



A brief recitation of the facts is as follows. In 1995, plaintiff Anita Alberts and Joanne Rathgeber, were partners in a small law firm ("R&A") consisting of two law partners and several support staff. Concerned with the rising cost of R&A's group health insurance premiums, the partners began exploring other group health insurance options. The partners eventually decided to replace their current group health insurance plan with one offered by defendants Independence Blue Cross and Pennsylvania Blue Shield ("IBC/PBS"). In May, 1995, R&A entered into a contractual agreement with IBC/PBS to provide group health insurance to R&A's five participants under the Personal Choice Option 7 Plan ("Personal Choice").

Under R&A's previous group health insurance plan, a traditional indemnity plan, the participants paid higher premiums, but were reimbursed 80% of the physician's actual bill without distinction as to in-network or out-of-network physicians. By contrast, the IBC/PBS Personal Choice Plan selected by R&A in May, 1995 is a managed care system with lower premiums. It is set up so as to distinguish between "Participating" physicians and "Non-Participating" physicians.<sup>1</sup> "Participating" physicians are those physicians who have contractually agreed with IBC/PBS to accept IBC/PBS's payment allowances for covered services as payment in full for those services. Those plan participants that choose "Participating" physicians thus receive benefits amounting to 100% of the "Participating" physician's bill, have no co-insurance, and no deductible. Ms. Alberts, however, did not choose to be treated by a "Participating" physician.

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<sup>1</sup> The IBC/PBS Personal Choice Plan also further differentiates between "preferred" and "non-preferred" physicians. However, that distinction refers only to whether a physician "is a member of the Greater Philadelphia Preferred Provider Network," a distinction which, as far as the Court can discern from the pleadings, essentially has no material bearing on the instant case.

Rather, she chose to receive treatment from “Non-Participating” physicians of her own choice.

It was permissible for Ms. Alberts’ to do this because the IBC/PBS Personal Choice Plan offers the advantage and derives its name from the fact that it also permits a participant to receive limited benefits for covered services from “Non-Participating” physicians of her own choice. This additional “choice” thus permitted Ms. Alberts to receive covered services from essentially any physician. It is Ms. Alberts’s understanding that the penalty for using “Non-Participating” physicians is that IBC/PBS only pays benefits amounting to 80% -- rather than 100% -- of the “Non-Participating” physician’s *actual bill*. It is IBC/PBS’s position, however, that they pay benefits amounting only to 80% of IBC/PBS’s *payment allowances* for the particular covered service. Moreover, it is IBC/PBS’s position that the plan participant is also responsible for that portion of the “Non-Participating” physician’s bill which exceeds IBC/PBS’s payment allowance for the particular covered service.<sup>2</sup>

In January, 1996, the plaintiff was diagnosed by, and then subsequently received treatment from, her “Non-Participating” physicians in New York. When she began receiving her Explanation of Benefits forms (“EOB”), she noted that IBC/PBS had not paid 80% of her physician’s actual bills as she had expected, but instead had paid significantly smaller benefit amounts which were far less than 80% of her physician’s actual bill. Out of the discrepancy between the amount of benefits Alberts expected and what IBC/PBS actually paid arose the instant dispute.

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<sup>2</sup> This is in addition to the plan participant’s responsibility for the 20% co-insurance and deductible which are not at issue here.

After pursuing some of the Plan's grievance procedures without satisfaction, plaintiff retained legal counsel and eventually filed the present lawsuit in the Bucks County Court of Common Pleas. In her complaint, plaintiff alleged claims pursuant to the 1974 Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461, as well as various state law claims.<sup>3</sup> In May, 1996, the defendants successfully removed the case to this Court, and on November 22, 1996, this Court granted the defendants' motion to dismiss all of the state law claims as being preempted by ERISA. (docket no. 24.)

Regarding plaintiff's remaining ERISA claims, she alleges in Count I that the Personal Choice Plan has breached the insurance contract by not paying the proper amount of benefits as set forth in the Contract and accompanying Benefits Booklet. Alternatively, plaintiff argues that the contract language is ambiguous as to how the specific amount of benefits are to be calculated and, thus, should be interpreted by the Court in favor of the insured plaintiff. Plaintiff further alleges in Count II that the nondisclosure of the "allowance schedule" on which benefits were based constitutes a breach of fiduciary duty by the defendants. Finally, plaintiff proposes to represent, as a class, all other similarly situated individuals and entities who have both selected the IBC/PBS Personal Choice Plan as their group health insurance and who have received limited benefits for services rendered by Non-Participating physicians. Accordingly, plaintiff has moved for class certification pursuant to Fed.R.Civ.P. 23.

