

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JERRY W. LAWSON, et al. : CIVIL ACTION
: :
v. : :
: :
NATIONWIDE MUTUAL INSURANCE : :
COMPANY, et al. : No. 05-1249

MEMORANDUM

Dalzell, J.

June 29, 2005

Plaintiffs, eight former managers of insurance agencies, contend that the administrators of two pension plans in which they participate have calculated their benefits improperly. Defendants have moved to dismiss most of plaintiffs' claims pursuant to Federal Rule of Civil Procedure 12(b)(6)¹ and to stay

¹ The Court may grant a motion to dismiss under Rule 12(b)(6) "only if, accepting all well pleaded allegations in the complaint as true, and viewing them in the light most favorable to plaintiff, plaintiff is not entitled to relief." In re Burlington Coat Factory Sec. Litig., 114 F.3d 1410, 1420 (3d Cir. 1997); see also Lum v. Bank of Am., 361 F.3d 217, 222 n.3 (3d Cir. 2004) ("In deciding motions to dismiss pursuant to Rule 12(b)(6), courts generally consider only the allegations in the complaint, exhibits attached to the complaint, matters of public record, and documents that form the basis of a claim."). "The issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." Scheuer v. Rhodes, 416 U.S. 232, 236 (1974). In other words, we will not grant such a motion "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Conley v. Gibson, 355 U.S. 41, 45-46 (1957); see also Semerenko v. Cendant Corp., 223 F.3d 165, 173 (3d Cir. 2000) (permitting dismissal "only if it appears that the [plaintiffs] could prove no set of facts that would entitle [them] to relief"). "The complaint will be deemed to have alleged sufficient facts if it adequately put the defendants on notice of the essential elements of the plaintiffs' cause of action." Nami v. Fauver, 82 F.3d 63, 65 (3d Cir. 1996).

Even if the allegations and attached exhibits are insufficient by themselves, we will still deny a motion to

(continued...)

the remaining claims.

Factual Background

Jerry W. Lawson, Robert E. McNichol, William C. Moore, Frank Palmieri, Ernest A. Sampson, Thomas A. Schirmer, Robert A. Szeyller, and Glenn Williams (collectively, "plaintiffs") were managers of some of Provident Mutual Life Insurance Company's ("Provident"'s) agencies. Compl. ¶ 2. On top of the salaries that they received from Provident,² plaintiffs received additional compensation pursuant to their Co-Manager's Agreements with Provident. See, e.g., Compl. Ex. C. Plaintiffs received at least some of the additional compensation from Provident's subsidiaries, including 1717 Capital Management Company and Provident Life and Annuity Company of America.³ Compl. ¶¶ 7, 36.

¹(...continued)

dismiss so long as the allegations "in addition to inferences drawn from those allegations, provide a basis for recovery." Menkowitz v. Pottstown Mem'l Med. Ctr., 154 F.3d 113, 124-125 (3d Cir. 1998); see also Scheuer, 416 U.S. at 236 ("[T]he allegations of the complaint should be construed favorably to the pleader."); Emerson v. Thiel College, 296 F.3d 184, 188 (3d Cir. 2002) ("A complaint will withstand an attack under Federal Rule of Civil Procedure 12(b)(6) if the material facts as alleged, in addition to inferences drawn from those allegations, provide a basis for recovery.").

With these principles in mind, we base our summary of this case's "factual background" on the allegations in plaintiffs' complaint and the accompanying exhibits.

² Plaintiffs' salaries were reported to the IRS on Form W-2. See Compl. Ex. D.

³ Plaintiffs' additional compensation was reported to the IRS on Form 1099. Compl. ¶ 7.

While plaintiffs were working, Provident had been the sponsor of a defined benefit plan called the Retirement Pension Plan for Certain Home Office, Managerial, and Other Employees of Provident Mutual Life Insurance Company (the "Defined Benefit Plan"). Compl. ¶ 3; see also Compl. Ex. A (reproducing the Defined Benefit Plan); 42 U.S.C. § 1002(35) (2005) (defining "defined benefit plan"). Provident also had sponsored an "excess defined benefit plan" called the Provident Mutual Life Insurance Company Excess Defined Benefit Plan (the "Top Hat Plan," and, with the Defined Benefit Plan, the "Plans"). Compl. ¶ 4; see also Compl. Ex. B (reproducing the Top Hat Plan); compare 42 U.S.C. § 1002(35) (2005) (defining "defined benefit plan") with § 1002(36) (defining "excess benefit plan").⁴

