UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

THOMAS O. FELTENBARGER,

Plaintiff,

v.

FARMERS INSURANCE EXCHANGE and TYSON FOODS, INC.,

Defendants.
/

File No. 1:95-CV-397

Hon. Benjamin F. Gibson

OPINION

Defendants, a no-fault carrier and an employer operating an employee benefit plan, dispute their liability for medical benefits required by plaintiff, their mutually insured, for injuries sustained in an automobile accident. Defendants have filed cross-claims against each other, asserting that the other is responsible for payment of the medical expenses. Pending before the Court are defendants' motions for summary judgment.

I.

Plaintiff alleges that on September 30, 1994, he sustained serious injuries in an automobile accident. At the time of the accident, plaintiff was an employee of Tyson Foods, Inc. ("Tyson"), and a participant in Tyson's self-funded employee benefits plan maintained pursuant to the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 et seq. ("ERISA")("the Plan"). At the same time, plaintiff was insured by Farmers Insurance Exchange ("Farmers") under a policy of Michigan no-fault automobile insurance. Plaintiff alleges that the Plan and

Farmers denied his benefits claims. Tyson asserts that coverage is excluded under the Plan. Farmers argues that coverage is not excluded under the Plan and that Tyson is the primary insurer under the Plan's coordination of benefits provision.

II.

Summary judgment is proper if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, 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. Fed. R. Civ. P. 56(c); Canderm Pharmacal, Ltd. v. Elder Pharmaceuticals, Inc., 862 F.2d 597, 601 (6th Cir. 1988). In ruling on a motion for summary judgment, the Court must determine "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986); see also Street v. J.C. Bradford & Co., 886 F.2d 1472, 1479 (6th Cir. 1989).

III.

The first issue presented is whether the Plan administrator's decision to cease advancing sums for plaintiff's medical expenses was based on a correct interpretation of the Plan.[1] The administrator relied on the "acts of third parties"

[1]Tyson argues that the Court should require plaintiff to exhaust the Plan's appeal procedure. The Court finds that in this case exhaustion of administrative remedies would be purposeless and futile. See Costantino v. TRW, Inc., 13 F.3d 969, 975 (6th Cir. 1994).

exclusion to deny plaintiff's claim. The parties dispute the meaning of the third party exclusion and whether the administrator correctly decided that plaintiff was not eligible for benefits.

The Court must first determine the standard of review to apply to the administrator's interpretation of the Plan. The Court reviews an administrator's interpretation of a plan provision de novo unless the plan clearly grants the administrator the discretionary authority to interpret the type of provision at issue. Wells v. United States Steel, 76 F.3d 731, 733-34 n.1 (6th Cir. 1996) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)); Lake v. Metropolitan Life Ins. Co., 73 F.3d. 1372, 1376-77 (6th Cir. 1996). If the administrator has such discretion, the Court reviews the interpretation under the more deferential "arbitrary and capricious" standard. Lake, 73 F.3d. at 1376. "[A] plan may grant discretionary authority over some aspects without granting such authority over others." Id. (citation omitted).

The Plan provides as follows:

> (6) Medical and Dental Claim Procedures:
>
> Claims for benefits under the Plan are to be submitted to the Provident [the Administrator] as provided herein. . . .
>
> If you are not satisfied with the decision, you may appeal to the Provident as the Claims Fiduciary for Medical and Dental Claims. It is the intent of Tyson Foods as Plan Sponsor that the Claims Fiduciary shall have the sole and exclusive discretion and authority to carry out all actions involving claims procedures. The Claims Fiduciary for Medical and Dental Claims shall have the sole and exclusive discretion and power to

> grant and/or deny any and all Medical or Dental Claims for benefits. All findings, decisions, and determinations made by the Claims Fiduciary shall not be disturbed, unless the Claims Fiduciary has acted in an arbitrary and/or capricious manner. Subject to the requirements of the law, the Claims Fiduciary shall be the sole judge of the standard of proof required in any Medical or Dental Claims for benefits or questions of eligibility. All decision of the Claims Fiduciary shall be final and binding on all parties. Whenever a decision or a claim is involved, the Claims Fiduciary is given broad discretion and powers, and the Claims Fiduciary shall exercise these powers in accordance with the Plan's terms.

