Breach of Fiduciary Duty

Under ERISA, a fiduciary is an entity that has discretionary authority over assets of an ERISA plan. Rud v. Liberty Life Assur. Co. of Boston, 438 F.3d 772, 774 (7th Cir. 2006)(citations omitted). Classification as an ERISA fiduciary serves an important function because ERISA mandates that a fiduciary "discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). Defendants do not dispute that defendant American Family is a fiduciary as such term is defined under ERISA. Additionally, defendants do not dispute that defendant American Family as a fiduciary must comply with Section 1104(a)(1). Rather, defendants argue that defendant American Family did not breach any fiduciary duty owed to plaintiff. Accordingly, defendants argue their motion for summary judgment should be granted as it concerns count two.

Fiduciaries breach their duties of loyalty and care "if they mislead plan participants or misrepresent the terms or administration of a plan." Anweiler v. Am. Elec. Power Serv.

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[4]An additional factor the Court considers in determining whether to award a penalty is the "conduct and intent of the [plan] administrator in not providing the relevant information." Hess, at 1224 (citations omitted). The facts of this action clearly demonstrate that defendant American Family did not intend to deprive plaintiff of information. Rather, it attempted to obtain a copy of the Plan documents from CIGNA on plaintiff's behalf.

Corp., 3 F.3d 986, 991 (7th Cir. 1993)(*citing* Berlin v. Mich. Bell Tel. Co., 858 F.2d 1154, 1163 (6th Cir. 1988)(listing cases)). Additionally, fiduciaries must disclose material facts affecting the interests of plan participants. Kamler v. H/N Telecomm. Services, Inc., 305 F.3d 672, 681 (7th Cir. 2002)(*citing* Bowerman v. Wal-Mart Stores, Inc., 226 F.3d 574, 590 (7th Cir. 2000)). This obligation exists when a beneficiary asks for information and "even when he or she does not." Anweiler, at 991 (citation omitted). However, not every error in communicating information concerning a plan violates a fiduciary's duty under ERISA. Bowerman, at 590 (citations omitted). Additionally, plaintiff must allege that the breach of fiduciary duty "caused some harm to him or her that can be remedied." Kamler, at 681.

Plaintiff argues defendant American Family breached its fiduciary duty because it: (1) willingly declined to provide complete and accurate plan information, (2) promulgated misleading information in response to plaintiff's inquiries when it knew or should have known that such information would be misleading; and (3) elected to subjugate plaintiff's interests to its own. However, the facts of this action demonstrate that defendant American Family did not breach its fiduciary duty. Accordingly, defendants' motion for summary judgment is granted as it concerns count two.

Plaintiff argues defendant American Family willingly declined to provide complete and accurate plan information. However, the

facts of this action clearly demonstrate the opposite. First, it is undisputed that defendant American Family never requested nor encouraged CIGNA to withhold its Resource Tools from plaintiff. Additionally, on April 23, 2004 Ms. Detmer, Assistant General Counsel for defendant American Family, contacted CIGNA and attempted to obtain a copy of its Clinical Resource Tool for plaintiff. Further, on May 20, 2004 Ms. Detmer informed Ms. Kehoe (legal intern at ABC for Health) that CIGNA refused to release its Clinical Resource Tool to either defendant American Family or plaintiff. However, Ms. Detmer provided Ms. Kehoe with Mr. Peterson's contact information at CIGNA. These facts establish that defendant American Family did not willingly withhold information from plaintiff. Rather, they demonstrate that defendant American Family attempted to obtain the documents plaintiff requested. While its attempt was unsuccessful, it does not negate the fact that defendant American Family intervened on plaintiff's behalf.

Additionally, plaintiff argues defendant American Family promulgated misleading information in response to plaintiff's inquiries when it knew or should have known that such information would be misleading. It is undisputed that defendant American Family provided only one written response to plaintiff's request for Plan documents which was its letter of October 16, 2003. Said letter provides as follows:

> American Family Insurance received communication from Jonathan Cope concerning a copy of the CIGNA Plan document. I have enclosed a copy of the AmeriPreferred Summary Plan Description. This Summary Plan Description is the Plan document; we do not have a separate plan document.

While the information contained within defendant American Family's letter was incorrect (because the Court found that CIGNA's Clinical Resource Tool and its BIRT document are also Plan documents) not every error in communicating information concerning a plan violates a fiduciary's duty under ERISA. Bowerman, at 590 (citations omitted). Additionally, the facts of this action clearly demonstrate that plaintiff was not harmed by defendant American Family's incorrect statement because she was not misled by its October 16, 2003 letter. This is evidenced by the fact that she made four additional requests for documents subsequent to said date. Accordingly, the Court finds that defendant American Family did not mislead plaintiff into believing that the Summary Plan Description was the only plan document. Anweiler, at 991 (citation omitted). As such, plaintiff failed to demonstrate that defendant American Family "caused some harm to [] her that can be remedied." Kamler, at 681.

Finally, plaintiff argues defendant American Family elected to subjugate plaintiff's interests to its own when it made an "affirmative decision to minimize its investment of staff resources in pursuit of rectifying [plaintiff's] confusion about the source and application of the alleged 'specific plan provisions' that

barred coverage of Zev's speech therapy services." (Pl.'s Br. Opp'n Defs.' Mot. Summ. J. page 12, lines 3-5). However, plaintiff failed to submit any evidence in support of her position other than conclusory statements contained within her opposition brief. To successfully defeat defendants' motion for summary judgment on the breach of fiduciary duty issue plaintiff must set forth "specific facts showing that there is a genuine issue for trial" which requires more than "just speculation or conclusory statements." Heft, at 283 (citations omitted). Plaintiff failed to do so with respect to her argument that defendant American Family elected to subjugate her interests to its own. Accordingly, defendants' motion for summary judgment is granted as it concerns count two of plaintiff's complaint.[5]

ORDER

IT IS ORDERED that defendants motion for summary judgment is GRANTED as it concerns count two of plaintiff's complaint and in all other respects is DENIED.

Entered this 21st day of November, 2006.

BY THE COURT:

s/

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JOHN C. SHABAZ
District Judge

[5]Because the Court determined that defendant American Family did not breach its fiduciary duty, it need not reach defendants' argument that plaintiff seeks impermissible legal remedies under 29 U.S.C. § 1132(a)(3).