Nationwide Mutual Insurance Company ("Nationwide") owns approximately seventy percent of the stock of Nationwide Financial Services, Inc. ("Nationwide Financial"). Compl. ¶ 18. In the autumn of 2002, Nationwide Financial acquired Provident. Id. ¶ 21. As part of the ensuing corporate reorganization, Provident came to be known as Nationwide Life Insurance Company of America ("Nationwide Provident"), and Nationwide Provident replaced Provident as the sponsor of both the Defined Benefit Plan⁵ and the Top Hat Plan. Id. ¶¶ 21-22. Immediately after the

⁴ ERISA does not include separate statutory definitions for an "excess defined benefit plan" or a "top hat plan."

⁵ During the brief period that Nationwide Provident
(continued...)

restructuring, the Benefits Committee of Provident Mutual Life Insurance Company (the "Provident Committee") continued to serve as the administrator of both the Defined Benefit Plan and the Top Hat Plan. Compl. ¶ 26.

Nationwide Provident and the Provident Committee still serve as the sponsor and the administrator, respectively, of the Top Hat Plan. Compl. ¶¶ 22, 26. The Defined Benefit Plan, however, is now sponsored by Nationwide and administered by the Administrative Committee of the Nationwide Mutual Insurance Company (the "Nationwide Committee," and, with the Provident Committee, the "Plan Administrators"). Id. ¶¶ 20, 25-26.

The Plan Administrators calculated plaintiffs' benefits based solely on their salaries. According to plaintiffs, the Plan Administrators should have calculated their benefits based on the sum of their salaries and their additional compensation. If the Plan Administrators had used plaintiffs' methodology, plaintiffs would have received greater benefits from the Plans. See Compl. ¶¶ 36-38.

Two of the plaintiffs, Palmieri and Schirmer, raised this argument before the Plan Administrators, see Compl. Exs. D-E, but the Plan Administrators rejected it on November 12, 2002,

⁵(...continued)
(a/k/a Nationwide Life Insurance Company of America) sponsored the Defined Benefit Plan, it changed the formal name of that Plan from the "Retirement Pension Plan for Certain Home Office, Managerial, and Other Employees of Provident Mutual Life Insurance Company" to the "Nationwide Life Insurance Company of America Retirement Plan." See Compl. ¶ 3.

see Compl. Ex. F. On January 8, 2003, Palmieri and Schirmer notified the Nationwide Committee by letter that they were appealing from its "denial of benefits letter dated October 22, 2002."⁶ See Compl. Ex. G. Defendants never responded to that correspondence. See Compl. ¶ 43.

On March 16, 2005, Palmieri and Schirmer, along with the other six plaintiffs (the "Lawson plaintiffs"), filed a five-count complaint against Nationwide, Nationwide Provident, the Defined Benefit Plan, the Top Hat Plan, the Nationwide Committee, and the Provident Committee.⁷ Count One seeks recovery from all defendants pursuant to 29 U.S.C. § 1132(a)(1)(B). In Count Two, plaintiffs claim that they can recover from Nationwide, Nationwide Provident, and the Plan Administrators pursuant to 29 U.S.C. § 1132(a)(2). Plaintiffs assert claims against Nationwide Provident, the Provident Committee, and the Top Hat Plan for breach of contract and unjust enrichment in Counts Three and Four, respectively. Finally, plaintiffs contend in Count Five that Nationwide Provident and the Provident Committee breached their common law fiduciary duties. Defendants argue that we should dismiss most of these claims, strike plaintiffs' jury demand, and stay the remaining claims.

⁶ The complaint fails to explain why the January 8, 2003 letter references an October 22, 2002 decision when the decision appears to have occurred on November 12, 2002.

⁷ In all future filings, we expect the parties to refer to the defendants using the same short-hand that appears in this Memorandum.

Analysis

A. Motion to Dismiss

1. Exhaustion of Remedies

Defendants contend that we should dismiss the portion of Count One that asserts the Lawson plaintiffs' claims against them because the Lawson plaintiffs did not exhaust their administrative remedies for the alleged breaches of the Plans' terms. See Defs.' Mem. at 5-7; Defs.' Reply at 2-7. We shall consider first whether an exhaustion requirement would ordinarily apply to claims like those that the Lawson plaintiffs assert and then whether it would be futile to enforce such a requirement in this case.

a. Applicability of Exhaustion Requirement

Although ERISA does not contain an explicit exhaustion requirement, it does mandate that every employee benefit plan "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." 29 U.S.C. § 1133(2) (2005); see also Compl. Ex. A, § 9.4, at 55-56; Compl. Ex. B, § 4.3, at 5-6. Reading § 1133 as an expression of Congress's intent "to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims

settlement; and to minimize the costs of claims settlement for all concerned," Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980), the courts of appeals have long held that a plaintiff seeking to recover benefits under 29 U.S.C. § 1132(a)(1)(B) usually must exhaust administrative remedies before proceeding to court. See, e.g., Wolf v. National Shopmen Pension Fund, 728 F.2d 182, 185 (3d Cir. 1984).

