



ROBERTS BARTOLIC  
— L L P —  
ERISA WATCH

*\* This document is a case summary compilation of select Employee Retirement Income Security Act of 1974 (“ERISA”) decisions as they were reported on Westlaw between January 1, 2015 and December 31, 2015. Nothing in this document constitutes legal advice. Case summaries prepared by Michelle L. Roberts, Partner, Roberts Bartolic LLP, 1050 Marina Village Parkway, Suite 105, Alameda, CA 94501. © Roberts Bartolic LLP*

I.	Attorneys' Fees .....	9
A.	First Circuit .....	9
B.	Second Circuit .....	10
C.	Third Circuit.....	15
D.	Sixth Circuit .....	19
E.	Seventh Circuit.....	23
F.	Eighth Circuit.....	25
G.	Ninth Circuit .....	27
H.	Tenth Circuit.....	28
II.	Breach of Fiduciary Duty.....	29
A.	U.S. Supreme Court.....	29
B.	Second Circuit .....	31
C.	Third Circuit.....	37
D.	Fourth Circuit .....	41
E.	Fifth Circuit.....	43
F.	Sixth Circuit .....	45
G.	Seventh Circuit.....	49
H.	Ninth Circuit .....	53
I.	Tenth Circuit.....	57
J.	D.C. Circuit.....	60
III.	Church Plan Status .....	61
A.	Third Circuit.....	61
B.	Sixth Circuit .....	61
C.	Ninth Circuit .....	61
IV.	Class Certification.....	62
A.	Eighth Circuit.....	62
V.	Class Action Settlements .....	65
A.	Sixth Circuit .....	65
VI.	Disability Benefit Claims.....	72
A.	First Circuit .....	72
B.	Second Circuit .....	77

C.	Third Circuit.....	83
D.	Fourth Circuit .....	93
E.	Fifth Circuit.....	97
F.	Sixth Circuit .....	102
G.	Seventh Circuit.....	113
H.	Eighth Circuit.....	117
I.	Ninth Circuit .....	121
J.	Tenth Circuit.....	138
K.	Eleventh Circuit.....	140
VII.	Discovery .....	147
A.	First Circuit .....	147
B.	Second Circuit .....	149
C.	Third Circuit.....	150
D.	Fourth Circuit .....	151
E.	Sixth Circuit .....	152
F.	Seventh Circuit.....	156
G.	Eighth Circuit.....	157
H.	Ninth Circuit .....	158
I.	Eleventh Circuit.....	161
VIII.	Exhaustion of Administrative Remedies .....	163
A.	First Circuit .....	163
B.	Second Circuit .....	163
C.	Third Circuit.....	163
D.	Fourth Circuit .....	164
E.	Sixth Circuit .....	164
F.	Seventh Circuit.....	167
G.	Eighth Circuit.....	168
H.	Ninth Circuit .....	168
I.	Tenth Circuit.....	168
J.	Eleventh Circuit.....	168
IX.	Governmental Plans.....	169

A.	D.C. Circuit.....	169
X.	Interpleader Actions.....	170
A.	Fourth Circuit.....	171
B.	Seventh Circuit.....	171
C.	Eighth Circuit.....	171
XI.	Life Insurance & AD&D Benefit Claims.....	172
A.	First Circuit.....	172
B.	Third Circuit.....	173
C.	Fourth Circuit.....	175
D.	Fifth Circuit.....	176
E.	Sixth Circuit.....	177
F.	Eighth Circuit.....	180
G.	Ninth Circuit.....	181
H.	Tenth Circuit.....	183
I.	Eleventh Circuit.....	184
XII.	Medical Benefit Claims.....	185
A.	Second Circuit.....	185
B.	Third Circuit.....	187
C.	Fourth Circuit.....	188
D.	Fifth Circuit.....	189
E.	Sixth Circuit.....	191
F.	Seventh Circuit.....	191
G.	Eighth Circuit.....	193
H.	Ninth Circuit.....	194
I.	Tenth Circuit.....	196
J.	Eleventh Circuit.....	197
XIII.	Pension Benefit Claims.....	197
A.	First Circuit.....	197
B.	Second Circuit.....	198
C.	Third Circuit.....	203
D.	Fourth Circuit.....	208

E.	Fifth Circuit.....	210
F.	Sixth Circuit .....	212
G.	Seventh Circuit.....	220
H.	Ninth Circuit .....	222
I.	Tenth Circuit.....	227
J.	Eleventh Circuit.....	229
XIV.	Plan Status.....	232
A.	Sixth Circuit .....	232
XV.	Pleading Issues & Procedure .....	242
A.	Second Circuit .....	242
B.	Third Circuit.....	245
C.	Fourth Circuit .....	250
D.	Sixth Circuit .....	255
E.	Seventh Circuit.....	258
F.	Eighth Circuit.....	262
G.	Ninth Circuit .....	265
H.	Tenth Circuit.....	273
I.	Eleventh Circuit.....	275
J.	D.C. Circuit.....	276
XVI.	Preemption .....	276
A.	First Circuit .....	276
B.	Second Circuit .....	278
C.	Third Circuit.....	280
D.	Fourth Circuit .....	283
E.	Fifth Circuit.....	284
F.	Sixth Circuit .....	287
G.	Seventh Circuit.....	292
H.	Eighth Circuit.....	295
I.	Ninth Circuit .....	297
J.	Tenth Circuit.....	303
K.	Eleventh Circuit.....	304

XVII. Provider Claims .....	306
A. Second Circuit .....	306
B. Fifth Circuit.....	308
C. Seventh Circuit .....	313
D. Ninth Circuit .....	316
E. Eleventh Circuit.....	318
XVIII. Remedies.....	320
A. Second Circuit .....	320
B. Third Circuit.....	321
C. Fourth Circuit .....	322
D. Fifth Circuit.....	323
E. Sixth Circuit .....	324
F. Seventh Circuit.....	325
G. Eighth Circuit.....	326
H. Ninth Circuit .....	327
I. Tenth Circuit.....	328
J. Eleventh Circuit.....	328
XIX. Retaliation/Discrimination Claims.....	329
A. Second Circuit .....	329
B. Third Circuit.....	330
C. Fifth Circuit.....	331
D. Sixth Circuit .....	332
E. Seventh Circuit.....	333
F. Eighth Circuit.....	334
G. Ninth Circuit .....	334
H. Eleventh Circuit.....	336
XX. Retiree Medical.....	336
XXI. Severance Benefit Plans.....	341
A. Second Circuit .....	342
B. Third Circuit.....	344
C. Seventh Circuit.....	345

D. Ninth Circuit .....	346
E. Eleventh Circuit .....	347
XXII. State Bans on Discretionary Clauses .....	347
A. Eighth Circuit .....	347
B. Ninth Circuit .....	349
C. Tenth Circuit .....	350
XXIII. Statute of Limitations .....	350
A. Second Circuit .....	350
B. Third Circuit .....	<b>Error! Bookmark not defined.</b>
C. Third Circuit .....	351
D. Fourth Circuit .....	353
E. Sixth Circuit .....	355
F. Seventh Circuit .....	359
G. Eighth Circuit .....	359
H. Ninth Circuit .....	360
I. Eleventh Circuit .....	362
XXIV. Statutory Damages & Notice Violations .....	365
A. Second Circuit .....	365
B. Fifth Circuit .....	366
C. Sixth Circuit .....	368
D. Eighth Circuit .....	368
E. Ninth Circuit .....	369
F. D.C. Circuit .....	370
XXV. Stock Bonus Plans .....	370
A. Eleventh Circuit .....	370
XXVI. Subrogation/Reimbursement Claims .....	370
A. Third Circuit .....	370
B. Fourth Circuit .....	371
C. Sixth Circuit .....	373
D. Seventh Circuit .....	376
E. Ninth Circuit .....	377

F.	Tenth Circuit.....	380
G.	Eleventh Circuit.....	380
XXVII.	Venue.....	380
A.	Third Circuit.....	380
B.	Fourth Circuit.....	383
C.	Sixth Circuit.....	383
D.	Seventh Circuit.....	385
E.	Ninth Circuit.....	385
F.	Tenth Circuit.....	387
G.	Eleventh Circuit.....	388
H.	D.C. Circuit.....	388
XXVIII.	Withdrawal Liability & Unpaid Benefit Contributions.....	388
A.	Second Circuit.....	388
B.	Third Circuit.....	398
C.	Fourth Circuit.....	403
D.	Sixth Circuit.....	405
E.	Eighth Circuit.....	408
F.	Ninth Circuit.....	415
G.	D.C. Circuit.....	420

## I. *Attorneys' Fees*

### A. First Circuit

**Court awards attorneys' fees and costs to successful long-term disability claimant.** In [\*Gross v. Sun Life Assur. Co. of Canada\*, No. CIV.A. 09-11678-RWZ, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 2414471 \(D. Mass. May 21, 2015\)](#), following Plaintiff's success on her long-term disability claim at the First Circuit, the district award fees at the rate of \$500/hour for one of her attorneys first admitted to practice in 1985, is based in Boston (where hourly legal fees are among the highest in the country), and has decades of experience in ERISA litigation. For Plaintiff's other attorney with 13 years of experience and based in Louisville, Kentucky, the court found that his standard billing practices and the expectations of his clients warrant a rate of \$375/hour. The court also awarded \$90/hour for work done by a paralegal based in Louisville. With respect to the number of hours, the court reduced the compensable time by approximately 10% of the requested hours due to the court's determination of unnecessary and erroneous time entries. Lastly, the court downward adjusted the total lodestar to remove time spent pursuing unsuccessful claims and to reflect the quality of plaintiff's victories.

In [\*Carpenters Pension Trust Fund for N. California v. Walker\*, No. 12-CV-01447-WHO, 2015 WL 1050479 \(N.D. Cal. Mar. 9, 2015\)](#) (**Not Reported in F.Supp.3d**), the court awarded attorneys' fees and costs under 28 U.S.C. §§ 1132(g)(2) and 1451(b) to the Fund after it prevailed on two motions for summary judgment against Defendants. Although its motion for \$250,080.00 in attorneys' fees and \$4,250.71 in litigation expenses was unopposed, the court reduced the fees sought by 10% because Plaintiff billed for six lawyers to handle a relatively uncomplicated matter, causing inevitable duplication. The court also reduced the costs because Plaintiff seeks some that are not allowed under ERISA. The court awarded \$225,072.00 in fees and \$418.50 in costs.

In [\*La Santa-Andreu v. Bristol Myers Squibb Mfg. Co.\*, No. CIV. 13-1118 ADC, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 331745 \(D.P.R. Jan. 27, 2015\)](#), the court denied Plaintiffs' motion for attorneys' fees under ERISA Section 502(g), where the court had found that the severance plan at issue was not an ERISA covered plan and had dismissed the Plaintiffs' ERISA breach of fiduciary duty claims as time-barred. Plaintiffs centered their arguments and briefs requesting attorneys' fees on the proposition that attorneys' fees are warranted because plaintiffs had to "do battle within the context of ERISA and its interpretative jurisprudence." The court noted that there was no support

for an award of fees in the scenario before this court, to wit, that Plaintiffs' claims do not fall under ERISA and were remanded to state court as breach of contract claims. The court declined to equate a remand to a plan administrator, or even a remand to the district court, with a remand to state court because the former presupposes that an ERISA covered plan exists, while the latter confirms that ERISA is inapplicable to the plan as a matter of law. The court explained that it will not apply ERISA in part when it cannot apply ERISA as a whole, and, in any event, it lacks subject-matter jurisdiction to do so.

## B. Second Circuit

**Fees denied to successful ERISA defendant.** [Scott Groudine, M.D. v. Albany Med. Ctr. Grp. Health Ins. Plan, No. 112CV473NAMCFH, 2015 WL 9484510 \(N.D.N.Y. Dec. 29, 2015\)](#) (Judge Norman A. Mordue). Defendant brought a motion for attorneys' fees following its success on appeal on Plaintiff's claim for payment of health benefits. The court denied the motion although it recognized that Defendant achieved success on the merits and thus is eligible for an award of attorneys' fees under *Hardt*. In determining whether to exercise its discretion to grant Defendant's motion, the court considered the *Chambless* factors and found that the first factor heavily favors plaintiff; the second factor is neutral; the third factor strongly favors plaintiff; the fourth factor is neutral; and the fifth factor favors Defendant. Particularly in view of the remedial purpose of ERISA, the court found that consideration of the *Chambless* factors strongly supports denial of Defendant's motion.

[Caban v. Employee Security Fund of the Electrical Products Industries Pension Plan, et al., No. 10-CV-389 \(SMG\), 2015 WL 7454601 \(E.D.N.Y. Nov. 23, 2015\)](#) (Magistrate Judge Steven M. Gold). The court awarded Plaintiff attorneys' fees, finding that he achieved the requisite success on the merits where his disability pension was awarded after taking a deposition and filing an amended complaint. The court awarded attorneys' fees in the amount of \$126,400 and denied Plaintiff's motion for an award of pre-judgment interest. Plaintiff's attorney, a solo practitioner with over 30 years of experience representing individuals in discrimination, criminal, and ERISA cases. Plaintiff requested \$675/hour but the court awarded fees at a reduced rate of \$400/hour. Plaintiff also sought fees for 782.10 hours of attorney time but the court found that time spent on the case after July 24, 2012, the date Plaintiff was awarded a disability pension, did not achieve any success for plaintiff whatsoever. The court further cut time based on vague and excessive time. The court awarded fees for only 258 hours of work but also awarded 58 hours of time spent on the fee petition. The court denied prejudgment interest because Plaintiff did not timely move for it.

**Plan fiduciaries breached their fiduciary duties to defined benefit plans resulting in a \$15 million verdict against them.** In [\*Severstal Wheeling, Inc. Ret. Comm. v. WPN Corp.\*, No. 10CV954-LTS-GWG, F.Supp.3d](#), 2015 WL 4726860 (S.D.N.Y. Aug. 10, 2015), the Severstal Retirement Committee along with various Severstal Plans brought this action against Defendants WPN Corporation and Ronald LaBow, who is WPN’s principal and sole executive officer, alleging that Defendants failed to prudently and loyally manage and diversify the Severstal Plans’ assets and advise the Plans’ fiduciaries, and that Defendants breached their contract with the Severstal Plans by failing to obtain fiduciary insurance covering claims for breach of fiduciary duty. Following a two-week bench trial, the court found that Defendants breached their fiduciary duties to the Severstal Plans in designating an undiversified portfolio for transfer and by failing to recommend and implement a diversified portfolio. The court further found that their breach caused the Severstal Plans to suffer a loss of \$9.6 million. The court held Defendants liable for the disgorgement of the \$110,438 in investment management fees paid to them during the relevant period due to their “near-total dereliction of their duties” under the Severstal Investment Management Agreement. In addition, the court awarded Plaintiffs prejudgment interest at the New York statutory rate of 9%. The court directed the Clerk to enter judgment against Defendants, jointly and severally, for damages and disgorgement in the total amount of \$9,710,438, plus \$5,305,889.74 as prejudgment interest for the period from July 16, 2009, to August 10, 2015, for a total judgment of \$15,016,327.74.

**Individual fiduciary held liable for withheld fringe benefit contributions, prejudgment interest, and attorneys’ fees.** In [\*Bricklayers & Allied Craftworkers Local 2 v. Moulton Masonry & Const., LLC\*, No. 1:13-CV-201, F.Supp.3d](#), 2015 WL 4086305 (N.D.N.Y. July 7, 2015), following the Second Circuit’s affirmation of Moulton’s individual liability as a fiduciary, the court entered default judgment against him in the amount of \$451,300.52 for withheld fringe benefit contributions. Plaintiffs sought prejudgment interest calculated at the highest rate of return on investments but the Court found that Plaintiffs did not provide any detailed information regarding their investments and the overall rate of return on them. The court awarded prejudgment interest on the unpaid contributions at the rates provided by the Trusts and CBA, which totaled \$104,628.81. Finally, the court awarded attorneys’ fees and costs for being the prevailing party on the motion for default judgment and appeal. The court awarded a total of \$31,598.43 in attorneys’ fees and costs to cover the expenses Plaintiffs incurred through the filing of their motion for default judgment and defending their judgment on appeal. The court entered judgment against Moulton in the amount of \$587,527.76.

**Appellate attorneys’ fees awardable even where circuit court is silent on fees; 14-day deadline set forth in FRCP 54(d) is inapplicable.** In [\*Buckley v. Slocum Dickson Med. Grp., PLLC\*, No. 6:10-CV-974, F.Supp.3d](#), 2015 WL 3990198 (N.D.N.Y. July 1, 2015), the

could find that Plaintiff's request for appellate attorneys' fees was appropriate even though the Second Circuit (on the matter's second appeal) was silent on whether Plaintiff was entitled to fees and even though Plaintiff did not submit his fee request in the 14-day timeframe set forth in FRCP 54(d). With respect to the latter, the court determined that FRCP 54(d) is not applicable to requests for appellate attorneys' fees in ERISA cases because the statute itself does not set out any time limits for making a motion for appellate attorneys' fees. A prevailing party must seek appellate attorneys' fees within a reasonable period of time after the circuit's entry of final judgment. Here, the Second Circuit entered final judgment on September 22, 2014 and Plaintiff filed his fee request on March 19, 2015 (a little under three months after the 90-day time limitation for a certiorari petition closed). The court found Plaintiff's fee request to be timely.

The court denied Plaintiff's request for fees associated with the work of a disbarred attorney but declined to deny Plaintiff's fee request altogether. With respect to the reasonableness of the fee request, the court determined that Plaintiff's request for an additional \$97,695.25 in fees, based on a total of over 500 hours, would be incongruous with the prior award of \$47,723 as well as a calculation of how much time could reasonably have been spent working on the appeal. The court found that the amount of time reasonably expended achieving the result on appeal was 106.5 hours. Applying an hourly rate of \$225 (which the court previously determined was reasonable), the court awarded a total of \$23,962.50 in fees.

In [\*Gill v. Bausch & Lomb Supplemental Ret. Income Plan I\*, No. 6:09-CV-6043 MAT, 2015 WL 2129546 \(W.D.N.Y. May 6, 2015\)](#), the court declined to exercise its discretion to award prejudgment interest on the award of attorneys' fees to Plaintiffs. However, the court did award Plaintiffs with post-judgment interest on their award of attorneys' fees in accordance with 28 U.S.C. § 1961, at the rate of 0.22 percent. The court awarded post-judgment interest starting from the date the court determined that Plaintiffs were entitled to attorneys' fees, rejecting Plaintiffs' argument that the interest should accrue when the court entered summary judgment in their favor.

In [\*Badalamenti v. Country Imported Car Corp.\*, No. CV 10-4993 GRB, 2015 WL 1862854 \(E.D.N.Y. Apr. 23, 2015\)](#), the court found that the lodestar calculation was unreliable, where Plaintiff submitted "wildly conflicting" sworn declarations initially seeking \$131,498.13 in his motion but then later changing this amount to \$192,491.25. The revised amount included an increase in the time charged by approximately 100 hours and retroactively raised the hourly rates by as much as 37.5%. In the absence of a reliable lodestar calculation, the court applied the "percentage of the recovery" method, although noting that it is ordinarily inappropriate for "an award of attorneys' fee be proportional to the damages recovered" under ERISA. Here, the total settlement amounted to \$29,839.80. Given the unusual factors in this case, the court found that

one-third of the settlement amount—\$9,946.60—represents what a reasonable client would be willing to pay given the quality of the representation and the outcome of the litigation. Therefore, the court awarded \$9,946.60 in attorney’s fees.

In [\*Sun Life Assur. Co. of Canada v. Diaz\*, No. 3:14-CV-01685-VAB, 2015 WL 1826088 \(D. Conn. Apr. 22, 2015\)](#) (**Not Reported in F.Supp.3d**), the court declined to award Sun Life costs and attorneys’ fees for bringing an interpleader action to determine the proper beneficiary of a \$24,000 death benefit. The court concluded that the expenses incurred by Sun Life in bringing this action are part of its ordinary costs of doing business as an insurance company, and that it would be unfair to deplete the relatively small death benefit where no claimant thereto has been represented by counsel in this action.

In [\*Delprado v. Sedgwick Claims Mgmt. Servs., Inc.\*, No. 1:12-CV-00673 BKS, 2015 WL 1780883 \(N.D.N.Y. Apr. 20, 2015\)](#), the court found that Plaintiff was entitled to attorneys’ fees after securing a decision finding her denial of benefits to be arbitrary and capricious and requiring remand.

In [\*Gill v. Bausch & Lomb Supplemental Ret. Income Plan I\*, 2015 WL 1632518 \(W.D.N.Y. Apr. 13, 2015\)](#), Plaintiffs prevailed on their lawsuit challenging Defendants’ termination of their monthly SERP I benefit payments pursuant to SERP I’s change-in-control provision, by distributing lump-sum payments to Plaintiffs. Follow success at the 2<sup>nd</sup> Circuit, Plaintiffs moved for fees and expenses totaling \$730,106.30. Defendants’ only challenge was to Plaintiffs’ request to have this Court (1) require Defendant B & L to pay any award for attorneys’ fees and expenses out of its own assets rather than from the assets of SERP I; and (2) preclude Defendants from using assets held by SERP I to pay the attorney’s fee award, or to hold back the attorney’s fees against the balance of Plaintiffs’ lump-sum payments. The court considered ERISA’s anti-inurement and anti-alienation provisions, finding only the latter helpful to Plaintiffs’ position. The court ordered B & L to pay the full amount requested.

In [\*Trustees of Empire State Carpenters Annuity, Apprenticeship, Labor Mgmt. Cooperation, Pension & Welfare Funds v. Sanders Constr., Inc.\*, No. 13-CV-5102 JFB ARL, 2015 WL 1608039 \(E.D.N.Y. Apr. 10, 2015\)](#), a matter seeking to confirm an arbitration award, the court found that hourly rates of \$225 for a senior associate, \$200 for a junior associate, and \$90 for legal assistants is reasonable. The court awarded plaintiffs \$3707.00 in attorneys’ fees and \$467.98 in costs.

In [\*Gesualdi v. Seacost Petroleum Products, Inc.\*, No. 14-CV-1938 ADS SIL, 2015 WL 1469295 \(E.D.N.Y. Mar. 30, 2015\)](#), a default action to collect unpaid liabilities and contributions, the court awarded attorneys' fees but with a 40 percent reduction in Plaintiffs' counsel's billed hours, from 39.55 to 23.73. The court also awarded fees at the following rates: \$300 per hour for a 1988 law graduate; \$275 per hour for a 2011 law graduate; and \$110 per hour for a paralegal with over ten years of litigation experience.

In [\*Bd. of Trustees of the UFCW Local 50 Pension Fund v. Baker Hill Packing Inc.\*, No. 13-CV-1888 JS SIL, 2015 WL 867013 \(E.D.N.Y. Feb. 27, 2015\)](#), where the court granted Plaintiff default judgment awarding withdrawal liability, interest, and liquidated damages totaling over half a million dollars, the court awarded attorneys' fees as follows: \$295/hour for a sixth-year associate; \$200/hour for a second-year associate; and \$100/hour for legal assistant and litigation support staff members. The court awarded an hourly rate less than that requested for the sixth-year associate, because although the firm is an international firm and a leader in ERISA litigation, Plaintiff did not identify which of the firm's extensive resources as an international firm were required in this default action. As to the number of hours billed, the court found that 20.25 hours of attorney time and 4.25 hours of non-attorney time was reasonable and in line with the amount of work required to effectively litigate an ERISA default case in this district. Accordingly, the court awarded Plaintiff \$4,736.25 in attorneys' fees and \$650 in costs (including the \$350 filing fee for this action and \$300 in costs related to effecting service of process upon Defendant).

In [\*Barbu v. Life Ins. Co. of N. Am.\*, No. 12-CV-1629 JFB SIL, 2015 WL 778325 \(E.D.N.Y. Feb. 24, 2015\)](#), the court previously granted in part and denied in part Plaintiff's motion for summary judgment in this action challenging LINA's termination of his long-term disability benefits. Plaintiff moved for attorneys' fees and costs, which the court awarded \$119,185 in attorneys' fees and \$6,178.30 in costs. The court concluded that the hourly rate of \$375 for a solo practitioner based on Long Island appropriately takes into consideration the *Arbor Hill* and *Johnson* factors. The court noted that the attorney expended many hours reviewing documents, drafting affidavits, proofreading documents, and performing basic legal research. He also billed time for serving papers and mailing courtesy copies to the court. The court concluded that it is appropriate to assign an associate's hourly rate of \$175 for half of Plaintiff's hours. With respect to litigation costs, the court awarded the following: \$185.00 for a process server, \$40.00 for serving defendant through the New York State Department of Finance, the \$350.00 filing fee for initiating this action, \$90.96 in copying costs, \$3,796.70 in deposition costs, \$1,687.08 in electronic research costs, and \$25.76 in postage. Lastly, the court granted Plaintiff pre-judgment

interest at a rate of nine percent from the date Defendant terminated Plaintiff's benefits, concluding that an award of pre-judgment interest is appropriate to compensate Plaintiff for the time value of the benefits he was delayed in receiving, and to prevent the Defendant from enjoying a windfall from the denial.

In [\*Laser Lite Elec. Inc. v. United Welfare Fund-Welfare & Sec. Divisions\*, No. 12-CV-3347 PKC, 2015 WL 459412 \(E.D.N.Y. Feb. 3, 2015\)](#), the court granted summary judgment on the Union's asserted counterclaims against Laser Lite pursuant to ERISA and the LMRA for breach of contract, and to compel an audit of the books and records of Laser Lite. The Union sought to recover attorneys' fees and costs incurred in connection with this action pursuant to 29 U.S.C. § 1132(g)(2) (D). Laser Lite did not respond to the Union's application. For an attorney who graduated in 2007 and worked on this case as a fifth to seventh-year associate, the court approved an hourly rate of \$250 for 20.4 hours of work performed prior to June 18, 2013, and an hourly rate of \$275 for 60.2 hours of work performed thereafter. The court awarded the Union \$21,655.00 in attorneys' fees and \$350.00 in costs.

### C. Third Circuit

**Philadelphia lawyer fee survey may be used to establish reasonable hourly rate in ERISA matter.** [\*Einhorn v. Dimedio Lime Co.\*, No. CV 13-3634 \(RBK/JS\), 2015 WL 5920911 \(D.N.J. Oct. 9, 2015\)](#) (Judge Robert B. Kugler). In matter involving withdrawal liability, the court awarded attorneys' fees in the amount of \$25,950 and costs in the amount of \$825.56. The court found that the 86.50 hours expended on this matter was reasonable and that the requested hourly rate of the two attorneys, \$300 per hour, is reasonable in light of the 2014 Philadelphia Community Legal Services ("CLS") survey of Philadelphia lawyer attorney's fees.

In withdrawal liability collection matter, the court found that the \$265 blended rate used by Plaintiff is a reasonable rate for the work performed. [\*Local 1245 Labor-Mgmt. Pension Fund v. Key Handling Sys., Inc.\*, No. CIV.A. 14-6907 JLL, 2015 WL 5255261\(D.N.J. Sept. 8, 2015\)](#).

In [\*IBEW Local Union No. 400 v. Lords Elec., Inc.\*, No. CIV.A. 13-1785 MAS, 2015 WL 3452473 \(D.N.J. May 29, 2015\)](#), the court found that Plaintiffs did not provide sufficient evidence to show that Defendant's contributions were delinquent in violation of § 1145. Therefore, the court denied Plaintiffs' motion for summary judgment for attorneys' fees and

costs because, at this juncture, the court cannot enter judgment in favor of Plaintiffs pursuant to § 1145, and a favorable judgment under § 1145 is a prerequisite to fees. The court also denied Defendant's cross-motion because payment of alleged delinquent payments after the commencement of suit but prior to a judgment does not automatically deny a plaintiff the remedy of attorneys' fees and costs under § 1132(g)(2). The court explained that if Plaintiffs can establish Defendant violated § 1145 at the time this litigation was commenced, an award of reasonable attorneys' fees and costs is mandatory.

In [Templin v. Independence Blue Cross, No. 13-4493, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 2151778 \(3d Cir. May 8, 2015\)](#), Plaintiffs filed suit against Defendants for failing to pay for blood-clotting-factor products. Defendants moved to dismiss for failure to exhaust administrative remedies. The district court denied the motion to dismiss but ordered Defendants to review the claims for benefits. Defendants paid the claims in full and the district court subsequently denied both parties' motions for attorneys' fees. On the first appeal, the Third Circuit remanded the case to the district court to consider whether Plaintiffs were entitled to interest on the delayed payment of benefits. The parties settled this claim after Defendants agreed to pay \$68,000 in interest to Plaintiffs. The district court then dismissed the case and denied Plaintiffs' motion for attorneys' fees because it did not substantively determine the question of interest and the settlement amount was "trivial" when compared to the millions of dollars Plaintiffs originally sought. On the second appeal in this case, the Third Circuit reversed the district court's denial of attorneys' fees and held that: 1) the catalyst theory was available to show "some success" on the merits without judicial action; 2) the claimants achieved some degree of success on the merits through their recovery of prejudgment interest from a settlement; and 3) the district court abused its discretion in its consideration of the award of attorneys' fees by misapplying the first (culpability) and fifth (relative merits) of the *Ursic* factors. The court expressed no opinion as to whether attorneys' fees should be awarded to Plaintiffs on remand, where the district court will exercise its discretion and a correct analysis of the *Ursic* factors.

In [Kessler v. Aetna Health Inc., No. CV 14-00939\(RGA\), 2015 WL 1775529 \(D. Del. Apr. 16, 2015\)](#) (**Not Reported in F.Supp.3d**), the court granted summary judgment to Aetna on Plaintiff's denial of inpatient treatment claim for drug and alcohol addiction. Aetna moved for attorneys' fees. In considering the five factors, the court found that: 1) Plaintiff does not have any level of culpability for bringing the action and there is no evidence at all of bad faith; 2) ability to satisfy an award weighs against awarding attorney's fees since Plaintiff has received treatment multiple times for drug and alcohol addiction and it is highly unlikely that Plaintiff has any money to pay attorneys' fees; 3) the deterrent effect weighs in favor of awarding attorney's

fees since Plaintiff brought this case without any medical opinion that inpatient treatment was medically necessary and there would be a deterrent effect on future plaintiffs considering bringing weak claims; 4) benefit to other members weighs against attorney's fees; and 5) the merits of the position weighs in favor of awarding attorney's fees since Plaintiff had no real basis for his claim. The court found that although factors three and five support awarding fees, the first, second, and fourth factors weigh against awarding fees. Accordingly, the court denied Aetna's motion for fees even though Plaintiff did not respond to Aetna's request.

In [\*Trustees of Empire State Carpenters Annuity, Apprenticeship, Labor-Mgmt. Cooperation, Pension & Welfare Funds v. Penco United, LLC\*, No. 13-CV-4745 SJF AKT, 2015 WL 1650960 \(E.D.N.Y. Apr. 14, 2015\)](#), a contributions collections matter, the court observed that recent prevailing hourly rates for attorneys practicing in the Eastern District of New York are: (a) between three hundred to four hundred fifty dollars (\$300.00–\$450.00) for partners in large law firms and attorneys with extensive litigation experience or significant experience in the particular area of law at issue. The court awarded an hourly rate of \$250 for an attorney with over fifteen years of experience representing employee benefit plans for work done prior to March 1, 2013 and an hourly rate of \$300 for work performed thereafter. For the attorney's associates, the court awarded hourly rates of \$200 and \$225 (for work after March 1, 2013). The court awarded fees in the total amount of \$5,000 and costs of \$545.62.

In [\*Einhorn v. DiMedio Lime Co.\*, No. CIV. 13-3634 RBK/JS, 2015 WL 1646831 \(D.N.J. Apr. 14, 2015\)](#), a withdrawal liability matter, the court denied without prejudice Plaintiff's request for \$25,950 in attorneys' fees because Plaintiff did not submit evidence establishing the reasonableness of the requested hourly rate of \$300. Plaintiff's attorney only submitted a "conclusory" affidavit stating that his fee is reasonable.

#### D. Fourth Circuit

**Attorneys' fees denied to prevailing defendants in lawsuit seeking to extend *Yiatchos* doctrine to ERISA and a QDRO.** [\*Dahl v. Aerospace Employees' Retirement Plan of the Aerospace Corp.\*, No. 1:15CV611 \(JCC/IDD\), 2015 WL 777989 \(E.D. Va. Dec. 1, 2015\)](#) (Judge James C. Cacheris). In this matter on appeal to the Fourth Circuit on the issue of whether the *Yiatchos* doctrine could be applied to ERISA and a QDRO, the court denied the Defendants' motion for attorneys' fees. The *Yiacthos* doctrine provides that a federal regulatory scheme's

preemption of state law should not be used as a shield for fraud or to prevent relief where the circumstances manifest fraud or a breach of trust tantamount thereto. The court found that although Defendants are the prevailing party, the balance of the factors weigh against an award of fees, including that fees would provide only a minimal positive deterrent effect here because the legal theories presented are not likely to arise again. The court explained that courts can resolve the typical ERISA benefit dispute between ex-spouses with clear Fourth Circuit precedent. Although Plaintiff's argument for the application of the *Yatchos* doctrine appears novel, it is not frivolous or foundationless. Once the Fourth Circuit issues its decision, it will communicate far more to future litigants than an award of attorneys' fees. The court denied attorneys' fees even though Plaintiff has the apparent capacity to pay.

**Defendant seeking attorneys' fees for obtaining voluntary dismissal of lawsuit did not achieve sufficient success on the merits to warrant fees.** [Jenkins v. Moses H. Cone Mem'l Health Servs. Corp., No. 5:15-CV-34-FL, 2015 WL 6449296 \(E.D.N.C. Oct. 23, 2015\)](#) (Judge Louise W. Flanagan). In a lawsuit alleging improper billing practices under state law, where Plaintiff voluntarily dismissed the lawsuit after another lawsuit (involving same counsel) was removed and determined preempted by ERISA, Defendant moved for attorneys' fees, claiming that the voluntary dismissal is sufficient success to be considered the "prevailing" party and that its success in the other lawsuit was a "catalyst" to Plaintiff's dismissal without prejudice. The court denied Defendant's motion for attorneys' fees, finding that even if Plaintiff's claims were preempted by ERISA Section 502(a), Defendant did not achieve any success on the merits. At most, Defendant achieved trivial success on the merits. Further, if Plaintiff's remaining claims had been preempted by Section 514, Defendant would have succeeded only on Plaintiff's state law claims, not any ERISA claim.

In [Savani v. URS Prof'l Solutions LLC, No. 1:06-CV-02805-JMC, 2015 WL 4644463 \(D.S.C. Aug. 4, 2015\)](#), following a settlement of class claims involving ERISA's anti-cutback rule, Class Counsel moved for payment of attorneys' fees, costs, and an incentive payment from the judgment fund of \$956,574.00. Defendants had already paid \$60,000 to Class Counsel as part of a partial fee settlement agreement that the court approved. After analyzing the various factors, the court awarded attorneys' fees in the amount of 39.57% of past benefits and interest paid for the Subclass which amounts to \$378,516.33, plus reimbursement of costs and expenses of litigation in the amount of \$12,924.15, and an incentive award in the amount of \$15,000 to Subclass Representative Robert P. Taylor, Jr.

In *Bd. of Trustees, Sheet Metal Workers' Nat. Pension Fund v. SustainableWorks*, No. 1:14-CV-1023, 2015 WL 300494 (E.D. Va. Jan. 22, 2015), the court granted default judgment for

Plaintiffs in this matter seeking to enforce the terms of a collective bargaining agreement, including for unpaid contributions, interest, liquidated damages, late fees, and attorneys' fees and costs. In support of their request for attorneys' fees and costs, Plaintiffs submitted an attorney declaration, as well as a time sheet itemizing the time spent by various attorneys and staff. Based on these submissions, Plaintiffs seek \$2,897.65 in attorneys' fees and costs (\$2,168.50 in attorneys' fees and \$729.15 in costs). The court found that the requested fees and costs are reasonable compensation for work necessarily expended to enforce Plaintiffs' rights.

E. Fifth Circuit

[\*Perez v. Bruister\*, No. 3:13CV1001-DPJ-FKB, 2015 WL 5712883 \(S.D. Miss. Sept. 29, 2015\).](#)

In a suit involving breach of fiduciary duty claims related to an ESOP's purchase of inflated stock, the court found that attorneys' fees and expenses should be awarded to Plaintiffs after it held that one participant had standing to sue and returned a judgment in his favor on behalf of the plan as a whole. The court awarded the Sealy Plaintiffs \$416,052 in expenses and \$2,700,459.25 in attorneys' fees against Defendants.

In [\*Rhea v. Alan Ritchey, Inc.\*, No. 4:13-CV-00506, 2015 WL 4776115 \(E.D. Tex. Aug. 12, 2015\)](#), the court previously granted Defendant's counterclaim against Plaintiff for \$71,644.77 based on the Welfare Plan's right to collect third party settlement funds. The Plan sought payment of fees and costs in the sum of \$31,415.50 based on the Plan's right to recovery of attorneys' fees. The court granted Defendant's motion after consideration of all the relevant factors.

In [\*Murphy v. Verizon Commc'ns, Inc.\*, No. 3:09-CV-2262-G, 2015 WL 1647371 \(N.D. Tex. Apr. 13, 2015\)](#), Plaintiffs filed the action alleging breach of duties to the Plans under ERISA and the failure of Defendants to produce documents and make disclosures to Plan members. Upon issuance of an order granting summary judgment and awarding costs to Defendants, Defendants timely filed separate bills of costs seeking a total of \$4,218.22. Of this amount, as costs for transcripts obtained for use in this case, Verizon claims \$2,244.73 and SuperMedia claims \$450.76. SuperMedia alone claims an additional \$1,522.73 in costs for the making of copies necessary for use in the case. The court overruled Plaintiffs' objections and permitted recovery of Defendants' non-attorney costs associated with the litigation.