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<sup>3</sup> Plaintiff's original complaint alleged a state law breach of contract claim, a claim for violation of the Pennsylvania Unfair Trade Practices and Consumer Protection Law, a claim for bad faith insurance practices, and a conspiracy claim.

Defendants argue that the contract is not ambiguous, but clear, and that under the clear terms of the contract, they paid the plaintiff the exact amount of benefits to which she was entitled. Defendants argue further that, with respect to plaintiff's complaint, they are not fiduciaries under ERISA. Also, defendants argue that, even if they are fiduciaries, they have not breached their fiduciary duty. Lastly defendants oppose class certification on two grounds. First defendants argue that plaintiff's individual breach of contract and fiduciary duty claims are without merit, and thus, may not support a class action. Second defendants argue that, even if there is merit to her individual claims, the plaintiff, herself, does not adequately represent the plaintiff's proposed class, and is not typical of the employees ERISA was designed to protect.

The recent procedural posture of the case is as follows. On December 8, 1997, following an in-chambers conference, this Court issued an Order (docket no. 60) which, among other things, granted defendants' Motion to Hold Plaintiff's Motion for Class Certification in Abeyance until after the cross motions for summary judgment on the merits of the plaintiff's individual claims had been resolved. The Court also granted the defendants' motion to compel plaintiff's deposition and denied the plaintiff's motion for partial summary judgment. Finally, the Order continued under advisement plaintiff's motion for class certification on her second amended complaint. After plaintiff's deposition had been taken, plaintiff moved again for partial summary judgment and for class certification, and the defendants again both opposed the plaintiff's motion and cross-filed their own joint motion for summary judgment.

## **II Discussion**

In the present case, plaintiff has moved for partial summary judgment on the

issue of liability. Plaintiff argues that defendants have breached their contract with the plaintiff to provide health insurance benefits by not providing benefits in the amounts specified in the insurance plan contract. Plaintiff argues alternatively that the language of the contract is ambiguous and therefore should be interpreted in favor of the non-drafting party. Furthermore, plaintiff argues that, even if there is no breach of contract, the defendants breached their fiduciary duty to disclose pertinent benefits information to the plaintiff.

Defendants have also cross-filed for summary judgment. Defendants argue that under the plain and unambiguous terms of the contract, they paid the appropriate amount of benefits to the plaintiff. Defendants argue further that they 1) did not owe a fiduciary duty to the plaintiff with respect to her claims, and 2) even if they did owe a fiduciary duty, they have not breached it. I begin with the motions for summary judgment.

Summary judgment is properly granted to the moving party 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 a judgment as a matter of law.” Fed.R.Civ.P. 56(c). A dispute regarding a material fact is genuine “if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S. Ct. 2505, 2510 (1986). The moving party has the initial burden of demonstrating that no genuine issue of material fact exists. See Celotex Corp. v. Catrett, 477 U.S. 317, 323, 106 S. Ct. 2548, 2553 (1986). Once the moving party has satisfied this requirement, the burden shifts to the nonmoving party to present evidence

that discloses a genuine issue for trial. Id. at 324, 106 S. Ct. at 2553; Fed.R.Civ.P. 56(e). In deciding a motion for summary judgment, all reasonable inferences and any ambiguities should be drawn in favor of the party against whom judgment is sought. American Flint Glass Workers, AFL-CIO v. Beaumont Glass Company, 62 F.3d 574, 578 (3d Cir. 1995). Additionally, the substantive law controlling the case will determine those facts that are material for the purposes of summary judgment. Anderson, 477 U.S. at 248, 106 S. Ct. at 2510. In the instant case, as both parties seek summary judgment based on an interpretation of the ERISA plan contract, the Court will address that issue first.

#### **A. The Breach of Contract Claim**

The proper interpretation of the ERISA plan contract is a matter of law. Ulmer v. Harsco Corp., 884 F.2d 98, 101-02 (3d Cir. 1989). In construing ERISA plans, the Court relies on federal common law rules of contract interpretation. Kemmerer v. ICI Americas, Inc., 70 F.3d 281, 287 (3d Cir. 1995). Federal common law of contracts under ERISA dictates that a court is required to interpret the policy as a whole and that the intended meaning of the contract should be determined from the actual language of the plan. Alexander v. Primamerica Holdings, 967 F.2d 90, 93 (3d Cir. 1992). Further, interpretation is based upon the plain and ordinary meaning of the language. Dewitt v. Penn-Del Directory Corp., 106 F.3d 514, 520 (3d Cir. 1997). Moreover, whether an ERISA plan is ambiguous is a question of law. In Re Unisys Long Term Disability Plan ERISA Litigation, 97 F.3d 710, 715 (3d Cir. 1996). A term is ambiguous if it is subject to reasonable alternative interpretations. Taylor v. Continental Group, 933 F.2d 1227, 1232 (3d Cir. 1991). The interpretation of ambiguous plan provisions is a question of

fact. Id. Thus, if a contract can reasonably be interpreted in two different ways, neither contracting party is entitled to summary judgment. American Flint Glass Workers, 62 F.3d at 581.