Summary Plan Description, Section IX, Part 6 at 55-56.

Under this language, the administrator has discretionary authority to determine who is eligible for benefits. Lake, 73 F.3d at 1376. However, this language does not give the administrator discretion to interpret the Plan's language. Id. at 1376-77. Because the grant of authority does not extend to contract interpretation, the Court must review the interpretation of the Plan de novo. Id. at 1377.

Tyson contends that the Plan excludes from coverage medical expenses incurred by plaintiff resulting from the acts or omissions of third parties and that the injuries for which plaintiff required benefits resulted from the negligence of three other persons. Plaintiff has brought a state court action against the third parties alleging negligence. Tyson asserts that since the Plan does not provide coverage, no "coverage" exists to coordinate with Farmer's no-fault policy.

The Plan contains the following third-party exclusion:

> Medical care and disability benefits are not payable to or for a person covered under this plan when the Injury or Illness to the covered person occurs through the act

> or omission of another person. However, the Administrator may elect to advance payment for medical/disability expenses incurred for an Injury or Illness caused by a third party. The covered person or guardian must sign an agreement to repay the Administrator in full any sums advanced for such medical or disability expenses from any judgment or settlement received. The Administrator has the right to recover in full the medical or disability expenses advanced regardless of whether that person actually signs the repayment agreement. It is only necessary that the injury occur through the act of a third party and the Administrator (sic) right of recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault benefits which are paid or payable. The Administrator will not pay fees or costs associated with the claim/lawsuit without express written authorization.

Summary Plan Description, Section VII, Part D at 52.

In interpreting this language, the Court notes that ERISA preempts the application of Michigan's No-Fault Act, Mich. Comp. Laws Ann. §§ 500.3101 et seq. (West 1993), to the Plan. See Auto Owners Ins. Co. v. Thorn Apple, 31 F.3d 371, 374 (6th Cir. 1994), cert. denied, ____ U.S. ____, 115 S. Ct. 1177 (1995) (citing Auto Club Ins. Ass'n v. Health & Welfare Plans, Inc., 961 F.2d 588, 593 (6th Cir. 1992) (discussing FMC Corp. v. Holliday, 498 U.S. 52 (1990))). Therefore, coverage is dependent upon the specific terms of the Plan.

"When applying the de novo standard of review, a court must interpret the terms of the plan 'without deferring to either party's interpretation.'" Lake, 73 F.3d at 1377 (quoting Bruch, 489 U.S. at 112). The Court's "primary goal is to give effect to the intent of the parties as expressed by the language of the ERISA plan." Id. (citation omitted). "Federal law gives effect

to straightforward language in ERISA-governed plans" and the courts will not artificially create an ambiguity in plan language. Id. at 1379 (citations omitted).

This contract unambiguously excludes benefits for an injury "which occurs through the act or omission of third parties" or, in other words, which is "caused by a third party." Summary Plan Description, Section VII, Part D at 52. Contrary to Farmer's argument, the exclusion includes a causation requirement.

Plaintiff argues that the state court action has not yet proceeded to judgment and that therefore it has not been determined that third parties caused his injuries. The Plan language does not require that for the exclusion to apply, a third party must be adjudicated liable in a court of law. Indeed, under such an interpretation, a Plan participant could obtain coverage for injuries caused by a third party simply by not filing an action against the third party. The Court finds that the language of the exclusion is clear and unambiguous. See Lake, 73 F.3d at 1379. Under the Plan, coverage is excluded for injuries caused by third parties.

The Court finds that since the Plan grants the administrator discretionary authority to determine who is eligible for benefits, the administrator has the discretion to determine whether an injury occurred through the acts or omission of a third party. The Court further finds that if an injury was caused by a third party, the administrator may elect, but is not obligated to, advance sums for medical expenses to the

participant, and that the participant is not entitled to any sums.