F. Sixth Circuit

**Court awards over \$11m in attorneys' fees to successful plaintiffs in matter involving failure to monitor recordkeeping fees.** [Tussey v. ABB Inc., et al., No. 2:06-CV-04305-NKL, 2015 WL 8485265 \(W.D. Mo. Dec. 9, 2015\)](#) (Judge Nanette K. Laughrey). In a breach of fiduciary duty lawsuit that the Eighth Circuit affirmed in part and reversed in part, the district court granted Plaintiffs' motion for attorneys' fees and awarded \$10,768,474 in attorneys' fees for time spent litigating the case before the district court using a blended rate of \$514.60/hour. The court also awarded \$900,000 for work done on appeal. These fees are to be paid by defendant ABB. The court also reaffirmed its prior award of costs and incentive fees – \$489,985.65 in taxable costs to be paid by ABB; \$1,712,834.85 for non-taxable costs to be paid out of the Class damages award; and \$25,000.00 to each of the three named Plaintiffs as an incentive award to be paid by ABB. The court did not reduce fees based on the argument that the fees are disproportionate to the amount recovered. “The litigation educated plan administrators, the Department of Labor, the courts and retirement plan participants about the importance of monitoring recordkeeping fees and separating a fiduciary’s corporate interest from its fiduciary obligations.”

**Attorneys' fees, costs, and 6% prejudgment interest awarded on remand to Plaintiff successful at Sixth Circuit.** [Raymond Shaw, Plaintiff, v. AT&T Umbrella Benefit Plan No. 1, Defendant., No. 13-CV-11461, 2015 WL 8177654 \(E.D. Mich. Dec. 8, 2015\)](#) (Judge Judith E. Levy). Following remand from the Sixth Circuit ordering the district court to award long-term disability benefits to Plaintiff, the court granted in part Plaintiff’s motion for benefits, interest, costs, and attorney fees. The court ordered Defendant to pay plaintiff \$35,412.72 in benefits, 6% pre-judgment interest, \$855 in costs, and \$90,341.50 in attorneys’ fees. The attorneys’ fees rates awarded were \$285/hour and \$250/hour, respectively, for work performed by a solo attorney who was undisputedly “an experienced and well-qualified attorney” with over twenty years’ experience and \$250/hour for a small firm attorney with over sixteen years’ experience. The court based these rates using a State Bar of Michigan, Economics of Law Practice publication which showed that attorneys’ fees in Ann Arbor ranged from \$330-\$450/hour for plaintiff’s-side employment law.

**Attorneys' fees awarded for success on life insurance claim but in an amount less than requested.** [Brown v. United of Omaha Life Insurance Company, No. 2:13-CV-830, 2015 WL 6506548 \(S.D. Ohio Oct. 28, 2015\)](#) (Judge George C. Smith). The court previously granted Plaintiff’s motion for summary judgment on his claim for life insurance benefits. Addressing a

subsequent motion concerning damages and fees, the court awarded \$181,666.67 in damages for benefits due under the policy, calculated based on the premiums deducted from the participant's paycheck. The court awarded Plaintiff prejudgment interest at the prevailing market rate of 3.25% from February 20, 2013 (the date the claim was initially denied) to the date final judgment is entered in this case. The court granted attorneys' fees but reduced the requested rate for one attorney from \$500 to \$400/hour and cut 50.6 hours of time which 1) did not reflect substantive legal work; (2) was too vague for the court to ascertain whether they were necessary to the success of Plaintiff's ERISA claim; or (3) related to work performed in conjunction with Plaintiff's unsuccessful state law claims. The court denied altogether work done by two other attorneys for failing to provide records detailing how much time they spent on compensable tasks. Lastly, the court denied all requested costs, mostly due to a lack of documentation on which costs are attributable to the successful ERISA claim rather than the unsuccessful state law claims.

In [\*Admin. Comm. of The Dillard's, Inc. Grp. Health, Dental, Vision Plan v. Sarrough\*, No. 1:14-CV-01165, 2015 WL 4459859 \(N.D. Ohio July 21, 2015\)](#), Plaintiff had unsuccessfully sought to invoke the Plan's right to recover reimbursement for medical expenses it paid from a wrongful death settlement against the estate and their attorneys. The defendant attorneys filed a motion for attorneys' fees, which the court granted in the amount of \$25,388.65 to one attorney, and \$17,250.00 to the other attorney. The court declined Plaintiff's request to stay its decision on attorneys' fees pending the resolution of Plaintiff's appeal before the Sixth Circuit. The court found that judicial economy counsels in favor of resolving the attorneys' fee issue sooner rather than later since Plaintiff will be able to file a consolidated appeal.

In [\*Tonguette v. Sun Life & Health Ins. Co. \(U.S.\)\*, No. 2:12-CV-00006, 2015 WL 4133238 \(S.D. Ohio July 8, 2015\)](#), Plaintiff prevailed on her claim for death benefits at the Sixth Circuit Court of Appeals after the district court ruled against her. Plaintiff was the beneficiary of an insured who died during the extended conversion period without having converted the policy into an individual policy. The court found that despite Plaintiff's achievement of success on the merits, consideration of the five factors did not lead it to conclude that a fee award under § 1132(g)(1) is appropriate.

In [\*Orrand v. Walters Excavating\*, No. 2:12-CV-389, 2015 WL 3409252 \(S.D. Ohio May 27, 2015\)](#), an action to recover unpaid fringe benefit contributions, the court issued a report and recommendation granting Plaintiffs' motion for an award of attorneys' fees and costs against Defendant WEI in the amount of \$29,424.75.

In [\*Greene v. Drobocky\*, No. 1:12-CV-00078-TBR, 2015 WL 1737772 \(W.D. Ky. Apr. 16, 2015\)](#), the court denied the prevailing Defendant's motion for attorneys' fees. Although the court found that there can be no doubt that Defendant demonstrated success on the merits by winning summary judgment on all but one of Plaintiff's claims and then prevailing on the remaining claim at trial, the court denied fees because Plaintiff did not bring the lawsuit with a culpable motive, it was unclear whether Plaintiff could satisfy a judgment, the court need not discourage plaintiffs from bringing such claims in the future (particularly in the absence of improper litigation tactics or otherwise vexatious acts), and Plaintiff's claims were not frivolous.

In [\*Dublin Eye Associates, P.C. v. Massachusetts Mut. Life Ins. Co.\*, No. CIV.A. 5:11-128-DCR, 2015 WL 1636160 \(E.D. Ky. Apr. 13, 2015\)](#), the Plaintiffs sought to stay enforcement of the Judgment awarding attorneys' fees pending appeal and requested a waiver of the supersedeas bond requirement, contending that the waiver of the supersedeas bond should be granted because Dublin Eye Associates does not have the financial ability to post the bond and that requiring them to do so would put their other creditors in undue jeopardy. The court held that Plaintiffs are personally liable for the Judgment and that there are no extraordinary circumstances that would justify waiving the bond requirement.

In [\*McCandless v. Standard Ins. Co.\*, No. 2:08-CV-14195, 2015 WL 869264 \(E.D. Mich. Feb. 27, 2015\)](#), Plaintiff sought an award of \$139,170.00 in attorneys' fees and \$850 in taxable costs, arguing that having been awarded remand three times classifies as some success on the merits. Additionally, Plaintiff filed a motion for summary judgment, arguing that Defendant's recent award of benefits constitutes a concession of liability. The court denied both motions and dismissed the present action. With respect to attorneys' fees covering the inception of the case through January 2, 2013, the court found that its previous order denying Plaintiff's motion for fees for this time stands since Plaintiff did not request reconsideration of that decision within the 14-day deadline or argued that there existed a palpable defect in the court's order. With respect to the fees incurred after January 2, 2013, the court assumed without deciding that the subsequent remands classify as some "success on the merits." However, after analyzing the *Sec. of Dept. of Labor v. King*, 775 F.2d 666, 669 (6th Cir.1985) factors, the court found that Plaintiff failed to demonstrate entitlement to fees.

In [\*Ohio & Vicinity Carpenters' Fringe Ben. Funds, Inc. v. BCS Contractors, Inc.\*, No. 5:12-CV-1565, 2015 WL 710955 \(N.D. Ohio Feb. 18, 2015\)](#), the court previously granted Plaintiff's motion on the issue of Defendant's liability but denied, without prejudice, plaintiff's motion on

the issues of damages and attorneys' fees. In this case, Plaintiff sought an hourly rate of \$150.00 for counsel of record in this case but did not submit affidavits from outside attorneys specializing in ERISA matters regarding the prevailing market rates, affidavits detailing the experience of the billing attorneys, or opinions from the attorneys regarding the prevailing market rate in the community. Based on the court's own experience in similar cases, however, it concluded that an hourly rate of \$150.00 is reasonable in this case for the lodestar analysis. Also, the work performed and time expended for each activity set forth, and the costs incurred, were reasonable. Accordingly, the court granted Plaintiff's motion for attorneys' fees in the amount of \$6,690.00, and costs in the amount of \$380.28.

In *Humes v. Elec. Workers' Pension Trust Fund of Local Union No. 58, I.B.E.W., Detroit, Mich.*, No. 13-10385, 2015 WL 249330 (E.D. Mich. Jan. 20, 2015), the court granted the prevailing Plaintiff attorneys' fees and costs. Specifically, the court granted Plaintiff's request of \$1,137.35 in costs for pursuing this action, which include the costs of filing the complaint, two depositions, mileage and postage and photocopies. With respect to fees, the court calculated the reasonable hourly rate of Plaintiff's three attorneys and paralegal using the 2014 State Bar of Michigan Economics of Law Practice Report, at the 50th percentile, as a guide. The court explained that compensating the attorneys at this rate complies with the purpose of § 1132(g)(1) yet avoids providing a windfall to the attorneys. For the attorney who had performed the most work and who had less than a year of experience when she performed the bulk of the, the court awarded an hourly rate of \$172. For the second attorney with over 35 years of experience and only a few hours in the case, the court awarded an hourly rate of \$285. For the third attorney with six to ten years of experience, the court awarded an hourly rate of \$236. And for the paralegal time, the court awarded an hourly rate of \$90, which is what Plaintiff's counsel charged to Plaintiff. Lastly, the court declined to exercise its discretion to award Plaintiff attorneys' fees for preparing the fees motion or for responding to Defendant's motion for relief from the court's order because it found no evidence that Defendant filed its motion for relief in bad faith or any other reason to justify these fees.

#### G. Seventh Circuit

In [\*Chesemore v. Alliance Holdings, Inc.\*, No. 09-CV-413-WMC, 2015 WL 5093283 \(W.D. Wis. Aug. 28, 2015\)](#), the court awarded Plaintiffs attorneys' fees for work related to post-judgment discovery, including preparing a motion to compel, reply in support of the motion and a fee petition. The court awarded Plaintiffs \$17,599.81 in attorneys' fees and awarded Alliance \$31,740.54.

In [\*Pactiv Corp. v. Sanchez\*, No. 13-CV-8182, 2015 WL 4508667 \(N.D. Ill. July 23, 2015\)](#) (discussed again below), involving a subrogation plan by a health plan against a plan participant where the health plan prevailed on the merits, the court exercised its discretion to deny attorneys' fees under the circumstances. The court found, most importantly, that there is no indication that Defendant took the position that it did in this litigation in bad faith or to harass Pactiv. Had the health plan asserted a Section 8(j) credit in the Workers; Compensation Proceeding for benefits that it already had paid on Defendant's behalf, this action may well have been unnecessary. Moreover, Defendant's waiver and preclusion arguments were not frivolous or patently unreasonable given Pactiv's initial failure to assert its right to a credit. The court also found that ordering Defendant to pay any of Plaintiff's attorneys' fees might be burdensome and unrealistic.

In [\*Admin. Comm. of The Dillard's, Inc. Grp. Health, Dental, Vision Plan v. Sarrough\*, No. 1:14-CV-01165, 2015 WL 4459859 \(N.D. Ohio July 21, 2015\)](#), Plaintiff had unsuccessfully sought to invoke the Plan's right to recover reimbursement for medical expenses it paid from a wrongful death settlement against the estate and their attorneys. The defendant attorneys filed a motion for attorneys' fees, which the court granted in the amount of \$25,388.65 to one attorney, and \$17,250.00 to the other attorney. The court declined Plaintiff's request to stay its decision on attorneys' fees pending the resolution of Plaintiff's appeal before the Sixth Circuit. The court found that judicial economy counsels in favor of resolving the attorneys' fee issue sooner rather than later since Plaintiff will be able to file a consolidated appeal.

**Attorneys for Class are only entitled to statutory fee award and not entitled to a fee from the common fund.** In [\*Pierce v. Visteon Corp.\*, No. 14-2542, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3985985 \(7th Cir. July 1, 2015\)](#), involving a certified class action, the Seventh Circuit held that attorneys of employees who prevailed against employer for COBRA notice violations were not entitled to a fee from the class's common fund in addition to fee awarded under ERISA Section 502(g). For 741 former employees who received untimely notice, they each will receive \$1,250. The district court ordered the employer to pay class counsel \$302,780 as attorneys' fees under Section 502(g), plus costs of about \$11,000. The court found that there are three principal reasons that justify limiting the common-fund approach to cases outside the scope of a fee-shifting statute. First, the fee-shifting provision in ERISA is a statutory replacement for the common law, which was devised by courts as a matter of necessity when there was no other way to compensate lawyers for work that substantially benefited a class. Second, fee-shifting statutes are designed to ensure that the victims retain full compensation and the wrongdoer pays the lawyers. Third, Section (g)(1) provides for an award of a "reasonable" fee so if the attorney were to pocket substantially more than that, his compensation would by definition be unreasonably high.

In [\*Trustees of the Michiana Area Elec. Workers Health & Welfare Fund v. TGB Unlimited Inc.\*, No. 2:13-CV-199-JEM, 2015 WL 1865561 \(N.D. Ind. Apr. 22, 2015\)](#), the court awarded attorneys' fees to the Fund, where Defendant contested that contributions were not delinquent and there was no judgment in favor of the Plan. The court found that it does not need to examine whether there was an actual delinquency because Defendant paid the full amount identified by Plaintiff as the amount of delinquent contributions. Further, as the Seventh Circuit has held, when a trustee of an ERISA benefit plan prevails in an action to recover delinquent contributions, the district court is required to award reasonable attorneys' fees.

In [\*Farr v. Rolls-Royce Corp.\*, No. 1:13-CV-01266-JMS-DK, 2015 WL 540505 \(S.D. Ind. Feb. 10, 2015\)](#), the court found that its conclusion that Rolls-Royce's Incentive Program was not an ERISA plan was a decision on the merits of Plaintiff's ERISA claim, rather than a decision regarding subject-matter jurisdiction, and Rolls-Royce can pursue fees under § 1132(g)(1). However, because Plaintiff's position that the Incentive Program was an ERISA plan was substantially justified, Rolls-Royce is not entitled to attorneys' fees.

*Operative Plasterers & Cement Masons Local 599 Pension Fund v. Valda Plastering Co.*, No. 14-CV-1-WMC, 2015 WL 273216 (W.D. Wis. Jan. 21, 2015), a matter involving default judgment in a withdrawal liability action, the court awarded attorney's fees of \$2,085.00 for 13.90 hours of work, based on an hourly rate of \$150, as well as \$451.80 in costs, pursuant to 29 U.S.C. § 1132(g)(2).

#### H. Eighth Circuit

**Attorneys' fees awardable to Plaintiff where Defendant "voluntarily remanded" the claim to the Plan Administrator after the lawsuit was filed.** [\*Barfield v. Ascension Health Long-Term Disability Plan\*, No. 4:12-CV-02116 JAR, 2015 WL 5813293 \(E.D. Mo. Oct. 5, 2015\)](#) (Judge John A. Ross). In this action where Plaintiff prevailed on "own occupation" long-term disability benefits following the Plan's unilateral voluntary remand after suit was filed and upon realizing that not all information submitted by Plaintiff had been reviewed and considered, the court concluded that ERISA's fee-shifting statute applies to the fees and costs Plaintiff incurred on remand. Defendant contested the award of fees because it "voluntarily remanded" the claim to the Plan Administrator and that the court made no substantive ruling in favor of Plaintiff on the merits of her complaint. However, the court found that the pertinent considerations are that it

ordered the remand, that it was not occasioned by Plaintiff's failure to satisfy the prerequisites under ERISA for filing suit, and that the court retained jurisdiction over the action on remand. The court granted prejudgment interest at the rate specified in 28 U.S.C. § 1961(b).

In [\*Krueger v. Ameriprise Fin., Inc.\*, No. 11-CV-02781 SRN/JSM, 2015 WL 4246879 \(D. Minn. July 13, 2015\)](#), Plaintiffs secured a settlement providing a \$27.5 million monetary recovery for the benefit of as many as 46,098 current and former participants in the 401(k) plan offered to employees of Ameriprise Financial (the "Plan"), as well as important affirmative relief designed to reduce fees and improve investment offerings in the Plan. The court approved of a fee award of one-third of the monetary settlement obtained, or \$9,166,666, and an additional \$782,209.69 for outstanding expenses. Here, Class Counsel spent approximately 27,991 attorney hours and 2,716 hours of non-attorney professional time litigating this case. Using a blended rate of \$514.60 (approved by the Eighth Circuit for use in an ERISA case in 2014), the lodestar totals \$14,404,168.60, more than the amount requested by Class Counsel. The court also approved \$25,000 incentive awards for each of the five Named Plaintiffs.

In [\*Broadbent v. Citigroup Long Term Disability Plan\*, No. CIV 13-4081-LLP, 2015 WL 1189565 \(D.S.D. Mar. 16, 2015\)](#), the parties filed a joint stipulation under which the Plan agreed to pay Plaintiff past long-term disability benefits and to reinstate her under the Plan subject to its terms and conditions. Thereafter, Plaintiff filed a motion seeking \$31,441.03 in attorney's fees and costs with a multiplier of 1.5 for a total of \$46,954.40. The court found that Plaintiff's suit served as a catalyst to cause the Plan to provide her with substantially all of the relief she sought in her complaint and this is sufficient "degree of success on the merits" to merit a fee award. Further, the majority of the *Westerhaus* factors favor an award of attorneys' fees. The court found that Plaintiff's attorney's requested hourly rate of \$250 per hour is reasonable given his experience, the prevailing market rate in South Dakota, and the lack of any objection from the Plan. The Court declined to reduce the 52.1 hours Plaintiff's attorney spent reviewing the record and preparing for the mediation but it did reduce the time spent on the motion for attorneys' fees by 50%. The court also reduced the hourly rate for legal assistants from \$125 to \$100 to be more in keeping with local rates. With respect to Plaintiff's request for a multiplier, the court considered the attorney's experience, that few lawyers in the geographic area take ERISA cases, and the risk of non-recovery. Because the case was not legally complex, however, the court awarded only a 1.25 enhancement and not 1.5 (with the enhancement only applying to the lawyer's work and not his legal assistants or other attorneys in the firm). The court awarded a total of \$37,581.75 in attorneys' fees and costs.

## I. Ninth Circuit

[Micha v. Sun Life Assur. Co. of Canada, No. 09CV2753 JM BGS, 2015 WL 5732124 \(S.D. Cal. Sept. 30, 2015\)](#). Group Disability, an employee welfare plan, was sued by one of its participants when Sun Life denied his disability claim. It filed a cross-claim against Sun Life for declaration of comparative fault and indemnification. Following a settlement between the participant and Sun Life, Group Disability sought legal fees from Sun Life pursuant to 29 U.S.C. § 1132(g)(1). The court granted Group Disability's motion for attorney's fees, and awarded \$36,216.75, which the Ninth Circuit upheld on appeal. Group Disability sought fees for defending Sun Life's appeal and opposition to its fee motion. The court denied the fee motion, noting that this case involved a novel application of law regarding attorney's fees in ERISA cases and application of the *Hummell* factors did not support a fee award.

In [Angel Jet Servs., LLC v. Giant Eagle, Inc., No. 13-15956, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 3876292 \(9th Cir. June 24, 2015\)](#), a matter involving a suit by an air ambulance company against a health insurance plan, the Ninth Circuit found that the district court clearly did not err in finding that Appellees achieved success on the merits, where Appellees prevailed on both the motion for remand and the motion for summary judgment. The district court awarded Appellees \$398,464.80 in fees and \$47,857 in costs. The court found that the district court did not err in finding that Appellant did not achieve success on the merits: Appellant received only \$92,460 as a result of this action—over \$60,000 less than Appellees originally offered in settlement and over \$900,000 less than Appellant demanded.

In [Day v. AT & T Disability Income Plan, No. 11-17150, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 1567857 \(9th Cir. Apr. 9, 2015\)](#), the Ninth Circuit held that the magistrate judge did not abuse his discretion by adjusting downward the lodestar amount in the attorneys' fees order because Plaintiff's counsel spent an excessive amount of time on several tasks as compared to the time spent on similar tasks by Plaintiff's prior counsel and attorneys in other ERISA cases; used block-billing to record his time; and charged his other clients a lower hourly rate than the lodestar rate he requested. The court also found that the district court did not abuse its discretion in limiting the fee award to the time expended pursuing his short-term disability claim on remand because this was the only claim on which Plaintiff prevailed in court after exhausting administrative remedies. Plaintiff did obtain LTD benefits but entirely through the administrative process and did not obtain any favorable court judgment or order on that issue. Lastly, the district court did not abuse its discretion by restricting the prejudgment interest award to the rate set forth in 28 U.S.C. § 1961 and declining to account for the timing of Plaintiff's LTD benefits claim when the court calculated the period for which prejudgment interest would be awarded.

In *Aviation W. Charters, Inc. v. United Healthcare Ins. Co.*, No. CV-14-00338-PHX-NVW, 2015 WL 143829 (D. Ariz. Jan. 12, 2015), Plaintiff brought suit seeking a declaration that Defendants violated certain ERISA requirements, to enjoin Defendants from continuing to pursue recoupment efforts against Plaintiff related to beneficiary claims, and to order Defendants to return to Plaintiff all monies recouped, and other relief. The court had granted summary judgment against Plaintiff on any federal law claims, finding that Plaintiff did not have a cause of action under ERISA because it is not a plan participant, beneficiary, or fiduciary and did not have a valid assignment of benefits from the beneficiary under the Plan. The court declined to exercise supplemental jurisdiction on any state law claim. United requested an attorneys' fee award under 29 U.S.C. § 1132(g) (1) in the amount of \$65,301.50. Defendants Renaud Cook Drury Mesaros, P.A. Welfare Benefit Plan and Renaud Cook Drury Mesaros, P.A. sought an award of attorneys' fees in the amount of \$3,080.00. The court found that Defendants may seek fees under 29 U.S.C. § 1132(g)(1) and the fact that Plaintiff failed to prove beneficiary status does not oust the court's discretion to award fees under ERISA. The court also found that Defendants achieved "some success on the merits" by obtaining dismissal of Plaintiff's ERISA action. But, the court found that the *Hummell* Factors weigh against a fee award.

In *Trustees of the IBEW/NECA Sound & Commc'ns Health & Welfare Trust v. Netversant Solutions II LP*, No. C-14-00611-RMW, 2015 WL 124633 (N.D. Cal. Jan. 8, 2015), a matter involving unpaid trust contributions and a default judgment against Defendant, the court found that Plaintiffs' requested attorneys' fees award of \$6,820.00 is reasonable. The award is based on 17 hours of attorney time billed at \$275.00 per hour and 11 hours at \$195 per hour. The court found that both the number of hours worked and hourly rates reasonable in this legal market for attorneys of similar skill and experience in an ERISA collections case. The court also awarded Plaintiffs their filing costs of \$400.00 in this case.

#### J. Tenth Circuit

[MICHELLE CAMPBELL, Plaintiff, v. BALL CORPORATION CONSOLIDATED WELFARE BENEFIT PLAN, Defendant., No. 13-CV-00132-MSK-KMT, 2015 WL 5352569 \(D. Colo. Sept. 15, 2015\)](#) The court granted attorneys' fees and prejudgment interest to Plaintiff, who was successful on her denial-of-LTD-benefit claim. However, due to the court's determination that the attorney's records were imprecise and reflected excessive time, the court applied a 25% reduction to the time entries and awarded a lodestar figure of \$24,375 based on 75 hours at a rate of \$325 per hour. The court also awarded prejudgment interest at the rate of 8% per annum compounded annually based on Colorado's statutory rate set forth in Colo. Rev. Stat. § 5-12-102.

In [Meyer v. Unum Life Ins. Co. of Am., No. CIV.A. 12-1134-KHV, 2015 WL 3843676 \(D. Kan. June 22, 2015\)](#) (**Not Reported in F.Supp.3d**), after the court ruled in favor of Plaintiff on his long-term disability claim, Plaintiff sought an award of costs and fees of \$98,850. Unum stipulated that it will not contest an award of costs and fees of this amount, but reserved the right to seek reversal of the award if the court's ruling on the merits is overturned or materially altered on appeal. The court granted Plaintiff's request.

In [Anderson v. CEMEX, Inc., No. 2:12-CV-136, 2015 WL 1543347 \(D. Utah Apr. 7, 2015\)](#) (**Not Reported in F.Supp.3d**), the court awarded Plaintiff \$93,597.06 in attorneys' fees after prevailing on her claim for pension benefits and document penalty claim. This was after the court reduced the amount requested by an additional 20% (in addition to the amount Plaintiff reduced for work relating to the standard of review since the court did not rule on that issue). The court reduced the fees because Defendants did prevail on the issue regarding discovery both initially and on appeal to the district judge and the discovery issues ended up playing a fairly large role in the case.

K. Eleventh Circuit

In [DeKalb Med. Ctr., Inc. v. Specialties & Paper Products Union No. 527 Health & Welfare Fund, No. 1:13-CV-343-TWT, 2015 WL 4231774 \(N.D. Ga. July 13, 2015\)](#), Plaintiff sought attorneys' fees and costs after Plaintiff prevailed on its claim for reimbursement from the Fund for medical services it provided to one of its plan participants. The court found that Plaintiff is entitled to \$219,738.65 in attorneys' fees and \$4,091.97 in litigation costs, for a total of \$223,830.62. This amount represents about a 5% reduction from the total amount Plaintiff requested.

II. ***Breach of Fiduciary Duty***

A. U.S. Supreme Court

**Ninth Circuit erred in concluding that breach of fiduciary duty claims were untimely, based solely on the initial selection of funds, and without considering the contours of the alleged breach of fiduciary duty.** In [Tibble v. Edison Int'l, No. 13-550, \\_\\_\\_ S.Ct. \\_\\_\\_, 2015 WL](#)

[2340845 \(U.S. May 18, 2015\)](#), the U.S. Supreme Court unanimously held that the 9th U.S. Circuit Court of Appeals erred by finding breach of fiduciary duty claims alleging imprudent fund offerings were time barred simply because their initial selection took place years ago. The Supreme Court remanded the case to the 9th Circuit to consider the plan participants' claims that various plan fiduciaries breached their duties within the relevant statutory period, by failing to remove the allegedly-imprudent funds from the investment lineup.

By way of background, this case involves breach of fiduciary duty claims brought by participants in the Edison 401(k) Savings Plan — an individual account, defined contribution plan— for, among other things, failing to act prudently by offering certain high-cost retail-class mutual funds as investment options. The 9th Circuit found that the plan fiduciaries did not act prudently when they decided to include retail-class shares of three specific mutual funds as investment options without considering the possibility of lower-cost institutional classes for the funds, but held that the act of designating an investment for inclusion starts the six-year period for claims asserting imprudence in the design of the plan menu.

The petitioners and the U.S. Department of Labor argued that the 9th Circuit erred by finding that the statute of limitations starts running under ERISA Section 413(1) for claims alleging imprudent fund offerings from the moment the fiduciaries made the decision to include those investments in the plan. Because fiduciary duties are ongoing, the petitioners contended that these claims are timely for as long as the underlying investments remain in the plan. The 9th Circuit rejected this argument and held that Section 413(1) barred any claim of fiduciary breach as to those mutual funds because plan fiduciaries have no duty to review and remove imprudent or disloyal investments from a plan unless changed circumstances warrant a full due diligence review of the funds.

The Supreme Court granted certiorari on the following question: “Whether a claim that ERISA plan fiduciaries breached their duty of prudence by offering higher-cost retail-class mutual funds to plan participants, even though identical lower-cost institution-class mutual funds were available, is barred ... when fiduciaries initially chose the higher-cost mutual funds as plan investments more than six years before the claim was filed.” Section 413(1) of ERISA provides that no actions claiming a fiduciary breach “may be commenced ‘after the earlier of’: (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation.”

In its decision, the Supreme Court explained that under trust law a fiduciary is required to conduct a regular review of its investment with the nature and timing of the review contingent on the circumstances. Perhaps seeing the writing on the wall, respondents conceded that under trust law the duty of prudence involves a continuing duty to monitor investments and remove imprudent ones. However, respondents argued that petitioners did not raise the claim below that respondents committed new breaches of the duty of prudence by failing to monitor their

investments and remove imprudent ones absent a significant change in circumstances. The Supreme Court left for the 9th Circuit to decide any questions of forfeiture. Assuming the 9th Circuit does not decide the case on the procedural ground of forfeiture, the questions it will have to address are: did the Plan fiduciaries have a duty to review the contested mutual funds and if so, what kind of review did it require? The Supreme Court left open the possibility that the 9th Circuit, after considering trust-law principles, will conclude that the Plan fiduciaries did indeed conduct the sort of review that a prudent fiduciary would have conducted absent a significant change in circumstances.

#### B. First Circuit

In [\*In re Fid. ERISA Float Litig.\*, No. CIV.A. 13-10222-DJC, 2015 WL 1061497 \(D. Mass. Mar. 11, 2015\)](#), Plaintiffs alleged that Fidelity violated its fiduciary duties by using float income for themselves to defray their own expenses and by giving float belonging to the purported class of retirement plans to other Fidelity clients. Plaintiffs further alleged that Fidelity engaged in prohibited transactions by dealing with the assets of a plan for its own interest or account. The court granted Fidelity's motion to dismiss, finding that Plaintiffs have not plausibly alleged that float income is a Plan asset and, even if float were a Plan asset, Fidelity is not an ERISA fiduciary as to float.

#### C. Second Circuit

**An ERISA fiduciary is a fiduciary for Bankruptcy Code § 523(a)(4) purposes.** [\*In re Kern\*, No. 13-71700-AST, 2015 WL 8481574 \(Bankr. E.D.N.Y. Dec. 10, 2015\)](#) (Bankruptcy Judge Alan S. Trust). In this case, Plaintiffs are ERISA benefit funds and the Debtor was the principal owner and control person of a closely held company which employed persons who were entitled to have contributions made on their behalf to the Benefit Funds. The court considered whether \$1,369,803.98 of unpaid contributions due to these Benefit Funds are non-dischargeable debts pursuant to § 523(a)(4) of the Bankruptcy Code. The court held that because ERISA is a federal law and fiduciary status and defalcation under the Bankruptcy Code are also determinations made under federal law, an ERISA fiduciary is a fiduciary for § 523(a)(4) purposes. In this case, the Debtor meets the functional test under ERISA and is therefore a fiduciary for purposes of § 523(a)(4) because the Debtor: (1) determined whether or not CSI made timely contributions to the Benefits Funds; (2) exercised authority, control and management over the disposition of assets of CSI and had decision making authority with respect to whether or not to pay the obligations of CSI; (3) had decision making authority with respect to whether or not to pay the obligations of CSI; and (4) decided which accounts payable were to be paid by CSI.

**Counterclaims alleging breach of fiduciary duty against trustees for bringing lawsuit against Fund are dismissed as not ripe for adjudication; breach of contract claim related to disclosure of allegedly privileged memo is preempted by ERISA.** [Wilhelm v. Beasley, No. 15CV4029LAKJLC, F.Supp.3d , 2015 WL 8035967 \(S.D.N.Y. Dec. 7, 2015\)](#) (Judge James L. Cott). This lawsuit involves a challenge by 11 trustees of the National Retirement Fund (the “Fund”) to the Fund’s decision to expel certain contributing employers—specifically subsidiaries of Caesars Entertainment Corporation (“Caesars”). Defendants counterclaim alleging that the trustees breached their fiduciary duty, violated the Fund’s confidentiality provision by which they were contractually bound, and caused the Fund to engage in a prohibited transaction pursuant to ERISA by: (1) the filing of the underlying action; (2) the filing of the action originally in Nevada; (3) the disclosure of an allegedly privileged document during the course of litigation; and (4) the request for injunctive relief enjoining the Fund from serving on the Unsecured Creditors’ Committee in a related bankruptcy proceeding involving Caesars. The court granted the Plaintiffs/Counterclaim Defendants’ motion to dismiss the counterclaims. The court found that the counterclaims contingent on the outcome of the underlying litigation are not ripe for adjudication. With respect to the claims related to the act of filing this lawsuit, the court found that initiation of this lawsuit does not constitute a breach of fiduciary duty. The court also found that the prohibited transaction claim is not ripe for adjudication since whether initiating this suit amounts to using the Fund’s assets to benefit a party in interest or engaging in actions adverse to the Fund will depend on the outcome of the underlying litigation. Similarly, with respect to the trustees seeking to enjoin the Fund from serving on the Committee, requesting such relief does not amount to a breach of fiduciary duty. The court also found not ripe for adjudication the issue of whether the filing of an allegedly privileged Memorandum that Caesars could access and use to the Fund’s detriment in bankruptcy proceedings is a breach of fiduciary duty. The court found that ERISA preempts the breach of contract claim based on the Memorandum’s disclosure.

[Piacente v. Int’l Union of Bricklayers & Allied Craftworkers, No. 11 CIV. 1458 ER, 2015 WL 5730095 \(S.D.N.Y. Sept. 30, 2015\)](#). Defendants counterclaimed against Plaintiff, alleging that he: (1) failed to administer the Fund assets in accordance with the Trust Agreement, as required under ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D); (2) failed to discharge his duties with respect to the Fund solely in the interest of the Fund participants as required under ERISA § 404(a)(1)(A); and (3) transferred value from the Fund to a party in interest. ERISA § 406(a)-(b), 29 U.S.C. § 1106(a)-(b). The court found that Plaintiff violated the trust agreement by executing checks with two union trustee signatures and no employer trustee signature. The court found that it does not have subject-matter jurisdiction over the third counterclaim and dismissed it.

**§ 502(a)(1)(B) claim may be brought against the claims administrator who has discretion to make final benefit determinations; § 502(a)(3) may impose a fiduciary duty arising indirectly from the Parity Act; simultaneous claims under § 502(a)(1)(B) and 502(a)(3) may proceed.** In [\*New York State Psychiatric Ass'n, Inc. v. UnitedHealth Grp., No. 14-20-CV, F.3d\*](#), 2015 WL 4940352 (2d Cir. Aug. 20, 2015), a matter involving alleged violations of ERISA and the Parity Act, Defendant United challenged New York State Psychiatric Association's ("NYSPA") associational standing to sue on behalf of its members. United also contended that it could not be sued under § 502(a)(3) for alleged violations of the Parity Act or under § 502(a)(1)(B), and that it would not be "appropriate" for the plaintiffs to obtain relief under § 502(a)(3) if § 502(a)(1)(B) offered an adequate remedy. NYSPA is a professional organization of psychiatrists practicing in New York State. Plaintiff Denbo, an employee of the CBS Sports Network, has health insurance benefits through the CBS Medical Plan, which incorporates the requirements of ERISA and the Parity Act. United is the claims administrator for the CBS Plan and has absolute discretion to interpret and to apply the rules of the Plan to determine claims for Plan benefits. Denbo alleged that United improperly administered the CBS Plan by treating claims submitted for routine, outpatient, out-of-network medical/surgical care more favorably than claims for ongoing, routine, outpatient, out-of-network psychotherapy sessions, in violation of the Parity Act. The district court (SDNY) agreed with United and granted its motion to dismiss. The Second Circuit affirmed in part and vacated in part and remanded.

With respect to NYSPA's associational standing, an association has standing to bring suit on behalf of its members when (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit. The only real dispute is whether at the motion to dismiss stage NYSPA has plausibly alleged that its claims do not require individualized proof. The court concluded that it has. NYSPA challenges United's systemic policies and practices insofar as they violate ERISA and the Parity Act, and it seeks only injunctive and declaratory relief. If at summary judgment or at trial NYSPA's claims require significant individual participation or proof, then the district court may dismiss NYSPA for lack of standing at that point. The court vacated dismissal of NYSPA's claims and remanded for it to consider in the first instance whether NYSPA's pleadings can survive the pleading standard set forth in *Twombly*.

With respect to Plaintiff Denbo, the court ultimately rejected United's argument that it cannot be sued under § 502(a)(1)(B) in its capacity as a claims administrator, since, by its plain terms, § 502(a)(1)(B) does not preclude suits against claims administrators. United has absolute discretion to make claims decision and if United's actions violated Denbo's rights under ERISA, United is the only entity capable of providing direct relief to Denbo. The court held that where the claims administrator has "sole and absolute discretion" to deny benefits and makes "final and binding" decisions as to appeals of those denials, the claims administrator exercises total control

over claims for benefits and is an appropriate defendant in a § 502(a)(1)(B) action for benefits. This holding is in accord with six other circuits: 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup>.