While it is clear that a plaintiff usually may not bring a § 1132(a)(1)(B) claim without exhausting his administrative remedies, our Court of Appeals only requires exhaustion of remedies when a plaintiff brings certain kinds of ERISA claims. The court has explained:

When a plan participant claims that he or she has unjustly been denied benefits, it is appropriate to require participants first to address their complaints to the fiduciaries to whom Congress, in [29 U.S.C. § 1133], assigned the primary responsibility for evaluating claims for benefits. This ensures that the appeals procedures mandated by Congress will be employed, permits officials of benefit plans to meet the responsibilities properly entrusted to them, encourages the consistent treatment of claims for benefits, minimizes the costs and delays of claim settlement in a nonadversarial setting, and creates a record of the plan's rationales for denial of the claim.

Zipf v. American Tel. & Tel. Co., 799 F.2d 889, 892 (3d Cir. 1986).

Other kinds of claims do not implicate these same concerns.

Unlike a claim for benefits brought pursuant to a benefits plan, a . . . claim [under 29

U.S.C. § 1140] asserts a statutory right which plan fiduciaries have no expertise in interpreting. Accordingly, one of the primary justifications for an exhaustion requirement in other contexts, deference to administrative expertise, is simply absent. Indeed, there is a strong interest in judicial resolution of these claims, for the purpose of providing a consistent source of law to help plan fiduciaries and participants predict the legality of proposed actions. Moreover, statutory interpretation is not only the obligation of the courts, it is a matter within their peculiar expertise.

Id. at 893. Thus, when "actions . . . are brought not to enforce the terms of a plan, but to assert rights granted by the federal statute [(i.e., ERISA)]," a plaintiff need not exhaust his administrative remedies before bringing his claim to federal court. Id. at 891. Regardless of how a claim is styled, however, our Court of Appeals "still require[s] exhaustion in cases where the alleged statutory violation . . . is actually a claim based on denial of benefits under the terms of a plan." D'Amico v. CBS Corp., 297 F.3d 287, 291 (3d Cir. 2002).

Although the parties have focused their briefing of the exhaustion issue on whether the Lawson plaintiffs may proceed with the § 1132(a)(1)(B) claim in Count One, we also must consider whether the exhaustion requirement applies to Count Two's § 1132(a)(2) claim. Count Two alleges that some of the defendants breached their fiduciary duties:

(a) by failing to discharge their duties in the sole interest of the participants and beneficiaries of the Defined Benefit Plan;

(b) by failing to act for the sole purpose of providing benefits to the participants and beneficiaries of the Defined Benefit Plan;

(c) by administering the Defined Benefit Plan contrary to the terms of the Defined Benefit Plan;

(d) by failing to pay vested and accrued benefits to participants and beneficiaries; and

(e) by otherwise breaching statutory provisions of ERISA.

Compl. ¶ 54. Sub-paragraphs (a), (c), and (e) provide no detail about how the defendants allegedly breached their fiduciary duties, so we find them wholly insufficient to put the defendants on notice of what conduct plaintiffs consider improper. On the other hand, sub-paragraphs (b) and (d) make plain that plaintiffs challenge defendants' "fail[ure]" to "provid[e]" (or "pay") "benefits" to "participants and beneficiaries." Lest there be any doubt about what is at stake, the complaint proclaims that "[t]his case is grounded on a single issue: defendants' failure to properly calculate pension benefits owed to plaintiffs under two retirement plans." Id. ¶ 1. However framed, Count Two is actually a claim based on denial of benefits.

