APPENDIX A

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS EASTERN DIVISION

W.A. GRIFFIN, M.D.

PLAINTIFF

Case No. 18 C 1772

v.

TEAMCARE, A CENTRAL STATES HEALTH PLAN, AND TRUSTEES OF THE CENTRAL STATES,
SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

DEFENDANTS
Judge Robert W. Gettleman

ORDER

Pro se plaintiff W.A. Griffin, M.D., has brought a three count complaint against defendants TeamCare, and Trustees of the Central States, Southeast and Southwest Areas Health and Welfare Fund ("Trustees") alleging: (1) failure to pay benefits allegedly due under § 502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B) (Count I); (2) breach of fiduciary duties under 29 U.S.C. § 1104 (Count II); and failure to provide requested documents in violation of 29 U.S.C. § 1132(c)(1)(B). Defendants have moved to dismiss under Fed. R. Civ. P. 12(b)(6) for failure to state a claim. For the reasons stated below, defendants' motion to dismiss is granted.

BACKGROUND

Plaintiff is a Georgia "medical provider" that is not in TeamCare's provider network. Plaintiff brings this action to recover for alleged underpayments by defendants for medical services plaintiff rendered to a patient who was a participant or beneficiary of a health benefit

plan sponsored by Trustees.[1] Blue Cross Blue Shield was the third party administrator overseeing the processing of claims and other administrative services related to the plan.[2] Plaintiff alleges that in exchange for rendering medical services to the patient in question plaintiff received an assignment of benefits owed to the patient under the plan. The complaint alleges that defendants have failed to reimburse plaintiff for out of network ("OON") services based upon the usual, customary, and reasonable rate of those same services, as required by the plan. Instead, plaintiff was paid far less than the amount billed for services rendered to the patient.[3]

---

[1] Plaintiff fails to explicitly allege that the patient was a participant or beneficiary of a health benefit plan sponsored by Central States, but this fact can be inferred from the allegations in the complaint.

[2] Blue Cross Blue Shield has not been named in this lawsuit.

[3] Plaintiff alleges that a claim of $6,963.00 was submitted for the medical services provided, of which defendants paid $1949.10.

DISCUSSION

Defendants have moved to dismiss the complaint under Fed. R. Civ. P. 12(b)(6) for failure to state a claim. A motion under Rule 12(b)(6) challenges the sufficiency of the complaint, not its merits. Gibson v. City of Chicago, 910 F.2d 1510, 1520 (7th Cir. 1990). The court accepts as true all well-pleaded factual allegations and draws all reasonable inferences in the plaintiff's favor. Sprint Spectrum L.P. v. City of Carmel, Ind., 361 F.3d 998, 1001 (7th Cir. 2004). The complaint must allege sufficient facts that, if true, would raise a right to relief above the speculative level, showing that the claim is plausible on its face. Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 555 (2007). To be plausible on its face, the complaint must plead facts

sufficient for the court to draw the reasonable inference that the defendant is liable for the alleged misconduct. Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009).

As defendants point out in their motion to dismiss, this court has recently considered nearly identical claims under remarkably similar circumstances. See LB Surgery Ctr., LLC v. United Parcel Serv. of Am., Inc., 2017 WL 5462180 (N.D. Ill. Nov. 14, 2017), appeal dismissed sub nom. LB Surgery Center, d/b/a Greater Long Beach Surgery Ctr., Plaintiff - Appellant v. United Parcel Service of America, Inc., et. al., Defendants - Appellees, No. 17-3555, 2018 WL2979912 (7th Cir. May 15, 2018). Despite having this pointed out, plaintiff has failed to distinguish the instant case, and the court sees no reason to depart from its previous analysis. Consequently, no more than a brief discussion is necessary.

In Count I, plaintiff alleges that defendants have failed to pay plaintiff the full billed charges in violation of § 502(a)(1)(B), which provides that a civil action may be brought by a participant or a beneficiary "to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his right to further benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

The Seventh Circuit has recognized that, "benefits payable under an ERISA plan are limited to the benefits specified in the plan." Clair v. Harris Tr. & Sav. Bank, 190 F.3d 495, 497 (7th Cir. 1999).

As numerous courts have noted, a plaintiff suing under § 502(a)(1)(B) "must identify a specific plan term that confers the benefit in question." Stewart v. Nat'l Educ. Ass'n, 404 F.Supp. 2d 122, 130 (D. D.C. 2005). Failure to specify the allegedly breached plan term is grounds for dismissal. Sanctuary Surgical Ctr., Inc. v. UnitedHealth Grp., Inc., 2013 WL 149356, at *3 (S.D. Fla. Jan. 14, 2013); Paragon Office Services, LLC v. UnitedHealthcare Ins.