With respect to United's challenge that it cannot be held liable under § 502(a)(3) for violations of the Parity Act because it is the claims administrator of a self-funded plan, the court held that § 502(a)(3) may impose a fiduciary duty arising indirectly from the Parity Act even if the Parity Act does not directly impose such a duty. And, because § 502(a)(3) admits of no limit on the universe of possible defendants, the court held that United is a proper defendant for Denbo's Parity Act claim under § 502(a)(3). The court found that the dismissal of Denbo's § 502(a)(3) claims on the ground that adequate relief is available under § 502(a)(1)(B) was premature. The court explained that the U.S. Supreme Court's decision in *Varity Corp.* did not eliminate a private cause of action for breach of fiduciary duty when another potential remedy is available. Instead, if a plaintiff succeeds on both claims, the district court's remedy is limited to such equitable relief as is considered appropriate. Here, the court found that it is not clear at the motion-to-dismiss stage of the litigation that monetary benefits under § 502(a)(1)(B) alone will provide Denbo a sufficient remedy. If, on remand, Denbo prevails on his claims under both § 502(a)(1)(B) and § 502(a)(3), the district court will determine whether equitable relief under § 502(a)(3) is appropriate. To the extent Denbo seeks redress for United's past breaches of fiduciary duty or seeks to enjoin United from committing future breaches, the relief sought would count as "equitable relief" under § 502(a)(3).

**Following remand and *Dudenhoeffer*, court again dismisses consolidated action against ESOP fiduciaries for alleged imprudent investments in Lehman stock.** In [\*In re Lehman Bros. Sec. & ERISA Litig.\*, No. 09-MD-2017 LAK, F.Supp.3d](#), 2015 WL 4139978 (S.D.N.Y. July 10, 2015), following remand by the Supreme Court in light of *Dudenhoeffer*, the court considered Plaintiffs Third Consolidated Amended Complaint ("TCAC"). Count I alleged that the Plan Committee Defendants knew or should have known, based on *public* information, that investment in Lehman had become increasingly risky throughout 2008 and that these defendants breached their fiduciary duty by failing to consider the prudence of continuing to invest in Lehman during this period. Count II alleged that there were "special circumstances affecting the reliability of the market price of Lehman stock as an unbiased assessment of Lehman's value." This included orders issued by the Securities and Exchange Commission ("SEC") in July 2008 that prohibited short selling the securities of certain large financial services firms, including Lehman. Plaintiffs asserted two alternative claims. Count III alleged that the Plan Committee Defendants breached their fiduciary duties by failing to investigate nonpublic information regarding the risks facing Lehman. Plaintiffs argued that they would have uncovered nonpublic information revealing the imprudence of continuing to invest in the company. Count IV claims that defendant Fuld inadequately monitored the Plan Committee Defendants and possessed nonpublic information about the risks facing Lehman and breached an alleged duty to share it with the Plan Committee Defendants.

The court dismissed Counts I and II, finding that they fail to allege plausibly that the Plan Committee Defendants breached their duty of prudence based on public information. Notwithstanding the July 2008 SEC orders, the court found that the TCAC did not allege facts or circumstances sufficient to have alerted the Plan Committee Defendants that Lehman was an imprudent investment. With respect to Count III, the court questioned how it should evaluate claims about whether an ESOP fiduciary's actions would have caused "more harm than good" to ESOP participants, noting that at least one court has adopted the view that this question ought to be a matter for expert proof and is inappropriate for disposition on a motion to dismiss. The court expressed skepticism that terminating the Plan as an investment option or disclosing the alleged inside information would have helped the Plan more than hurt it, but concluded that it need not resolve the question of how to assess such claims on a Rule 12(b)(6) motion since it found the basis for Plaintiffs' duty to investigate claim to be insufficient. Lastly, with respect to Count IV, the court found that the duty to monitor claim against Fuld fails because the TCAC failed to allege plausibly any primary breach of fiduciary duty on the part of the Plan Committee Defendants and allege a plausible duty to monitor claim in the absence of a breach of fiduciary duty. As such, the court found that Plaintiffs' separate claim that Fuld violated a fiduciary duty to provide the Plan Committee Defendants with nonpublic information fails as a matter of law.

***Tibble* does not impact dismissal of breach of fiduciary claims related to ESOPs.** In [\*In re Citigroup ERISA Litig.\*, No. 11 CV 7672 JGK, F.Supp.3d](#), 2015 WL 4071893 (S.D.N.Y. July 6, 2015), the court denied Plaintiffs' motion for reconsideration of the court's dismissal of their Third Consolidated Amended Complaint, alleging breach of fiduciary duties based on Defendants' purported mismanagement of Plaintiffs' employee stock ownership plans ("ESOPs"). Plaintiffs argued that the Supreme Court's decision in *Tibble v. Edison Int'l*, 135 S.Ct. 1823 (2015) compels reconsideration of the court's decision that Plaintiffs' claims were time-barred and failed to show any special circumstances that would have made it imprudent for Defendants to rely on market valuations of Citigroup common stock. The court found that *Tibble* has little in common with this case since it did not concern ESOPs or the duties of fiduciaries faced with a drop in the price of company stock held by such plans. ERISA's statute of limitations bars a claim after "the earlier of" (1) six years after "the date of the last action which constituted a part of the breach or violation ..." or (2) "three years after the earliest date on which the plaintiff had actual knowledge of the breach of violation." *Tibble* only addressed the six-year statute of limitations in § 1113(1) but this court dismissed Plaintiffs' claims based on the three-year statute of limitations in § 1113(2) because Plaintiffs acquired actual knowledge of the alleged violations more than three years before they filed the Complaint. Lastly, *Tibble*'s reaffirmation of ERISA's reliance on trust law did not involve claims based on a drop in an employer's stock price. Rather, *Tibble* concerned allegations of buying mutual funds at a retail price when they could have been obtained more cheaply at an institutional price. The court

concluded that Plaintiffs have not shown any change in controlling law that warrants reconsideration of the court's prior opinion.

**Imprudent investment claims are time-barred and fail to state viable breach of fiduciary duty claims.** In [\*In re Citigroup Erisa Litig.\*, No. 11 CV 7672 JGK, F.Supp.3d](#), 2015 WL 2226291 (S.D.N.Y. May 13, 2015), Plaintiffs allege that Defendants violated their fiduciary duties of prudence and loyalty by allowing the Plans to continue to hold and purchase Citigroup stock despite abundant public information regarding Citigroup's precarious condition and the riskiness of Citigroup stock. Plaintiffs also allege a duty of prudence claim based on Defendants' failure to respond prudently to nonpublic information. Plaintiffs allege further claims for the failure of Citigroup, Citibank, and the Director Defendants to monitor and adequately inform other fiduciaries, and a claim for co-fiduciary liability against all defendants. Defendants moved to dismiss the Third Consolidated Amended Complaint pursuant to FRCP 12(b)(6). The court found that Plaintiffs' ERISA claims are time-barred because Plaintiffs had knowledge of all of the facts necessary to constitute their ERISA claims prior to December 8, 2008 and they did not file the present action until December 8, 2011. The court determined that one defendant's 2008 public statement that Citigroup was "entering 2009 in an even stronger position than [it] entered 2008," cannot be termed "concealment" for purposes of the ERISA statute of limitations because it did not wipe away the actual knowledge that Plaintiffs had of the perilous condition of Citigroup, the precipitous drop in the stock price, and the continued availability of the Citigroup Common Stock Fund as an investment option in the Plans.

The court found that Plaintiffs did not have standing to bring breach of fiduciary duty claims under the Citibuilder Plan because it is only available to employees who are bona fide residents of Puerto Rico or who perform services primarily in Puerto Rico and there are no named plaintiffs that qualify as participants or beneficiaries for the Citibuilder Plan. The court also dismissed all claims against defendants other than the Investment Committee and Administration Committee members because they depend on allegations that those defendants breached fiduciary duties that they did not have. The allegation that Citigroup may direct the trustee (Citibank) to receive company stock in lieu of cash dividends and to sell the shares so acquired, or an equivalent number of shares already held in the Trust, at such market price, is not enough to constitute fiduciary conduct. The court also determined that because Plaintiffs did not identify any special circumstances rendering reliance on the market price of the stock imprudent, *Dudenhoeffer* requires that their duty-of-prudence claim based on publicly available information be dismissed. With respect to the claim that the fiduciaries failed to act prudently in response to nonpublic information, the court dismissed this claim because Plaintiffs did not sufficiently allege that there was any material, nonpublic information to be disclosed. Lastly, the court dismissed the breach of the duty to monitor and for co-fiduciary liability claims since there were no antecedent breaches.

In [Taveras v. UBS AG, No. 14-4009, Fed.Appx. , 2015 WL 1934576 \(2d Cir. Apr. 30, 2015\)](#), the court determined that the district court did not err in denying the Plus Plan Plaintiffs' motion to revive their duty-of-prudence claims in light of the Supreme Court's decision in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S.Ct. 2459 (2014). In March 2011, the district court granted Defendants' motion to dismiss the entire consolidated Amended Complaint, including the Plus Plan Plaintiffs' duty-of-prudence claims, holding that the fiduciaries of both plans were entitled to the then-established "presumption of prudence" under *Moench*. On appeal from the final judgment, the Second Circuit affirmed the dismissal of all of the Plus Plan Plaintiffs' claims and denied their motion for panel rehearing or rehearing en banc on their duty-of-prudence claims. The time to petition for a writ of certiorari expired on August 5, 2013, rendering the judgment dismissing those claims final.

#### D. Third Circuit

**Breach of fiduciary duty and disgorgement claims dismissed where LTD claim for benefits provides an adequate remedy.** [Hilbert v. The Lincoln National Life Insurance Company, No. 1:15-CV-0471, 2015 WL 8150418 \(M.D. Pa. Dec. 8, 2015\)](#) (Judge Sylvia H. Rambo). Plaintiff claimed that Lincoln National wrongfully denied her long term disability benefits and, in doing so, breached its fiduciary duties. Plaintiff provided the following 8 bases upon which she asserts Defendant breached its fiduciary duties: 1) establishing a claims process in which its claims personnel systematically delay claims decisions; 2) establishing a claims process in which its claims personnel automatically accept the opinions of its paid medical reviewers; 3) establishing a claims process in which its claims personnel do not seek to reach an accurate decision, but instead only seek to render a reasonable decision; 4) establishing a claims process in which it places financial interests ahead of the participants and beneficiaries; 5) establishing a claims process in which it does not consult with health care professionals with appropriate training and experience; 6) establishing a claims process that requires two levels of appeal, but fails to render decisions within the timelines mandated by ERISA; 7) establishing a claims process that does not accurately apply the plan terms as written, but alters and adds terms for its own benefit; and 8) establishing a claims process in which it does not seek independent and unbiased medical opinions, but instead seeks opinions favorable to its own financial interests. Defendant moved for judgment on the pleadings with respect to Plaintiff's breach of fiduciary duty and disgorgement claims. The court concluded that Plaintiff is limited to a denial of benefits claim under § 1132(a)(1)(b), and granted Defendant's motion in its entirety. The court relied on *Varity Corp. v. Howe*, 516 U.S. 489 (1996) for the proposition that if a plaintiff is seeking a remedy under the terms of a plan, Section 1132(a)(1)(B) is the exclusive vehicle for bringing claims for breaches of fiduciary duty with respect to the interpretation of plan documents and the payment

of claims. Because Plaintiff did not allege that she suffered any additional injury (besides the lost benefits), Section 1132(a)(1)(B) provides her with adequate relief and there is no need for further equitable relief as any potential fiduciary breach can be fully remedied by an award of benefits.

**Plaintiff adequately alleged a breach of fiduciary duty claim for failing to provide adequate notice of life insurance conversion.** [Brady v. AIRGAS, Inc., No. 15-4099, 2015 WL 6599750 \(E.D. Pa. Oct. 30, 2015\)](#) (Judge Jan E. DuBois). The sole claim in this case alleges that Airgas breached its fiduciary duty to its former employee (now deceased) by failing to provide adequate notice of his right to convert his group life insurance to individual policies. Plaintiff, the widow and executor of the estate, seeks an equitable award of surcharge in the full amount of the life insurance policies pursuant to 29 U.S.C. § 1132(a)(3)(B). The court denied Defendant's motion to dismiss. Taking as true Plaintiff's allegation that the decedent never received the summary plan descriptions for the life insurance plans and the only relevant notices are a termination letter and two conversion notices (which allegedly did not describe the eligibility or terms for conversion of the life insurance), the court found that Plaintiff has alleged sufficient facts to present a plausible claim that there is a substantial likelihood of confusion for a reasonable employee making a retirement decision. With respect to detrimental reliance, the court noted that the decedent failed to convert the policy following receipt of the conversion notices and his subjective motivation for failing to renew the policy is a fact issue inappropriate for resolution in a motion to dismiss.

[Perez v. Am. Health Care, Inc. 401\(k\) Plan, No. CIV. 2:15-0377 WJM, 2015 WL 5682446 \(D.N.J. Sept. 25, 2015\)](#). The court granted the Secretary of Labor's motion to enter default judgment and appoint an independent fiduciary in order to terminate the America Health Care, Inc. 401(k) Plan and distribute its assets to its beneficiaries.

[Perez v. First Bankers Trust Servs., Inc., No. CV124450MASDEA, 2015 WL 5722843 \(D.N.J. Sept. 29, 2015\)](#). In a matter arising from the SJP Group, Inc. Employee Stock Ownership Plan's purchase of thirty-eight percent of the outstanding stock of SJP Group, Inc., a total of 380,000 shares, from DiPano for \$16 million, the DOL brought this action alleging, among other things, that Defendant failed to conduct a thorough review of the valuation, to read and understand the valuation documents, to verify that the conclusions of the valuation were consistent with the data and analyses, to verify that the valuation was internally consistent and sensible, and to hire a second valuator if warranted. The court denied Plaintiff's motion to preclude the expert opinions of Bradley Van Horn and Joel Stoesser without prejudice. It granted in part and denied in part Plaintiff's motion to preclude the expert opinion of Steven Fischer. The court denied FBTS's

motion to preclude the expert opinion of Richard Puntillo without prejudice. Lastly, the court denied Defendants' motions for summary judgment.

In [Huffman v. Prudential Ins. Co. of Am., No. 10-CV-5135, 2015 WL 4486676 \(E.D. Pa. July 22, 2015\)](#), a putative class action challenging Prudential's practice of investing death benefits due under ERISA-governed employee plans for Prudential's own account, the court granted Plaintiffs' Motion for Leave to File an Amended Complaint. The Amended Complaint asserts that insurance contracts purchased by employers are plan assets and asserts a new prohibited transaction theory under ERISA § 406(a) based on a new theory that Prudential is a "party in interest" of the plans whose fiduciaries have purchased a Prudential contract to provide benefits, and has received unreasonable compensation. The Amended Complaint also adds a common law cause of action for breach of fiduciary duty with respect to profiting from investment of funds backing the retained asset accounts to the extent ERISA does not govern this conduct. It withdraws the request for class certification under Rule 23(b)(1) and (2) and eliminates the request for injunctive relief. The court rejected Defendant's argument that the amendment is futile, given the current state of the law governing use of retained asset accounts; and the request for leave to amend was unduly delayed and the amendment, if permitted, will prejudice Prudential.

**Plan participant has no standing to seek monetary relief and disgorgement of profits against breaching fiduciary where Plaintiff suffered no individual harm.** In [Perelman v. Perelman, No. 14-1663, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4174537 \(3d Cir. July 13, 2015\)](#), Plaintiff, a plan participant, brought suit against his employer, pension plan administrator, and plan trustee, alleging that plan administrator breached his fiduciary duties by investing plan assets in the trustee's brother's company, and failing to disclose investments as party-in-interest transactions. In affirming the decision of the district court, the Third Circuit held that Plaintiff lacked standing to seek monetary relief and disgorgement of profits, and the district court did not abuse its discretion by declining to award attorneys' fees. The Third Circuit found that Plaintiff did not have constitutional standing because he did not suffer injury-in-fact since the plan was appropriately funded. Plaintiff did not have standing to seek disgorgement of profits based on the fiduciary's failure to report party-in-interest transactions since he could not show an individual right to the fiduciary's profit. The court rejected Plaintiff's argument that he need not prove an individualized injury insofar as he seeks monetary equitable remedies in a "derivative" or "representative" capacity on behalf of the Plan. With respect to fees, the court disagreed with the district court that Plaintiff did not achieve a level of substantive success. After the filing of the lawsuit, an independent trustee was appointed, some Plan losses were reimbursed, Plan records were amended to reflect party-in-interest transactions, and trustee-indemnification provisions were modified or removed. These changes were made to "get rid of this case." Although these

victories were substantive, the district court nonetheless did not abuse its discretion in declining to award fees after considering the *Ursic* factors: (1) the offending parties' culpability or bad faith; (2) the ability of the offending parties to satisfy an award of attorneys' fees; (3) the deterrent effect of an award of attorneys' fees against the offending parties; (4) the benefit conferred on members of the pension plan as a whole; and (5) the relative merits of the parties' positions.

In [\*Hoover v. Besler\*, No. CIV.A. 14-5786 MAS, 2015 WL 4027472 \(D.N.J. June 30, 2015\)](#), Plaintiff alleged that, as a result of the sale of the improperly valued stock, she and other ESOP participants received less than the fair market value of certain stock held in their individual ESOP accounts. The complaint alleges no claims against the ESOP but joined the ESOP a party Defendant pursuant to Rule 19(a) "solely to assure that complete relief can be granted." The ESOP sought to be dismissed from the action and the court dismissed the ESOP, finding that Plaintiff did not show that the ESOP is a necessary party under Rule 19.

In [\*Johnson & Towers, Inc. v. Corporate Synergies Grp., LLC\*, No. CIV. 14-5528 NLH/KMW, 2015 WL 3889438 \(D.N.J. June 23, 2015\)](#), Plaintiffs brought suit against their insurance brokers for failing to obtain stop-loss insurance that would pay for coverage of a widowed spouse of one of the company's shareholders. The court found that Plaintiffs have statutory standing under ERISA Section 502(a)(2) to bring a claim as fiduciaries to recover losses to the Plan. The court also found that the diminution in the value of the Plan's assets demonstrates that the Plan has suffered a concrete and particularized injury as a result of Defendants' alleged failure to procure appropriate stop-loss insurance coverage. As such, the court found that Plaintiffs have demonstrated that they satisfy the "injury in fact" requirement for constitutional standing.

In [\*Spear v. Fenkell\*, No. CIV.A. 13-02391, 2015 WL 518235 \(E.D. Pa. Feb. 6, 2015\)](#), the court dismissed a counterclaim seeking contribution and equitable indemnification under federal common law and state law, finding that ERISA does not permit contribution claims by non-fiduciaries in response to ERISA liability under *Harris Trust and Savings Bank v. Salomon Smith Barney*, 530 U.S. 238 (2000). The court explained that the rationale of *Chemung Canal Trust Co. v. Sovran Bank/Maryland*, 939 F.2d 12, 16 (2d Cir.1991), the seminal case providing for contribution between co-fiduciaries faced with ERISA liability, has been undercut in the years since the decision, and that it should not be extended to provide a contribution claim for non-fiduciaries.

In [Perez v. Koresko, No. CIV.A. 09-988, 2015 WL 505471 \(E.D. Pa. Feb. 6, 2015\)](#), the Secretary of Labor brought suit against Defendants for violating their ERISA fiduciary duties in connection with a multiple-employer employee death benefit arrangement. The court held a three-day bench trial and found for the Secretary on all claims. The Court concluded that the plans at issue are employee welfare benefit plans as defined by ERISA; that the plans have plan assets in the form of employee contributions, insurance policy proceeds, and earnings therefrom; and that the defendants are ERISA fiduciaries with respect to those plan assets. The defendants' violations of ERISA included: (1) the diversion of tens of millions of dollars of plan assets through more than 21 accounts in the names of more than 18 different entities at 8 or more different banks; (2) the transfer of millions of dollars of plan assets into accounts which only Mr. Koresko controlled and which were out of the reach of the Trustee; (3) the taking out of over \$35 million in loans on the Trusts' insurance policies, and the transfer of the resulting monies to accounts which only Mr. Koresko controlled and which were out of the reach of the Trustee; (4) the creation and subsequent depositing of plan assets into various IOLTA accounts and accounts in Mr. Koresko's personal name; (5) the transfer of millions of dollars of plan assets to law firms and consulting firms, from which neither the plans nor the beneficiaries benefitted, and only the defendants benefitted; (6) the use of death benefit proceeds to purchase property in the Caribbean island of Nevis and in South Carolina in Mr. Koresko's personal name; (7) the use of plan assets to pay Mr. 'expenses, including utility bills and boat rentals; and (8) the use of plan assets to pay the defendants directly. The court removed the defendants from any position of fiduciary authority and permanently barred the defendants from ever serving as fiduciaries or service providers to ERISA-covered plans. The court also found the Koresko Defendants liable for \$19,852,114.88 in restitution for losses and disgorgement of profits.

E. Fourth Circuit

**Defendant is a fiduciary with respect to the making of employee contributions notwithstanding language in plan disclaiming responsibility.** [Longo v. Trojan Horse Ltd., No. 5:13-CV-418-BO, 2015 WL 7015841 \(E.D.N.C. Nov. 12, 2015\)](#) (Judge Terrence W. Boyle). In breach of fiduciary duty claim against Ascensus Trust, the court decided the issue of whether it is a fiduciary with regard to the marking of employee contributions. Although Defendant appeared to have included language in the Plan to try to escape responsibility for ensuring Plan contributions were made, the Trust Agreement and Basic Plan Document expressly provide that Defendant is responsible for ensuring that Plan contributions were made. The court found that Defendant's attempt to evade liability via the language in the Plan cannot take precedence over the discretion conferred upon Ascensus Trust to manage contributions by the documents themselves. The court rejected Defendant's argument that it is not a fiduciary because of its role as a directed trustee.

[GREENBRIER HOTEL CORPORATION, et al., Plaintiffs, v. UNITE HERE HEALTH, et al., Defendants., No. 5:13-CV-11644, 2015 WL 5626514 \(S.D.W. Va. Sept. 24, 2015\).](#) The court denied summary judgment on the issues of whether the decision(s) of the Trustees to (i) amend Plan documents and (ii) not remit excess assets breached fiduciary duties. The court found that there remains a genuine dispute of material fact as to whether the Trustee-Defendants breached their fiduciary duties by amending the plan documents to purportedly bolster their (subsequent) position of denying a transfer of the excess assets. In the light most favorable to Plaintiffs, the facts and inferences therefrom indicate that the Defendants amended certain plan documents before making the decision not to transfer excess assets.

In [Betts v. Benefit Solutions, Inc., No. CIV.A. 3:13-11772, 2015 WL 4772568 \(S.D.W. Va. Aug. 12, 2015\)](#), Plaintiffs brought suit against Defendants for breach of fiduciary duties for allegedly causing Retirement Plan assets to be off the market for two weeks. Defendants filed a third-party complaint against Hartford seeking indemnity and contribution. Hartford filed a motion for summary judgment, which the court granted. The court found that assuming Defendants are liable to Plaintiffs, Defendants did not identify any direct act or omission on the part of Hartford to justify the delays in the liquidation, transfer, or reinvestment of Plan funds. The only faults to be found related to delays in the liquidation, transfer, or reinvestment of Plan funds are the result of Defendants' independent acts and omissions. Hartford had no express or implied obligation to adequately direct Defendants' actions. Further, to the extent that Hartford may have assumed a coordinating role, the court found that Hartford made every reasonable effort to prompt Defendants to fulfill their obligations. Even if some fault may be attributed to Hartford, Defendants were not without fault. As a matter of law, Defendants are not entitled to implied indemnification from Hartford.

In [Malinowski v. Lichter Grp., LLC, No. CIV. WDQ-14-917, 2015 WL 857511 \(D. Md. Feb. 26, 2015\)](#), Plaintiffs alleged that Lichter provided professional services to protect Hicks, in his individual capacity, and made negligent misrepresentations in Form 5500s to shield Hicks from personal liability and criminal sanctions. Plaintiffs filed a class action complaint, suing the Defendants for breach of fiduciary and statutory duties under ERISA. Defendants moved to dismiss and Plaintiffs sought leave to file an amended complaint. The court found that Letters of Engagement referenced by Plaintiffs show that Lichter informed Hicks about its fees, thus complying with ERISA section 408(b)(2), and was not hired to prepare the Form 5500s that it allegedly failed to disclose its fees on. Accordingly, the Plaintiffs' allegation that Lichter's fees were unreasonable, would not survive a motion to dismiss. The court also found that Plaintiffs' allegation that Lichter's services were unnecessarily rendered to prevent Hicks's personal liability is unreasonable in light of other allegations that Lichter was retained, and paid, to audit the Plan, and Trojan Horse and Lichter entered into Letters of Engagement for that purpose. The

court held that Plaintiffs have failed to state a claim under ERISA section 406(a), and its amendment would be futile.

In [Winburn v. Progress Energy Carolinas, Inc., No. 4:11-CV-03527-RBH, 2015 WL 505551 \(D.S.C. Feb. 6, 2015\)](#), the court found that Plaintiff's claim for equitable relief fails to allege an actionable violation of ERISA against Prudential because Prudential was not responsible for communicating with plan participants about plan terms. ERISA allocates to the plan administrator the responsibility for providing notice of plan provisions and changes that affect the benefits of all. Further, the plan documents specifically designate Progress Energy with the responsibility to comply with all requirements of the law with respect to notice and disclosure and to prepare and distribute information explaining the Plan and the applicable Component Plans. Thus, even if there was a failure to provide any required notice, Prudential is not the Plan Administrator and cannot be held liable for such failure. The court granted Prudential's motion for judgment as to the breach of fiduciary duty claim on the basis that, as claims administrator and not plan administrator, it would have no liability for breach of fiduciary duty.

#### F. Fifth Circuit

**Disability insurer's initial denial of short-term disability benefits based on determination that the claimant had no coverage as of date of disability is not misrepresentation constituting a breach of fiduciary duty.** [Browdy v. Hartford Life & Acc. Ins. Co., No. 15-30044, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 7252717 \(5th Cir. Nov. 16, 2015\)](#) (STEWART, Chief Judge, and BARKSDALE and PRADO, Circuit Judges). The Fifth Circuit affirmed the district court's determination that Hartford's initial denial of short-term disability benefits based on its finding that Plaintiff had no coverage (which was later overturned on appeal) constitutes a misrepresentation and resulting breach of fiduciary duty. Plaintiff sought to prevent Hartford from taking as an offset pension benefits that she elected to receive prior to Hartford's approval of benefits. She alleged that she only applied for her pension because her disability benefit claim was denied. In challenging the summary judgment awarded Hartford, Plaintiff contended the court erred by: articulating the breach-of-fiduciary-duty standard as one of bad faith; ruling she presented no facts in support of misrepresentation; and failing to consider Plaintiff's evidence in a cumulative fashion. Hartford argued that Plaintiff's claim is foreclosed because she impermissibly re-packaged her original § 502(a)(1)(B) claim as one under § 502(a)(3). The First Circuit explained that it need not reach Hartford's contention because, even assuming, arguendo, Plaintiff's claim may be considered under § 502(a)(3), summary judgment for Hartford was proper. The court found that because Plaintiff presented no evidence of misrepresentation constituting a breach of fiduciary duty, it need not reach her assertions concerning the court's claimed improper application of a bad-faith standard.

**Following reconsideration in light of *Dudenhoeffer*, the court dismisses most of the amended complaint related to investment in BP Stock Fund.** [In re BP p.l.c. Sec. Litig., No. 4:10-CV-4214, 2015 WL 6674576 \(S.D. Tex. Oct. 30, 2015\)](#) (Judge Keith P. Ellison). Plaintiffs allege that Defendants breached their fiduciary duties to the Plan from January 16, 2007 to June 24, 2010 and assert two general theories of liability (“Count I” and “Count II,” respectively): (1) The “Insider Defendants” and “Corporate Defendants” breached their duties of prudence and loyalty by permitting Plan participants to invest in the BP Stock Fund, and (2) The “Designated Officer Defendants,” the “Appointing Officer Defendants,” the Savings Plan Investment Oversight Committee Defendants (the “SPIOC”), the “Board Defendants,” and the Corporate Defendants breached their duties to adequately monitor other fiduciaries and provide them with accurate information. Plaintiffs contend that Defendants’ actions and/or inaction cost Plan participants hundreds of millions of dollars in losses following the Deepwater Horizon explosion. The court granted Defendants’ motion to dismiss in its entirety. All claims against the Corporate Defendants, Anthony Hayward, and Lord John Browne are dismissed; Count I of the Complaint is dismissed to the extent that it is based on a Defendant’s role as a Designated Officer or member of the Board of Directors; Count II of the Complaint is dismissed in its entirety; and Plaintiffs’ demand for a jury trial is stricken.

**“Plan Manager” is not in an ERISA fiduciary.** In [\*Humana Health Plan, Inc. v. Nguyen\*, No. 14-20358, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 2205661 \(5th Cir. May 11, 2015\)](#), the Fifth Circuit determined that the district court erred in determining that Humana, a “Plan Manager” providing administrative services to the API Enterprises Employee Benefits Plan, is an ERISA fiduciary. In this matter, the Plan determined that Defendant’s settlement from an uninsured motorist policy was not subject to the Plan’s subrogation provisions. Humana disregarded the Plan and sued Defendant seeking, *inter alia*, an injunction prohibiting him from disposing of the insurance payout and an equitable lien to enforce ERISA and the terms of the Plan. The court explained that the subrogation and recovery services clause in the Plan Management Agreement (PMA) did not show that Humana had discretion over the Plan or its assets. Even if the PMA gave Humana broad power, the district court failed to explain why Humana is not a ministerial agent since its various duties outlined in the subrogation and recovery clause describe the tasks performed by many law firms and collections agencies. The mere fact that Humana serves as the Plan’s legal or collections agent is insufficient to show that Humana was the Plan’s fiduciary absent specific facts that show that Humana exercised discretion as described in § 1002(21)(A)(i) and (iii). As such, the court held that Humana does not have the statutory right to seek relief against Defendant under 29 U.S.C. § 1132(a)(3). Because the district court based its decision on its interpretation of the subrogation and recovery clause, the court did not consider other evidence that might show whether Humana exercised actual, decision-making authority over the Plan or its assets.

In [\*In re BP p.l.c. Sec. Litig.\*, No. 10-MD-2185, 2015 WL 926199 \(S.D. Tex. Mar. 4, 2015\)](#), the court modified its order granting leave to amend to certify the following question for immediate, interlocutory appeal under 28 U.S.C. § 1292(b):

What plausible factual allegations are required to meet the “more harm than good to the fund” pleading standard articulated by the Supreme Court in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S.Ct. 2459, 2472–73 (2014).

However, the court declined the stay the proceedings pending the Fifth Circuit’s decision since this matter has been pending for over four years and Plaintiffs have been unable to move the litigation past the pleadings stage and into discovery.

#### G. Sixth Circuit

**Breach of fiduciary duty claim relating to amendment eliminating COLA benefit is dismissed because same injury can be adequately remedied by a claim for benefits.** [\*Johnson v. AXA Equitable Long Term Disability Plan\*, No. 13-13067, 2015 WL 7075910 \(E.D. Mich. Nov. 13, 2015\)](#) (Judge Arthur J. Tarnow). Plaintiff a claim for breach of fiduciary duty pursuant to 29 U.S.C. § 1132(a)(3), alleging that Defendants violated their fiduciary duties by failing to verify that the COLA-eliminating amendment followed plan procedures and by depriving participants of COLAs despite knowing that the amendment was invalid. Plaintiff sought a surcharge of the wrongfully withheld benefits and disgorgement of Defendants’ profits. Defendants argued that Plaintiff’s breach of fiduciary duty claim must be dismissed because it asserts the same injury as Plaintiff’s claim for benefits, which can be adequately remedied by the claim for benefits. The Court agreed. But, as noted below, the court dismissed the benefits claim as being time-barred.

**In ESOP case, fiduciary investment decision to continue to buy and not sell GM common stock is not actionably imprudent.** [\*Pfeil v. State St. Bank & Trust Co.\*, No. 14-1491, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 6874769 \(6th Cir. Nov. 10, 2015\)](#) (BOGGS, J., delivered the opinion of the court in which SUHRHEINRICH, J., joined. WHITE, J. delivered a separate dissenting opinion). In suit brought by participants in employee stock ownership plan (ESOP) against plan fiduciary, alleging that it breached its fiduciary duty under ERISA to manage plan’s assets prudently, the Sixth Circuit affirmed the district court’s grant of summary judgment in favor of the fiduciary. The majority held that: 1) a plaintiff claiming that an ESOP’s investment in a publicly traded security was imprudent must show special circumstances to survive a motion to dismiss; 2) participants failed to show a special circumstance such that fiduciary should not have relied on market pricing in determining whether to continue to buy and to decline to sell employer’s

common stock during the relevant period; and 3) fiduciary's actual processes for monitoring employer's stock demonstrated the requisite prudence.

**Where complaint alleges only an injury for which § 1132(a)(1)(B) provides an adequate remedy, it fails to state a plausible claim for breach of fiduciary duty or disgorgement.**

[Gluc v. The Prudential Insurance Company of America, No. 3:14-CV-519-DJH-DW, 2015 WL 6394522 \(W.D. Ky. Oct. 22, 2015\)](#) (Judge David J. Hale). Plaintiff alleged that the termination of her long-term disability benefits was based on a number of errors, including speculation as to her future condition; reliance on outdated data, including a functional capacity evaluation from 2012; and failure to seek further medical examination or explain why it disagreed with her treating physician. In addition to a claim for benefits, Plaintiff brought a claim for breach of fiduciary duty. The court found that the alleged injury can be remedied through § 1132(a)(1)(B). Though Plaintiff alleges numerous flaws in Prudential's claims process, ultimately, the only injury she purports to have suffered is loss of benefits—an injury § 1132(a)(1)(B) is designed to address.

**Breach of fiduciary duty claim related to denial of long-term disability benefits does not meet *Iqbal* standard and must be dismissed.** [Myers v. Anthem Life Insurance Company, No. 3:14-CV-00948-JHM, 2015 WL 6394524, at \\*2 \(W.D. Ky. Oct. 21, 2015\)](#) (Judge Joseph H. McKinley, Jr.). Plaintiff's complaint alleges that she submitted a claim for long-term disability benefits to Defendant, and Defendant subsequently denied the claim and later appeal despite her continuing disability and adverse effects of her medication. The court found that the complaint is "glaringly bereft" of any reference to Defendant's breach of fiduciary duty or to any facts that could lead a reader to infer a breach of fiduciary duty. The court further found that Plaintiff has not provided any facts, apart from those surrounding her denial of benefits claim under § 1132(a)(1)(B), for the court to even guess what the § 1132(a)(3) claim for equitable relief might entail.

[\*In re Trans-Indus., Inc.\*, No. 06-43993, 2015 WL 5635278 \(Bankr. E.D. Mich. Sept. 25, 2015\).](#)

In this bankruptcy proceeding, the breach of fiduciary duty claims are based on (1) the Plan's purchase of 19,000 shares of Series A Preferred Stock of Trans-Industries, Inc. on June 5, 2001 (the "Acquisition Claim"); (2) the Plan's retention of that preferred stock for a period of several years thereafter, and the Plan's retention of the Debtor's common stock allegedly in amounts too great and for too long (the "Retention Claims"); and (3) a series of transactions between the Plan, Debtor, Coenen, and Fields in 2005, which resulted in Coenen and Fields receiving lump sum cash distributions of the entire amount of their vested interests in the Plan, and which left the Plan unable to satisfy its obligations to all of the other Plan participants (the "Distribution Claim"). The court concluded that 11 U.S.C. § 108(a) has no practical impact on ERISA's

statute of limitations for the Trustee's breach of fiduciary duty claims and none of the Trustee's claims are barred by ERISA's 3-year statute of limitations. But, ERISA's 6-year limitations period bars some, but not all, of the Trustee's Retention Claims. It does not bar the Distribution Claim. The court denied summary judgment to any of the parties on the Trustee's Retention Claim and Distribution Claim, finding the genuine issues of material fact include whether, during the time period after December 14, 2001, the Plan could have divested itself of the preferred and common stock in a way that would have avoided or reduced the alleged losses to the Plan, and if so, when and how this could have been done, and by how much this would have reduced or avoided the alleged losses to the Plan. The court rejected one defendant's argument that he had no discretion in permitting the distributions to Coenen and Fields because the Plan required distributions of a participant's entire vested balance if that individual was terminated. The court discusses in length who is an ERISA fiduciary.

[\*Loo v. Cajun Operating Co.\*, No. 14-CV-10604, 2015 WL 5460693 \(E.D. Mich. Sept. 17, 2015\).](#)

In a matter alleging breach of fiduciary duty against an employer for failing to inform a now-deceased insured that to qualify for supplemental coverage over \$300,000, she had to submit an EIF certifying the state of her health at the time her coverage crossed the \$300,000 threshold, the court dismissed the cross claim against Reliance, the insurer. In so doing, the court found that the Plan does have standing to sue and that misjoinder is not a sufficient basis to dismiss the Plan as a cross-plaintiff. However, the claims against Reliance are futile because the court concluded the breach occurred in 2008 and Reliance did not purportedly become a fiduciary until 2010, after the breach had occurred. Even if Reliance was a co-fiduciary of the employer, no right of co-fiduciary indemnification exists.

[\*Deschamps v. Bridgestone Americas, Inc. Salaried Employees Ret. Plan\*, No. 3:12-CV-86, 2015 WL 5254338 \(M.D. Tenn. Sept. 9, 2015\).](#)

Plaintiff brought claims against Defendants based on Defendants' promise that the Plan would count, for pension calculation purposes, Plaintiff's years of service at the Joliet plant before he transferred to Bridgestone. The court granted Plaintiff's motion with respect to his claims for equitable estoppel, breach of fiduciary duty, and violation of ERISA's "anti-cutback" provision. The court denied Plaintiff's motion on the claims for contract reformation and the claims brought under North Carolina state law.