Since Counts One and Two are claims based on defendants' denial of benefits, plaintiffs ordinarily would be required to exhaust their administrative remedies before filing those claims in federal court. It is undisputed that the Lawson plaintiffs have failed to satisfy the exhaustion requirement.

b. Futility

"Although the exhaustion requirement is strictly enforced, courts have recognized an exception when resort to the administrative process would be futile." Berger v. Edgewater Steel Co., 911 F.2d 911, 916 (3d Cir. 1990). A plaintiff must make a "clear and positive showing of futility" to "merit waiver of the exhaustion requirement." Harrow v. Prudential Ins. Co., 279 F.3d 244, 249 (3d Cir. 2002) (quotations and citations omitted). When considering whether a plaintiff has made such a showing, we must weigh several factors, including:

- (1) whether plaintiff diligently pursued administrative relief;
- (2) whether plaintiff acted reasonably in seeking immediate judicial review under the circumstances;
- (3) existence of a fixed policy denying benefits;
- (4) failure of the insurance company to comply with its own internal administrative procedures;
- and (5) testimony of plan administrators that any administrative appeal was futile.

Id. at 250. This list does not encompass every factor that we could consider, but we shall begin our analysis with the five Harrow factors. The Lawson plaintiffs do not allege that any of the defendants failed to comply with their internal administrative procedures, and they have not suggested that the Plan Administrators informed them that an administrative appeal would be futile. Having never even filed administrative claims, they cannot assert that they pursued administrative relief "diligently."

Still, the Lawson plaintiffs submit that it would have been futile for them to file administrative claims because they "are in materially the same factual and legal position" as Palmieri and Schirmer, and defendants did deny Palmieri's and Schirmer's claims. Pls.' Mem. at 4; see also Compl. ¶ 44. To use Harrow's language, the Lawson plaintiffs argue that defendants had a fixed policy of denying claims like theirs that made it reasonable for them to seek judicial review without first filing administrative claims.

At this stage of the proceedings, we must accept as true plaintiffs' contention that there are no material differences between the circumstances of Palmieri and Schirmer on one hand and the Lawson plaintiffs on the other. Moreover, it seems reasonable to infer that the Plan Administrators would treat similar cases similarly. Putting these principles together, we hold, only for purposes of the instant motion to dismiss, that the Lawson plaintiffs could reasonably expect that the Plan Administrators would deny their claims because the Administrators had already denied the claims of Palmieri and Schirmer. Since it would have been futile for them to pursue administrative remedies, the Lawson plaintiffs may press their ERISA claims in this Court, at least for now, in spite of their failure to seek administrative redress first.

Our holding, of course, depends entirely on the unquestioning deference that we owe to the allegations in the complaint on a motion to dismiss. Should the Lawson plaintiffs

fail to substantiate their allegations after the parties have completed discovery, we may grant summary judgment against them for failure to exhaust their administrative remedies.

2. Count Two

Count Two alleges that Nationwide, Nationwide Provident, and the Plan Administrators breached their fiduciary duties to the plaintiffs in violation of 29 U.S.C. § 1132(a)(2).⁸ Defendants suggest that we should dismiss Count Two because it seeks only "individual benefits that provide no benefit at all to the Plan itself." Defs.' Mem. at 8; see also Defs.' Reply at 7-10; Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 105 S. Ct. 3085 (1985).

Implicitly conceding that § 1132(a)(2) authorizes only those remedies that benefit an entire employee benefit plan, plaintiffs argue that Count Two does seek relief that would benefit the Defined Benefit Plan, not just themselves. See Pls.' Mem. at 6-7. Indeed, the ad damnum clause in Count Two requests that we require defendants "to make the Defined Benefit Plan

⁸ Section 1132(a)(2) authorizes participants and beneficiaries to bring civil actions "for appropriate relief" under 29 U.S.C. § 1109. If a fiduciary breaches its fiduciary duties, Section 1109(a) makes that fiduciary "personally liable to make good to [the] plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary."

whole for the losses incurred through [their] breaches of their fiduciary duties" and to "account for and return to the Defined Benefit Plan all profits and gains they enjoyed from their improper use of the Defined Benefit Plan's assets." Compl. at 13.

While Count Two purports to request relief that would benefit the Defined Benefit Plan, the complaint fails to allege any factual basis that would entitle plaintiffs to that relief. For example, the complaint contains no allegations that the Defined Benefit Plan suffered any losses from defendants' allegedly improper benefit calculations, and it seems more likely that the Plan actually benefitted from the refusal to pay as much as plaintiffs demand. Moreover, the complaint does not even hint that any defendant absconded with any Plan assets, so it is unclear how plaintiffs could expect that we would require defendants to "return" anything. In short, Count Two requests an appropriate kind of relief for a § 1132(a)(2) claim, but it fails to state a § 1132(a)(2) claim upon which such relief could be granted. We shall, therefore, dismiss Count Two pursuant to Fed. R. Civ. P. 12(b)(6).