In the instant case, the contract can only reasonably be interpreted in one way. Here, the R&A Personal Choice Contract, governs the terms of the agreement out of which the instant dispute arises. Though plaintiff offers the Personal Choice Option 7 Benefit Booklet ("Benefit Booklet") in support of her argument, the Court notes initially that the Benefit Booklet states in the introduction on the first page that the "health care coverage described in this booklet is subject to the terms and conditions of the group contract issued by Independence Blue Cross and Pennsylvania Blue Shield." (Pl.'s Mot. For Part. Summ. J., Ex. "B," at Intro.) No one disputes that the "group contract" referred to by the Benefit Booklet is the R&A Personal Choice Contract ("PCC").

Turning to the PCC, the section entitled "Schedule of Benefits," beginning on page 24, includes an introductory paragraph which states,

[s]ubject to the Exclusions, conditions and limitations of this Contract, a subscriber is entitled to benefits for Covered Services and Covered Expenses described in this Benefits section . . . and in the amounts as specified in this schedule of Benefits.

(Pl.'s Mot. For Part. Summ. J., Ex. "A," at 24.) The terms "Covered Services" and "Covered Expenses" are defined in the PCC at page 7. The term "Covered Services" is defined as "a service or supply specified in this Contract for which benefits will be provided. (Id. at 7, ¶ 17.) Thus, "Covered Services" are simply the particular medical services covered under the contract, as opposed to other particular medical services which are not covered. For instance, certain family planning services are medical

services which may not be covered at all under the contract and, accordingly, would not be considered a “covered service” under the Plan contract. In the present case, however, there is no dispute that the medical services received by the plaintiff were indeed “covered services” under the contract. The dispute arises as to the basis by which benefits for those covered services were calculated.

“Covered Expenses” is also defined in the PCC at page 7 as follows:

COVERED EXPENSE - refers to the basis on which a subscriber’s deductibles, co-insurance, benefit maximums and benefits will be calculated.

(Id. at 7, ¶ 16 (emphasis in original).) Here, the Court interprets the term “Covered Expense” to refer to the basis by which benefits -- for those particular services that are covered -- are calculated. As stated above, there is no dispute that the particular services received by plaintiff are covered services. Thus, it is the definition of the term “Covered Expense” that is at the heart of this dispute. The definition of “Covered Expense” in the PCC continues:

(b) For services rendered by a Professional Provider [including physicians], “Covered Expense” means the Professional Provider’s Reasonable Charge for the Covered Services.

(Id.)

The term “Professional Provider’s Reasonable Charge” is defined at page 17 of the PCC as, “the charge that the Plan determines is reasonable for Covered Services provided to a Subscriber by a Professional Provider.” (Id. at 17, ¶ 80.) Professional Providers are then categorized into three groups: 1) “Preferred,” 2) “Non-Preferred Participating,” and 3) “Non-Preferred, Non-Participating.” (Id.) In this case, it is not disputed that plaintiff’s physicians fall into the third category, the so-called “Non-

Preferred, Non-Participating Professional Provider.” With respect to this third category of Professional Provider, the contract then states that the Professional Provider’s Reasonable Charge for a Non-Preferred, Non-Participating Professional Provider is:

the lesser of the Preferred Professional Provider Allowance, or the charge, whichever is lower.

(Id. at 17, ¶ 80 (c).) The contract then defines, on page 16, the “Preferred Professional Provider Allowance” as:

a schedule of allowances as approved by the Insurance Department of the Commonwealth of Pennsylvania for the purposes of this Contract.<sup>4</sup>

(Id. at 16, ¶ 73.)

Thus under the express terms of the PCC, for covered services received from a Non-Preferred, Non-Participating Professional provider, plaintiff is entitled to benefits amounting to 80% of the allowance described in the contract as the “Provider’s Reasonable Charge.” Moreover, the PCC expressly provides that “any difference between the Non-Preferred, Non-Participating Professional Provider’s charge and the Plan Payment shall be the personal responsibility of the subscriber.” (Id. at 76, ¶ T.2.)