In [\*Murray v. Invacare Corp.\*, No. 1:13 CV 1882, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 5093438 \(N.D. Ohio Aug. 28, 2015\)](#), a putative class action alleging breach of fiduciary duty for imprudent investment, failure to monitor co-fiduciaries, and knowing participation in co-fiduciaries' breaches, the court denied Defendants' Motion to Dismiss Plaintiff's Second Amended Complaint. The court found that Plaintiff sufficiently alleged loss causation under *Dura*

*Pharmaceuticals, Inc. v. Broudo*, 554 U.S. 336 (2005) to sustain the imprudent investment claim. Because the failure to monitor and knowing participation claims are derivative, the court also declined to dismiss these claims.

In [\*Chesemore v. Alliance Holdings, Inc.\*, No. 09-CV-413-WMC, 2015 WL 5093334 \(W.D. Wis. Aug. 28, 2015\)](#), defendant Alliance Holdings, Inc., and nominal defendant Alliance Holdings, Inc. Employee Stock Option Plan sought a post-judgment, temporary restraining order against defendant David Fenkell. They requested: (1) an order requiring Fenkell to restore \$2.044 million to Alliance ESOP within seven days or hold him in civil contempt; (2) an order freezing Fenkell's assets and establishing a constructive trust to cover the \$3.25 million indemnity requirement in the judgment, pending disposition of the Seventh Circuit appeal from this court's final judgment; and (3) an order requiring Fenkell to pay all of their attorneys' fees and costs attendant to obtaining enforcement of the judgment. The court ordered that on or before September 4, 2015, Fenkell is ordered to restore to the Alliance ESOP \$2,044,014.42. The court denied the other aspects of the motion without prejudice.

In [\*Page v. Unimerica Ins. Co.\*, No. 3:12-CV-103, 2015 WL 4549473 \(S.D. Ohio July 27, 2015\)](#), Plaintiff is a beneficiary who brought breach of fiduciary duty claims against her deceased spouse's employer and life insurance claims administrator for alleged miscommunications which led her and her husband to believe that he had continued life insurance coverage after he became disabled and stopped working. The court found that the claims administrator did not make the challenged representations upon which Plaintiff's breach of fiduciary duty claim is based, so it could not have been acting in a fiduciary capacity when the representations were made. For this reason, the court found that the claims administrator is entitled to summary judgment on the breach of fiduciary duty claim against it. With respect to the employer, however, the court found that a reasonable fact-finder could conclude that the representations and omissions were material. Here, the employer failed to respond to Plaintiff's letter and sent an enrollment form concerning her husband's "eligibility under a plan" and "the extent of benefits" he was entitled to as his employment terminated. The employer's failure to respond to the participant's inquiry misled him into thinking that his life insurance premium would continue to be paid by the company, which prevented him from making an adequately informed decision about whether to pursue the conversion option under the Plan. The court also found that no evidence supported the employer's claim that they did not rely on the misrepresentations to Plaintiff's detriment, especially where Plaintiff testified that her, "husband died believing that he was taking care of his family through that life insurance, and [the employer] gave us no reason to believe that it was not [in effect]." As such, the court did not grant summary judgment to the employer for the breach of fiduciary duty claim. Lastly, with respect to the equitable estoppel claim against the employer, the court found there is no evidence to support the elements of Plaintiff's equitable

estoppel claim against employer, and the company cannot be estopped from denying her claim because the Plan did not give it the right to deny it or obligate it to pay the life insurance benefit she seeks. Accordingly, the court granted summary judgment on the equitable estoppel claim.

In [\*Computer & Eng'g Servs., Inc. v. Blue Cross & Blue Shield of Michigan\*, No. 12-CV-15611, 2015 WL 4207150 \(E.D. Mich. July 10, 2015\)](#), the court dismissed BCBSM's counterclaims seeking contribution and indemnification from Plaintiffs. The court followed the weight of authority finding that there is no right of contribution among ERISA co-fiduciaries so the contribution claim is not a viable legal theory. Alternatively, even if Defendant could seek contribution from a co-fiduciary, BCBSM would not be entitled to contribution from Plaintiffs in the present case since BCBSM acted in "bad faith" with regard to the disputed fees.

In [\*Stiso v. Int'l Steel Grp.\*, No. 13-3503, Fed.Appx. , 2015 WL 3555917 \(6th Cir. June 9, 2015\)](#), Plaintiff, a beneficiary of long-term disability insurance, brought action against his employer and insurance provider seeking an equitable remedy equivalent to a 7% per year cost-of-living increase to his benefits. Both the disability plan and the summary of the plan refers to a 7% increase in predisability earnings. The district court granted judgment to the employer and insurance provider. The Sixth Circuit held that: (1) the employer's preparation and furnishing of the plan summary that was misleading as to the benefits it intended to provide was a breach of fiduciary duty; (2) the insurance provider owed a fiduciary duty to the beneficiary; and (3) insurance provider's denial of beneficiary's claim for a cost-of-living increase was a breach of fiduciary duty.

In [\*Greene v. Drobocky\*, No. 1:12-CV-00078-TBR, 2015 WL 1737772 \(W.D. Ky. Apr. 16, 2015\)](#), Plaintiff filed a motion to alter or amend judgment pursuant to Rule 59(e), arguing that the court erred in finding that her employer was not a fiduciary, where Plaintiff alleged that the pension plan administrator removed Plaintiff as a plan participant via a handwritten alteration of the Adoption Agreement per her employer's instruction. The court denied the motion, explaining that it will not depart from the clear precedent indicating that no breach of fiduciary claim arises when an employer acts as a settlor of the plan.

#### H. Seventh Circuit

**Default judgment entered against alleged breaching fiduciary of benefit plans.** [\*Perez v. Hanco, Inc.\*, No. 3:14-CV-1908-PPS-CAN, 2015 WL 6118565 \(N.D. Ind. Oct. 15, 2015\)](#) (Judge Philip P. Simon). The court granted the Secretary's motion for Default Judgment against

Defendant Hanco, Inc., who the Secretary alleged failed to contribute the requisite funds to its employees' 401(k) plans, health plans, and dental plans while it served as fiduciary of those plans. Defendant also allegedly failed to terminate the 401(k) plans and failed to authorize distributions to participants and beneficiaries. The court ordered Hanco to restore \$25,697.32 to the Hanco, Inc. Health Plan and \$2,609.44 to the Hanco, Inc. Dental Plan. The court permanently enjoined Hanco from violating the provisions of Title I of ERISA, from serving as a fiduciary for any Hanco employee benefit plan or Hanco employee welfare benefit plan, and from serving as a fiduciary or service provider to any ERISA-covered employee benefit plan.

[\*Mintjal v. Prof'l Benefit Trust\*, No. 08-CV-5681, 2015 WL 5721612 \(N.D. Ill. Sept. 29, 2015\).](#)

Plaintiffs' employer, General Produce Distributors, Inc., participated in the Professional Benefit Multiple Employer Welfare Benefit Plan & Trust ("the PBT Trust"), which provided death and living benefits to employees of participating employers. Plaintiffs were beneficiaries of the Trust between 1995 and 2006. Defendant Professional Benefit Trust, Ltd. ("PBT Ltd.") was the trustee of the PBT Trust, Defendant PBT Administration, LLC ("PBT Administration") was the administrator, and a company called Professional and Small Business Council Inc. was the trust sponsor. Plaintiffs allege that Tracy Sunderlage owned, controlled, and operated PBT, Ltd. and PBT Administration and that he was a fiduciary with respect to the PBT Trust. Tracy Sunderlage was the CEO and Chairman of the PBT Trust. Linda Sunderlage, Tracy's wife and business partner, also was a fiduciary as she exercised discretionary authority and control over the management of the Trust. The court granted Plaintiffs' motion on the issues of (1) liability against the Sunderlages for breaches of their fiduciary duties with regard to the transactions with Maven Assurance, Ltd. (a captive insurance company), (2) Maven's liability as a party in interest in prohibited transactions with the named plan fiduciaries PBT Administration and PBT Ltd., (3) the termination of the PBT Trust, (4) the award of the \$2,163,000 administrative fee when the PBT Trust was terminated, and (5) SRG Inc.'s liability and SRG International's liability for aiding and abetting the breaches of fiduciary duties by Tracy Sunderlage. The Court denied Plaintiffs' motion as to the 2002 and 2004 Loans from the PBT Trust to Dufferin (an offshore company located in Nevis in the Caribbean in which Tracy Sunderlage owned 50%). The court found that Plaintiffs claim arising from the transfer of assets is not time-barred.

In [\*Perez v. Stratton\*, No. 14-CV-95-WMC, 2015 WL 4232442 \(W.D. Wis. July 13, 2015\)](#), the Secretary of Labor filed this civil suit under 29 U.S.C. §§ 1132(a)(2) and (5), alleging that defendants David Stratton and corporate defendant IDS Sales and Engineering, Inc. failed to remit employee salary deferral contributions to the IDS Sales & Engineering, Inc. Retirement Savings Plan. Stratton initially filed an answer but then filed an unopposed motion to withdraw that answer, which the court. Following Plaintiff's motion for default judgment, the court entered default judgment against Stratton in the amount of \$19,114.94, ordered Stratton to correct the

prohibited transactions in which he engaged, and ordered a permanent injunction preventing Stratton from serving as an ERISA fiduciary.

**A constructive trust can be imposed on a non-fiduciary where funds in its possession are directly traceable to plan assets.** In [\*Fish v. GreatBanc Trust Co., No. 09 C 1668, F.Supp.3d\*](#), 2015 WL 3669739 (N.D. Ill. June 12, 2015), Plaintiffs, former employees of the Antioch Company and participants in its Employee Stock Ownership Plan (“ESOP”), sought to impose a constructive trust on more than \$40 million dollars transferred to the Morgan Family Foundation (MFF), which came from the proceeds of a 2003 buyout transaction. In 2003, seeking a way to avoid making huge annual distributions to shareholders to cover their tax liability, Antioch made the company 100% ESOP-owned, although it would still be controlled and managed by the Morgan family. MFF moved to dismiss on the basis that the relief Plaintiffs seek is unavailable. MFF argued that as non-fiduciaries they may be held liable under § 1132(a)(3) only where they “are or were in possession of plan assets” and in this case MFF received no assets that belonged strictly to the ESOP; it received only corporate cash and borrowings via the Morgan defendants. The court found that Plaintiffs could impose a constructive trust on any funds in MFF’s possession that are directly traceable to the 2003 buyout transaction via the Morgan defendants because it is “appropriate equitable relief” for the alleged breach of fiduciary duty and knowing participation in a prohibited transaction. The court interpreted the Supreme Court’s *Harris Trust & Savings Bank v. Salomon Smith Barney* decision as not requiring that the 1132(a)(3) defendant have acquired plan assets. “The thrust of *Harris* is simply that a court may fashion ‘appropriate equitable relief’ to redress ERISA violations, regardless of whether the defendant is a fiduciary.” Similar relief was granted in *Chesemore v. Alliance Holdings, Inc.*, 948 F.Supp.2d 928 (W.D. Wis. 2013). Lastly, the court rejected MFF’s argument that it cannot properly be sued in this case because it did not participate in the transaction. That a transferee was not the original wrongdoer does not insulate him or her from liability for restitution. The court found that if MFF received the claimed assets from fiduciaries who acquired them by breaching their fiduciary duties, MFF can equitably be required to render them to the victim of the breach.

In [\*Kaiser v. Wisconsin Energy Conservation Corp., No. 14-CV-762-WMC, 2015 WL 3397548 \(W.D. Wis. May 26, 2015\)\*](#), the court granted Defendants’ motion to dismiss Plaintiff’s claim under 29 U.S.C. § 1132(a)(3), where Plaintiff also brought a claim pursuant to § 1132(a)(1)(B) in connection with a denial of long-term disability benefits. Plaintiff contended that merely remanding for a claim brought pursuant to § 1132(a)(1)(B) would not “prohibit Defendants from repeating history by engaging in backward-looking reinterpretation of medical records to hide behind the pre-existing condition clause.” The court disagreed and explained that if the court agrees with Plaintiff that Defendants acted arbitrarily in applying the pre-existing condition

clause, then on remand, Defendants will necessarily not be allowed to rely on that provision. As such, § 1132(a)(1)(B) provides “adequate relief” and there is no need for further equitable relief under § 1132(a)(3).

In [\*Perez v. Stratton\*, No. 14-CV-95-WMC, 2015 WL 1866101\(W.D. Wis. Apr. 23, 2015\)](#), the Secretary of Labor filed suit under 29 U.S.C. §§ 1132(a)(2) and (5), alleging that defendants David Stratton and IDS failed to remit employee salary deferral contributions to the IDS Sales & Engineering, Inc. Retirement Savings Plan. Following a hearing on default judgment, the court entered default judgment against defendant IDS in the amount of \$19,114.94 and entered a permanent injunction preventing IDS from serving as an ERISA fiduciary.

In [\*Int’l Bhd. of Teamsters Union Local No. 710 Pension Fund v. Bank of New York Mellon Corp.\*, No. 13 C 1844, 2015 WL 1234091 \(N.D. Ill. Mar. 16, 2015\)](#) (**Not Reported in F.Supp.3d**), the court denied Defendant’ motion for judgment on the pleadings where Plaintiffs allege that, under the circumstances as they existed in the market at the time, no reasonably prudent securities lending fiduciary would have concluded that Lehman debt was a sufficiently safe investment for a securities lending client and no reasonably prudent securities lending fiduciary would have maintained the collateral investments in the Lehman Notes through Lehman’s bankruptcy filing. The court explained that the claim is not that Defendants were imprudent in failing to recognize that Lehman would file for bankruptcy and not pay out on the notes, but that it was imprudent to hold the Lehman debt, given the circumstances existing in the market and given Plaintiffs’ investment profile. As such, nothing in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), forecloses such claims.

In [\*Payne v. Pentegra Ret. Servs.\*, No. 1:14-CV-00309-TWP, 2015 WL 898467 \(S.D. Ind. Mar. 3, 2015\)](#), Plaintiff filed suit against the Office of the Comptroller of the Currency (“OCC”) and Defendants Pentegra Retirement Services, Pentegra Defined Benefit Plan for Financial Institutions, and Plan Administrator of the Pentegra Defined Benefit Plan for Financial Institutions (collectively, “Pentegra”), asserting various claims for violations of ERISA based on these facts: (1) Waller, the Lead Expert for Compensation and Benefits at the OCC, represented to the Paynes that their benefits would not be significantly different whether Mr. Payne retired and that he should continue working for an additional 120 days; (2) relying on Waller’s representations, Mr. Payne did not retire and eventually died while still in service; and (3) because Mr. Payne died before he retired, the benefits payable to Mrs. Payne as Mr. Payne’s beneficiary are approximately \$205,000.00 less than if Mr. Payne had retired before his death. The court dismissed the United States as a party because of sovereign immunity and ERISA does not provide an express waiver of sovereign immunity. The court also dismissed Plaintiff’s breach

of fiduciary duty claim, finding that under ERISA, there is no individual relief for a breach of fiduciary duty under defined benefit plans.

## I. Eighth Circuit

**Failing to remit employee contributions to a health plan constitutes breach of fiduciary duty.** [Perez v. Harris, No. 12-CV-3136 \(SRN/FLN\), 2015 WL 6872453 \(D. Minn. Nov. 9, 2015\)](#) (Judge Susan Richard Nelson). Plaintiff Secretary of Labor alleged that Defendant Harris was a fiduciary to the Faribault Woolen Mills, Inc. Fully Insured Hospital Life Welfare Plan and that he breached his fiduciary responsibilities under ERISA by failing to remit \$55,040.61 in employee contributions to the Health Plan between January 9, 2009 and March 20, 2009. The Secretary asserted that Harris breached his duty of loyalty to the Health Plan participants in violation of ERISA § 404(a), 29 U.S.C. § 1104(a), and caused the Health Plan to engage in prohibited transactions in violation of ERISA § 406, 29 U.S.C. § 1106. The court determined that Harris is liable under ERISA § 404(a)(1)(A) for breach of fiduciary duty and declined to address the Secretary's claim that Harris also is liable for engaging in prohibited transactions in violation of ERISA § 406. The court denied as moot the Secretary's Motion in Limine to Narrow the Issues at Trial, which concerned whether ERISA's proscriptions in § 406(a)(1)(D) against prohibited transactions and self-dealing require a subjective intent to benefit a party in interest. The court found Harris liable for restitution and prejudgment interest. The court further found that injunctive relief of removing Harris as a fiduciary of the plan is not appropriate since the plan is no longer in existence and Harris's conduct was not so egregious as to warrant a broader injunction on his ability to serve as a fiduciary or service provider to any ERISA-covered employee benefit plan.

[3M Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, No. 14-CV-1058 \(PJS/JSM\), 2015 WL 5687879 \(D. Minn. Sept. 28, 2015\)](#). In this matter where Plaintiffs brought suit against their insurers seeking coverage for loss of returns through fraud of its investment providers, the court considered whether the lost earnings are deemed to be plan assets under ERISA regulations. The court found this to be a question of contract interpretation and the phrase "owned by the Insured" in Endorsement 8 should be construed to refer to a traditional notion of property rights, as governed by state law. The court rejected the argument that the phrase should encompass anything defined as a "plan asset" under an ERISA regulation, notwithstanding that the purpose of Endorsement 3 (the ERISA rider to the Policy) is to comply with ERISA's bonding requirement.

[United States v. Claus, No. CRIM. 10-165 DSD/JJK, 2015 WL 5432108 \(D. Minn. Sept. 15, 2015\)](#). On the government's application for a writ of garnishment to collect part of a restitution

obligation under the Mandatory Victim Restitution Act, the court granted the request to have Defendant's individual retirement account (IRA) with American Funds Service Company liquidated to pay towards the restitution obligation. The court rejected Defendant's argument that the writ of garnishment is unenforceable because under ERISA retirement accounts are exempt from garnishment. The MVRA authorizes the United States to garnish ERISA covered accounts by providing that a restitution judgment may be enforced against all property notwithstanding any other Federal law.

In [\*Perez v. Harris\*, No. CIV. 12-3136 SRN/FLN, 2015 WL 774109 \(D. Minn. Feb. 24, 2015\)](#), the Department of Labor alleged that an employer failed to properly remit health insurance plan payments on behalf of its employees. The Secretary filed limited objections to the Magistrate Judge's Report & Recommendation, contending that the R & R inadvertently misstated the definition of a fiduciary under ERISA and requesting the court to correct that alleged misstatement. The R & R noted that ERISA defines a fiduciary as one who "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." Later in that same paragraph, the R & R paraphrased this definition, to which the Secretary now objects: "Accordingly, in order for Harris to be considered an ERISA fiduciary, he must have exercised discretionary authority of control over these plan assets or the management of the Health Plan." The court explained that the R & R's later statement of the definition was not intended to supplant the earlier, more complete, definition from the statute. Moreover, it is clear from the R & R that the issue to be resolved is not whether Harris possessed any discretionary authority over the plan assets in question, but rather whether he exercised that authority. Because the court determined that the R & R's statement of the ERISA definition of fiduciary is correct, it overruled the Secretary's objections.

#### J. Ninth Circuit

**Alleged representations by Trustee's employee regarding Plan requirements do not state a claim for breach of fiduciary duty where Plan is unambiguous.** [\*Wilson v. Cox\*, No. 3:15-CV-00059-SI, 2015 WL 6123776 \(D. Or. Oct. 16, 2015\)](#) (Judge Michael H. Simon). The Health & Welfare trust denied coverage for Defendant/Counterclaimant's discograms because Cox did not submit the bills within one year of the date of the treatment and the Plan establishes that "in no event shall benefits be allowed if the bill is submitted or the notice of claim is made beyond one calendar year from the date on which expenses were incurred. Cox alleged that the Trust should be estopped because he relied on certain statements by a Trust employee in failing to submit the discogram bills. The court found that the Plan expressly and unambiguously requires that all bills be submitted within a year of treatment and the representations alleged by Cox were not an interpretation of the Plan but would serve to modify or contradict the Plan. The court

found that Cox failed to satisfy the additional requirements of equitable estoppel in the ERISA context, which require a showing that the Plan is ambiguous and that a representation interpreted that ambiguity. Because Cox failed to state a claim for breach of fiduciary duty under Section 1132(a)(3)(B), the court dismissed this counterclaim with prejudice.

**Unpaid employer contributions are not plan assets until they are paid to the plan.** [Unite Here Health v. Gilbert, No. 213CV00937JADGWF, 2015 WL 5766511 \(D. Nev. Sept. 30, 2015\)](#) (Judge Jennifer A. Dorsey). In this action seeking more than half a million dollars in unpaid benefits allegedly due under the terms of a CBA, the court held that unpaid employer contributions to an employee-benefits plan are not “plan assets” making the persons and entities that control them ERISA fiduciaries. The court found no reason to depart from the Ninth Circuit’s decision in *Cline v. Indust. Maint. Engr. & Contracting Co.*, where the court announced the general rule that contributions by employers to an employee-benefits plan are not plan assets until they are paid to the plan. The court granted the defendants’ motion for summary judgment.

In a bankruptcy proceeding where the Board of Trustees of various employee benefit trust funds sought to except from discharge debts for unpaid contributions owed by the Quinoneses, the court held that the board cannot establish, as a matter of law, that the Quinoneses were fiduciaries of the Board with respect to any plan assets. Specifically, the Board cannot prevail on its § 523(a)(4) defalcation and fraud claim because it failed to establish that an express trust existed. The Quinoneses established that there is no genuine issue of material fact and that they are entitled to judgment as a matter of law with regard to the Board’s § 523(a)(4) defalcation and fraud claim arising from the unpaid employer contributions. [In re Quinones, No. 12-46834, 2015 WL 5444106 \(Bankr. N.D. Cal. Sept. 15, 2015\)](#).

In [Perez v. California Pac. Bank, No. 13-CV-03792-JD, 2015 WL 5029452 \(N.D. Cal. Aug. 25, 2015\)](#), an enforcement action brought by the Secretary of Labor against the bank for its handling of the Bank Employee Stock Ownership Plan, the court denied Defendants’ motion for summary judgment and granted in part and denied in part the Secretary of Labor’s motion. The court found that the bank failed to liquidate and distribute shares as cause upon termination and improperly diverted \$132,506 of plan assets. Although the court found in favor of the bank on liability, it stated that it was unclear what losses, if any, were suffered by the Plan as a result of Defendants’ breach. As such, the determination of the specific amount of liability is reserved for trial. The court denied summary judgment on the Secretary’s claims that Defendants’ unlawfully transferred \$69,745.93 in plan assets from the Plan to the Plan Sponsor and its claim that Defendants violated ERISA by holding Plan assets in noninterest bearing accounts at the bank.

In [\*Perez v. California Pac. Bank\*, No. 13-CV-03792-JD, 2015 WL 4448061 \(N.D. Cal. July 20, 2015\)](#), an enforcement action brought by the DOL Secretary against Defendants for their handling of the California Pacific Bank Employee Stock Ownership Plan, which was terminated close to three years before this action was initiated while the Bank was under investigation by the Secretary. Count I alleged that Defendants failed to liquidate and distribute shares as cash upon termination. Defendants moved for summary judgment on that count which the court denied. The court found that there is no genuine issue of material fact that Defendants violated ERISA but questioned whether any relief available for the violation since it is unclear that there were any losses suffered by the Plan. The court deferred the issue of relief to a bench trial. The Secretary moved for summary judgment on the other counts. Count II alleged that Defendants improperly diverted \$132,506 account receivable. The Court found that Defendants diverted to the Bank a significant portion (\$81,407.18) of the \$132,506 account receivable that belonged to the Plan, and by doing so, violated ERISA Sections 403, 404 and 406. The court deferred the issue of the appropriate remedy for trial. Count III alleged that Defendants transferred \$69,745.93 in plan assets from the Plan to the Plan sponsor. On the current record, the court denied the Secretary's motion because the court was unable to determine whether the Bank did not make any further contributions to the Plan after a certain time or what legal effect the Plan's termination may have had on the Bank's clock for permissibly taking back any over-contributions. Count IV alleged that Defendants held assets in noninterest bearing accounts at the bank. The court found that as a preliminary matter the Secretary failed to establish that holding Plan cash assets in noninterest bearing accounts constitutes a violation of ERISA as a legal matter.

In [\*Perez v. Bar-K, Inc.\*, No. C 14-05549 JSW, 2015 WL 4480359 \(N.D. Cal. July 20, 2015\)](#), the court removed Defendant Bar-K, Inc. as a fiduciary to the Bar-K 401(k) Plan and ordered the Company to pay Plan losses in the amount of \$1,320,252.16, including pre-judgment interest. The court appointed Receivership Management, Inc. as the Independent Fiduciary to the Plan who will be responsible for collecting, marshaling, paying out, and administering all of the Plan's assets and taking further action with respect to the Plan as appropriate, including terminating the Plan when all of its assets are distributed to all eligible participants and beneficiaries and other responsibilities.

**Breach of fiduciary duty claims survive dismissal upon omissions-based theory of liability.**

In [\*Monper v. Boeing Co.\*, No. 2:13-CV-01569-RSM, F.Supp.3d , 2015 WL 2250419 \(W.D. Wash. May 13, 2015\)](#), Plaintiffs brought breach of fiduciary duty claims against several defendants based on their alleged provision of misinformation concerning Plaintiffs' pension benefits. Plaintiffs claim that they were told numerous times by recruiters and HR personnel that

their pension benefits would not change or be reduced upon transfer of employment; however, their early retirement benefits were significantly reduced in accordance with the terms of the written plan documents (which they received after they relocated). The court dismissed the claims against the recruiters and HR representatives, finding that they are not ERISA fiduciaries, but rather ministerial employees. To hold otherwise would essentially permit a recruiter to elevate herself or himself to the position of Plan administrator simply by speaking about the Plan, with all the responsibility and liability that doing so would entail. With respect to “Committee Defendants,” the court found that although they cannot be liable on the basis of *respondeat superior* for misrepresentations by the recruiters and HR personnel, the Committee’s failure to act rather than its role in affirmatively misrepresenting benefits, merits greater consideration. An ERISA fiduciary may be held liable not only for disseminating materially misleading information, but also for failing to affirmatively provide material benefits information, whether on its own accord or when prompted by a participant’s inquiry. The court also found that Plaintiffs plead sufficient facts giving rise to an inference that Boeing and McDonnell Douglas played a role in the production and dissemination of the misinformation. Lastly, the court declined to dismiss the co-fiduciary and failure to monitor claims against these defendants.

**“Hold in trust” requirement of §1103(a) does not require the creation of a document including express words of trust; fiduciary engaged in prohibited transaction by paying its own fees out of plan assets.** In [\*Barboza v. California Ass’n of Prof’l Firefighters, No. 11-15472, F.3d\*](#), 2015 WL 1529088 (9th Cir. Apr. 7, 2015), the court held that: 1) ERISA’s requirement that “all assets of an employee benefit plan shall be held in trust by one or more trustees,” under 29 U.S.C. § 1103(a), means that a person (legal or natural) must hold legal title to the assets of an employee benefit plan with the intent to deal with these assets solely for the benefit of the members of that plan, rejecting the argument that compliance with § 1103(a) requires a party to record its responsibilities with respect to the assets of an employee benefit plan in a document that is entitled “trust instrument,” uses the terms “trust” and “trustee,” and expressly states that the party is holding the assets “in trust;” 2) a fiduciary that paid its own fees from Plan assets engaged in a prohibited transaction under 29 U.S.C. § 1106(b)(1) and § 1108(c)(2)’s safe harbor for fiduciary compensation is not applicable in this context; and 3) the administrator was not required to provide a summary annual report to each Plan member annually under 29 C.F.R. § 2520.104b–10(a) because it is a totally unfunded welfare plan exempt from doing so under 29 C.F.R. § 2520.104b–10(g).

#### K. Tenth Circuit

[\*Jenkins-Dyer v. Drayton, No. 2:13-CV-02489-JAR, F.Supp.3d\*](#), 2015 WL 5671209 (D. Kan. Sept. 25, 2015). In a challenge by the deceased participant’s daughter for Savings Plan

benefits paid to the surviving spouse, the court found that the terms of the Savings Plan undisputedly state that the participant's spouse is the rightful beneficiary of the Plan; the participant's child is a beneficiary only if the participant does not have a spouse. With respect to Plaintiff's breach of fiduciary duty claims, the court found that because she has a potential remedy to recover the benefits to which she claims entitlement, she may not recover in equity for breach of fiduciary duty. Further, even if § 1132(a)(3) did provide for some remedy under these circumstances, Defendants would still be entitled to summary judgment on Plaintiff's claim for breach of fiduciary duty because it enforced the plan according to its terms.

In [\*Faltermeier v. Aetna Life Ins. Co.\*, No. 15-CV-2255-JAR-TJJ, 2015 WL 3440479 \(D. Kan. May 28, 2015\)](#) (**Not Reported in F.Supp.3d**), the court granted Plaintiff's motion to amend his complaint to add a breach of fiduciary duty claim pursuant to ERISA § 502(a)(3), in addition to his § 502(a)(1)(B) claim for the denial of his long-term disability benefit claim. Plaintiff alleged that Aetna issued its final denial of his claim for benefits without considering an independent medical examiner's report that supports his disability. Plaintiff advised Aetna that he would be providing the report and provided the report one day before Aetna issued its final denial. The denial letter made no mention of the report. The court rejected Defendant's argument that amending the complaint would be futile because Plaintiff's breach of fiduciary duty claim is subject to dismissal. The court found that Plaintiff's breach of fiduciary duty claim is not simply a repackaged claim for benefits. If the court determines that Defendant's denial was not arbitrary and capricious based on the administrative record, then Plaintiff has a separate cause of action for breach of fiduciary duty arising out of Defendant's exclusion of relevant medical evidence from the administrative record.

In [\*Teets v. Great-W. Life & Annuity Ins. Co.\*, No. 14-CV-2330-WJM-NYW, 2015 WL 2455464 \(D. Colo. May 22, 2015\)](#) (**Not Reported in F.Supp.3d**), a putative class action involving a 401(k) Savings Plan's interest rates and fees, Defendant moved to dismiss on the basis that (1) the Fund falls under the guaranteed benefit policy ("GBP") exemption in ERISA, and thus Defendant was not an ERISA fiduciary that could have breached any fiduciary duties; and (2) Plaintiff's Claim 3 fails because Defendant cannot be both a fiduciary and a party in interest under ERISA § 406(a). The court noted that the Contract here bears many of the indicia of a GBP as defined under *Harris Trust*: it allocates to the insurer the risk of loss of principal, and guarantees a benefit amount at the beginning of each quarter. But the court could not definitively conclude at this stage of the case that the rate of return was "reasonable," that Defendant's discretionary authority did not extend to management of Plan assets, or that the Contract's discretionary rate model did not allocate risk to Plan participants invested in the Fund sufficient to foreclose applicability of fiduciary duties under ERISA. The court concluded that Plaintiff has stated a claim that Defendant was a fiduciary under ERISA when it took the challenged actions

and denied Defendant's motion to the extent that it contends otherwise. The court also concluded that as pled, Claim 3 alleges that Defendant has engaged in self-dealing, which is a violation of ERISA § 406(b), not (a), and is thus duplicative of Claim 2. The court dismissed Claim 3 without prejudice.

L. Eleventh Circuit

**PBGC's failure to intervene or bring its own action under ERISA against the pension defendants does not satisfy requirements for equitable subordination of its claim.** [In re Durango Georgia Paper Co., No. 02-21669, 2015 WL 5813627 \(Bankr. S.D. Ga. Oct. 5, 2015\)](#) (Bankruptcy Judge John S. Dalis). The court granted the PBGC's motion to dismiss the complaint for equitable subordination of claim. The court found that the liquidating trustee is thus incorrect that the alleged injury to the unsecured creditors is alone a sufficient ground for equitable subordination of the PBGC's claim since it must be shown that the PBGC's conduct was inequitable. Further, the PBGC is not an "insider" and its exercise of statutory discretion was not inequitable. The court also found that there is no causal connection between the PBGC's decision to not pursue legal action against the pension defendants and the alleged injury to the unsecured creditors.

In [Smith v. Delta Air Lines Inc., No. 13-15155, Fed.Appx. , 2015 WL 4546170 \(11th Cir. July 29, 2015\)](#), on remand from the U.S. Supreme Court for reconsideration in light of *Fifth Third Bancorp v. Dudenhoeffer*, the court held that Plaintiff's prudence claim falls squarely within the class of claims the Supreme Court deems "implausible as a general rule." Specifically, his prudence claim is that the Delta fiduciaries should have foreseen that Delta stock would continue to decline, but the court found no allegation in the amended complaint that the fiduciaries had material inside information about Delta's financial condition that was not disclosed to the market, nor is there any allegation of a special circumstance that rendered reliance on the market price imprudent, such as fraud, improper accounting, illegal conduct or other actions that would have caused Delta stock to trade at an artificially inflated price. As such, the Delta fiduciaries cannot be held liable for failing to predict the future performance of the airline's stock and *Fifth Third* does not change the outcome of the court's prior disposition. The court affirmed the judgment of dismissal.

**ERISA fiduciary exception to employee liability insurance applies to fiduciary duty to inform a participant about life insurance conversion rights.** In [Fed. Ins. Co. v. Am. Home Assur. Co., No. 1:14-CV-929-SCJ, 2015 WL 1964303 \(N.D. Ga. Apr. 30, 2015\)](#), Plaintiff, Federal Insurance Company, filed suit against Defendant, American Home Assurance Company, for contribution, indemnity, and declaratory relief to recover a payment it made to settle a claim

made against Career Systems Development Corporation, a subsidiary of Owl Companies, an insured of both Federal and American Home. The settled claim involved an ERISA breach of fiduciary duty claim against Career Systems for failing to inform a former employee of his right to convert group life insurance although it was aware that the employee had terminal cancer. The American Home Employee Benefits Liability Endorsement contained an ERISA exclusion which provides that the Endorsement does not apply to damages for which any insured is liable because of liability imposed on a fiduciary by ERISA. Although ERISA does not require notice of conversion rights for life insurance, the court found that the duties of an ERISA fiduciary are not limited to those requirements expressly set forth in the statute. An ERISA fiduciary has a duty to disclose material information and to inform a beneficiary of material facts when it knows the beneficiary is not aware of them. The court found that Career Systems was acting in a fiduciary capacity when it failed to provide its employee with notice of his conversion rights as to his life insurance policy. As such, the ERISA exclusion in the American Home policy applies. The court denied Plaintiff's motion for summary judgment and granted Defendant's motion for summary judgment.

In [\*Owens v. Metro. Life Ins. Co.\*, No. 2:14-CV-00074-RWS, 2015 WL 1651125 \(N.D. Ga. Apr. 14, 2015\)](#), Plaintiff brought a putative class action involving the issue of whether the creation of a "Total Control Account" to pay life insurance death benefits constitutes a breach of fiduciary duty. Plaintiff alleged the following causes of action: breach of the duty of loyalty imposed by ERISA § 404(a)(1)(A) (Count I); breach of the fiduciary duties imposed by ERISA § 406(b)(1) (Count II), § 406(a)(1)(B) (Count III), and § 406(a)(1)(C) (Count IV); declaratory relief regarding coverage by state insurance guaranty funds for the Georgia subclass (Count V); and postmortem interest for the Georgia subclass (Count VI). The court found that Plaintiff did not have constitutional standing to bring Count V and dismissed that claim. However, the court denied dismissal of the remaining claims, finding that this case more closely resembles *Mogel v. Unum Life Insurance Co.*, 547 F.3d 23 (1st Cir.2008) rather than *Merrimon v. Unum Life Ins. Co. of Am.*, 758 F.3d 46 (1st Cir.2014).

M. D.C. Circuit

### III. *Church Plan Status*

#### A. Third Circuit

**A church agency, in addition to maintaining an exempt church plan, cannot also establish a plan exempt from ERISA.** [Kaplan v. Saint Peter’s Healthcare Sys., No. 15-1172, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 9487719 \(3d Cir. Dec. 29, 2015\)](#) (Before McKEE, Chief Judge, AMBRO, and HARDIMAN, Circuit Judges). A participant in an ERISA plan brought a putative class claim against his employer, a religiously affiliated hospital, alleging that, as a mere qualifying agency of a church, the hospital was precluded from establishing a church plan entitled to certain exemptions under ERISA. The district court denied the employer’s motion to dismiss and the employer appealed. ERISA § 3(33)(A) defines a church plan as one that is established and maintained for its employees (or their beneficiaries) by a tax-exempt church and Subsection 3(33)(C)(i) clarifies that a plan established and maintained by a church includes a plan maintained by a qualifying agency of a church. The district court concluded that a church agency, in addition to maintaining an exempt church plan, cannot also establish such a plan. The Third Circuit explained that per the plain text of ERISA, only a church can establish a plan that qualifies for an exemption under § 4(b)(2) and because no church established St. Peter’s Healthcare System’s retirement plan, it is ineligible for a church plan exemption. The Third Circuit affirmed the district court’s decision and held that: (1) relevant ERISA provision was unambiguous in requiring a church to establish a church exempt plan; (2) legislative history indicated that agencies were precluded from establishing church exempt plans; and (3) provision did not violate Free Exercise Clause.