Co., 2012 WL 5868249, at *3 (N.D. Tex. Nov. 20, 2012); Midwest Special Surgery, P.C. v. Anthem Ins. Cos., 2010 WL 716105, at *2 (E.D. Mo. Feb. 24, 2010). In addition, the complaint must also "provide the court with enough factual information to determine whether the services were indeed covered services under the plan." Sanctuary Surgical, 2013 WL 149356, at *3.Plaintiff fails to identify any provision that provides for the claimed benefits.

Instead, the complaint alleges generally that defendants are required to pay benefits for OON services based on the usual, customary, and reasonable rate for those services, but fails to identify any plan provision on which it relies. Plaintiff further failed to attach a copy of the plan or provide enough factual information for the court to determine that the services rendered were covered services.

Plaintiff argues that the "complaint and support document show an overload of references that point to broken plan provisions that resulted in this lawsuit." She further cites to a series of communications, one of which mentions Section 11.09 of the plan,[4] which states as follows:

In all instances, other than when a specific dollar amount is the stated allowance, benefits to be paid by the Fund will be based upon a charge which is the usual, Reasonable and Customary charge for the treatment, supply or service, determined by comparison with the charges customarily made for similar treatments, supplies or services to individuals with similar medical conditions within a given geographical area.

This does not suffice because the only provision plaintiff relies upon does not confer benefits, but rather describes how conferred benefits are calculated. As explained above,

---

[4] Defendants attached a copy of the plan to their motion to dismiss. The court may consider documents referenced in the complaint and central to plaintiff's claims. Hecker v. Deere & Co., 556 F.3d 575, 582-83 (7th Cir. 2009).

plaintiff is required to identify the plan provisions that provide for the benefits sought. Plaintiff has failed to do so. Consequently, Count I fails to state a claim and is dismissed.

In Count II, plaintiff alleges that defendants breached their fiduciary duties in violation § 502(a)(3) by failing to pay the amounts owed. As an initial matter, this count suffers from the same deficiency as Count I because it fails to identify any provision requiring such payment. In addition, the count is entirely duplicative of Count I, because it is based on the same grounds and seeks the same relief. An ERISA plaintiff may bring an equitable claim under § 502(a)(3) only when no adequate remedy is available under § 502(a)(1)(B), Halley v. Aetna Life Ins. Co., 2014 WL 4463239, at * 3 (N.D. Ill. Sept. 10, 2014), and a failure to state a claim under § 502(a)(1)(B) does not allow a plaintiff to assert a § 502(a)(3) claim in the alternative. Moffat v. Unicare Midwest Plan Grp., 314541, 2005 WL 1766372, at *5 (N.D. Ill. July 25, 2005). "Courts in this district have almost uniformly held that § 502(a)(3) claims must be dismissed if relief may be obtained under § 502(a)(1)(B)." Roque v. Roofers' Unions Welfare Tr. Fund, 2013 WL2242455, at *6 (N.D. Ill. May 21, 2013) (collecting cases). Consequently, Count II is dismissed.

Finally, in Count III plaintiff seeks a civil penalty under § 501(c)(1)(B) from defendants for failure to supply requested documents. This provision provides that an administrator may be personally liable to a participant or beneficiary for up to $100 per day for failure to provide requested materials. Unfortunately for plaintiff, ERISA does not authorize "participants or beneficiaries to assign away their rights to statutory penalties" under § 502(c)(1). See Elite Ctr for Minimally Invasive Surgery, LLC v. Health Care Serv. Corp., 221 F. Supp. 3d 853, 860 (S.D.Tex. 2016). Consequently, plaintiff lacks standing to bring Count III.

CONCLUSION

For the reasons described above, defendants' motion to dismiss (Doc. 11) is granted.

ENTER: June 21, 2018

/s/ Robert W. Gettleman
United States District Judge

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Everett McKinley Dirksen United States Courthouse

Room 2722

219 S. DearbornStreet
Chicago, Illinois 60604

Office of the Clerk Phone:
(312) 435-5850
www.ca7.uscourts.gov

NOTICE OF DOCKETING - Short Form

June 22, 2018

To: Thomas G.Bruton Clerk of Court

The below captioned appeal has been docketed in the United States Court of Appeals for the Seventh Circuit:

Appellate Case No: 18-2374

Caption:
W.A.
GRIFFIN,
M.D., Plaintiff
- Appellant
v.
TEAMCARE, a Central States Health Plan, et al., Defendants - Appellees

District Court No: 1:18-cv-01772 District Judge Robert W. Gettleman Clerk/Agency Rep Thomas G. Bruton
Date NOA filed in District Court: 06/22/2018

If you have any questions regarding this appeal, please call this office.
form name: **c7_Docket_Notice_short_form**(form ID: **188**)