The PCC is undoubtedly lengthy. It consists of 88 single-spaced pages. Determining how benefits are calculated is tedious and requires a careful reading of the contract. Nonetheless, tediousness does not equate to ambiguity. When read in its

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<sup>4</sup> Counsel for plaintiff’s suggestion at the April 22, 1998 oral arguments that the document entitled “Proposed Fee Schedule” had, in fact, never been approved by the Pennsylvania Department of Insurance has resulted in a flurry of supplemental filings by the parties (docket entries 74, 75, 76, 79 & 80). Plaintiff has not offered any evidence to contradict the Gallaher affidavits which establish that the Proposed Fee Schedule was approved by the Pennsylvania Department of Insurance on October 12, 1994 prior to the commencement of this action, and that upon its approval, it became the “Professional Fee Schedule” that is currently on file with the Department of Insurance in Harrisburg. Nor has plaintiff established the existence of a genuine issue of fact as to whether the Professional Fee Schedule is anything other than the “schedule of allowances as approved by the Insurance Department of the Commonwealth for the purposes of [the PCC].”

entirety, as ERISA case law mandates, the Court finds that the particular contract provision is subject to only one interpretation. See Alexander, 967 F.2d at 93. (requiring contract to be interpreted as a whole and based on plain and ordinary language).

Plaintiff, in this case, made the rational choice to seek treatment from nationally recognized New York physicians. In doing so, she was aware that she was receiving covered services from Non-Preferred, Non-Participating Professional Providers. Under the express terms of her PCC, she was entitled to benefits amounting to 80% of the “Professional Provider’s Reasonable Charge.” Further, under the express terms of the PCC, in addition to being responsible for a co-insurance payment amounting to 20% of the Professional Provider’s Reasonable Charge, she was also responsible for any difference between the Professional Provider’s Reasonable Charge and the amount her out-of-network physicians ultimately charged for their services. The monetary difference between plaintiff’s out-of-network physician’s charge and the IBC/PBS Professional Provider’s Reasonable Charge is rather large. Nonetheless, this does not alter the fact that, under the clear terms of the contract, she is responsible for that difference, however large.

Accordingly, the plaintiff’s motion for partial summary judgment on her breach of contract claim will be denied and the defendants’ cross motion for summary judgment on the breach of contract claim will be granted.

#### **B. The Breach of Fiduciary Duty Claim**

Plaintiff alternatively argues that, even if IBC/PBS did not breach the Personal Choice contract between IBC/PBS and R&A, they, nonetheless, breached their fiduciary

duty under ERISA. Specifically plaintiff argues that the defendants' failure to disclose to plan participants that the benefits paid on out-of-network physicians consist of 80% of the allowance schedule on file in Harrisburg, and not 80% of the physician's actual bill, constitutes a breach of fiduciary duty. Defendants argue that: 1) under ERISA, plaintiff's breach of fiduciary duty claim is precluded by her contract breach claim, 2) with respect to plaintiff's complaint, they are not fiduciaries under ERISA, and 3) even if they are fiduciaries under ERISA, they have not breached a fiduciary duty to plaintiff.

Under ERISA:

a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. . . .

29 U.S.C. § 1002(21)(A).

Thus in considering who is a fiduciary under ERISA, the courts must consider the extent to which a party possessed or exercised decision-making control or authority with respect to the wrongs alleged by plaintiffs. Arber v. Equitable Beneficial Life Ins., 848 F. Supp. 1204, 1212 (E.D. Pa. 1994). Moreover, the mere fact that someone is a fiduciary under a plan does not necessarily mean that he or she is a fiduciary with respect to all fiduciary obligations under the plan. Id.

In the instant case, plaintiff has not provided on motion for summary judgment evidence to suggest that IBC/PBS exercised any discretion in the calculation of her benefits. She has not shown, for example, that IBC/PBS deviated, in her case, from the

way benefits are supposed to be calculated under the terms of the PCC. There is no evidence to suggest that IBC/PBS claims administrators had any discretionary authority whatsoever to deviate from the PCC terms during the calculation of benefits. Plaintiff claims that the benefits she received were less than what she had a right to expect under the PCC, but she has not shown that IBC/PBS administrators exercised any discretion in arriving at the disputed amounts. Thus, plaintiff has failed to show the existence of a genuine issue of fact as to whether the defendants are ERISA fiduciaries for the purposes of her complaint.

Moreover, plaintiff's argument that defendants violated their fiduciary duty to disclose to plan participants such pertinent information about how benefits are calculated also fails. It is true that ERISA requires disclosure by fiduciaries of such information to plan participants. See In Re Unisys Corp., 57 F.3d 1255, 1263 (3d Cir. 1995) (stating under ERISA, fiduciaries have certain duties which include disclosure of specified information regarding plan terms). Such a fiduciary may satisfy its statutory disclosure obligations regarding the terms of a plan by distributing a summary plan description that complies with ERISA. Id. However, ERISA places this fiduciary duty of disclosure upon the plan administrator.