#### B. Sixth Circuit

#### C. Ninth Circuit

#### D. Tenth Circuit

**Catholic Health Initiatives Retirement Plan is a church plan exempt from ERISA’s requirements.** [Medina v. Catholic Health Initiatives, No. 13-CV-01249-REB-KLM, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 8144956 \(D. Colo. Dec. 8, 2015\)](#) (Judge Robert E. Blackburn). Plaintiff, a former employee of Catholic Health Initiatives (“CHI”), brought a putative class action against CHI and the members of its Board of Stewardship Trustees and Human Resources Committee. CHI offers employees retirement benefits through a defined benefit pension plan, the Catholic Health Initiatives Retirement Plan (the “CHI Plan”), which was established to qualify as a “church plan” and it has been recognized as such by the IRS since 2002. Plaintiff

challenges the CHI Plan's status as a church plan exempt from the requirements of ERISA. The court concluded that the CHI Plan is properly classified as a church plan and is entitled to the benefit of the ERISA exemption for such plans. The court rejected Plaintiff's suggestion that the plain meaning of "church" is simply "a house of worship." Instead the court found that under a more resonant definition of church as "where such people gather to express, in word or deed, the principles and mission of their faith, they are the church," CHI is, at the very least, a constituent part of the Catholic Church. The court found unremarkable that CHI and the Catholic Health Care Federation ("CHFC") are separate legal entities since there is a substantial overlap in the membership of the board of directors and the officers of both CHCF and CHI. The court also found that the DB Plan Subcommittee is plainly associated with the Catholic Church under 29 U.S.C. Section 1002(33)(c)(iv). The court found no requirement under ERISA that all entities covered by a church plan be associated with or controlled by a *single* church. The court rejected Plaintiff's argument that recognition of the church plan exemption in this instance violates the First Amendment's Establishment Clause.

#### IV. *Class Certification*

##### A. Sixth Circuit

In [\*Int'l Union, United Auto., Aerospace, & Agr. Implement Workers of Am. v. Kelsey-Hayes Co.\*, No. 2:11-CV-14434, 2015 WL 1906133 \(E.D. Mich. Apr. 28, 2015\)](#), Plaintiffs challenge Defendants replacement of health insurance for retirees over age 65 with health reimbursement arrangements. Defendants also assert the right to further alter or terminate retiree healthcare in the future. In an order on an unopposed motion for class certification, the court certified the following class: Employees who retired under the 1998 collective bargaining agreement from the UAW-represented unit at the now-closed Kelsey-Hayes/TRW Detroit, Michigan plant and the retirees' surviving spouses and other dependents eligible for company-paid retiree health insurance.

##### B. Eighth Circuit

**Putative class actions consolidated and interim class counsel appointed.** [\*Roe v. Arch Coal, Inc.\*, No. 4:15-CV-1026 \(SNLJ\), 2015 WL 6702287 \(E.D. Mo. Nov. 2, 2015\)](#) (Judge Carol E. Jackson). Plaintiffs filed separate complaints against employees of Arch Coal, Inc., alleging breach of fiduciary duties: *Bush v. Arch Coal, Inc., et al.*, Case No. 4:15-CV-1026 (E.D. Mo. June 30, 2015); *Roe v. Arch Coal, Inc., et al.*, Case No. 4:15-CV-910 (E.D. Mo. June 9, 2015).

The court granted Plaintiffs' motion to consolidate the actions and appoint interim class counsel. The court appointed the firms of Kessler Topaz Meltzer & Check, LLP and Stull, Stull & Brody as interim co-lead counsel, and the firm of Blitz, Bardgett & Deutsch, LC as interim liaison counsel.

*In re Express Scripts, Inc.*, No. 4:05MD01672HEA, 2015 WL 128073 (E.D. Mo. Jan. 8, 2015) involves multi-district litigation wherein Plaintiff alleges that ESI retained undisclosed rebates from manufacturers and enriched itself through various practices at the expense of the beneficiaries of the Local 153 Health Fund. Plaintiff sets out allegations which it contends establish ESI as a fiduciary, both at common law and under ERISA. Count I is brought under a theory of Breach of Fiduciary Duty; Count II, Deceptive Practices, in violation of N.Y. General Business Law § 349; Count III, Breach of Contract, Count IV, Conversion; Count V, Breach of the Covenant of Good Faith and Fair Dealing; and Count VI, Unjust Enrichment. Plaintiff sought certification of a class consisting of: All self-funded ERISA employee benefit plans ("ERISA Plans") for which National Prescription Administrators, Inc. ("NPA"), at least initially, served as the ERISA Plans' pharmacy benefits manager, and which utilized the NPA Select Formulary, at any time from January 1, 1996 through April 13, 2002. Based on this proposed definition, Plaintiff requested that the court certify a class under Rule 23(b)(3). The court denied Plaintiffs' Motion for Class Certification because: (1) Plaintiff's claims fail to satisfy the commonality requirement of Rule 23(a)(2); (2) Plaintiff's claims fail to satisfy the typicality requirement of Rule 23(a)(3); (3) Plaintiff's claims fail to satisfy the adequacy requirement of Rule 23(a)(4); and (4) Plaintiffs' proposed "liability class" does not raise questions of law or fact that predominate over individual issues, and is not a superior method of adjudication as required Rule 23(b)(2).

### C. Ninth Circuit

**401(k) excessive fee class not certified but court noted that a fiduciary's fees can be unreasonable under ERISA even if other fiduciaries are also charging unreasonable fees.** In [JACLYN SANTOMENNO; KAREN POLEY; BARBARA POLEY, Plaintiff, v. TRANSAMERICA LIFE INSURANCE COMPANY; TRANSAMERICA INVESTMENT MANAGEMENT, LLC; TRANSAMERICA ASSET MANAGEMENT INC., Defendants., No. CV1202782DDPMANX, F.Supp.3d](#), 2015 WL 5096388 (C.D. Cal. Aug. 28, 2015), a matter where Plaintiffs alleged that the fees they were charged for 401(k) plan products targeted at small and mid-size employers were excessive and in violation of ERISA, the court denied Plaintiffs' Motion for Class Certification. The court found that each of the Rule 23(a) prerequisites were satisfied but that under Rule 23(b)(3) individual inquiries potentially loom large where Plaintiffs seek to certify a class of about 300,000 participants in about 7,400 plans. The fees charged to individual plans must be compared to the expense of providing services to those plans and these individualized inquiries would be significantly more complex than Plaintiff's proposed inquiry

into a single fee whose reasonableness (Plaintiffs argue) could be straightforwardly determined as to all plans equally. The court also found that whether there was actually a misrepresentation may not be susceptible to classwide proof because many class members appear to have received disclosures which explained the subsidization of plan-level costs and provided estimates of the amount spent on such subsidization. Although the court denied certification, it emphasized that its decision is limited to the particular facts of this motion and this proposed class. The court is appreciative of the problem that the majority (83%) of 401(k) participants do not know how much they pay in fees and expenses. The court made clear that “[t]his order is not intended to approve of ERISA plan service providers playing ‘hide the ball’ with their fees” or that “the reasonableness of fees is measured against what other providers are charging.”

In *Bryant v. Arizona Pipe Trades Pension Trust Fund*, No. CV-13-01563-PHX-GMS, 2015 WL 300385 (D. Ariz. Jan. 22, 2015), Plaintiff alleges that Defendants improperly withheld and miscalculated his pension benefits and sought to certify two classes and one sub-class. Plaintiff is a member of the America Pipe Trades Pension Trust Fund (“Pension Plan”), a defined benefits plan, and the Arizona Pipe Trades Defined Contribution Plan (“DC Plan”) (together, the “Plans”). Pursuant to local union contracts, Plaintiff’s employers were required to make contributions to the Plans on his behalf. A Reciprocity Program permitted the transfer of reciprocal contributions to the Plans on behalf of participants working out of state. Often, the rates paid by out-of-state employers and transferred to the Plans exceeded those required to be contributed by Arizona employers. Under the terms of the Reciprocity Program and the Plans, the full value of the out-of-state contributions would be prorated between the Plans at the current contribution rates.

In 2004, the Trustees of the Plans allegedly approved Amendment 1 to the Plans, retroactive to June 1, 2002, which provided that, for employees on whose behalf reciprocal contributions were made at rates higher than those required under the collective bargaining agreements, any excess over the current hourly contribution rate would be paid into the DC Plan participants’ individual accounts and they would be given credit for the full amount of excess contributions. Thus, excess contributions received by the Pension Plan on behalf of any DC Plan participant would have constituted accrued benefits for those participants in the DC plan. Plaintiff alleges that the Pension Plan failed to make contributions to the DC Plan and took no action to collect such contributions on behalf of the trust and deserving participants.

A second amendment to the Plans required a participant to earn a full pension credit before any reciprocal contributions would be paid into the DC Plan. As a result, excess contributions were withheld from the DC Plan for months longer than authorized under Amendment 1, without interest. Amendment 2 amended the Plans retroactively and the parties dispute whether it did so without notice to participants. Plaintiff contends that benefits were unlawfully diminished as a result. Then, in 2008, the DC Plan was amended retroactively to

adopt a mid-year valuation date of November 30, 2008 rather than a single end-of-year valuation date as was prescribed by the terms of the DC Plan. Account balances of participants for whom contributions were paid to Defendants between June 1, 2008 and November 30, 2008 were calculated using the depressed investment yield rather than the year-end, positive investment income adjustment, and participants' received reciprocal contributions were never credited with the investment gains received during that time frame.

After analyzing the relevant factors, the court granted in part and denied in part Plaintiff's Motion for Class Certification and certified the following classes under Federal Rule of Civil Procedure 23.

Class 1: All DC plan participants who had accrued benefits on or after June 1, 2002 and their eligible spouses and beneficiaries. (Counts I, II, III).

Sub-class 1: All Class 1 members who were DC Plan participants between June 1, 2002 and June 24, 2004, and for whom excess contributions were received by the Pension Plan on or after June 1, 2002. (Counts I, II, III)

Class 2: All participants in the DC Plan as of November 30, 2008 for whom contributions were received by the Plans between June 1, 2008 and November 30, 2008 and their eligible spouses and beneficiaries. (Counts II, III)

The court appointed Plaintiff as the Class Representative and the law firm of Martin & Bonnett P .L.L.C. as Class Counsel.

## V. *Class Action Settlements*

### A. Second Circuit

**Class entitled to reformation of Plan terms based on fiduciary's false, misleading, and incomplete Plan descriptions.** [Osberg v. Foot Locker, Inc., No. 07 CIV. 1358 KBF, 2015 WL 5786523 \(S.D.N.Y. Oct. 5, 2015\)](#) (Judge Katherine B. Forrest). In a certified class action seeking reformation of a pension plan to conform to the benefits employees understood Foot Locker had promised them, the court found that the evidence is overwhelming that the changes in the Retirement Plan resulted in an effective freeze of pension benefit accruals—and that this freeze was not adequately disclosed to Participants. The court found that the evidence is clear that (1) wear-away was an intended feature of the Plan, (2) Plan disclosures and other communications to Participants failed to disclose wear-away, (3) this lack of disclosure was intentional, (4) wear-away impacted thousands of employees—many, including the named plaintiff, terminated employment and were paid benefits while they were still in wear-away, (5)

Participants did not understand that, as a result of wear-away, additional periods of service after January 1, 1996 would not and did not increase the benefit received, and (6) Appropriate disclosure would not have been too confusing and had it been given, Participants would have understood the consequences of wear-away. The court found that Plaintiff has shown all of the elements to obtain reformation of the Plan, including: violations of ERISA §§ 404(a) and 102(a), based on the preponderance of the evidence; mistake or ignorance by employees of “the truth about their retirement benefits,” based on clear and convincing evidence; and “fraud or similar inequitable conduct” by the plan fiduciaries, based on clear and convincing evidence. The court found in favor of the Class on all claims.

[Osberg v. Foot Locker, Inc., No. 07 CIV. 1358 KBF, 2015 WL 5707107 \(S.D.N.Y. Sept. 29, 2015\)](#). Following a lengthy bench trial, the court found that the Class has proven by a preponderance of the evidence that Foot Locker violated ERISA §§ 404(a) and 102 by issuing false, misleading, and incomplete Plan descriptions. The court also found that the Class has proven by clear and convincing evidence that, as a result of Foot Locker’s ERISA violations, employees reasonably but mistakenly believed that growth in their cash balance benefit equaled growth in their pension benefit—and that Foot Locker obtained an undue advantage vis-à-vis its workforce. To remedy Foot Locker’s misrepresentations, the court found that the Plan must be reformed to actually provide the benefit that the misrepresentations inequitably caused Class members to reasonably expect.

#### B. Third Circuit

[McDonough v. Horizon Blue Cross Blue Shield of New Jersey, No. 14-3558, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 5573821 \(3d Cir. Sept. 23, 2015\)](#). Over six objectors from a class of approximately 2.8 million, the Third Circuit affirmed the district court’s grant of final approval of a class action settlement in an ERISA lawsuit involving allegations that Horizon Blue Cross Blue Shield of New Jersey’s use of two flawed databases—Ingenix and Top of Range—caused it to systematically underpay both subscribers and providers for out-of-network healthcare services.

In [DeMaria v. Horizon Healthcare Servs., Inc., No. 11-7298 WJM, 2015 WL 3460997 \(D.N.J. June 1, 2015\)](#), Plaintiffs brought ERISA claims and state law claims on behalf of themselves and other chiropractors who were denied E/M and PT benefits under Horizon plans during the Class Period. Count I seeks the recovery of benefits due under ERISA-covered plans pursuant to ERISA § 502(a) (1)(B), and Count II seeks an order requiring Horizon to provide a “full and fair review” of denied benefit claims under ERISA § 502(a)(3) and 29 C.F.R. § 2560.503–1(h)(2).

The court certified the proposed “ERISA Class” under Rule 23(b)(3) and Rule 23(b)(1)(B) defined as: All chiropractors who, during the Class Period, received payment from Horizon pursuant to an employer benefit plan covered by ERISA for CMT services, but were denied payment for E/M and/or PT services provided on the same date as the CMT service. Excluded from this Class are benefit claims submitted by Non-Participating providers under Horizon's Multi-Plan Liaison (“MPL”) Program. This Class has two sub-classes: (1) chiropractors who were, at the time they rendered the services, participating providers; and (2) chiropractors who were, at the time they rendered the services, non-participating providers.

C. Fourth Circuit

[Kruger v. Novant Health, Inc., No. 1:14CV208, F.Supp.3d](#), 2015 WL 5511052 (M.D.N.C. Sept. 17, 2015). In a putative class action challenging Defendants’ alleged payment of excessive fees stemming from imprudent investments in unnecessarily expensive funds and overpayment to two service providers, the court denied Defendants’ motion to dismiss. It found that Plaintiffs have stated enough of a claim for breach of fiduciary duty to survive Defendants’ motion to dismiss based on the imprudent retention of the retail class funds when institutional class shares were available. Although Plaintiffs did not allege facts regarding why the amount of the recordkeeping fees are excessive, the services provided, or how the fees charged to the Plan were excessive in light of those services, the court found that those are the types of facts warranting discovery, and, therefore, dismissal at this stage is not appropriate. The court also found that at this stage it is impossible to deduce whether or not Davis’ compensation was reasonable without further discovery.

D. Fifth Circuit

In [Lee v. Verizon Commc’ns, Inc., No. 14-10553, Fed.Appx.](#), 2015 WL 4880972 (5th Cir. Aug. 17, 2015), Plaintiffs, representing two certified classes, alleged violations under ERISA by the pension plan sponsors and administrators as a result of a plan amendment and subsequent annuity purchase in December of 2012. The certified classes include the Transferee Class, comprising Plan participants whose retirement-benefit obligations were transferred to the annuity, and the Non-Transferee Class, whose retirement-benefit obligations remained with the Plan. The court affirmed the district court’s dismissal of the claims of the Transferee Class for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6), as well as the dismissal of the sole claim of the Non-Transferee Class under Rule 12(b)(1) for lack of constitutional standing.

**Court orders final approval of class action settlement against Unum alleging underpayment of long-term disability benefits.** [Kemp v. Unum Life Insurance Company of](#)

[America, No. 14-0944, 2015 WL 8526689 \(E.D. La. Dec. 11, 2015\)](#) (Judge Nannette Jolivette Brown). The court granted final settlement approval for the following Settlement Class: All current or former Humana employees who (1) received long-term disability benefits from Unum under the Policy; (2) became disabled within the meaning of the Policy between and including May 1, 2002, and October 31, 2013; (3) received Perpetuity Payments from Humana; and (4) whose long-term disability benefit payment amount was calculated without including Perpetuity Payments as Monthly Earnings as defined in the Policy. The settlement amount totals \$3,738,402 and the court approved attorneys' fees of 33.33%, or \$3,738,402, reimbursement of litigation expenses of \$17,878.65, and a class representative incentive award of \$5,000.

E. Sixth Circuit

**Class action settlement results in independent VEBA for retirees.** [OFFICE AND PROFESSIONAL EMPLOYEES INTERNATIONAL UNION, LOCAL 494, et al. v. INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, No. 214CV14868DPHEAS, 2015 WL 6774248 \(E.D. Mich. Nov. 6, 2015\)](#) (Judge Denise Page Hood). In this matter involving retiree health care benefits, the court approved finally approved a class action settlement which provides for the establishment and funding of an independent VEBA trust fund to provide health care benefits to eligible current and future UAW retirees, surviving spouses and dependents. As funding for the retiree health care benefits to be provided by the VEBA, the UAW will contribute to the VEBA approximately \$346 million, with that figure to be adjusted to account for any amounts paid by the UAW or by its sponsored employee benefit plans to cover the costs attributable to retiree medical benefits provided to Class Members during the period commencing January 1, 2013 and ending on the date that the VEBA is implemented, plus interest using an annual rate of 6.5 percent. For fees and expenses incurred through May 31, 2015, the court awarded class counsel \$150,240.50. For work subsequent to that date, class counsel may submit a supplemental petition.

[Int'l Union v. Kelsey-Hayes Co., No. 11-CV-14434 VS., \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 5460631 \(E.D. Mich. Sept. 17, 2015\)](#). In a certified class action challenging Defendants' decision to terminate retiree medical benefits, the court entered judgment for Plaintiffs on their LMRA and ERISA claims, and ordered that: (1) Defendants must comply with ERISA and their 1998 and 2001 CBA retiree healthcare obligations; (2) Defendants must promptly restore the *status quo ante*; (3) Defendants must provide the promised health insurance at no premium cost to class members, for the lifetime of each class member (4) Defendant must promptly take such action as necessary to identify, account for, and make whole class members for the expenses incurred by class members due to Defendants' unilateral changes; and (5) that the court retains jurisdiction over the remaining issues in this case, as well as any post-judgment matters.

In [\*Amos v. PPG Indus., Inc.\*, No. 2:05-CV-70, 2015 WL 4881459 \(S.D. Ohio Aug. 13, 2015\)](#), the court finally approved the following class action settlement involving a challenge to Defendant's unilateral modification of collectively-bargained retiree health benefits. The Settlement Agreement provides Plaintiffs and their spouses and dependents with post-retirement health benefits through December 31, 2025, the amount and form of which differs based on the Medicare eligibility of the settlement class members.

**Non-Medicare Eligible Settlement Class Members** - Axiall Corporation will continue to provide its benefits plan for non-Medicare eligible Settlement Class members through December 31, 2015. From January 1, 2016 through December 31, 2025, Axiall Corporation will continue to provide each non-Medicare eligible member with a monthly credit of \$495 to be used for reimbursement for qualified medical expenses. When these members become Medicare eligible, they may receive the benefits provided to Medicare-eligible Settlement Class members as described below.

**Medicare-Eligible Settlement Class Members** - Axiall Corporation will continue to provide a monthly credit of \$100 to Medicare-eligible Settlement Class members through December 31, 2015. From January 1, 2016 through December 31, 2025, Axiall Corporation will provide each Medicare-eligible member with a monthly credit of \$100 to be used for reimbursement for qualified medical expenses. Additionally, Axiall Corporation will provide each member with a one-time lump sum subsidy credit of \$325.

The Settlement Agreement also provided for \$200,000 in attorneys' fees. The court found this reasonable given that the total lodestar was \$257,942.75. Hourly rates of the attorneys ranged from \$240/hour to \$625/hour.

In *Ford v. Fed.-Mogul Corp.*, No. 2:09-CV-14448, 2015 WL 110340 (E.D. Mich. Jan. 7, 2015), the court finally certified a class action and approved the Settlement Agreement for the class defined as:

Any (1) individual formerly employed at a Champion Spark Plug facility, in a unit represented by the UAW, who retired before January 1, 1994 (excluding deferred vested retirements, unless made eligible for retirement healthcare coverages under a plant closing agreement) with retirement healthcare coverages, and who is eligible for retirement healthcare coverages sponsored by Federal-Mogul Corporation; and (2) surviving spouse of a deceased individual identified in item (1) who is eligible for retirement healthcare coverages sponsored by Federal-Mogul Corporation.

Under the Settlement Agreement, class members will have the choice of enrolling in one of two health insurance plans. Federal–Mogul will implement the two settlement plans based on individual retiree and surviving spouse election, and Federal–Mogul will be released from any claims for monetary damages in connection with the November 2009 benefit modifications. As part of the settlement, Federal–Mogul will pay class counsel reasonable attorney’s fees and costs for work done in this litigation in the amount of \$340,000. From this amount, class counsel will reimburse UAW for certain attorney fees and costs advanced by UAW during the litigation.

F. Seventh Circuit

[Merrill v. Briggs & Stratton Corp., No. 10-CV-700, 2015 WL 5172943 \(E.D. Wis. Sept. 2, 2015\)](#). In class action suit alleging that defendants violated the parties’ collective bargaining agreement by reducing health benefits of employees who retired before August 1, 2006, the court concluded that Plaintiffs’ claim challenging the 2010 changes to retiree benefits is not barred by the statute of limitations. The court denied the parties’ *Daubert* challenges to the other side’s experts. The court found that summary judgment is not appropriate, and Plaintiffs are entitled to a trial on the issue of whether the 2010 and subsequent changes are reasonably commensurate with the pre–2006 benefits. Plaintiffs will first need to succeed in proving that the parties intended for the benefits to vest, using extrinsic evidence, before it is entitled to reasonably commensurate benefits.

G. Eighth Circuit

H. Ninth Circuit

[JUAN M. REYES, et al., Plaintiffs, v. BAKERY AND CONFECTIONERY UNION AND INDUSTRY INTERNATIONAL PENSION FUND, et al., Defendants., No. 14-CV-05596-JST, 2015 WL 5569462 \(N.D. Cal. Sept. 22, 2015\)](#). In an action challenging an amendment to a pension plan, on an unopposed motion for class certification, the court certified a class defined as follows:

All participants in the Bakery and Confectionery Union and Industry International Pension Fund or, if deceased, their beneficiaries or Estates, who (i) accrued (a) years of Covered Employment credits and (b) age credits towards eligibility for pension benefits under Plan C (also known as the “Golden 90”) or Plan G (also known as “Golden 80”), and (ii) who would be eligible for Plan C or Plan G benefits except that their age and years of service first totaled 80 (with respect to Plan G eligibility) or 90 (with respect to

Plan C eligibility) on or after May 1, 2012, at a time when they were not working in covered employment.

The court appointment Class Representatives: Plaintiffs Juan M. Reyes, Salvatore Tagliareni, Angel De La Cruz, Antonio Merolla, Smail Musovic, Tesfaye Ghebremedhin, Philip Rogers, Almond Reid, Carmelo Calabro, Russell Neubert, and John Williams. Class counsel includes the Law Office of Geoffrey V. White, Sinclair Williams LLC, Frumkin & Hunter LLP, and Abbey Spanier LLP.

[Bush v. Liberty Life Assurance Co. of Boston, No. 14-CV-01507-YGR, F.Supp.3d , 2015 WL 5475082 \(N.D. Cal. Sept. 16, 2015\)](#). In a putative class action challenging veteran benefit offsets in Liberty Life’s group disability policies; the court granted in part and denied in part Defendants’ motion to dismiss several claims in Plaintiffs’ First Amended Complaint (“FAC”). The FAC asserted twelve claims for: (1) disability benefits under section 502(a)(1)(B), against Liberty Life; (2) equitable relief pursuant to sections 102 and 502(a)(3), against Hyundai and the Administrator Class; (3) equitable relief and disgorgement pursuant to section 502(a)(3), against Liberty Life; (4) breach of fiduciary duty under section 404, against Liberty Life; (5) breach of fiduciary duty under section 404, against Hyundai and the Administrator Class; (6) co-fiduciary liability under section 405(a), against Liberty Life; (7) prohibited transactions under section 406(a) and (b), against Liberty Life based on its recoupment of alleged benefit overpayments; (8) violations of sections 104 and 402 and monetary penalties under sections 502(a)(1)(A) and 502(c), against Hyundai; (9) violation of section 503, against Liberty Life and Hyundai; (10) declaratory and injunctive relief under section 502(a)(3), against Liberty Life; (11) declaratory and injunctive relief and restitution under sections 2201–02, against Liberty Life for making an “attachment, levy or seizure” in violation of the anti-attachment provision in 38 U.S.C. § 5301(a)(1); and (12) knowing participation in a fiduciary breach by a non-fiduciary under section 502(a)(3), against Liberty Life. The court dismissed only Count IV for breach of fiduciary duty under section 404 to the extent it seeks to hold Liberty Life responsible for deficiencies with the Summary Plan Description; Count VII (prohibited transaction); and Count XI (purported violation of 38 U.S.C. § 5301(a)).

In [K.M. v. Regence Blue Shield, No. C13-1214RAJ, 2015 WL 519932 \(W.D. Wash. Feb. 9, 2015\)](#), Plaintiffs filed unopposed motions for certification of settlement subclasses and for preliminary approval of a settlement agreement that appears to fundamentally change the insurance landscape for all of defendants’ Washington insureds with developmental disabilities and autism. The court granted the motion for certification and but denied the motion for preliminary approval. If approved, the settlement agreement would resolve three cases: the instant action, *K.M. v. Regence BlueShield*, Case No. 13–1214–RAJ, another matter pending

before this court, *J.T., S.A. v. Regence BlueShield*, Case No. 1290–RAJ, and a third action which is pending in state court, *O.S.T. v. Regence BlueShield*, Case No. 11–2–34187–9 SEA, King County Superior Court (J. Erlick). Although the court found that the global agreement appears to be fair and reasonable, the court declined to issue a ruling that impacts cases which are not pending before it. Additionally, Plaintiffs did not provide the court with any authority that suggests the court would have jurisdiction to bind parties to the agreement who are not parties to the actions pending before this court. Accordingly, the court directed Plaintiffs’ counsel to submit a revised motion for preliminary approval that separates the relief sought from this court from the relief sought in state court.

I. D.C. Circuit

**Court approves class action settlement for interest on delayed lump-sum retirement payments.** In [Stephens v. US Airways Grp., Inc., No. 07-1264 \(RMC\), F.Supp.3d , 2015 WL 1949749 \(D.D.C. Apr. 30, 2015\)](#), the court wrote an Opinion to further explain its grant of the parties’ Joint Motion for Final Approval of Class Action Settlement and Class Counsel’s Motion for Approval of Attorneys’ Fees and Expenses. The court approved of a \$5.25 million class action settlement to remedy claims of certain retired U.S. Airways pilots. The Class consists of pilots who chose to receive a lump sum payment as a full or partial distribution of their retirement benefits, but who did not receive their lump sum payment on the first day of the month after the pilot retired and did not receive interest on the delayed payment. The court granted Class Counsel’s motion for an award of \$2 million in attorneys’ fees, \$75,000 in litigation expenses, and a maximum of \$75,000 for settlement administrative expenses. After accounting for attorneys’ fees and costs, the settlement amount represents a recovery of over 70% of the damages for the Class based on an administrative delay of 45 days at 6% interest, without prejudgment interest.

VI. *Disability Benefit Claims*

A. First Circuit

**Denial of LTD benefits not an abuse of discretion where administrator relied on three reviewing doctors and surveillance to support its claim decision.** [Smith-Emerson v. Liberty Life Assurance Co. of Boston, No. 14-CV-120-PB, 2015 WL 8483293 \(D.N.H. Dec. 9, 2015\)](#) (Judge Paul Barbadoro). After being struck in the head with a soccer ball, Plaintiff experienced ongoing neck pain and other complications for which she saw a myriad of doctors to treat her pain. Liberty Life paid her short-term disability benefits but did not approve her claim for long-term disability benefits. In reviewing Liberty Life’s decision under an abuse of discretion

standard of review, the court found that Liberty Life's decision was supported by an array of medical and non-medical evidence. This evidence included paper reviews from Dr. Philipp Chemaly, Dr. David Monti, and Dr. Steven Lobel, who each concluded that she was capable of working a full-time sedentary or light-duty job. Further, five of Plaintiff's own treating providers concluded, at various times, that Plaintiff was capable of performing either a sedentary or light-duty job and only one doctor concluded that Plaintiff was entirely disabled and incapable of working, and he reached this conclusion without reviewing the surveillance videos. The court found that the surveillance videos reinforce the conclusion that Plaintiff is capable of working a sedentary or light-duty job. The surveillance shows Plaintiff gardening, walking on a treadmill, shopping, and carrying bags, among other activities. Plaintiff did not address the wide discrepancies between her reported activity – spending “most of the day in bed” with debilitating pain – and the surveillance showing her leading a generally active lifestyle. The court found that at a minimum, the videos lend support to Liberty Life's conclusion that Plaintiff could perform a job that requires mostly sitting, typing, and answering the phone.

[Cannon v. Aetna Life Insurance Company, et al., No. CV 12-10512-DJC, 2015 WL 7566674 \(D. Mass. Nov. 23, 2015\)](#) (Judge Denise J. Casper). The court granted Aetna's motion for summary judgment on Plaintiff's claim for short-term disability benefits, finding that Plaintiff did not meet his burden of establishing his eligibility for those benefits. Although his treating doctor's Attending Physician Statement and the Social Security Administration's determination letter provide some supporting evidence, Aetna need not defer to the treating doctor or the SSA.

**Aetna abused its discretion in terminating long-term disability claim by relying on faulty medical reviews and failing to take into consideration impact of chronic medication usage.** [Young v. Aetna Life Insurance Company and Children's Hospital Boston Group Long Term Disability Plan](#), No. 4:13-CV-40154-TSH, 2015 WL 7194812 (D. Mass. Nov. 16, 2015) (Judge Timothy S. Hillman). On abuse of discretion review, the court found that Aetna's determination that Plaintiff can function in a fulltime capacity as a dispatcher, a hospital admitting clerk, or a medical social worker is simply not plausible, nor supported by the record. The court found this to be a case in which “the claims administrator failed to provide reasoned support for its conclusions and ignored credible evidence of disability, choosing instead to rely selectively on discrete findings, which appear reasonable when sewn together to form a termination letter, but are highly questionable when viewed in the context of the entire record.” Aetna's decision was supported by the reports of Dr. Topper, Dr. McPhee, and Dr. Polanco, which the court criticized in detail. The court also found that Aetna abused its discretion by failing the address the impact of Plaintiff's chronic medication usage on her ability to perform a fulltime sedentary occupation at the requisite wage rate. The court was convinced that Plaintiff was clearly entitled to benefits

so declined to remand the case to the claims administrator for further evaluation. The court reinstated Plaintiff's long-term disability claim.

[ELIZABETH A. ROSS, Plaintiff, v. HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY, GENZYME CORPORATION, & GROUP LONG TERM DISABILITY PLAN FOR EMPLOYEES OF GENZYME CORPORATION, Defendants., No. 14-12748-GAO, 2015 WL 5680329 \(D. Mass. Sept. 25, 2015\).](#) The court granted Hartford's motion to dismiss, finding that Plaintiff does not state a claim for relief under the ADA by alleging that Defendants refused to extend a particular benefit for one disabled population to all disabled populations because it limits benefits for mental disabilities to 24 months. Because the ADA claim fails, the court also found that the ERISA claim for benefits cannot stand.

[Gladstein v. Lincoln Fin. Grp., No. CA 14-390-ML, 2015 WL 5615173 \(D.R.I. Sept. 23, 2015\).](#) The court granted Lincoln's motion for summary judgment on several issues related to Plaintiff's long-term disability claim. The court found that Lincoln's acceptance of the annotated \$90,000 check Plaintiff submitted as offset for the SSDI payments she received does not constitute full accord and satisfaction and she is obligated to repay the full amount of any overpayments she incurred. Further, the SSDI benefits awarded to Plaintiff's daughter are included in "Other Income," as defined in the Policy, and they must be included in the calculation of the overpayment which Plaintiff incurred. The court found that Lincoln is authorized to reduce LTD benefit payments awarded to Plaintiff until full reimbursement of the overpaid amounts were made.

[BARBARA NEWMAN, Plaintiff v. METROPOLITAN LIFE INSURANCE COMPANY, et al., Defendants. Additional Party Names: Lehman Bros. Holdings, Inc., No. 12-10078-DJC, 2015 WL 5447613 \(D. Mass. Sept. 16, 2015\).](#) MetLife did not abuse its discretion denying Plaintiff's short-term, long-term, and supplemental long-term disability claims, where Plaintiff claimed disability following neck and back injuries she sustained in a fall.

[JULIE COWERN, Plaintiff, v. THE PRUDENTIAL INSURANCE COMPANY OF AMERICA & STAPLES VOLUNTARY LONG TERM DISABILITY PLAN, Defendants., No. 14-10123-ADB, F.Supp.3d , 2015 WL 5330851 \(D. Mass. Sept. 11, 2015\).](#) Prudential's decision to terminate Plaintiff's long-term disability benefits was arbitrary and capricious and remanded the claim to Prudential for further proceedings. The court found that Prudential's decision was arbitrary and capricious because it selectively focused on evidence undermining Plaintiff's claim

while failing to address contrary evidence. The court found that Prudential did not abuse its discretion in applying the “self-reported symptoms” limitation to her claim. However, the court cautioned Prudential that on remand it should interpret the limitation and apply it consistently with the language of the disability policy and its own internal guidelines. Prudential’s reviewing doctors and consultants included Dr. David Dickison (Occupational Medicine), Dr. Richard Day (Prudential VP and Medical Director), Dr. Elena Antonelli (Occupational Medicine), Dr. Raj Vuppalanchi (Gastroenterology/Internal Medicine), Dr. Thomas Liebermann (Gastroenterology/Internal Medicine), Dr. Rajesh Wadhwa (Prudential’s Medical Director, Occupational and Internal Medicine), Frances Grunden, MS, CRC.

**Failure to consider material duties of “Own Occupation” is an abuse of discretion and \$5,000 document penalty affirmed against Aetna.** In [\*McDonough v. Aetna Life Ins. Co.\*, No. 14-1293, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 1684079 \(1st Cir. Apr. 15, 2015\)](#), the First Circuit reversed the district court’s decision in favor of Aetna and found that Aetna abused its discretion by not considering the material duties of Plaintiff’s particular position and assessing how those duties align with the position as it is normally performed in the national economy. The court held that Aetna’s failure to articulate the contours of the own occupation standard, apply that standard in a meaningful way, and reason from that standard to an appropriate conclusion regarding the Plaintiff’s putative disability renders its benefits-termination decision arbitrary and capricious. None of the four internal reviewers upon whom Aetna relied compared Plaintiff’s symptoms or impairments to any description of the physical and cognitive demands of his own occupation. Aetna also never took the obligatory step of assessing whether and to what extent Plaintiff’s impairments compromised his ability to carry out the material duties of his own occupation as normally performed in the national economy. Because the court deemed this “a close case” with voluminous and conflicting medical evidence, it vacated the entry of summary judgment on the benefits-termination claim and remanded to the district court with instructions to remit the matter to Aetna for further review in light of the opinion. Lastly, the court affirmed the district court’s imposition of a \$5,000 penalty pursuant to 29 U.S.C. § 1132(c)(1)(B), which averaged \$4/day (instead of the available \$110/day penalty) for each day the administrator was late in producing a plan document. The document was a policy agreement that contained discretionary language which impacted the standard of review. The court found that Plaintiff was not prejudiced by the late production and the administrator did not act in bad faith.

In [\*Clark v. Janssen Pharm., Inc.\*, No. 14-1701, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 1567097 \(1st Cir. Apr. 8, 2015\)](#), the court affirmed the district court’s dismissal of Plaintiff’s claims for short and long-term disability benefits against her employer, her employer’s parent company, and the Reed Group (third-party benefits administrator), because Plaintiff did not demonstrate disability during the seven consecutive day waiting period required by the short-term disability plan. Further,

receipt of long-term disability benefits was contingent upon receipt of short-term disability benefits. In this case, Plaintiff terminated employment on the same day she sought disability benefits based on an inability to do her work owing to narcolepsy cataplexy syndrome.

**Disability plan's limited conditions provision applies where limited condition co-exists with non-limited condition.** In [\*Dutkewych v. Standard Ins. Co.\*, No. 14-1450, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 1412590 \(1st Cir. Mar. 30, 2015\)](#), the court upheld Defendant's denial of LTD benefits based on the plan's mental disorder limitation because, even though Plaintiff had been diagnosed with chronic Lyme disease, his mental disorders, regardless of their cause, contributed to his disability. Defendant interpreted the statement that "[p]ayment of LTD benefits [was] limited to 24 months during [a participant's] entire lifetime for a Disability caused or contributed to by" mental disorders (as well as by another plan provision governing what would occur when a period of disability was extended by a new cause while LTD benefits were payable) to mean that the mental disability limitation continues to apply after two years if a physical non-limited condition co-exists with a limited condition. The court found that this was not an unreasonable interpretation of the plan terms. Lastly, the court found that Defendant was permitted to rely on the plan's limited conditions provision because it relied on the provision throughout the internal appeals process, such that its analysis for purposes of litigation was not a mere post-hoc rationalization or new basis for the denial of benefits.