3. State Law Claims

Counts Three, Four, and Five assert claims for breach of contract, unjust enrichment, and breach of common law fiduciary duties, respectively, against various combinations of the Top Hat Plan and its fiduciaries. Defendants maintain that

we should dismiss these state law claims because ERISA expressly preempts them. See Defs.' Mem. at 11-14, Defs.' Reply at 8-10.

ERISA "supersede[s] any and all State laws insofar as they may . . . relate to any employee benefit plan described in [29 U.S.C. § 1003(a)] and not exempt under section 1003(b)." 29 U.S.C. § 1144(a) (2005) (the "preemption clause"). This provision is "deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.'" Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46, 107 S. Ct. 1549, 1552 (1987) (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523, 101 S. Ct. 1895, 1906 (1981)). Because of this expansiveness, the Supreme Court has given "the phrase 'relate to' . . . its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739, 105 S. Ct. 2380, 2389 (1985) (some internal quotations and citation omitted). Thus, "a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139, 111 S. Ct. 478, 483 (1990). Plaintiffs do not dispute that Counts Three, Four, and Five are based on "State laws" that "relate to" the Top Hat Plan within the meaning of ERISA's preemption clause.

Despite that implicit concession, plaintiffs insist that we still should not dismiss Counts Three, Four and Five because the Top Hat Plan may be an unfunded excess benefit plan and no part of ERISA, not even the preemption clause, applies to those kinds of plans. See Pls.' Mem. at 8-9; see also 29 U.S.C. § 1003(b)(5) (2005). ERISA defines an excess benefit plan as "a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of Title 26 on plans to which that section applies." § 1002(36) (emphasis added).⁹

The Top Hat Plan's formal name is the "Provident Mutual Life Insurance Company Excess Defined Benefit Plan," see Compl. Ex. B. at 1 (emphasis added), but that appellation does not speak to the Top Hat Plan's purpose, the most important consideration in determining whether a plan is an excess benefit plan. The Top Hat Plan's preamble, on the other hand, explicitly provides that:

The purpose of [the Top Hat Plan] is to provide certain eligible employees . . . who retire under the [Defined Benefit Plan] with benefits which would otherwise be reduced by reason of the restrictive provisions of law applicable to the [Defined Benefit Plan]. To fulfill this purpose, the eligible employees will be provided with supplemental benefits . . . to compensate for the loss of benefits that would otherwise have been payable under the [Defined Benefit Plan] were it not for the application of sections 401(a)(17) and 415 of the Internal Revenue Code of 1986, as

⁹ We need not decide whether the Top Hat Plan is funded or unfunded.

amended. The [Top Hat] Plan is intended to be a top-hat plan, that is, an unfunded, non-qualified benefit plan for the purpose of providing benefits to a select group of management or highly compensated individuals and, therefore, is not intended to comply with the requirements of section 401(a) of the Code or to be subject to Parts 2, 3 and 4 of Title I of ERISA.

Id. This language could not be clearer. The Top Hat Plan was maintained to provide benefits to certain employees without running afoul of the limitations imposed by Sections 415 and 401(a)(17) of the Internal Revenue Code. Thus, the Top Hat Plan was not maintained "solely" to evade the limitations of section 415 of the Code, and it is not an "excess benefit plan." See 29 U.S.C. § 1002(36) (2005); see also Olander v. Bucyrus-Erie Co., 187 F.3d 599, 604 (7th Cir. 1999) (holding that a plan was not an excess benefit plan when the plan document stated that the plan had other purposes, in addition to a purpose to avoid the § 415 limitations).

Since the Top Hat Plan is not an excess benefit plan, ERISA's preemption clause exempts it from state regulation. We shall, therefore, dismiss Counts Three, Four, and Five as preempted.

B. Motion to Strike

After we dismiss Counts Two through Five, only Count One, which asserts an ERISA claim, will remain. Defendants have moved to strike plaintiffs' jury demand, and plaintiffs recognize that "no right to a jury trial arises from the statutory claims

under ERISA." Pls.' Mem. at 10. Because plaintiffs concede that they do not have a right to a jury trial of their only viable claim, we shall strike their jury demand.

C. Motion to Stay

Finally, defendants have requested that we stay the remaining claims against them. Before addressing their motion, however, we must review recent developments that the complaint does not discuss.