The administrator's eligibility determination is not arbitrary and capricious if it is "rational in light of the plan's provisions." Perry v. United Food & Commercial Workers Dist. Unions 405 and 422, 64 F.3d 238, 242 (6th Cir. 1995) (citation omitted). This standard "is the least demanding form of judicial review of administrative action. . . . When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious." Id. (citation omitted). The Court finds that, under the facts presented, the administrator's determination that plaintiff's injuries occurred through the acts or omissions of third parties was neither arbitrary nor capricious. Therefore, the Court will grant Tyson's motion for summary judgment.

IV.

Because there is no coverage to coordinate, the Court finds that Farmers is obligated to pay plaintiff's claims. Accordingly, the Court will deny Farmer's motion for summary judgment.

V.

Farmers and the Plan both have advanced sums to plaintiff. In their cross-claims, defendants request reimbursement from the other of sums advanced to plaintiff. Defendants agree that the Court's disposition of the coverage issue will resolve the cross-claims as well. Because the Court has found that Farmers must

pay plaintiff's claim, the Court will grant Tyson's request for summary judgment on the cross-claims.

VI.

Plaintiff requests attorney fees, costs, and penalty interest against both defendants under the No-Fault Act. Mich. Comp. Laws Ann. § 500.3148(1) (West 1993). Again, this act does not apply to plaintiff's claim against Tyson. Farmers has not responded to plaintiff's argument. Moreover, plaintiff has not submitted proof as to the amount owed for benefits or proof as to the alleged delay in payment. Similarly, Tyson has not submitted proof as to the amounts the Plan advanced to plaintiff. Therefore, while the Court has determined that Farmers must pay plaintiff's claims, the Court cannot on the record before it determine the amount Farmers must pay plaintiff and the amount Farmers must pay the Plan.

VII.

For the foregoing reasons, the Court finds that under the clear and unambiguous language of the Plan coverage is excluded for injuries caused by third parties. The Court further finds that, under the facts presented, the administrator's determination that plaintiff's injuries occurred through the acts or omissions of third parties was neither arbitrary nor capricious. Therefore, the Court will grant Tyson's motion for summary judgment.

Because there is no coverage to coordinate, the Court finds that Farmers is obligated to pay plaintiff's claims.

Accordingly, the Court will deny Farmer's motion for summary judgment. Therefore, Farmers is obligated to pay plaintiff's claims and to pay the Plan the sums it advanced to plaintiff. The Court's ruling on the motions for summary judgment is on the issue of liability only, since a genuine issue as to the amount of damages remains. Fed. R. Civ. P. 56(c).

The Court will order that the parties meet and confer to attempt to agree on the outstanding damages issues. If the parties cannot reach an agreement, the action will proceed to trial in October 1996, as previously ordered.

BENJAMIN F. GIBSON
U.S. DISTRICT JUDGE

DATED: September 13, 1996

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

THOMAS O. FELTENBARGER,

Plaintiff,

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FARMERS INSURANCE EXCHANGE and TYSON FOODS, INC.,

Defendants.
_____/

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Hon. Benjamin F. Gibson

ORDER

At a session of the Court held in and for said District and Division, in the City of Grand Rapids, Michigan, this 13th day of September, 1996.

PRESENT: HON. BENJAMIN F. GIBSON, U.S. DISTRICT JUDGE

In accordance with the Opinion entered this date,

IT IS HEREBY ORDERED that defendant Farmers Insurance Exchange's motion for summary judgment (pleading no. 20) is DENIED.

IT IS FURTHER ORDERED that defendant Tyson Foods, Inc.'s motion for summary judgment (pleading no. 33) is GRANTED.

IT IS FURTHER ORDERED that the parties meet and confer to attempt to agree on the outstanding damages issues and that **on or before September 30, 1996**, the parties file a written **joint** status report as to their efforts. If the parties cannot reach

an agreement, the action will proceed to trial in October 1996, as previously ordered.

IT IS SO ORDERED.

BENJAMIN F. GIBSON
U.S. DISTRICT JUDGE