**Discretionary language contained in late-produced policy document is enforceable.** In [\*Young v. Aetna Life Ins. Co.\*, No. CIV.A. 13-40154-TSH, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 849053 \(D. Mass. Feb. 27, 2015\)](#), a matter challenging the termination of long-term disability benefits, Plaintiff filed a motion to exclude documents from the record, which included documents submitted by Defendants marked as "Young Policy 000001 to 000062" ("Proposed Policy"), on the basis that they were not disclosed to Plaintiff during the internal appeals process. The Proposed Policy contains language granting to Aetna "discretionary authority" to determine whether covered employees are entitled to benefits under the plan. During the internal appeals process, despite Plaintiff's repeated requests for a full set of documents for the Children's Hospital Boston Group Long Term Disability Plan, she was never given a version containing the discretionary authority language. Now, at the eleventh hour, the discretionary authority provision appears on the last page of the Proposed Policy submitted by Defendants. Although an insurer's failure to provide beneficiaries with correct plan documents after repeated requests is worthy of reproach, and despite the troubling fact that Aetna appears to be a repeat offender, that a plaintiff lacks notice of a plan's discretionary authority provision during the initial determination process is not so consequential that it warrants exclusion from the record. The court did note, however, that the failure to provide beneficiaries with complete plan documents during the initial determination and internal appeals process may reflect on the insurer's ability to engage in a

reasoned and principled decision making process. The court declined to exclude the discretionary authority provision and denied Plaintiff's motion.

B. Second Circuit

[Sobhani v. Reliance Standard Life Ins. Co., No. 14-3430-CV, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 9245104 \(2d Cir. Dec. 18, 2015\)](#) (Present JOSÉ A. CABRANES, BARRINGTON D. PARKER, RAYMOND J. LOHIER, JR., Circuit Judges). Insurer did not abuse discretion denying long-term disability benefits to aircraft engineer who worked full-time during the Elimination Period and was not incapable of performing at least some of his material duties.

***De novo* review applies where discretionary language is contained only in SPD and not Plan documents.** [The Estate of Kim Bochniarz v. Prudential Insurance Company of America, No. 1:11-CV-0867EAW, 2015 WL 8516432 \(W.D.N.Y. Dec. 11, 2015\)](#) (Judge Elizabeth A. Wolford). The court adopted the magistrate judge's recommendation that the *de novo* standard of review apply to Prudential's denial of Plaintiff's long-term disability benefits claim and premium waiver for group life insurance coverage. Here, the parties disagree as to whether the Sunbelt Beverage Company, LLC Long Term Disability Coverage Plan gave Defendant, as the plan administrator, discretionary authority to determine when a covered individual was disabled. The only document containing language concerning discretionary authority is the Summary Plan Description. The documents comprising the Plan (including the Plan Contract and the Group Insurance Certificate) are silent on this point. The court expressed disappointment that Prudential did not disclose a case where the arguments it put forward in support of its motion were rejected in *Hamill v. Prudential Ins. Co. of America*, No. 11-cv-1464 (SLT)(CLP), 2013 WL 27548 (E.D.N.Y. Jan. 2, 2013), a matter involving its current counsel. In *Hammill*, the court held that a conflict existed between the SPD and the formal plan documents and that, pursuant to *Amara*, the plan documents controlled.

**Disability pension benefits denied to participant who was neither employed nor actively seeking covered employment as of the date of disability.** [Labombard v. Winterbottom, No. 8:14-CV-00071 MAD, 2015 WL 6801206 \(N.D.N.Y. Nov. 6, 2015\)](#) (Judge Mae A. D'Agostino). The court granted summary judgment in favor of Defendants on Plaintiff's claim for disability benefits under the Laborers' Pension Fund of Local Union No. 186 (the "Fund"). Plaintiff was an enrolled member of Local Laborers' Union No. 186, Plattsburgh, New York starting in 1988 and undisputedly was engaged in covered employment with the Union from 1988 to 2008. On February 8, 2013, Plaintiff submitted an application to the Fund for a disability pension resulting from injuries sustained in a car accident on November 13, 2012, stating that his last day of covered employment was November 13, 2012. Plaintiff's application was denied on April 17,

2013 in a letter from Defendant Winterbottom stating that “[a] participant must be employed or actively seeking employment that would earn Pension or Vesting Service when the incident or illness that causes the disability occurs. According to our records, you last worked in covered employment in 2008 and your Social Security Award does not start until May 2013.” Plaintiff appealed and claimed that he was entitled to benefits because he was a dues paying member of the Fund and that he was at all times, ready, willing and able to appear for any jobs assigned by the Laborers’ Union and was actively seeking employment but none had been assigned since 2008. Defendant Winterbottom informed Plaintiff that his appeal was denied based on the absence of any evidence that Plaintiff was actively seeking work during the period between his last date of covered employment in 2008 and the date he became disabled. The Trustees also found that Plaintiff was working as an operating engineer (non-covered employment) during this time and that he was not on the Union’s out of work list when his disability began. Plaintiff claimed that he was never told that he had to fill out an out of work form, but he did not raise this argument during the administrative review process. The court found that it was not arbitrary and capricious for the Trustees to rely on statements made by a union trustee that he observed Plaintiff working as an operating engineer. The court also found that it was not the Fund’s burden to show that Plaintiff was called for work and turned it down.

**On *de novo* review, claimant disabled by degenerative disc disease is entitled to “any occupation” long-term disability benefits.** [Solnin v. Sun Life & Health Ins. Co., No. 08-CV-2759 DRH AYS, 2015 WL 6550549 \(E.D.N.Y. Oct. 28, 2015\)](#) (Senior Judge Denis R. Hurley). Previously in this matter the court determined that *de novo* review applied because Sun Life did not render a decision within the timelines set forth in ERISA’s regulations. On review of the merits of Plaintiff’s long-term disability claim, the court determined that Plaintiff has proven by a preponderance of the evidence that she is entitled to disability benefits. In sum, Plaintiff’s case was supported by the clinical findings of an orthopedic surgeon who treated Plaintiff for over 15 years, and who has consistently opined based on his longitudinal treatment of Plaintiff, that she is totally disabled and unable to work in her own or any occupation. Plaintiff also relied on a detailed vocational examination which confirmed that Plaintiff is totally disabled from any competitive job. Sun Life relied primarily on video surveillance of Plaintiff conducted on 17 days throughout 2002–2012 as well as the medical records of several other physicians, including that of an independent medical examiner, which they claim demonstrate that Plaintiff is not Totally Disabled under the plan. With respect to the surveillance, the court found that although it shows Plaintiff driving and leaving her home to attend physical therapy, eat, and shop, as well as carrying items to and from her car, it does not speak to Plaintiff’s ability to sit/stand/walk/lift/carry on a *consistent* basis.

In [Valentine v. Aetna Life Ins. Co., No. 14-CV-1752 JFB GRB, 2015 WL 5024569 \(E.D.N.Y. Aug. 25, 2015\)](#), the court granted summary judgment in favor of Plaintiff on her claim for long-term disability benefits, finding that even under the deferential standard of review, Dr. Stuart Rubin's (Independent Physician Consultant who is certified in Physical Medicine and Rehabilitation) report and Aetna's corresponding denial of Plaintiff's claim after June 30, 2012, failed to address substantial parts of the claim file, and are, therefore, "not reasonably consistent with the record as a whole." Plaintiff is disabled by trigeminal nerve disorder. The court remanded the claim to Aetna for reconsideration.

**The ACA's contraceptive coverage mandate does not substantially burden religious exercise in violation of the RFRA.** In [Catholic Health Care Sys. v. Burwell, No. 14-427-CV, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4665049\(2d Cir. Aug. 7, 2015\)](#), the Second Circuit reversed the district court's summary judgment decision concluding that regulations promulgated under the Patient Protection and Affordable Care Act that allow religious non-profit employers to opt out of providing contraceptive coverage themselves violate these religious employers' rights under the Religious Freedom Restoration Act. The Second Circuit concluded that the challenged accommodation for religious objectors relieves, rather than imposes, any substantial burden on Plaintiffs' religious exercise, and thus does not violate the Religious Freedom Restoration Act.

In [Silverman v. Unum Grp., No. 14-CV-6439 DLI SMG, 2015 WL 4603345 \(E.D.N.Y. July 30, 2015\)](#), Plaintiff was part owner and employee of a company where his siblings were the other owners. Plaintiff contested that the relevant disability policy covering him and his siblings constituted an ERISA plan. The court disagreed. Although the Second Circuit has not addressed whether a plan is governed by ERISA where the only participants are shareholder co-owners of a corporation who are not spouses, following the Fifth Circuit's decision in *Provident Life & Acc. Ins. Co. v. Sharpless*, 364 F.3d 634 (5th Cir.2004), the court found that Plaintiff is considered an employee under ERISA and his plan is an ERISA plan.

**Claimant sort of wins!** In [Mead v. Reliastar Life Ins. Co., No. 2:05-CV-332, 2015 WL 4203956 \(D. Vt. July 10, 2015\) \(Not Reported in F.Supp.3d\)](#), the court found that Defendant's denial of "any occupation" benefits was not adequately supported by substantial evidence and the court remanded the case to the plan administrator to conduct a more thorough analysis to give credence to Plaintiff's subjective statements of pain, to contrary medical reviews, and to the court's previous findings about Plaintiff's limitations. Notably, with respect to the standard of review, the court found that it was reasonable to view the SPD with discretionary language as part of the Plan itself. The SPD is in the final section of a document entitled "Long Term Disability Plan," and is included the document's table of contents. The SPD contains a detailed

description of claim procedures, a statement of ERISA rights, and Defendant's final discretionary authority, which are not provided elsewhere in the Plan. The court found that the fact that the SPD and the Long Term Disability Plan are in a single document, with some critical information provided exclusively in the SPD, supports ReliaStar's assertion that the SPD is a part of the Plan. The court distinguished *Amara*, finding that the SPD complements, rather than conflicts with, other information in the Plan and is bound as part of the Plan documents.

**Claimant wins!** In [\*Doe v. Unum Life Ins. Co. of Am.\*, No. 12-CV-9327 LAK, 2015 WL 4139694 \(S.D.N.Y. July 9, 2015\)](#), where Plaintiff, a litigation partner, who claimed disability due to depression, OCD, ADHD, and OCPD, exacerbated by his wife's medical problems, had his long-term disability claim denied by Unum. On *de novo* review (stipulated by the parties), the court found that Plaintiff was entitled to benefits notwithstanding negative reviews conducted by F. William Black, Ph.D. (a medical consultant for Unum specializing in neuropsychology), Nicholas B. Kletti, M.D., (a medical consultant for Unum and board certified in psychiatry), and Keith A. Caruso, M.D., (a medical consultant for Unum and board certified in psychiatry). The court rejected Unum's contention that Plaintiff's highly successful legal career undercuts his diagnoses because these illnesses typically begin in adolescence or early adulthood. The court credited Plaintiff's doctor's opinion that his conditions likely have been lifelong but remained latent until his debilitating symptoms emerged in 2010. The court also rejected Unum's criticism of Plaintiff's doctor for providing a summary of treatment rather than his complete office visit notes, where Unum agreed to accept a summary of care letter in lieu of original medical records. The court also found there was more than sufficient documentation from Plaintiff's doctor to credit his medical opinion. Lastly, the court rejected Unum's reviewers' claims that neuropsychological testing suggested that Plaintiff was exaggerating his symptoms or possibly malingering. Other doctors concluded that the results reflected psychopathologically significant findings rather than malingering.

**Claimant loses.** In [\*Dukes v. Liberty Life Assur. Co. of Boston\*, No. 14-CV-00806, 2015 WL 4132975 \(D.N.J. July 7, 2015\)](#), the court found that Liberty's termination of "own occupation" LTD benefits for a former Wells Fargo Service Manager impaired by degenerative disc disease and multilevel facet arthropathy was not arbitrary and capricious. Liberty relied on a pure paper medical review conducted by Raymond J. Chagnon, M.D. to deny Plaintiff's claim and a paper review by Dr. Jamie L. Lewis to uphold the denial on appeal.

In [\*Arnone v. Aetna Life Ins. Co.\*, No. 13-CV-5168 SJF, 2015 WL 3915607 \(E.D.N.Y. June 25, 2015\)](#), the court denied Plaintiff's claims seeking to recover LTD benefits. He alleged that he is entitled to reimbursement of the amount by which Defendant offset his LTD benefits with

Workers' Compensation benefits; his future LTD benefits should not be offset by his personal injury settlement award; and dependent Social Security benefits should not be considered in calculating his LTD benefits. The court granted Defendant's counterclaim seeking reimbursement for overpayment of Plan LTD benefits in the sum of \$40,125.28.

**Denial of short-term disability benefits was *de novo* wrong but failure to render a timely decision on the long-term disability claim does not warrant *de novo* review.** In [Rao v. Life Ins. Co. of N. Am., No. 5:12-CV-1459, F.Supp.3d , 2015 WL 1849866 \(N.D.N.Y. Apr. 23, 2015\)](#), the court found that Plaintiff, a cashier disabled by herniated cervical disk without myelopathy and bipolar I disorder – mixed, was entitled to short-term disability benefits under a policy insured by LINA, but remanded Plaintiff's long-term disability ("LTD") claim to LINA for a determination. Because the parties did not clearly indicate their intent or consent to a bench trial on the papers with the court acting as the finding of fact, the court applied the well-established summary judgment standard to each party's motion. The court made several notable findings with respect to Plaintiff's disability claims.

Plaintiff's treating physicians were unified in their opinion about the disabling nature of her condition; repeatedly concluding at various points that Plaintiff was so disabled as to be precluded from even the demands of "medium" work as that term is defined in the DOT. In contrast, LINA's denial was based only on the assessment of Dr. Stephen Jacobson, LINA's Medical Director, who discounted the opinions of Plaintiff's doctors on the basis of perceived deficiencies in their medical records rather than on the basis of any genuine medical determination and discounted Plaintiff's MRI studies for their failures to "quantify" the degree of resulting impairment. Denial of benefits based on the lack of "time concurrent" medical evidence and alleged failure of Plaintiff's various physicians to perform certain methods of testing – requirements not found in the short-term disability policy, is improper. Although LINA had no duty to accord any special weight to the opinions of treating doctors, it cannot arbitrarily ignore credible medical evidence simply because it comes from a claimant's treating source.

With respect to the LTD claim, LINA's failure to render a timely decision was not a deemed "denial" terminating LINA's authority to exercise its discretion. As such, Plaintiff's claim for LTD benefits should be reviewed under the more deferential arbitrary and capricious standard. The court remanded Plaintiff's entire LTD benefits claim to LINA to render a decision since reviewing this claim without reference to any underlying decision by LINA would essentially amount to a *de novo* determination by the court.

In [Delprado v. Sedgwick Claims Mgmt. Servs., Inc., No. 1:12-CV-00673 BKS, 2015 WL 1780883 \(N.D.N.Y. Apr. 20, 2015\)](#), the court found that Defendants' decision to deny Plaintiff's first STD claim was reasonable based on Plaintiff's unclear diagnosis at the time, but that its

decision to deny Plaintiff's second STD claim, after she was diagnosed with fibromyalgia, was arbitrary and capricious. Defendants committed myriad errors in making their decision, including not properly considering subjective symptoms of pain and fatigue and the opinions of the doctors who examined her, relying on a flawed report, failing to issue a formal determination letter regarding Plaintiff's appeal, and failing to provide adequate notice of what information was necessary to show disability due to fibromyalgia. Defendants rejected the claim on the basis that Plaintiff had not satisfied the required waiting period, and therefore, the claim was never considered on the merits. Defendants' own errors in deciding Plaintiff's underlying second STD claim prevented Plaintiff from possibly satisfying the condition precedent of being found disabled for 180 days. The court remanded the claims to Defendants to consider all the relevant evidence under the appropriate standards but declined to order the matter stayed and retain jurisdiction during the remand.

In [\*Asberry v. Hartford Life & Acc. Ins. Co.\*, No. 14-CV-69 JMF, 2015 WL 857883 \(S.D.N.Y. Feb. 27, 2015\)](#), the court upheld Hartford's termination of Plaintiff's long-term disability benefit claim in this matter where Plaintiff claimed disability due to chronic back pain following a thoracic spinal fusion surgery to treat her scoliosis. Hartford found Plaintiff was no longer disabled after receiving information that Plaintiff was able to garden and serve as the president of her local community association, and surveillance of Plaintiff over a two-day period showed her carrying grocery bags, cleaning up outside her apartment, walking her dog, and attending a community meeting. Hartford also had Plaintiff evaluated in person by Dr. Robert DePorto, who concluded that Plaintiff was capable of "working in a sedentary capacity" and provided parameters for that definition, including sitting no more than six hours a day, standing no more than two hours a day, lifting no more than ten pounds at a time, and occasionally carrying small items such as office files. Hartford also commissioned an employability analysis report that identified two occupations—Sales Manager and Merchandise Manager—that are consistent with Plaintiff's physical limitations, educational background, and salary requirements. After Plaintiff appealed the denial to Hartford, Hartford retained Dr. Steven Lobel to conduct a peer review of Plaintiff's files and he concluded that Plaintiff was capable of "light level occupation" subject to restrictions similar to those imposed by Dr. DePorto. Plaintiff's treating doctor submitted an opinion that Plaintiff could not engage in full-time employment and Plaintiff was also considered disabled by the Social Security Administration. The court found that Hartford's denial of benefits was not an abuse of discretion.

In [\*Tretola v. First Unum Life Ins. Co.\*, No. 13 CIV. 231 PAE, 2015 WL 509288 \(S.D.N.Y. Feb. 6, 2015\)](#), Plaintiff alleged that she was entitled to long-term disability benefits due to fibromyalgia, irritable bowel syndrome ("IBS"), and syringomyelia. The court denied the parties' cross-motions for summary judgment to the extent they are based on Plaintiff's fibromyalgia and

IBS. The court found that a trial is necessary to enable the court to reach a judgment as to whether termination of Plaintiff's benefits was justified based on either or both of those conditions. The court ordered Plaintiff's counsel to produce to defense counsel and the Court all medical records of Plaintiff's treating physicians as of February 14, 2012, which First Unum requested but which were not produced. Counsel for each side will be at liberty at trial to offer these records into evidence and examine witnesses about them. However, the court granted First Unum's motion for summary judgment with respect to Plaintiff's syringomyelia because 1) none of Plaintiff's treating physicians, First Unum's medical consultants, or the SSA have opined that Plaintiff's syringomyelia was disabling; 2) there is no medical evidence to that effect; 3) those physicians consistently regarded that condition as stable and not as worsening; and 4) Plaintiff's own account of her symptoms belies her assertion that her syringomyelia was disabling.

### C. Third Circuit

**Under terms of policy, insurer may require disability claimant to exhaust all administrative appeals for SSDI benefits before paying estimated benefit offsets.** [McGlynn v. Reliance Standard Life Insurance Company, No. 3:14-CV-2033, 2015 WL 9182871 \(M.D. Pa. Dec. 17, 2015\)](#) (Judge A. Richard Caputo). In dispute in this case is whether Reliance Standard was obligated under the terms of the long-term disability policy to reimburse to Plaintiff estimated Social Security Disability Insurance ("SSDI") benefit offsets after Plaintiff's request for SSDI benefits was denied but not denied at the highest level without ability for further appeal. Plaintiff argued that the policy language requires only expiration of the social security appeal period before the estimated amount is paid and that the policy language does not require an insured to endlessly pursue a possibly frivolous appeal to the "highest level" in the federal court system. Plaintiff did not appeal her SSDI denial. The court found that the policy language was ambiguous but that Reliance's interpretation requiring Plaintiff to exhaust all administrative appeals before recovering the estimated offset was reasonable and not an abuse of discretion. The court denied Plaintiff's motion for judgment on the pleadings and granted Reliance Standard's motion for summary judgment.

**Denial of LTD benefits based on a perfunctory paper review and failure to investigate is an abuse of discretion.** [Granville v. Aetna Life Insurance Co., No. 3:14-CV-00211, 2015 WL 9026025 \(M.D. Pa. Dec. 15, 2015\)](#) (Judge Robert D. Mariani). The court granted Plaintiff's motion for summary judgment on her claim seeking long-term disability benefits. The court found that Aetna engaged in multiple procedural irregularities, including conducting a self-serving paper review of the medical files based on the incorrect disability standard, relatedly relying on the opinion of a non-treating, non-examining physician without reason, and denying benefits based on inadequate information and lax investigatory procedures, as evidenced by Aetna's decision not to pursue an independent medical examination and its failure to analyze the

specific requirements of Plaintiff's own occupation. The court found that these irregularities compounded each other throughout the review and appeal of Plaintiff's administrative claim and constituted an arbitrary and capricious denial of benefits. Here, Plaintiff's claim is based on objective evidence, specifically multilevel degenerative disc changes at the C4/C5 with severe changes at C6/C7 accompanied by a right posterior disc protrusion with moderate to severe narrowing of the right neural foramina at that level and severe spinal stenosis. The court found that nothing in Aetna's review indicates in any way that it challenges the existence of these significant limitations which Plaintiff has been objectively shown to possess. Aetna's decision to deny Plaintiff benefits on the strength of a perfunctory paper review, coupled with the absence of any effort on the part of Aetna to undertake any other action to support its decision, requires that its denial of Plaintiff's claim be deemed arbitrary and capricious.

**Abuse of discretion review applies to Aetna's LTD claim denial and it abused its discretion in finding that the claimant could work in a reasonable occupation making 60% of adjusted pre-disability earnings.** [Charles v. UPS National Long Term Disability Plan, et al., No. CV 12-06223, 2015 WL 6600399 \(E.D. Pa. Oct. 30, 2015\)](#) (Judge Lawrence F. Stengel).

This suit involves a denial of "any occupation" long-term disability benefits to Plaintiff, who suffers from a complex seizure disorder. Plaintiff had worked as a package car driver for UPS prior to his disability and returned to UPS on only a part-time basis as a pre-loader. On the issue of the standard of review, which the parties contested, the court found that abuse of discretion review applies based on discretionary language in the long-term disability policy. The court rejected Plaintiff's argument that the discretionary authority only applied to health claims and the argument that discretion has not been delegated to Aetna by the plan administrator. Here, the court found that Aetna was given discretionary authority by the terms of the Plan. On the claim for benefits, the court found that Aetna's requirement of clinical or objective evidence was an abuse of discretion. Specifically, the court found that Aetna's expectation that Plaintiff undergo some additional "clinical" test to prove that he is, in fact, experiencing fatigue from his medication, Lacmital, is arbitrary and capricious. The FDA has indicated that certain symptoms are common side effects of Lacmital. Plaintiff's doctors were continuously monitoring his treatment and to expect more under these circumstances is an abuse of discretion. The court also found that Aetna has an inherent conflict of interest that appeared to taint its claims decision. Only after finding that Plaintiff needed to make over \$30/hour under his current restrictions did Aetna seek a peer review to determine whether or not only the part-time restriction was necessary. The court further found that Aetna's use of a vocational analysis was an abuse of discretion. It did not comply with the plan terms and/or Aetna's interpretation of those plan terms. The court also found that Aetna's determination gave more weight to their own experts while giving little, if any, consideration to Plaintiff's own treating physicians. Aetna did not do anything to resolve conflicting medical opinions, including ordering an independent medical examination.

**Denial of LTD benefits not an abuse of discretion.** [Neno v. Aetna Life Ins. Co., No. CV RDB-14-03071, 2015 WL 6326445 \(D. Md. Oct. 20, 2015\)](#) (Judge Richard D. Bennett). The court granted summary judgment in favor of Aetna on Plaintiff's long-term disability claim. It found that the denial of LTD benefits was not arbitrary and capricious where Aetna reasonably defined the material duties of Plaintiff's "own occupation" (i.e., that his job duties were closer to those of a Satellite-Instruction Facilitator than a Training Instructor) and reasonably determined that Plaintiff could perform his material duties. The court further found that Aetna did not abuse its discretion by extending Plaintiff's short-term disability claim but subsequently denying his LTD benefit claim. Lastly, Plaintiff's SSDI award does not indicate that Aetna abused its discretion.

**Abuse of discretion review applies in face of challenge that unauthorized third-party made the benefits determination.** [Cipriani v. Liberty Life Assurance Co. of Boston, No. 4:12-CV-1335, 2015 WL 5923454 \(M.D. Pa. Oct. 9, 2015\)](#) (Judge Matthew W. Brann). The court adopted the Magistrate Judge's Report and Recommendation denying Plaintiff's motion seeking *de novo* review of his long-term disability denial. The court rejected Plaintiff's argument that Defendant delegated its responsibility for determining his eligibility for benefits to Liberty Mutual Insurance Company, an unauthorized third party. The LTD policy vests Liberty Life with the authority, "in its sole discretion, to construe the terms of [the] policy and to determine benefit eligibility." Stephanie Berry, an Appeal Review Consultant who was chiefly responsible for the final appeal decision, testified in a deposition that she believed she was employed by Liberty Life but actually paid by Liberty Mutual and that they were essentially "one and the same." Defendant relied on an affidavit from James Pugh (Liberty Life's Assistant Secretary) in which he asserted that although Ms. Berry and other Liberty Life personnel may have been paid by Liberty Mutual, at the time they were making the determinations, they were working for Liberty Life under the direction and control of Liberty Life's officers and board of directors. The court found that the evidence sufficiently indicates that Liberty Life made the benefits decisions being challenged and that Plaintiff's claims are subject to review for abuse of discretion. The court noted that "this controversy would be entirely avoidable if the defendant exercised greater care and clarity in its administration of this plan."

[ROBERT EMMERLING v. STANDARD INSURANCE COMPANY, No. CV 14-5202, 2015 WL 5729240 \(E.D. Pa. Sept. 30, 2015\)](#). The court determined that Standard's decision to not award Plaintiff short-term disability benefits was supported by substantial evidence and was not arbitrary and capricious, granting summary judgment in favor of Standard. The court found that

Standard took steps to minimize any structural conflict and Drs. Jacob Hart and Mark Shih's alleged conflicts of interest did not taint Standard's decision.

[\*DONA SNYDER, Plaintiff, v. HARTFORD LIFE INSURANCE COMPANY Defendant., No. 13-461-SLR-SRF, 2015 WL 5545055 \(D. Del. Sept. 18, 2015\).\*](#) On abuse of discretion review, the court ruled in favor of Hartford on Plaintiff's claim for long-term disability benefits, where Plaintiff suffered from panhypopituitarism and diabetes insipidus. Hartford had obtained four "independent" reviewing physicians: Dr. A. Wayne Meikle (endocrinology), Dr. James Lambur (orthopedic surgery), Dr. Charles Bliss (gastroenterology), Dr. Robert Cooper (endocrinology and internal medicine).

[\*Smith v. Metro. Life Ins. Co., No. CIV.A. 14-2288 ES, 2015 WL 5177633 \(D.N.J. Sept. 3, 2015\).\*](#) Plaintiff claimed that MetLife erroneously recovered overpayments made to him, in breach of a purported settlement reached by the parties. The court granted summary judgment to MetLife and dismissed the complaint in its entirety. First, to the extent that Plaintiff's Complaint is premised on characterizing March 2008 correspondence between the parties as a "contract/settlement," such claim is preempted by ERISA. Second, even applying the disability policy's three-year contractual limitations period generously to Plaintiff, his claim is time-barred.

**Court orders remanding benefit claims to the administrator do not constitute final and appealable decisions under 29 U.S.C. § 1291.** In [\*Stevens v. Santander Holdings USA Inc., No. 14-1481, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5000809 \(3d Cir. Aug. 24, 2015\).\*](#) the Third Circuit considered whether the district court's decision – finding that Liberty Life's termination of Plaintiff's short-term disability benefits was arbitrary and capricious and remanding the case to the plan administrator with instructions to reinstate STD benefit payments retroactively and to determine Plaintiff's eligibility for long-term disability benefit payments – constitutes a final and appealable decision under 29 U.S.C. § 1291. After applying the three-prong test the court recognized in *Papotto v. Hartford Life & Accident Insurance Co.*, 731 F.3d 265 (3d Cir.2013), the court held that the district retained jurisdiction over the case and that the order from which Defendants have appealed is not yet appealable. First, the remand order which instructs Liberty Life to consider fully Plaintiff's long-term disability benefits claim does not end the litigation on the merits and leave nothing for the court to do but execute the judgment. Second, the dismissal of this appeal for lack of jurisdiction will not mean that there can never be an appellate review of the order awarding Plaintiff's STD benefits. The district court did not intend to enter a final judgment under Fed.R.Civ.P. 54 as it did not make the findings required by that rule to enter a final judgment on either the STD or LTD claim. The court dismissed the appeal for lack of jurisdiction. The court made clear, "that regardless of delay or resource costs, this Court

generally will consider remands to ERISA plan administrators nonfinal because, in the ordinary case, they contemplate that the plan administrator will engage in further proceedings. We also make clear that we will interpret a district court's remand order to a plan administrator in an ERISA case as including a reservation of the court's jurisdiction over the case so that, after a determination by the administrator on remand, either party may seek to reopen the district court proceedings and obtain a final judgment." Lastly, the court declined to address Plaintiff's argument that orders remanding cases to plan administrators are not permissible under ERISA and "may even be unconstitutional" since Plaintiff did not file a cross-appeal from the district court's order remanding the case.

In [Musser v. Harleysville Life Ins. Co., No. 1:14-CV-2041, 2015 WL 4730091 \(M.D. Pa. Aug. 10, 2015\)](#), Plaintiff filed a motion to determine the standard of review and supplementation of the record, wherein Plaintiff argued that the court should review the administrators' denial of his long-term disability benefits *de novo* and permit discovery beyond the administrative record. The court found that the denial of benefits will be reviewed *de novo* and that no further discovery is warranted under the facts of this case. The court found *de novo* review applicable because Defendant did not issue a determination on Plaintiff's appeal and there is no analysis to which the court may defer. With respect to Plaintiff's proposed discovery, the court found that any discovery relating to Defendants' previous interpretations of the policy or why the claims representatives did or did not rely on certain information is not relevant to the court's *de novo* review, as the court gives no "deference or presumption of correctness" to the administrator's decisions.

In [Srivastava v. Guardian Life Ins. Co. of Am., No. CIV.A. 14-2568, 2015 WL 4610981 \(E.D. Pa. Aug. 3, 2015\)](#), the court found that Guardian's denial and termination of Plaintiff's long-term disability benefits was not arbitrary and capricious. Plaintiff is an oncologist and hematologist allegedly suffering from hemianopia and partial field of vision loss. Plaintiff argued that (1) Guardian's reliance on the independent medical opinions of Drs. Lawrence Reese (ophthalmologist) and Grant T. Liu (neuro-ophthalmologist), to the exclusion of her treating ophthalmologist, was arbitrary and capricious; (2) Guardian violated ERISA by relying on Dr. Reese's peer review for its initial decision and on appeal; (3) Guardian accepted the diagnoses of Drs. Reese and Betz, but ignored the caveats accompanying those diagnoses; and (4) Guardian ignored Plaintiff's self-reported symptoms. The court rejected each of these arguments and found that Guardian's determinations were supported by substantial medical evidence, especially where Plaintiff's treating doctors described the peer review as providing an excellent summary of Plaintiff's problems and was "outstanding and very thorough."

**Claimant wins!** In [\*Horn v. Life Ins. Co. of N. Am.\*, No. 5:14-CV-3699, 2015 WL 4477039 \(E.D. Pa. July 22, 2015\)](#), Plaintiff, disabled by pain caused by cervicalgia and cervical facet arthropathy, challenged LINA's denial of her claim for LTD benefits. Here, the parties agreed that the court should apply a *de novo* standard of review because the policy language requiring "proof satisfactory" to the insurance company does not change the standard of review from *de novo*. LINA had her claim reviewed by LINA's Associated Medical Director Dr. R. Norton Hall, Medical Director Dr. Paul Seiferth, and Dr. Marcus J. Goldman (psychiatry). Defendant did not directly challenge the notion that Plaintiff was in pain, but rather contended that Plaintiff's physicians failed to articulate how Plaintiff's pain prevented her from performing her job. The court found that pain in itself may be disabling and her doctors each identified specific ways in which Plaintiff's pain affected her ability to work. In view of this consistent and detailed evidence from Plaintiff's treatment providers, and in the context of a *de novo* review, the court found that Plaintiff offered satisfactory proof of her disability pursuant to Defendant's policy. The court also found that Plaintiff's depression and drug addiction stemmed from a physical condition, namely her chronic and severe pain, which had already rendered her disabled, so the twenty-four month limitation did not apply. The court remanded the "any occupation" disability decision to LINA.

In [\*Sessa v. Dell, Inc., Long Term Disability Ins. Plan\*, No. 14-CV-2518, 2015 WL 3631735 \(E.D. Pa. June 11, 2015\)](#), the court upheld Aetna's decision to deny short-term disability benefits since Plaintiff was no longer a "participant" within the meaning of Article III of the Plan when she filed her claim for those benefits and was therefore no longer eligible to receive them under Section 4.1 of the Plan, having been terminated from her employment nearly one year prior to filing her claim. With respect to the LTD claim, the court could not make a conclusive finding as to whether Aetna abused its discretion due to genuine issues of material fact. The record lacked definitive evidence as to when Plaintiff's income dropped to less than 80% of what it had been before her disability began to manifest itself, whether premium payments were made on Plaintiff's behalf, and whether and when Dell informed Aetna that Plaintiff had been terminated from her employment. With respect to the breach of fiduciary duty claim, the court also found that there are genuine issues of material fact that cannot be resolved by the existing record itself. "In particular, the inconsistencies in the explanations provided for the denial of Plaintiff's claims, the evident disregard for those portions of the medical reports and records which supported a finding of disability in favor of the far more limited portions which might be understood to support a contrary finding, and the glaring disregard of Plaintiff's reports of her medical problems to her supervisor and the human relations officers at her employer all militate in favor of a finding that the fiduciary obligations which one or more of these defendants owed to Plaintiff under the Plan were breached. Inasmuch as the record is relatively undeveloped as to the role which each defendant played in the decision making process and in relaying or not

relaying information, however, we cannot make a definitive assessment of the extent to which each party or parties may be held liable to plaintiff.”

In [Reeder v. Aetna Life Ins. Co., No. 4:14-CV-0161, 2015 WL 3622300 \(M.D. Pa. June 9, 2015\)](#), the court granted summary judgment in favor of Aetna on Plaintiff’s long-term disability claim. The court concluded that substantial evidence existed to support the finding that Plaintiff was capable of working full time in a light duty capacity. Aetna relied upon the opinions of “qualified consultants” who reviewed Plaintiff’s medical records, the opinion of an independent medical examiner, and the results of a Transferable Skills and Labor Market Analysis. The results of a functional capacity evaluation concluded that the results were invalid based on the examiner’s statements that Plaintiff had put forth inconsistent efforts. Aetna considered but ultimately rejected certain opinions of Plaintiff’s treating physicians. “It is not for this Court to say whether Defendant made the ‘right’ decision, only whether Defendant had substantial evidence on which to base its decision. I conclude today that it did.”

In [Kelly v. Reliance Standard Life Ins. Co., No. CIV. 09-2478 KSH, 2015 WL 3448033 \(D.N.J. May 28, 2015\)](#), the court granted Reliance’s motion to remand and denied Plaintiff’s cross-motion for civil contempt sanctions. Although Plaintiff claimed that he was disabled under the “any occupation” standard of disability, Reliance only issued a determination as to the “regular occupation” standard and the court previously ruled that Plaintiff was entitled to “regular occupation” benefits. The court explained that it could not award “any occupation” benefits where Reliance did not make a decision about Plaintiff’s entitlement to those benefits in the first instance. The court remanded Plaintiff’s claim to Reliance to exhaust administrative remedies.

In [Duda v. Standard Ins. Co., No. CIV.A. 12-1082, 2015 WL 1961170 \(E.D. Pa. Apr. 30, 2015\)](#), Plaintiff, an orthopedic surgeon and co-owner of Northwest Orthopaedic Specialists, LLC (“Northwest”), applied for total and partial disability benefits under a policy issued by Standard Insurance Company. Plaintiff alleged that an accident in 2000 and 2007 triggered his entitlement to benefits under the policy. Northwest (as the Group Policy Sponsor) and Plaintiff’s business partner and co-owner of Northwest also sued Standard (“Northwest Plaintiffs”). With respect to the ERISA claim against Standard, the court found that Standard did not abuse its discretion by defining Plaintiff’s Own Occupation without reference to pre-2006 data regarding his practice, despite his claim that his wrist injury began to manifest in 2002–2003. Because Plaintiff successfully returned to practice before the degenerative condition manifested itself, the court found that there is no reason to treat his situation differently than any ordinary claim for total disability. The court also concluded that the Northwest Plaintiffs had Article III standing to sue Standard but lacked statutory standing under Section 502(a)(3). Northwest is not a fiduciary

under ERISA, but in any event, ERISA does not afford fiduciaries a cause of action for benefits. Further, all of the relief sought by the Northwest Plaintiffs are or would have been achievable by Plaintiff himself under Section 502(a)(1)(B).

In [\*Hershberger v. Liberty Life Assur. of Boston\*, No. 1:CV-13-2795, 2015 WL 1945022 \(M.D. Pa. Apr. 29, 2015\)](#), Plaintiff challenged Liberty Life's denial of "any occupation" disability benefits, where Plaintiff alleged work impairment due to coronary disease, hypertension, diabetes, sleep apnea, and diabetic peripheral neuropathy. In determining whether Liberty Life's determination was arbitrary and capricious, the court gave the conflict-of-interest factor some weight as Liberty Life is responsible for both benefit determinations and payment of benefits, and as its disability determination under the Policy was inconsistent with the Social Security Administration's determination that Plaintiff was disabled under the Social Security Act. However, the court determined that Liberty's treatment of medical opinion evidence was reasonable, where it rejected earlier opinions of treating physicians and credited other opinions advanced by other treating and consulting physicians. Liberty Life had Plaintiff's claim reviewed by Dr. Albert C. Fuchs (consulting internist), Dr. Raye L. Bellinger (consulting cardiologist), Dr. Mark Nathan (consulting cardiologist), Dr. Lucien Parrillo (consulting internist), Dr. Ira M. Fox (consulting podiatrist).