As we mentioned earlier, Palmieri and Schirmer claim to have notified defendants by letter dated January 8, 2003 that they intended to appeal from the Plan Administrators' November 12, 2002 denial of benefits. See Compl. Ex. G. Though plaintiffs insist that they have proof that the January 8, 2003 letter was sent, see Mot. to Stay Ex. 2, defendants claim that they did not receive the letter until March 22, 2005 (when they received the complaint, which attached the January 8, 2003 letter as an exhibit). On April 22, 2005, defendants informed Palmieri and Schirmer that they would consider their appeal on May 19, 2005. See Mot. to Stay Ex. 1. Plaintiffs did not object to such consideration. See Mot. to Stay Ex. 2. On June 13, 2005, defendants informed plaintiffs' counsel that they would decide the appeal by July 22, 2005. See Baran Decl. Ex. A.

In light of this recent activity, defendants believe that we should stay consideration of Count One until after they decide the appeal. In resolving the appeal, defendants will

either (1) reverse their long-standing position and find that plaintiffs have interpreted the Plans correctly after all; or (2) affirm their initial decision in a new opinion that is more thorough and better reasoned than their November 12, 2002 letter.¹⁰ Since plaintiffs could not complain about the first possibility, we concentrate on the likely effects of the second.

Should defendants affirm their November 12, 2002 denial of benefits in a new opinion, they likely will argue that we should treat the new opinion -- rather than the November 12, 2002 letter -- as their final denial of benefits.¹¹ When plaintiffs realize that the new opinion makes it harder for them to prevail on Count One, they will insist that the November 12, 2002 letter was the defendants' final decision and encourage us to disregard the new opinion. We express no opinion on how we would resolve this still-hypothetical dispute.

Having identified what we believe to be the true -- though unstated -- motivation behind defendants' motion to stay,¹² it is clear that this case can proceed in an orderly and expeditious fashion even if we deny the motion to stay. It will

¹⁰ While it is possible that the new opinion would not be better reasoned than the first, we suspect that defendants offered to consider the appeal because they hoped to write an opinion that would be more likely to survive judicial review for arbitrariness.

¹¹ Our consideration of Count One's merits would focus only on whichever decision is considered "final."

¹² That is, defendants appear not to want this case to proceed until they have had an opportunity to reformulate their decision to deny plaintiffs' claims.

not prejudice defendants to answer the complaint before they resolve the appeal, and we shall defer our usual pretrial conference until after July 22, 2005, the date by which they have promised to render their decision. The liability aspects of this case probably will not require much discovery, but the parties should not conduct any discovery until after the pretrial conference.

Conclusion

Though the Lawson plaintiffs have failed to exhaust their administrative remedies, we shall excuse that failure because, assuming that the allegations in the complaint are true, it would be futile to require exhaustion in this case. We shall dismiss Count Two because it fails to state a claim upon which the kind of relief available under 29 U.S.C. § 1132(a)(2) could be granted. ERISA preempts Counts Three, Four, and Five so we shall also dismiss them. Since only an ERISA claim survives, we shall strike plaintiffs' jury demand. Finally, we shall deny defendants' motion to stay because we can address their concerns through less drastic procedural techniques.

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JERRY W. LAWSON, et al. : CIVIL ACTION

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v. :

:

NATIONWIDE MUTUAL INSURANCE :

COMPANY, et al. : No. 05-1249

ORDER

AND NOW, this 29th day of June, 2005, upon consideration of defendants' motion to dismiss and motion to strike (docket entry # 8), plaintiffs' response thereto, defendants' application for leave to file reply memorandum (docket entry # 14), defendants' reply, and defendants' motion to stay proceedings (docket entry # 15), and in accordance with the accompanying Memorandum, it is hereby ORDERED that:

1. Defendants' application for leave to file reply memorandum is GRANTED;

2. The Clerk shall DOCKET defendants' reply memorandum, a copy of which is attached hereto;

3. Defendants' motion to dismiss and motion to strike is GRANTED IN PART;

4. Counts Two, Three, Four, and Five of the complaint are DISMISSED;

5. Plaintiffs' demand for jury trial is STRICKEN;

6. Defendants' motion to stay proceedings is DENIED;

7. By July 13, 2005, defendants shall ANSWER the complaint;

8. Counsel shall APPEAR in our Chambers for a pretrial conference at 1:30 p.m. on July 26, 2005; and

9. Until after the pretrial conference, the parties shall NOT CONDUCT discovery and shall NOT MAKE their initial disclosures.

BY THE COURT:

/s/ Stewart Dalzell, J.