Regarding the plan administrator's duties, ERISA states in relevant part:

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan-- (1) a summary plan description described in section 1022 (a)(1) of this title . . .

29 U.S.C. § 1021(a)(1). Moreover ERISA states:

Publication of the summary plan description and annual reports shall be

made to participants and beneficiaries of the particular plan as follows: (1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary plan description, and all modifications and changes referred to in section 1022(a)(1) of this title. . .

29 U.S.C. § 1024(b)(1). ERISA requires the summary plan description to explain to participants and beneficiaries their rights and obligations in a manner which the average plan participant can understand. ERISA section 1022 states in relevant part:

A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

29 U.S.C. § 1022(a)(1). Further, ERISA requires the summary plan description to “explain the circumstances which may result in disqualification, ineligibility, or denial or loss of benefits . . . in a manner that is calculated to be understood by the average plan participant.” In re Unisys Corp., 57 F.3d at 1263 (quoting 29 U.S.C. §§ 1022(b) & 1022(a)(1)). This summary plan description must not mislead, misinform, or fail to inform participants and beneficiaries of the Plan. See 29 C.F.R. § 2520.102(b) (1983); Genter v. ACME Scale & Supply Co., 776 F.2d 1180, 1185 (3d Cir. 1985). Thus, it was the function of the summary plan description to decipher and explain the language of the eighty-eight page PCC so that participants and beneficiaries of the plan could understand how their benefits were calculated.

Here, plaintiff’s argument fails because, first of all, there was no summary plan description created, and more importantly, it was Ms. Alberts’s own law firm’s obligation

-- and not IBC/PBS's -- to create a summary plan description for its plan participants. Under ERISA, if a plan administrator is not specifically designated, then the plan sponsor becomes plan administrator by default. 29 U.S.C. § 1002(16)(A). The term "plan sponsor" means the employer in the case of an employee benefit plan established or maintained by a single employer. 29 U.S.C. § 1002(16)(B)(I). Therefore, as a general rule, the employer is deemed to be the plan sponsor in those cases where an employee welfare benefit plan is established or maintained by a single employer, and the plan sponsor is the plan administrator if another administrator is not designated under the plan. Arber, 848 F. Supp. at 1213.

In the instant case, the plan administrator is the plaintiff's own law firm, R&A. This conclusion is supported by the fact that R&A signed an application to enroll with IBC/PBS which stated, "[t]he Employer understands and agrees that Independence Blue Cross and Pennsylvania Blue Shield are not the Employer's Plan Administrator for any purposes under ERISA or COBRA." (Defs.' Suppl. Brief in Support of its Cross Mot. For Summ. J., Ex."E," at 2, ¶ V.B.) Moreover, it is undisputed that Lisa Weiss, an employee of R&A, served as the firm's plan administrator. (Id. at Ex. "K.") Because the plan administrator was not IBC/PBS, but rather, Lisa Weiss of R&A, it was her fiduciary duty to create and distribute the summary plan description. See Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1158 (3d Cir. 1990) (holding that when employers serve as plan administrators, they assume role of ERISA fiduciary). Moreover, in choosing not to create a summary plan description, R&A exercised discretion in the administration of the plan, further supporting the notion that R&A, and not IBC/PBS, served as the fiduciary with respect to plaintiff's complaint.

In summary, plaintiff has offered nothing to suggest the existence of a material factual dispute as to whether IBC/PBS exercised any discretion in the administration or management of the plan with respect to plaintiff's complaint over the amount of benefits paid. Nor has she established the existence of a genuine issue of fact as to whether the ERISA fiduciary responsible for the statutorily required dissemination of information to plan participants was anyone other than the plan administrator, R&A's own Lisa Weiss. Accordingly, plaintiff's motion for summary judgment as to the breach of fiduciary duty claim will be denied, and defendants' cross motion for summary judgment will be granted.

In light of the above discussion, as both of plaintiff's claims have been decided against her on summary judgment, her motion for class certification also will be denied. Obviously, a plaintiff whose own claims do not survive a motion for summary judgment will not adequately represent a prospective class in bringing the same claims. Moreover, the defendants' Motion for Protective Order (docket entry 61) as well as defendants' Motion for Leave to Submit a Second Supplemental Affidavit in Support of Its Motion for Summary Judgment (docket entry 79) will be dismissed as moot.

An appropriate order follows.