In [\*Menes v. Chubb & Son\*, No. 3:13-CV-02094-PGS, 2015 WL 1867059 \(D.N.J. Apr. 23, 2015\)](#), the court found that MetLife's decision to terminate Plaintiff's disability benefits was not an abuse of discretion, where MetLife viewed surveillance videos showing Plaintiff engaging in physical activity that contradicted his disability claims and relied on the evaluation provided by several medical practitioners and an independent consultant who reached a consensus that was only contradicted by Plaintiff's primary doctor. The court found that the Social Security Administration's determination of disability was not dispositive in this matter, where MetLife's claim determination was based on information SSA did not consider, including the surveillance videos and the opinion of other physicians.

In [\*Rodriguez v. Reliance Standard Life Ins. Co.\*, No. 14-1986, 2015 WL 1727419 \(3d Cir. Apr. 14, 2015\)](#), the Third Circuit affirmed the district court's decision that Reliance Standard Life Insurance Company did not arbitrarily and capriciously determine that Plaintiff was ineligible to continue to receive long-term disability benefits. Reliance determined that Plaintiff was diagnosed with a mental or nervous disorder and that she did not meet the Plan's definition of "totally disabled." The court rejected Plaintiff's argument that she was denied procedural due process because Reliance failed to inform her of the evidence required to perfect her appeal.

In [\*Chiodo v. Aetna Life Ins. Co.\*, No. CIV.A. 14-02270, 2015 WL 1525049 \(E.D. Pa. Apr. 6, 2015\)](#), the court held that the undisputed material facts show that Aetna's decision to deny Plaintiff's claim for long-term disability benefits, based on multiple intracranial abscesses causing balance and memory problems, was supported by substantial evidence and not an abuse of discretion. Aetna was not required to give any special weight to Plaintiff's treating doctors. Construing the evidence in the light most favorable to Plaintiff, Aetna was left with conflicting opinions, both based on reliable evidence, and it did not abuse its discretion by resolving the conflict in a way that was unfavorable to Plaintiff.

In [\*Bechter v. Fed. Exp. Corp. Long Term Disability Plan\*, No. CIV.A. 13-7389, 2015 WL 1455807 \(E.D. Pa. Mar. 31, 2015\)](#), the court upheld the Plan's denial of LTD benefits, finding that the administrative record does not contain significant objective findings of impairments that would preclude Plaintiff from performing any compensable employment for a minimum of 25 hours per week. Although some of Plaintiff's subjective complaints of pain can be substantiated by objective findings in the record, Defendants could reasonably find that those findings are insufficient to meet the definition of a Total Disability because there is nothing in the record linking them with Plaintiff's inability to work. Even though Aetna did not submit Plaintiff for an IME or specifically address her doctor's Total Disability Any Occupation physician report, the court's overall assessment of Aetna's conduct in this case was that it did not act in an arbitrary and capricious manner in denying benefits.

In [\*Morrison v. PNC Fin. Servs. Grp., Inc.\*, No. CIV.A. 13-804 JEI, 2015 WL 1471865 \(D.N.J. Mar. 31, 2015\)](#), the court found that certain procedural irregularities reduced the deference afforded to Liberty Life's determination of Plaintiff's entitlement to disability benefits, including that Liberty Life (1) failed to adequately provide written notice of an adverse benefit determination as required by ERISA; (2) failed to consider the specific requirements of the claimant's job; and (3) cherry-picked among its various consulting physicians' medical reports for favorable findings. The court found that the combination of Liberty's failure to give appropriate notice and its imposition of non-existent requirements rendered Liberty's denial of Plaintiff's claim arbitrary and capricious. Because Plaintiff sought a retroactive award of benefits and Liberty improperly denied Plaintiff long-term disability benefits from the outset, the court remanded to Liberty to reevaluate whether Plaintiff is disabled.

In [\*Suarez v. Provident Life & Cas. Ins. Co.\*, No. CIV. NO. 2:13-2445, 2015 WL 1021288 \(D.N.J. Mar. 9, 2015\)](#), Plaintiff pled four causes of action in connection with the termination of his long-

term disability benefits: (1) violation of ERISA; (2) breach of contract and breach of implied covenant of good faith and fair dealing; (3) fraud; and (4) RICO conspiracy. Provident moved to dismiss the second and third causes of action under Federal Rule of Civil Procedure 12(b)(6). One question is whether the LTD policy at issue is a group policy that was converted to an individual plan or an ERISA plan that was just “continued.” The court denied Provident’s motion, finding that whether Plaintiff’s insurance policy qualifies as an ERISA plan will likely involve a detailed factual inquiry that is more appropriately undertaken at the summary judgment stage. If Plaintiff’s policy is an ERISA plan, the two state-law claims are preempted; if it is not an ERISA plan, the ERISA claim is invalid but the state law claims are not preempted.

In [Pavlovitz v. Reliance Standard Life Ins. Co., No. CIV.A. 13-1575, 2015 WL 851846 \(E.D. Pa. Feb. 27, 2015\)](#), Plaintiff alleged that she was disabled by Chronic Pain Syndrome and a mental disorder which entitles her to long term disability benefits. Applying a deferential standard of review, the court found that Reliance Standard did not act in an arbitrary and capricious manner when it denied benefits after it determined: 1) the record did not support Plaintiff’s satisfaction of the Elimination Period; Plaintiff was no longer a covered employee under the Policy; and 3) Plaintiff’s Bipolar disorder was a pre-existing condition because she was receiving medications to treat this condition during the 90-day look back period. The court also found that Plaintiff’s breach of contract claim is preempted by ERISA, and that her ERISA claim fails against Matrix because Matrix did not issue the LTD policy in question and has no discretion in how the plan is managed or benefits paid. The court granted Defendants’ motion for summary judgment.

In [Quinlan v. Reliance Standard Life Ins. Co., No. CIV.A. 13-7052, 2015 WL 519430 \(D.N.J. Feb. 9, 2015\)](#), the court found that Reliance Standard did not abuse its discretion in denying Plaintiff long-term disability benefits where the court determined that Reliance Standard’s denial was based on an in-depth review of Plaintiff’s medical records, three physicians’ reports (including an independent medical examination), a functional capacity evaluation, and a national labor survey.

In [Plank v. Devereux Found., No. CIV.A. 13-7337, 2015 WL 451096 \(E.D. Pa. Feb. 2, 2015\)](#), Aetna conceded that Plaintiff was disabled under the “own occupation” provision of the Plan and the court ordered Aetna to pay Plaintiff benefits owed under that provision for the remainder of that period, which totaled about four months’ worth of benefits. With respect to the denial of benefits under the “any occupation” provision of the Plan, the court found that Aetna never determined whether Plaintiff was disabled from any occupation. As such, there was no record for the court to review. Bearing in mind the high “abuse of discretion” standard applicable in this case, and recognizing that the court’s review has been confined to the analysis under the “own

occupation” provision of its policy, the court declined to address the question of whether Plaintiff is entitled to “any occupation” benefits. The court remanded the matter back to Aetna for consideration of whether Plaintiff is entitled to benefits under the “any occupation” provision.

D. Fourth Circuit

[Canlas v. Metropolitan Life Insurance Company, No. CV DKC 15-0702, 2015 WL 9302936 \(D. Md. Dec. 22, 2015\)](#) (Judge Deborah K. Chasanow). Court granted MetLife’s motion to dismiss Plaintiff’s claim that it improperly reduced his LTD benefits under two separate disability plans by the amount received in SSDI benefits, effectively doubling the reduction.

**Claims against employer and disability plan dismissed; court grants motion to seal administrative record.** [Frank v. Liberty Life Assurance Company of Boston, No. GJH-15-124, 2015 WL 7871335 \(D. Md. Dec. 3, 2015\)](#) (Judge George J. Hazel). In a lawsuit seeking denied long-term disability benefits, the court granted the employer and the Plan’s motion to dismiss the Section 502(a)(1)(B) claim as to the Plan, finding that Plaintiff failed to allege facts against the Plan that it did or failed to do anything with respect to her claim for benefits. The court also granted the employer’s motion to dismiss the breach of fiduciary duty claim against it, finding that Plaintiff failed to demonstrate that the employer violated a fiduciary duty and, additionally, that relief is fully available under Section 502(a)(1)(B). The court denied the employer’s and the Plan’s attorneys’ fee motion against Plaintiff since there was no indication of bad faith when she presented her claims against them. With respect to the claim for benefits against Liberty Life, the parties agreed that *de novo* review applies and the court granted Liberty Life’s motion to seal the administrative record due to privacy concerns and the burden of redacting the 970-page file.

[GREGORY O’DELL, Plaintiff, v. ZURICH AMERICAN INSURANCE COMPANY, Defendant., No. 2:13-12894, 2015 WL 5724376 \(S.D.W. Va. Sept. 29, 2015\)](#). The court denied the parties’ motions for summary judgment but found that Plaintiff’s claim was timely filed. The court remanded the matter to Zurich for further review, including to conduct a thorough inquiry into whether, and for what period of time, Plaintiff was permanently and totally disabled and make the full and fair review directed by the court in its opinion. The court further ordered that if Zurich concludes after reconsideration that Plaintiff’s claim should be denied, it must clearly explain the reasons supporting its decision and provide Plaintiff with a reasonable opportunity to obtain a full and fair review of that decision.

[Moore v. Liberty Life Assur. Co. of Boston, No. 6:14-CV-00043, 2015 WL 5227954 \(W.D. Va. Sept. 8, 2015\)](#). Plaintiff alleged disability from Ehlers Danlos Syndrome. The court granted Liberty Life's motion for summary judgment on Plaintiff's claim for disability benefits under the "any occupation" standard of disability, rejecting Plaintiff's argument that policy's offset for Social Security benefits caused a conflict of interest. Peer reviewers involved include MES Peer Review Services, Dr. Terence McAlarney (Neurology), Dr. Simeon A. Boyadjiev (Genetics).

In [Wilkinson v. Sun Life & Health Ins. Co., No. 5:13CV87-RLV, 2015 WL 5124323 \(W.D.N.C. Sept. 1, 2015\)](#), court found that Sun Life's Statement of ERISA Rights, and its provision for broad discretionary authority, is a valid mechanism for conferring discretionary authority to Sun Life. The court also considered an FMLA document produced by Plaintiff's employer, which Sun Life argued was not part of the administrative record. The court determined that whether Sun Life ever had actual possession of the FMLA form, or whether Sun Life acted purposefully or with an improper motive in not ensuring that the FMLA form became a part of the administrative record concerning long term disability is less than transparent, but including the form in the court's evaluation promotes a reasoned and fair evaluation of the claims. On the merits of Plaintiff's long-term disability claim, the court found that Sun Life abused its discretion in discontinuing Plaintiff's LTD benefits. Specifically, Sun Life's determination that Plaintiff was working less than 30 hours per week in the weeks leading up to the onset of his disability is not supported by substantial evidence. The court also concluded that Sun Life's decision making process was not reasoned and principled where it did not engage in a "searching or leave no stone unturned investigation."

In [Foster v. Sedgwick Claims Mgmt. Servs., Inc., No. 14-1241 \(JEB\), F.Supp.3d , 2015 WL 5118360 \(D.D.C. Aug. 28, 2015\)](#), Plaintiff, allegedly disabled by fibromyalgia, fatigue, and anxiety disorder, brought suit claiming that Defendants Sedgwick Claims Management Services, Inc. and the Bank's Short-Term and Long-Term Disability Plans improperly denied her disability benefits. The court granted summary judgment to Defendants, finding that the Short-Term Disability Plan is not governed by ERISA because it is a "payroll practice," and that the denial of LTD benefits was appropriate in light of the aggregate medical evidence and the eligibility requirements of the Plans.

In [Caldwell v. Standard Ins. Co., No. 2:14-CV-25242, 2015 WL 5031485 \(S.D.W. Va. Aug. 25, 2015\)](#), on review of Standard's termination of Plaintiff's long-term disability benefits, the court found that it need not reduce the amount of deference afforded to Standard on the basis of the alleged conflict of interest since Standard paid benefits for a two-year period, and only terminated benefits after engaging in an independent review of Plaintiff's medical records and

vocational aptitude. Moreover, the court disagreed with Plaintiff that Standard withheld information from the consulting physicians who reviewed her medical records. Standard stopped paying Plaintiff based on the LTD policy's 24-month limitation on disabilities related to disorders of the cervical, thoracic, or lumbosacral back, and depression. It also determined that for Plaintiff's non-limited impairments, they did not cause her to be disabled from "any occupation." The court granted summary judgment to Standard, finding that Standard engaged in a reasoned and principled decision-making process that took into account all of the evidence that Caldwell presented, relied on the judgment of independent consulting physicians, and reached a conclusion logically consistent with the language of the relevant provisions of the policy. Standard retained Dr. Mark Shih, Susan Martin (a certified rehabilitation counselor), Dr. Hans Carlson, and Karol Paquette (a second Certified Rehabilitation counselor) to review Plaintiff's claim and appeal.

In [\*Dooley v. Matrix Absence Mgmt., Inc.\*, No. 1:14CV2, 2015 WL 4644446 \(N.D.W. Va. Aug. 4, 2015\)](#), involving a *pro se* plaintiff seeking short-term disability benefits, the court determined that Matrix has no conflict of interest because the employer, not Matrix, is responsible for paying benefits under the STD Plan. The court also found that Matrix did not abuse its discretion in denying Plaintiff's claim for benefits where its reviewer, RN Vivienne Esty-Fenton, reviewed Plaintiff's records and determined that "claimant's psychiatric functional impairment of anxiety and depression cannot be supported as other than claimant and provider stating that claimant has anxiety, Generalized Anxiety Disorder ... and a GAF score of 50, no other symptoms or observed objective information noted on review to substantiate claim."

**Claimant loses.** In [\*Realmuto v. Life Ins. Co. of N. Am.\*, No. CIV.A. GLR-14-1386, 2015 WL 4528182 \(D. Md. July 24, 2015\)](#), the court determined that after extensive review of the administrative record, including the surveillance video, the record does not support the subjectively reported severity of Plaintiff's condition and the resulting physical limitations and restrictions. The surveillance showed Plaintiff engaging in various physical activities including pushing and pulling a lawn mower, trimming the edges of his lawn, using a leaf blower, riding his bike while simultaneously holding his dog's leash, and playing a round of golf. The court found that the record supports the conclusion that he is able to perform the material duties of at least two occupations that would meet his Indexed Covered Earnings requirement and for which he is reasonably qualified. Accordingly, the court granted LINA's Motion for Summary Judgment in part and denied LINA's request for attorneys' fees and costs.

**Claimant loses.** In [\*Lohr v. UnitedHealth Grp. Inc.\*, No. 1:12CV718, 2015 WL 4210830 \(M.D.N.C. July 10, 2015\)](#), the court determined that United's decisions that Plaintiff was not

disabled earlier than June 30, 2011, and that, as of that date, her disability coverage had expired were reasonable and no basis exists to conclude that United abused its discretion in denying Plaintiff's claims for STD benefits, and consequently for LTD benefits. Plaintiff's impairment was the result of depression and anxiety. Sedgwick, the TPA, had Plaintiff's claim "independently" reviewed by Reginald Givens, M.D. (board certified in psychiatry and neurology), who determined that the medical information only supports an inability to perform occupational duties starting from June 30, 2011, the date Plaintiff saw her psychiatrist for treatment.

In [Hastings v. Long Term Disability Plan for Go-Getters, Inc., No. RDB-13-0042, 2015 WL 3995721 \(D. Md. June 30, 2015\)](#) (Not Reported in F.Supp.3d), the court denied Plaintiff's motion to supplement the record of Plaintiff's disability claim, finding that a four-year-old email in which one of Plaintiff's former physicians admitted to having no recollection of a phone call about Plaintiff's disability claims would enhance this court's understanding of the case.

In [Bilheimer v. Fed. Exp. Corp. Long Term Disability Plan, No. 13-1859, Fed.Appx. , 2015 WL 2058811 \(4th Cir. May 5, 2015\)](#), the court affirmed the district court's application of *de novo* review to the Plan's decision on Plaintiff's long-term disability claim because Aetna, who made the decision on appeal, did not have discretionary authority to do so. Appeals of benefits denials are handled by an appeal committee, and FedEx, the administrator of the Plan, is charged with appointing this appeal committee. Originally, FedEx appointed its internal Benefit Review Committee to serve as the appeal committee, but in 2008, the director of FedEx's Employee Benefits Department recommended that the Board outsource all long-term disability appeals to Aetna. The Board approved this recommendation, but did not expressly state that the Board was appointing Aetna as the appeal committee contemplated under the Plan. FedEx and Aetna amended their service agreement such that Aetna became fully responsible for final appeal benefit determinations for the disability plans. The court construed the term "appoint" to incorporate the notion of a selection and designation process and not to include "outsource." In order to comply with the Plan the Board needed to actually designate Aetna as the appeal committee, which it did not do.

In [Horton v. Life Ins. Co. of N. Am., No. CIV.A. ELH-14-3, 2015 WL 1469196 \(D. Md. Mar. 30, 2015\)](#) (Not Reported in F.Supp.3d), the decedent was found dead in the Patapsco River on April 25, 2012, and his sailboat was found floating upside down. An autopsy revealed that he had a blood alcohol content of 0.13%. LINA denied accidental death benefits premised on an alcohol exclusion in the insurance policies. The court denied summary judgment to both parties, finding that due to the competing and reasonable narratives about what happened to the decedent,

evaluating the persuasiveness of conflicting evidence in the Administrative Record is beyond the scope of the Court's function under Rule 56. Additionally, the court declined to consider LINA's post hoc alternative rationale offered for the first time on judicial review.

E. Fifth Circuit

**District court erred by imposing “treating physician” rule in review of denied disability claim.** [Schiro v. Office Depot, Inc., No. 15-30066, Fed.Appx. \\_\\_\\_, 2015 WL 9147748 \(5th Cir. Dec. 16, 2015\)](#) (Before JONES, SMITH, and SOUTHWICK, Circuit Judges). The Fifth Circuit reversed the district court's grant of summary judgment in favor of Schiro. The district court concluded that Sedgwick had abused its discretion by relying on its internal medical staff's opinions rather than Schiro's treating physicians. The Fifth Circuit held that the denial was supported by substantial evidence, and the district court imposed a “treating physician” rule that is inappropriate in the context of plans covered by ERISA. The court explained that under proper abuse-of-discretion review, Sedgwick was not required to explain why it credited its internal opinions over those of the treating physicians, nor was Sedgwick's evidence less substantial in light of conflicting opinions offered by the treating physicians. The court found that the district court did not conduct a proper abuse-of-discretion review when it imposed such a burden.

In [Hill v. Bert Bell/Pete Rozelle NFL Player Ret. Plan, No. 14-41159, Fed.Appx. \\_\\_\\_, 2015 WL 4926501 \(5th Cir. Aug. 19, 2015\)](#), the Fifth Circuit affirmed the judgment of the district court, which found that the Plan did not abuse its discretion in determining that Plaintiff was entitled to a lower monthly disability benefit amount.

In [Arnold v. Aetna Life Ins. Co., No. 5:14-CV-44-DCB-MTP, 2015 WL 3794894 \(S.D. Miss. June 17, 2015\)](#), the court found that there was substantial evidence to support Aetna's position that Plaintiff is not disabled as a result of Lyme Disease or Fibromyalgia and granted summary judgment in its favor. The court found that Aetna's peer reviewer, Dr. Bowman, conducted a thorough and adequate review of Plaintiff's claim, including review of the treating doctor's treatment and diagnoses, and found insufficient evidence to support the treating doctor's findings. The court explained that the Fifth Circuit “has held that an administrator does not abuse its discretion when it relies on the medical opinion of a consulting physician whose opinion conflicts with the claimant's treating physician. This is so even if the consulting physician only reviews medical records and never physically examines the claimant, taxing to credibility though it may be.” The court found that Plaintiff abandoned her claim for disability based on chronic fatigue syndrome because she did not address Aetna's argument that this condition is barred by the pre-existing condition exclusion in her response to Aetna's motion.

In [\*Bible v. Parker Hannifin Corp. Ben. Fund\*, No. 2:14-CV-05, 2015 WL 3756435 \(E.D. Tenn. June 16, 2015\)](#), the court found that the Plan did not deprive Plaintiff of a “full and fair review” of her claim because it did not identify the nurse case manager who consulted her claim during the administrative appeals process where Plaintiff never requested such information prior to filing her suit. Even if it did, at best, Plaintiff would be entitled to a remand to pursue the merits of her claim. Because the court concluded that Defendant substantially complied with the twin purposes of § 1133, remand is not necessary. Additionally, Defendant’s exclusive reliance on the opinion of a physician that never physically examined her was not arbitrary and capricious, where Plaintiff’s treating physician presented completely contradictory opinions as to her condition just two days apart.

[\*Dix v. Blue Cross & Blue Shield Ass’n Long Term Disability Program\*, No. 14-31200, Fed.Appx. , 2015 WL 3429134 \(5th Cir. May 29, 2015\)](#), the court found that there was no conflict of interest where Plaintiff’s employer, BCBSL, paid into a trust which in turn funded the payment of benefits under the Blue Cross and Blue Shield Association Long Term Disability Program. The Blue Cross and Blue Shield Association (“the Association”) is an Illinois not-for-profit corporation which provides fiduciary administrative services to BCBSL and other Blue Cross and Blue Shield Organizations through its National Employees Benefits Committee (“NEBC”) and National Employees Benefits Administration (“NEBA”). NEBA and NEBC administer the Program at issue in this case. The Association determined eligibility for benefits through NEBA and NEBC. Although the district court found that “BCBS’s Board of Directors comprised the committee charged with administering the disability plan,” the record shows that it was the Association’s board of directors which comprised the eligibility committee, not the board of directors of the Program or of BCBSL. The court found that these facts show that a structural conflict of interest did not exist because the Association, through NEBA and NEBC, made benefits eligibility decisions, while the Program paid benefits claims, and BCBSL had no financial interest in individual disability determinations.

In [\*Stout v. Pathfinder Energy Servs., LLC\*, No. CIV.A. 14-02457, 2015 WL 3413328 \(W.D. La. May 26, 2015\)](#), Plaintiff filed a lawsuit for the denial of his long-term disability benefits two days prior to submitting an internal appeal to MetLife. MetLife reinstated Plaintiff’s LTD benefits after considering his appeal. The court denied as moot Plaintiff’s claim for reinstatement of LTD benefits and dismissed his claims for future benefits, breach of fiduciary duty, conflict of interest, attorney’s fees, and statutory penalties.

In [\*Avena v. UNUM Life Ins. Co. of Am.\*, No. CIV.A. 13-5947, 2015 WL 1726173 \(E.D. La. Apr. 15, 2015\)](#), Plaintiff claimed long-term disability benefits following his involvement in a car accident, which Unum denied. The court found that Unum did not err in failing to order an independent examination of Plaintiff. The court further found that Unum's denial of benefits was not arbitrary and capricious, where, Plaintiff was able to work for several months after the accident; he attended a fishing trip after the accident; despite Plaintiff's continued complaints of pain, recommended pain management was limited to as-needed use of the same conservative medications prescribed immediately after the accident; only one doctor placed restrictions or limitations on Plaintiff's movement; further testing was not conducted despite Plaintiff's continued complaints of pain; the reviewing doctors felt Plaintiff's MRI results were consistent with age-related changes; Plaintiff provided no proof that he ever attended physical therapy; and the accident report indicated that the accident resulted in minor damages to both vehicles and emergency medical attention was not sought.

In [\*Sylve v. Lincoln Nat. Life Ins. Co.\*, No. CIV.A. 14-219, 2015 WL 1565035 \(E.D. La. Apr. 8, 2015\)](#), the court dismissed with prejudice Plaintiff's claim for long-term disability benefits, finding that Plaintiff failed to exhaust administrative remedies before filing suit. Plaintiff was required to appeal twice, notified to do so by Lincoln National, and he appealed only once. The court rejected Plaintiff's argument that his attorney's subsequent contact with Lincoln National, by way of emails, phone calls, or re-sending old letters, constituted a second appeal.

In [\*Adkins v. AT & T Umbrella Benefit Plan No. 1\*, No. 1-14-CV-082-LY, 2015 WL 632093 \(W.D. Tex. Feb. 13, 2015\)](#), the court granted summary judgment to the Plan on Plaintiff's claim for short-term disability benefits, where Plaintiff claim disability related to lupus/Sjögren's syndrome and depression. The Plan relied on the file reviews of several physicians retained by Network Medical Review Co., Ltd. ("NMR"), an allegedly independent company that provides physician reviews for ERISA claims. The physicians retained by NMR are Dr. Neal J. Sherman, Dr. Dennis Payne, Dr. Charles Brock, Dr. Jose A. Perez, and Dr. Michael A. Rater. Plaintiff alleged these physicians failed to take into consideration her fatigue and chronic pain. The court determined that Sedgwick (the administrator) is not required to rely on subjective or self-reported evidence, and may require the production of objective evidence documented by a physician and based on medical examinations. But, even if the medical records had included objective medical evidence, such as mobility tests, and recent opinions regarding Plaintiff's ability to perform her work, the NMR physicians and Sedgwick are not obligated to accord special deference to the opinions of treating physicians. The court found that Plaintiff failed to show Sedgwick's weighing of the evidence in this case was an abuse of discretion.

In *Banks v. Aetna Life Ins. Co.*, No. 3:13-CV-4848-L, 2015 WL 413558 (N.D. Tex. Jan. 30, 2015), Plaintiff filed a motion seeking a remand to the plan administrator on his claim for short-term disability benefits. The court found that the case should not be remanded pursuant to general equitable principles to have any previously unavailable diagnosis or medical records considered. But, the court concluded that Plaintiff has properly invoked the court's authority to remand based on Defendant Aetna's failure to provide full and fair review pursuant to 29 U.S.C. § 1133 due to violations of ERISA's procedural requirements. The court found that Aetna 1) failed to provide required disclosures pursuant to 29 C.F.R. §§ 2560.503-1(h) (2)(iii), 2560.503-1(i)(5), and 2560.503-1(j)(3); and 2) failed to identify the medical experts from whom it obtained advice on Plaintiff's STD claim; and 3) consulted the same health care professionals at both the initial and appellate denial review stage in violation of 29 C.F.R. § 2560.503-1(h)(3)(v).

**A court is limited to reviewing reasons for denial provided to Plaintiff during the claim review process. A policy limitation on disabilities “caused by or contributed to by” a mental disorder only limits benefits if a physical impairment is insufficient to support total disability.** In *George v. Reliance Standard Life Ins. Co.*, No. 14-50368, \_\_\_F.3d\_\_\_, 2015 WL 216729 (5th Cir. Jan. 15, 2015), the majority of the 5<sup>th</sup> Circuit panel reversed and remanded the district court's decision that Reliance Standard (“RSL”) did not abuse its discretion in determining that the relevant long-term disability policy's 24-month payment maximum for Total Disabilities “caused by or contributed to by mental or nervous disorders” limited Plaintiff's right to benefits. The district court held that the evidence supported RSL's determination that Plaintiff's depression and PTSD contributed to his Total Disability. Based on this finding, the district court held that RSL did not abuse its discretion, but it did not reach the question whether Plaintiff was Totally Disabled under the Policy.

The 5<sup>th</sup> Circuit held that it was limited on review to considering whether the record supported the reasons that RSL provided to Plaintiff during the claim review process, and not a new reason it offered afterwards. Specifically, the court declined to consider whether Plaintiff carried his burden to show a right to benefits because RSL did not deny Plaintiff's claim because he failed to carry his burden. RSL denied his claim because it determined that there was sufficient evidence in the record to show that he was not Totally Disabled and that, even if he was, a mental disorder contributed to this Total Disability. The court further held that RSL abused its discretion when it determined that Plaintiff was not totally disabled. The court found that RSL failed to cite any evidence in the record that supports its conclusion that Plaintiff's ability to perform sedentary work, and to work in the alternative occupations, would allow him to obtain “substantially the same earning capacity” that he obtained as a pilot. Lastly, the court held that Plaintiff's mental disabilities did not cause or contribute to his total disability; and on issue of first impression, the “caused by or contributed to by” language excludes coverage only when a claimant's physical disability is insufficient to render him totally disabled.

The dissent, Circuit Judge King, disagreed with the majority's conclusion that RSL abused its discretion when it determined that Plaintiff's disability was "caused by or contributed to by" a mental disorder. Judge King noted that the the majority concedes that "George's depression and PTSD impaired his ability to hold down a job." In Judge King's view, this should end the inquiry since it was more than reasonable for RSL to conclude that Plaintiff's mental conditions at least contributed to his disability, thus triggering the exclusion. Notwithstanding, Judge King noted that "[i]t is a dreadful result, driven by a dreadful provision in the policy. The more serious a claimant's physical problems (and resulting employment problems), the more likely he is to suffer from a "mental disorder" (e.g., depression), just at the time when he most needs the coverage otherwise afforded by a policy like this."

**Where abuse of discretion review applies, a court is not required to view evidence in a light most favorable to the non-movant plaintiff. And, a full and fair review does not require that an administrator consider a post-appeal submission addressing evidence the administrator obtained on review.** In *Killen v. Reliance Standard Life Ins. Co.*, No. 14-10052, \_\_\_F.3d\_\_\_, 2015 WL 127379 (5th Cir. Jan. 8, 2015), the 5<sup>th</sup> Circuit Court of Appeals affirmed the district court's grant of summary judgment to Reliance Standard in a dispute concerning its denial of Plaintiff's claim for extended long-term disability benefits. The district court held that Reliance Standard did not abuse its discretion in finding that Plaintiff could perform sedentary work. In so doing, the court rejected Plaintiff's argument that the summary judgment standard requires that the evidence and inferences drawn from that evidence be viewed in the light most favorable to her since she is the non-movant. The court explained that Plaintiff "misapprehends the nature of appellate review of summary judgment decisions on ERISA benefits cases where the plan at issue vests discretion, as this one does, in a plan administrator." The court clarified that its decision in *Baker v. Metropolitan Life Ins. Co.*, 364 F.3d 624 (5th Cir. 2004) explained that appellate courts review district court decisions in the ERISA context *de novo* and draw all inferences in favor of the non-movant, but "when an administrator has discretionary authority with respect to the decision at issue, the standard of review should be one of abuse of discretion." *Id.* at 627. The court found that in this case, substantial evidence supported Reliance Standard's decision to deny long-term disability benefits to Plaintiff. Although there is evidence in the record to support Plaintiff's claim for disability, there is also more than enough evidence supporting a denial to insulate the decision from reversal, particularly under the court's "narrow review for abuse of discretion." Such evidence included: 1) Reliance Standard's vocational expert identified between three and five sedentary jobs Plaintiff could perform; 2) the examining physician, Dr. Burgessser, opined that Plaintiff was capable of performing at a sedentary work capacity; and 3) Plaintiff's own treating physicians equivocated at different times about the extent of her disability – though her primary care physician ultimately concluded that she was totally disabled, her orthopedic surgeon's reports are ambiguous at best on the issue.

The court also rejected Plaintiff's argument that Reliance Standard failed to provide a full and fair review of her claim because (1) the company did not provide sufficient evidence in support of its initial denial of benefits and (2) the company brought forward its strongest evidence of Plaintiff's continued ability to perform full-time sedentary work during the final appeal without giving her a meaningful opportunity to respond. The court found that Plaintiff's first argument is foreclosed by its decision in *Wade v. Hewlett-Packard Dev. Co.*, 493 F.3d 533 (5th Cir.2007), where the court held that a failure to substantially comply with ERISA and its accompanying regulations at each and every level of review of a Plan's internal claims processing does not deprive a claimant of a full and fair review. In this case, the court found that Reliance Standard substantially complied with ERISA at every step, including its initial denial. With respect to the second argument, the court found that Plaintiff was not "sandbagged" by a report containing unanticipated factual findings since she was on notice beginning with the initial denial that she needed to bring forward evidence of her inability to perform sedentary work. Reliance Standard provided her an adequate opportunity to do so. The court also found that although Reliance Standard has a financial conflict of interest, it adequately considered Plaintiff's favorable Social Security Disability Insurance award where it twice addressed the SSA benefits awarded to Plaintiff, once distinguishing its denial in detail. The court found no procedural unreasonableness on these facts suggesting that it should accord the conflict of interest factor any special weight.

Lastly, Plaintiff argued that Reliance Standard improperly failed to allow her to supplement the administrative record with a letter from a doctor that she submitted four months after the third claim denial. Before filing suit, a claimant's lawyer can add additional evidence to the administrative record simply by submitting it to the administrator in a manner that gives the administrator a fair opportunity to consider it, but such opportunity must come in time for the administrator to reconsider his decision. The court found that Plaintiff's late submission, only four weeks before Plaintiff filed suit, gave Reliance Standard a fair opportunity. The court declined to find an abuse of discretion in Reliance Standard's decision not to supplement the record and found no fault in the district court's choice not to consider the letter.

#### F. Sixth Circuit

**California Insurance Code banning discretion is not preempted by ERISA but does not apply to Ohio resident; Liberty Life did not abuse discretion in denying LTD claim.** [Pfenning v. Liberty Life Assurance Company of Boston, No. 3:14-CV-471, 2015 WL 9460578 \(S.D. Ohio Dec. 28, 2015\)](#) (Judge Thomas M. Rose). The court held that California Insurance Code § 10110.6, a state law banning discretionary clauses from disability plans, is not preempted under ERISA because it is a law that regulates insurance and satisfies the Supreme Court's *Miller* test: (1) the state law must be specifically directed towards entities engaged in insurance

and (2) the state law must substantially affect the risk pooling arrangement between insurer and the insured. Although not preempted, the court determined that the Code is inapplicable to this case because Plaintiff is a resident of Ohio and the Code explicitly states that voids discretionary clauses for “*any California resident.*” Applying abuse of discretion review, the court determined that Liberty Life did not abuse its discretion by relying on the DOT and SOC/O\*NET to determine Plaintiff’s occupation. Although Plaintiff’s job contains additional field duties, the court found that not every single duty needs to be reflected as long as his other comparable duties are considered. The court also found that Liberty Life did not act arbitrarily or capriciously by rejecting the results of a Functional Capacity Evaluation and relying on the conclusions of peer reviewers, Dr. David Lang (neurologist) and Dr. Sarah White.

**Standard did not abuse discretion denying LTD claim where there was no evidence supporting disability as of the date claimed.** [Connelly v. Standard Ins. Co. of Am., No. 5:14CV1635, 2015 WL 8483132 \(N.D. Ohio Dec. 10, 2015\)](#) (Judge John R. Adams). The court found that Standard did not err in denying Plaintiff’s claim for disability benefits where the Social Security Administration found a date of disability later than the date claimed by Plaintiff. Standard’s reviewing doctors concluded that the record was void of any evidence of disability in the month that Plaintiff stopped working and lost coverage under the disability policy. Although Plaintiff’s treating doctors gave statements that they recommended Plaintiff stop work, there was no evidence of these recommendations in the contemporaneous treatment records.

**Abuse of discretion to deny disability benefits where administrator, without a medical examination, determined that claimant’s pain symptoms were not objective evidence of disability.** [Godmar v. Hewlett-Packard Co., No. 15-1480, Fed.Appx. , 2015 WL 8290186 \(6th Cir. Dec. 9, 2015\)](#) (Before DAUGHTREY, COOK, and WHITE, Circuit Judges). Godmar involves abuse of discretion review of an ERISA plan administrator’s denial of disability benefits. The Sixth Circuit found that Sedgwick, the claims administrator, abused its discretion by selectively reviewing the record and improperly dismissing Godmar’s pain symptoms as subjective. Three of Godmar’s treating doctors informed Sedgwick that Godmar could not perform his job and corroborated Godmar’s significant pain complaints. Sedgwick determined that their reports were not credible and relied on three consulting physicians. The court explained that, “[f]ile reviews are particularly troubling when the administrator’s consulting physicians—who have never met the claimant—discount the claimant’s limitations as subjective or exaggerated.” The court found that Sedgwick decided Godmar’s pain was subjective without examining him, and that failure weighs in favor of a determination that the denial of his claim was arbitrary and capricious. The court further found that the consulting physicians did not respond to Godmar’s claim that he was disabled by the side effects of medication prescribed to treat his chronic pain. The court did not agree with Godmar on the issue of whether Sedgwick

needed to show improvement in order to terminate his benefits since it had only approved his claim for one month.

[Safdi v. Covered Employer's Long Term Disability Plan Under the Union Cent. Employee Sec. Ben. Trust, No. 14-3598, Fed.Appx. , 2015 WL 7434695 \(6th Cir. Nov. 24, 2015\)](#) (GUY, BATCHELDER, and GIBBONS, Circuit Judges). The Sixth Circuit affirmed the district court's holding that under the terms of the disability plan, a plan participant must return to work full time for the Recurrent Disability provision to become operative. The court found that Plaintiff did not satisfy the Recurrent Disability provision because he cannot show two distinct periods of Residual Disability separated by a return to work on a full-time basis.

**Workers' Compensation permanent partial disability award is offsettable income under terms of disability plan.** [Izzarelli v. Lubrizol Corp. Long Term Disability Plan, No. 1:15 CV 457, 2015 WL 6437210 \(N.D. Ohio Oct. 22, 2015\)](#) (Judge Patricia A. Gaughan). Plaintiff challenged Defendant's decision to deduct his Workers' Compensation permanent partial disability ("PPD") benefit from his long-term disability benefits. The Court found that the Plan's decision was not arbitrary and capricious as there is no patent ambiguity in the offset provision. The court concluded that on its face, the term clearly provides that long-term benefits shall be reduced by the amount of any disability benefits provided for by worker's compensation laws—without regard to whether the payments were for loss of income. The court declined to consider statements in the summary plan description since they were not part of the administrative record and because they cannot change the plain terms of the long-term disability plan.

**Retroactive termination of employment and denial of disability benefits due to a failure to comply with reporting deadlines, which was caused by the disability itself, is an abuse of discretion.** In [Waskiewicz v. UniCare Life & Health Ins. Co., No. 14-1479, F.3d , 2015 WL 5751585 \(6th Cir. Oct. 2, 2015\)](#), the court reversed the district court's grant of summary judgment to UniCare based on its conclusion that Plaintiff did not qualify for long-term disability benefits under the Plan because she had already been terminated by Ford when she sought those benefits. Plaintiff suffers from type-1 diabetes, major depression, and gender identity disorder. The Plan at issue included the following subsection:

An Active Employee whose employment is terminated under the Ford Involuntary Salaried Separation Policy (FISSP) ... shall cease to be eligible for Benefits as of the earlier of:

(a) the date the Employee has been notified; or

(b) the day prior to the date of such termination (in the case of retroactive terminations) and shall cease to be a Covered Employee hereunder as of such date.

The Plan requires the employee to notify “the Claim Processor and the Company if the employee is absent for more than five (5) consecutive Workdays.” Plaintiff did not inform Ford within the five-day period. Plaintiff’s father notified UniCare of the disability claim on behalf of his daughter in December after losing contact with her for a couple of months and then finding her a “mess” barricaded in her house. Unicare denied the claim because Plaintiff was terminated effective October 26<sup>th</sup> and not eligible for benefits. Plaintiff did not seek medical help until November 24<sup>th</sup> and the doctor certified her disability as of October 25<sup>th</sup>.

The court found Ford’s retroactive termination of Plaintiff, which thereby deprived her of disability benefits, inconsistent with the spirit of employer-provided health care benefits generally and with this Plan specifically. The court was also “hard pressed to believe” that Plaintiff’s failure to comply with reporting deadlines prescribed by the Plan should result in the denial of benefits as long as the failure to comply was directly caused by the disability itself. On remand, the court instructed that Plaintiff shall be given the opportunity to show that her alleged failure to comply with certain of the requirements found in the Plan was due to the very disability for which she seeks benefits.

[TERI HANING, Plaintiff, v. THE HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY, Defendant., No. 2:14-CV-308, 2015 WL 5729342 \(S.D. Ohio Sept. 30, 2015\).](#) The court found that Hartford abused its discretion in terminating Plaintiff’s long-term disability benefit claim and awarded judgment to her. The court agreed that that Hartford’s rejection of the opinions of her treating medical providers, one of whom had treated her for more than twenty years, did not demonstrate deliberate, principled reasoning. Particularly, the court found that evidence from Plaintiff’s treating medical providers was strong, where the doctors stated that in no uncertain terms that Plaintiff was disabled from returning to work. In contrast, the court found that opposing evidence (not including the file reviews) was weak. The court explained that “Hartford relies on an overly crabbed view of what constitutes ‘objective medical evidence’ and ‘documented clinical findings.’ Neither fibromyalgia nor depression easily lends itself to laboratory results or other quantitative medical testing.” The court agreed that Hartford’s (near) exclusive reliance on a series of file reviews submitted by paid consultants shows that its benefits termination was arbitrary and capricious. The court found that Plaintiff was clearly entitled to disability benefits and a retroactive award, rather than remand, is warranted. Further, Hartford did not argue that the court should remand the claim for reconsideration in the event that the court found the benefits termination arbitrary and capricious—thus forfeiting the issue.

[ROGER SCHLEBEN, Plaintiff, v. CARPENTERS PENSION TRUST FUND- DETROIT AND VICINITY, & TRUSTEES OF CARPENTERS PENSION TRUST FUND-DETROIT AND VICINITY, Defendants. THOMAS E. UNDERWOOD, individually & on behalf of all others similarly situated, Plaintiff, v. CARPENTERS PENSION TRUST FUND- DETROIT AND VICINITY, & TRUSTEES OF CARPENTERS PENSION TRUST FUND-DETROIT AND VICINITY, Defendants., No. 13-CV-14464, 2015 WL 5655838 \(E.D. Mich. Sept. 25, 2015\).](#) The court resolved the following question: if an ERISA plan's amendment procedure expressly prohibits amendments that reduce benefits for anyone already receiving them, can the Trustees amend the amendment procedure to allow them to do just that—reduce the benefits of someone already receiving them? The court concluded that the Plan gave Plaintiffs who had started to receive disability benefits a vested right to those benefits. To the extent that the amendments reduced benefits that Plaintiffs had already started to receive, the amendments violated the Plan and are thus unenforceable.

[RANDY HATFIELD, Plaintiff, v. LIFE INSURANCE COMPANY OF NORTH AMERICA d/b/a CIGNA GROUP INSURANCE, Defendant., No. 5: 14-432-DCR, 2015 WL 5680347 \(E.D. Ky. Sept. 25, 2015\).](#) The court denied Plaintiff's motion for de novo review because the policy language entitles LINA to abuse of discretion review notwithstanding that it did not render a timely decision on Plaintiff's long-term disability claim.

[Koning v. United of Omaha Life Ins. Co., No. 14-2188, Fed.Appx., 2015 WL 5603094 \(6th Cir. Sept. 24, 2015\).](#) The Sixth Circuit remanded Plaintiff's long-term disability claim to the district court with instructions to remand to the Plan for appropriate consideration of the claim. The court found that United of Omaha Life ignored favorable evidence from Plaintiff's treating physicians; selectively reviewed treating physician evidence; failed to conduct its own physical evaluation; and that Plaintiff may be able to meet her burden of showing a significant change in physical functional capacity as shown by objective evidence – hundreds of pages of medical records detailing back surgeries, physical therapy, and numerous pain treatment programs, and MRIs and other tests documenting degenerative disk disease.

[Burriss v. Bridgestone Americas Tire, Operations, LLC, No. 3:14-CV-01546, 2015 WL 5577456 \(M.D. Tenn. Sept. 22, 2015\).](#) The court granted Defendant's motion for judgment on the administrative record on Plaintiff's claim for disability retirement benefits based on his diagnoses of major depression and post-traumatic stress disorder (PTSD). The court rejected Plaintiff's argument that a contemporaneous Workers' Compensation lawsuit is evidence of an actual conflict of interest.

[Ling v. Life Ins. Co. of N. Am., No. 3:13-CV-0839, 2015 WL 5254360 \(M.D. Tenn. Sept. 9, 2015\).](#) Life Insurance Company of North America denied Plaintiff's claim for long-term disability benefits, determining that he was not disabled throughout his mandatory benefits waiting period ("Elimination Period"). Plaintiff is a former forklift operator impaired by degenerative disc disease of the cervical and lumbar spine. The court ruled in favor of LINA, finding that its decision was not arbitrary and capricious. LINA relied in part on an independent peer reviewer Dr. Kenneth Palmer (orthopedic surgeon) and two in-house registered nurses.

In [Crox v. Unum Grp. Corp., No. 1:14-CV-254, 2015 WL 5133670 \(E.D. Tenn. Sept. 1, 2015\).](#) the court overruled Plaintiff's objections to the Magistrate Judge's Report and Recommendation denying Plaintiff's Motion of Judgment on her long-term disability claim. Although the Magistrate Judge did not consider any applicable conflict of interest, the court found that given the particular circumstances of this case, Unum's decision to deny Plaintiff's benefits claim was neither arbitrary nor capricious. Unum based its decision upon the opinions of seven physicians who stated that the Plaintiff was capable of working full-time in a sedentary capacity and two physicians who opined that Plaintiff's disability was caused by a mental illness. No physician opined that Plaintiff cannot work full-time in a sedentary capacity.

In [PATTI OKUNO, Plaintiff, v. RELIANCE STANDARDLIFE INSURANCE COMPANY, Defendant., No. 2:14-CV-662, 2015 WL 5118077 \(S.D. Ohio Sept. 1, 2015\).](#) applying abuse of discretion review, the court held that Reliance acted reasonably in declining to pay long-term disability benefits for Plaintiff's Crohn's disease, narcolepsy, and Sjogren's syndrome. In this case, Plaintiff was also disabled by fibromyalgia and certain spinal conditions, which were deemed "pre-existing conditions."

In [Hardy v. Prudential Life Ins. Co. of Am., No. 3-14-0614, 2015 WL 5093249 \(M.D. Tenn. Aug. 28, 2015\).](#) the court adopted the Magistrate Judge's Report and Recommendation finding in favor of Prudential on Plaintiff's claims for short-term and long-term disability benefits. The court reviewed Plaintiff's claim under the arbitrary and capricious standard of review. The court disagreed with Plaintiff that Prudential ignored favorable, objective evidence from her treating physicians and relied on opinions of file reviewers who never examined Plaintiff. Plaintiff's objections included that the file reviewers, the independent physicians who reviewed her medical records, were biased. The court found that Plaintiff failed to present credible evidence that the file reviewers in this case were biased or that any such bias affected their decision with regard to her benefits.

In [\*Usztics v. Unum Life Ins. Co. of Am.\*, No. 14-CV-11940, 2015 WL 5013854 \(E.D. Mich. Aug. 24, 2015\)](#), the court held that Unum Life Insurance Company of America did not abuse its discretion in denying Plaintiff's claim for short-term disability benefits following a flare-up of her fibromyalgia syndrome. Specifically, it was not arbitrary and capricious for Unum to fail to order an independent medical examination or have a nurse (rather than a rheumatologist) review Plaintiff's medical record.

In [\*Fenwick v. Hartford Life & Accident Ins. Co.\*, No. 3:13-CV-1090-DJH, 2015 WL 5005803 \(W.D. Ky. Aug. 21, 2015\)](#), the court granted partial summary judgment to Hartford on Plaintiff's breach of fiduciary claim, finding such claim not sustainable as equitable relief under ERISA. Plaintiff claimed that Hartford breached its duty by: (a) utilizing a claims process designed to systematically delay decisions; (b) automatically accepting the opinions of Hartford's medical reviewers, discounting the opinions of treating physicians; and (c) training its reviewers to seek reasonable, rather than accurate, decisions. The court rejected the systematic delay claim because Plaintiff has no proof of systematic delay (although admitting that without further discovery, it would be impossible to determine if there was systematic delay), but also because the case presents a justiciability problem: once her benefits claim is adjudicated, her fiduciary duty argument is moot (this would be different if Plaintiff were part of a class). Second, the court found that when a § 1132(a)(1)(B) remedy is available, § 1132(a)(3) will not provide an appropriate equitable remedy. Third, procedural discrepancies typically do not warrant substantive remedies: if a procedural failing would not warrant reversal of an adverse claims decision, it would be inconsistent for it to trigger a claim for breach of fiduciary duty. With respect to the claim that Hartford systematically accepts the determination of its own medical reviewers without considering the opinions of treating physicians, the court found that the argument failed factually because none of Plaintiff's treating doctors said she was disabled. Lastly, the court found that Plaintiff's accuracy argument had more traction, but ultimately concluded that striving for an accurate decision usually come to the same result as searching for a reasonable one. Further, Hartford's alleged pursuit of a merely reasonable decision did cause Plaintiff harm since even her own doctors did not opine that Plaintiff was disabled.

In [\*Beasley v. Unum Life Ins. Co.\*, No. 13-CV-12349, 2015 WL 4966875 \(E.D. Mich. Aug. 20, 2015\)](#), the court granted summary judgment in favor of Unum on Plaintiff's claim for lifetime long-term disability benefits, where Unum stopped paying benefits after Plaintiff reached the age of 65 per the terms of a specimen policy. In previous litigation between the parties, neither party had a copy of the original disability policy so they stipulated to the terms of a specimen policy. Relying on those terms, Plaintiff prevailed and his benefits reinstated. As such, the court found

that Plaintiff was judicially estopped in this litigation from arguing that the specimen policy does not govern his right to continued disability benefits.

In [\*Stephens v. Prudential Ins. Co. of Am.\*, No. 14-11809, 2015 WL 4934543 \(E.D. Mich. Aug. 18, 2015\)](#), a matter challenging the denial of short-term and long-term disability benefits, the court determined that Prudential abused its discretion in denying Plaintiff's claims. Prudential retained an occupational health specialist, Dr. Joseph Rea, to review Plaintiff's medical records. Dr. Rea found "insufficient support for any significant physical limitations." Prudential denied Plaintiff's appeal for STD benefits in a letter that borrowed heavily from Dr. Rea's report. The court explained that all three of Plaintiff's treating physicians thought that she should remain off work at least through July 15, 2013—two weeks after Prudential terminated benefits. None of the reasons Prudential provided in its denial letter support rejecting the consistent opinions of three treating doctors. Because the court could not determine that Plaintiff was clearly entitled to benefits after July 15, 2013, it remanded the claim to Prudential for a full and fair review.

In [\*McKenna v. Aetna Life Ins. Co.\*, Fed.Appx. \\_\\_\\_, No. 14-2445, 2015 WL 4880042 \(6th Cir. Aug. 14, 2015\)](#), the Sixth Circuit reversed the judgment of the district court which affirmed Aetna's denial of Plaintiff's claim for long-term disability benefits. Plaintiff suffered from significant degenerative disc disease and Aetna paid and approved benefits for five months. Aetna's denial relied on the conclusions of Aetna's file reviewer, Dr. Stuart Rubin, a physician board certified in Physical Medicine and Rehabilitation and Pain Management. Upon *de novo* review, the court gave little weight to Dr. Rubin's conclusion that Plaintiff could return to work because he failed to explain the basis for his opinion that Plaintiff's condition and symptoms—which he agreed both prevented her from performing the material duties of her occupation and had exhibited a chronic pattern—would continue only through an estimated "recovery date." The record contained sufficient evidence that Plaintiff's disability continued beyond the expected initial recovery date. The court explained that although it is the claimant's burden to prove that she was entitled to LTD benefits, Aetna failed to explain how one office note documenting a steady and even gait and decreased pain level overcomes the remaining evidence and the treating physician's opinion, indicating that Plaintiff remained disabled beyond that date. The court remanded to Aetna to determine the scope of Plaintiff's entitlement to benefits beyond the termination date of February 23, 2013.

In [\*Guest-Marcotte v. Life Ins. Co. of N. Am.\*, No. 15-CV-10738, 2015 WL 4644936 \(E.D. Mich. Aug. 5, 2015\)](#), Plaintiff filed a lawsuit against the Life Insurance Company of North America to recover disability benefits and a Persons with Disabilities Civil Rights Act ("PWDCRA") claim against the her employer, who terminated her employment after her claim for short-term

disability benefits was denied. Defendants moved to dismiss the PWDCRA claim, asserting that, given Plaintiff's repeated and unequivocal statements that she was completely disabled for the purpose of receiving long-term benefits, she is estopped from now claiming that she could perform the duties of her job. Because Plaintiff provided no explanation for the apparent inconsistency between her PWDCRA and ERISA claims, the court dismissed her PWDCRA claim.

**Claimant loses.** In [\*McAlister v. Liberty Life Assur. Co. of Boston\*, No. CIV.A. 14-22-DLB-HAI, 2015 WL 4529297 \(E.D. Ky. July 27, 2015\)](#), the court found that Liberty Life's decision limiting Plaintiff's long-term disability benefits to 24 months under the Plan's mental illness limitation was not arbitrary and capricious where Liberty Life determined that Plaintiff was not physically impaired from performing even her own occupation, and therefore was not entitled to additional benefits.

**Claimant loses.** In [\*Kennard v. Means Indus., Inc.\*, No. 11-CV-15079, 2015 WL 4094611 \(E.D. Mich. July 7, 2015\)](#), the Sixth Circuit had issued an opinion reversing the district court's decision because it found that Plaintiff was completely disabled within the meaning of the Plan and that no jobs existed which he was able to perform. Plaintiff had suffered a severe injury to his lungs when he was exposed to an improperly mixed batch of synthetic oil. The Sixth Circuit remanded the case "with instructions to award Kennard disability benefits, retroactive to the date they accrued under the Plan, and to consider his request for attorney fees and costs under 29 U.S.C. § 1132(g) (1)." On remand, the district court entered judgment in favor of Plaintiff, consistent with the Sixth Circuit's mandate and remanded the case to the plan administrator for a calculation of the benefits owed Plaintiff, retroactive to the date they accrued. On remand, the plan administrator determined that even if Plaintiff was disabled, the workers' compensation coordination provision in the plan applied to Plaintiff, resulting in a complete set-off to any disability benefits. The plan administrator found that Plaintiff was not entitled to a disability benefit in addition to the workers' compensation benefit. The Sixth Circuit subsequently denied Plaintiff's petition for mandamus, finding that Defendant had not waived the workers' compensation coordination provision by denying benefits based on its conclusion that Plaintiff was not disabled. The district court denied Plaintiff relief from its order remanding the claim to the plan administrator and found that Defendant's interpretation of the coordination provision was not arbitrary and capricious.

In [\*Niswonger v. PNC Bank Corp. & Affiliates Long Term Disability Plan\*, No. 13-4282, Fed.Appx. , 2015 WL 2239653 \(6th Cir. May 14, 2015\)](#), the Sixth Circuit reversed the district court's order upholding Liberty Life's denial of Plaintiff's claim for long-term "any

occupation” disability benefits. Plaintiff previously won a court order finding that Liberty Life abused its discretion in denying him “own occupation” disability benefits. The Sixth Circuit noted that the court in *Niswonger I* held, the record contains “verifiable objective results including a diagnosis of obstructive lung disease.” 2011 WL 3360262, at \*8. Relying exclusively on a “paper review,” and with no evidence in the record indicating Plaintiff’s disease was cured after October 20, 2011, Liberty concluded that Plaintiff had attained full-time capacity from that date forward, including ability to perform his own occupation. The court found that Liberty effectively disregarded reliable medical evidence, including objective test results and the medical conclusions of Plaintiff’s treating physicians. The court also found that its failure to satisfactorily rebut the medical evidence and not to request an independent examination constituted arbitrary and capricious decision making.

In [\*Brown v. Fed. Exp. Corp.\*, No. 14-5777, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 2056463 \(6th Cir. May 5, 2015\)](#), the court affirmed the district court’s decision that FedEx’s denial of short-term disability benefits was not arbitrary and capricious. Plaintiff alleged that several doctors had diagnosed her with Lyme disease and thyroiditis, but Aetna Life Insurance Company, the claims administrator, denied her request for benefits due to the contradiction between negative lab results and her doctors’ diagnoses. The court found that Aetna did not act arbitrarily and capriciously in concluding that the opinions of her doctors did not establish – or were not based on – “significant objective findings” as required by the Plan. Aetna did not need to credit a diagnosis predicated on a “multitude of symptoms” since the STD Plan clearly states that observable symptoms may not be the basis for a finding of disability.

In [\*Zuke v. Am. Airlines, Inc. Long-Term Disability Plan\*, No. 1:13CV403, 2015 WL 1475073 \(S.D. Ohio Mar. 31, 2015\)](#), the court upheld Defendants’ decision to deny benefits under the “any occupation” standard of disability. The court rejected Plaintiff’s argument that the cancellation of benefits in the absence of evidence showing that her condition had improved was arbitrary and capricious where no explanation existed for the apparent discrepancy from earlier assessments. Here, the court found that Defendants set forth specific reasons for the change, which were due in part to a lack of objective data. Plaintiff also argued that the termination of benefits was arbitrary and capricious because MetLife failed to perform a physical exam of Plaintiff even though the Plan requires a participant to undergo a physical exam. However, the court found that the file review of her claim was adequate. Both reviewing doctors listed the records which were provided for their review. Additionally, although Plaintiff was found to be disabled by the Social Security Administration in 2001, the Sixth Circuit has explained that a Social Security finding is entitled to less weight when it occurred years before.

In [\*Bennett v. Unum Life Ins. Co. of Am.\*, No. 3:13-CV-426, 2015 WL 1476669 \(S.D. Ohio Mar. 31, 2015\)](#), the court upheld Unum’s denial of Plaintiff’s long-term disability benefits. The court found that it was arguable that Plaintiff did submit evidence that could allow one to conclude, based upon his pain and the effect of pain medications, that he was disabled as of March 2012. But, even the evidence weighing in Plaintiff’s favor is equivocal. His doctors’ determinations of disability were interim decisions recommending further evaluation that Plaintiff did not pursue. The court found that there was substantial medical evidence to demonstrate that Plaintiff was not disabled with regard to performing his job as it is normally performed in the national economy.

In [\*Godmar v. Hewlett Packard Co.\*, No. 14-CV-12153, 2015 WL 1469559 \(E.D. Mich. Mar. 30, 2015\)](#), the court found that Sedgwick’s initial decision was not arbitrary and capricious after: (1) Sedgwick provided reasons for reversing its course on its initial disability decision, and relied on objective evidence to determine that Plaintiff was not prevented from performing the functions of his usual occupation; and (2) Sedgwick provided Godmar with two opportunities to appeal his decision regarding the denial of benefits, and had three physicians consult with—and review multiple reports from—Godmar’s physicians.

In [\*Hammonds v. Aetna Life Ins. Co.\*, No. 2:13-CV-310, 2015 WL 1299515 \(S.D. Ohio Mar. 23, 2015\)](#), the court upheld Aetna’s denial of Plaintiff’s “any occupation” long-term disability benefits, finding in part, that the Plan terms do not require Aetna to identify a particular position that a claimant might fill before it determines that the claimant is not disabled, or that such a position existed in a given geographic area. Because the Plan does not require the identification of a specific job currently available within Plaintiff’s geographical area, Aetna’s failure to do so does not render its decision arbitrary or capricious, where the court found that it obtained through proper sources a determination that Plaintiff could perform a broad range of sedentary jobs, and the specific jobs listed were merely illustrations of what plaintiff could perform.

In [\*Breland v. Liberty Life Assur. Co. of Boston\*, No. 14-CV-10508, 2015 WL 1132948 \(E.D. Mich. Mar. 12, 2015\)](#), Plaintiff brought suit against Liberty Life seeking reinstatement of his terminated claim for long-term disability benefits. As part of its answer, Liberty Life filed a counterclaim against Plaintiff seeking the return of overpaid LTD benefits pursuant to 29 U.S.C. § 1132(a)(3). The court found that: 1) Liberty Life’s reliance on its “independent reviewers” was not arbitrary and capricious; 2) Liberty Life adequately considered Plaintiff’s SSDI award because it expressly acknowledged that it considered the SSA’s ruling and claimed to have reviewed medical records that were not considered by the SSA in its determination process; 3) Liberty Life did not rely on a “stale” vocational report prepared 10 months before Liberty Life denied Plaintiff’s disability claim; and 4) Plaintiff did not point to any evidence showing that a

conflict of interest affected the benefits decision. Lastly, the court granted summary judgment to Liberty Life on its overpayment counterclaim based on Plaintiff's receipt of SSDI benefits.

In [\*Sears v. Drees Co.\*, No. CIV.A. 13-132-DLB, 2015 WL 779003 \(E.D. Ky. Feb. 24, 2015\)](#), Plaintiff alleged that Defendants wrongfully terminated and refused to pay her long-term benefits. The court adopted the Magistrate Judge's Report & Recommendation granting Defendants' Motion for Summary Judgment. The court found that Union's decision to terminate benefits was not arbitrary or capricious, where Union relied on a "file review" of Plaintiff's claim and Plaintiff's post-final denial evidence of disability was not before the plan administrator at the time of its decision. The court also found that Plaintiff failed to exhaust available administrative remedies with respect to her § 1132(a)(1)(B) and § 1132(a)(3) claims against U.S. Bank because two letters sent by her attorney do not conform to the plan's procedure requiring disability claim forms be sent to a certain address. The court declined Plaintiff's request to refrain from adjudicating the cross-motions for summary judgment until she has exhausted her administrative remedies, finding that judicial economy prevents the court from granting such a request.

In [\*Hess v. Metro. Life Ins. Co.\*, No. 13-CV-10696, 2015 WL 669409 \(E.D. Mich. Feb. 17, 2015\)](#), the court found that MetLife abused its discretion when it denied Plaintiff's long-term disability claim because there was no finding that Plaintiff's job could accommodate her need to lie down due to orthostatic intolerance. Defendant's consultant agreed that lying down would be an accommodation possibly required for Plaintiff to continue working. Defendant interpreted an assessment not as it actually read, that plaintiff might need to sit or lay down based on her orthostatic intolerance, but instead that either sitting or lying down would do equally well. Defendant was required to assess the impact of her potential need to lay down on her ability to do her job. Because it did not, its decision was arbitrary and capricious. The court ordered MetLife to pay to Plaintiff all unpaid long-term disability benefits owed to her under the Plan at issue from the time benefits became payable to the present along with prejudgment interest on those unpaid benefits, and to pay ongoing benefits in accordance with that same plan.

#### G. Seventh Circuit

**Denial of disability pension benefits was not an abuse of discretion.** [\*Hilderbrand v. Nat'l Elec. Benefit Fund\*, No. 13-3170, 2015 WL 7274023 \(C.D. Ill. Nov. 17, 2015\)](#) (Judge Sue E. Myerscough). The court granted the Fund's motion for summary judgment, finding that its decision to deny Plaintiff's disability pension benefits during a three-and-a-half-year period was not arbitrary and capricious. Of note, Plaintiff argued that the Fund had an obligation to conduct a good faith investigation of his functional ability to work and should have hired a vocational

expert. The court noted that the Seventh Circuit has not expressed an opinion as to whether ERISA plan administrators as a rule must hire vocational experts or perform a transferrable skills analysis, however, seven other circuits have held, to varying degrees, that, even in the absence of specific plan language, benefit administrators cannot outright ignore vocational considerations. The court found that regardless, in this case, the Trustees took the vocational considerations into account, including by expressly considering Plaintiff's vocational consultant's report, the Social Security Administration decisions, and Plaintiff's treating physicians' medical reports. Plaintiff's first Social Security decision contained evidence that a vocational expert concluded that jobs existed in the national economy for an individual with Plaintiff's age, education, work experience, and residual functional capacity.

[Halley v. Aetna Life Ins. Co., No. 13 C 6436, 2015 WL 5731853 \(N.D. Ill. Sept. 30, 2015\)](#). On *de novo* review, the court found in favor of Plaintiff on his claim for long-term disability benefits where Plaintiff alleged disability from multiple spinal disorders and osteoarthritis. The court found that while Plaintiff—in theory—is now capable of working, the preponderance of the evidence shows that no “reasonable occupation” is available to him. A reasonable occupation does not include jobs where Plaintiff would earn 80% or less of his adjusted pre-disability earnings.

**Accommodations for religious organizations under the ACA do not impose a substantial burden.** In [Grace Sch. v. Burwell, No. 14-1430, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5167841 \(7th Cir. Sept. 4, 2015\)](#), the Seventh Circuit held that the ACA's accommodations for religious organizations with respect to its “contraceptive mandate” does not impose a substantial burden on their free exercise of religion, in violation of the Religious Freedom Restoration Act of 1993 (“RFRA”). Although Plaintiffs are not required to pay for the objectionable services, they contended in the district court that being forced to contract with insurers or third-party administrators who must then provide those services makes them a facilitator of objectionable conduct, complicit in activity that violates their core religious beliefs. The court held that the accommodation does not serve as a trigger or a conduit for the provision of contraceptive services. Every other circuit court to consider the issue of whether the mandate imposes a substantial burden on religious exercise has come to the same conclusion.

**Designation of TPA for coverage of emergency contraception does not violate ERISA.** In [Wheaton Coll. v. Burwell, No. 14-2396, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3988356 \(7th Cir. July 1, 2015\)](#), the Seventh Circuit held that the government did not violate ERISA by designating the third-party administrator for a Christian liberal arts college's health plans to be the plan administrator for coverage of emergency contraception under the ACA after the college notified the

government that it objected to providing certain forms of contraceptive methods approved by the FDA.

In [Rogers v. Reliance Standard Life Ins. Co., No. 14 C 4029, 2015 WL 2148406 \(N.D. Ill. May 6, 2015\)](#) (**Not Reported in F.Supp.3d**), the court enforced the disability policy's discretionary clause and Texas choice of law provisions, finding that neither Illinois nor Texas law could be applied to strip the administrator of deferential review. The court also found that Reliance's decision to uphold its denial of LTD benefits because Plaintiff did not submit to its requested Independent Medical Evaluation ("IME") was an abuse of discretion. Plaintiff refused to participate in the IME because it was allegedly requested after Reliance's 45-day deadline to make a decision on her appeal. The court rejected Plaintiff's argument that Reliance's request for an IME during the appeal process was impermissible because the Policy only allows Reliance to request an IME "while a claim is pending." The court found that the administrative appeal process is still considered part of the pending claim. The court also rejected Reliance's contention that Plaintiff failed to exhaust her administrative remedies. The court found that nothing in the Policy, including under the "LEGAL ACTIONS" section, discusses administrative remedies. As such, Plaintiff is not required to have exhausted administrative remedies before filing suit. The court ordered the parties to proceed with the IME, which is to be conducted within a practicable time frame and with an agreed-upon physician. The court remanded the claim so Reliance can conduct a new review of Plaintiff's eligibility with the inclusion of the resulting IME.

In [Cheney v. Standard Ins. Co., No. 13 C 4269, 2015 WL 1185053 \(N.D. Ill. Mar. 13, 2015\)](#), the court ruled in favor of Plaintiff's motion for entry of judgment requesting a determination of the appropriate calculation of Predisability Earnings. The court found it to be a reasonable expectation for an employee to believe she would remain "Actively At Work" while still employed, and prior to taking any official leave. There was no dispute that Plaintiff was returned to salaried status in January 2011 and tracked her billable hours throughout that year. There was no evidence supporting Defendants' position that plaintiff stopped "performing with reasonable continuity the Material Duties of" her job suddenly on December 19, except that there was no billing logged after that date. The official change in Plaintiff's work status was not until January, and she continued to receive her regular pay through the end of December 2011. If Plaintiff's benefits were based on her 2010 earnings, it would not be reflective of Plaintiff's long-time career at the law firm. A reasonable expectation would be that Plaintiff would be paid based on her regular compensation, not based on a year that was vastly different than other years. Because the court found the term "Active Work" is subject to reasonable alternative interpretations, and construing ambiguities in favor of Plaintiff, the court found that reading the policy in "an ordinary and popular sense" leads to the conclusion that Plaintiff ceased "Active Work" when

her leave began in January. Therefore, her prior tax year upon which her disability benefits should be based is 2011.

In [\*Karul v. S.C. Johnson & Son Long Term Disability Plan\*, No. 13-C-900, 2015 WL 1034150 \(E.D. Wis. Mar. 10, 2015\)](#), the court granted Plaintiff's motion for judgment in her favor, finding that Defendants' decision to terminate her LTD benefits claim as of April 1, 2012 was arbitrary and capricious. A key issue is Plaintiff's pain and its impact on her ability to lift or carry, sit, and work on a sustained basis. The court found that Defendants' reliance on obesity—a condition that was relatively constant during the entire time of Plaintiff's claimed disability—as a basis for subsequently finding her not disabled calls into question the purported reasonableness of the Defendants' determination. The court also found that SSA's determination of disability corroborates the conclusion that Plaintiff is disabled. Notably, the court found that Defendants' use of Dr. Aubrey Swartz, an IME doctor with a history of bias against claimants, was of minimal significance. There was no evidence that the choice of Dr. Swartz was improper or that the doctor was biased in his review of Plaintiff's claim. The court reinstated Plaintiff's claim retroactively, with prejudgment interest at the prime rate compounded annually, and awarded attorneys' fees and costs.

In [\*Schilling v. Epic Life Ins. Co.\*, No. 13-CV-438-WMC, 2015 WL 856575 \(W.D. Wis. Feb. 27, 2015\)](#), the court granted Defendant's motion for summary judgment on Plaintiff's complaint seeking to recover long-term disability insurance benefits. With respect to Plaintiff's procedural challenges, the court found that Defendant provided adequate notice of the reasons for terminating benefits, where it denied Plaintiff's claim because she could perform "light" duty work and then found on appeal that she could perform "sedentary" work. The determination that Plaintiff could perform light duty work necessarily subsumes a determination that she could perform even less strenuous sedentary work and Plaintiff was not prejudiced by any shift in reasoning. The court also found that Defendant was not required to identify in its initial denial letter what additional information Plaintiff could provide to perfect her claim because the notice requirement under 29 C.F.R. § 2560.503–1(f) only applies when more information is needed for a plan administrator to review the denial of a claim. Here, there remained no unresolved material factual questions so there was no need for Defendant to identify additional information Plaintiff could provide to perfect her claim. The court rejected Plaintiff's substantive challenges, including that Defendant (A) failed to conduct a second vocational analysis as part of the appeal; (B) failed to adequately consider the SSA's finding of disability; and (C) selectively reviewed the medical evidence submitted.

In [Kennedy v. Lilly Extended Disability Plan, No. 1:13-CV-1103-WTL-TAB, 2015 WL 631391 \(S.D. Ind. Feb. 13, 2015\)](#), Plaintiff, who was diagnosed with fibromyalgia, received long-term disability benefits under the Defendant Plan before her benefits were terminated by Anthem Life, the plan administrator. The court granted Plaintiff's motion for summary judgment, finding that Anthem's claim decision was an abuse of discretion. Specifically, the court found that the lack of objective evidence of Plaintiff's functional limitations as a result of her subjective symptoms could have been fatal to her claim for benefits had Plaintiff been informed of the need to provide such evidence and been unable (or simply failed) to do so. But, Anthem did not inform her of the need to do so, as required by 29 C.F.R. § 2560.503-1(g)(iii), and it would be impossible for Plaintiff to go back in time and undergo testing to demonstrate what her functional capacity was as of December 1, 2012. The court determined that remanding "for further findings or explanations" would be a useless exercise because the court has reviewed the evidence of record and determined that it does not offer any affirmative support for terminating Plaintiff's benefits. Accordingly, the court found that the appropriate remedy in this case is the reinstatement of benefits.

#### H. Eighth Circuit

[Jalowiec v. Aetna Life Ins. Co., No. CV 14-4332 \(DWF/LIB\), 2015 WL 9294269 \(D. Minn. Dec. 21, 2015\)](#) (Judge Donovan W. Frank). Aetna abused its discretion in denying Plaintiff's LTD claim by finding own occupation to be "sedentary" based on its vocational reviewer on appeal and heavily relying on the conclusions of its three independent reviewers. Plaintiff is entitled to award of attorneys' fees.

**LTD claim remanded to Hartford to consider functional capacity evaluation submitted after it issued a final denial.** [McKenna v. Hartford Life & Accident Insurance Co., No. CV 14-3257 \(MJD/LIB\), 2015 WL 8483275 \(D. Minn. Dec. 9, 2015\)](#) (Judge Michael J. Davis). Here, Hartford denied Plaintiff's LTD claim because it argued that Plaintiff was required, but failed, to submit objective evidence of the extent of her limitations. Hartford explained to the court that one method of objective proof of disability, for instance, is a functional capacity evaluation but when it terminated Plaintiff's benefits in August 2013, it told her that its independent reviewing physician had concluded "that there are no objective clinical physical exam findings to support any restrictions or limitations." Hartford did not mention that an FCE was necessary, although the only physician who examined her and concluded that she might be able to return to work without substantial restrictions had opined that an additional FCE was necessary to fully assess her capabilities. While unrepresented by an attorney, Plaintiff submitted her own administrative appeal and described how fibromyalgia affects and limits her life and also provided a supportive letter from her doctor. The court concluded that from a layperson's point of view, neither the initial nor the final termination letter clearly identified what type of objective evidence would be

sufficient beyond what Plaintiff had already submitted. Further, Hartford did not put Plaintiff on notice of the type of evidence she needed to provide with her appeal and she did not know Hartford was seeking evidence such as an FCE until after her appeal was denied and she was represented by counsel. The court concluded that Plaintiff has shown good cause for failing to obtain and submit her late-produced FCE before Hartford closed the administrative record and ordered Hartford to consider the FCE along with the rest of the administrative record, before making its final benefits determination. The court remanded the matter to Hartford to evaluate the FCE and consider the expanded record before issuing its claim decision.

**Preliminary injunction enjoining enforcement of contraceptive mandate affirmed.** In [\*Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.\*, No. 14-1507, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5449491 \(8th Cir. Sept. 17, 2015\)](#), the Eighth Circuit affirmed the district court's order granting a preliminary injunction enjoining the government from enforcing certain provisions of the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. § 300gg-13, against CNS International Ministries, Inc. (CNS) and Heartland Christian College (HCC), each of which is a nonprofit religious organization that offers healthcare coverage to employees through a self-insured plan. Applying the substantial-burden test set forth in *Hobby Lobby*, the court concluded that CNS and HCC have established that they are likely to succeed on the merits of their challenge that the contraceptive mandate and the accommodation process substantially burden their exercise of religion in violation of the Religious Freedom Restoration Act of 1993 and that the current accommodation process is not the least restrictive means of furthering the government's interests. The court also found that they established that in the absence of an injunction they will be forced to violate their sincerely held religious beliefs by complying with either the contraceptive mandate or the accommodation process or to incur severe monetary penalties for refusing to comply. Following its decision in *Sharpe Holdings*, the court affirmed the same injunction in [\*Dordt Coll. v. Burwell\*, No. 14-2726, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5449504 \(8th Cir. Sept. 17, 2015\)](#).

In [\*Lanpher v. Metro. Life Ins. Co.\*, No. CIV. 12-2561 JRT/JSM, 2015 WL 4920042 \(D. Minn. Aug. 18, 2015\)](#), Plaintiff prevailed on his claim for benefits and breach of fiduciary duty claim against MetLife for Supplemental Long Term Disability Benefits, where MetLife approved his application for the benefits but did not communicate the approval to the employer, who in turn did not deduct the required insurance premiums from Plaintiff's paychecks. The court granted Plaintiff's motion for partial summary judgment against MetLife and ordered the parties to ascertain whether any disputes exist regarding the appropriate amount of damages, and to submit letter briefs if a dispute exists. Based on its resolution of the submissions, the court granted damages to Plaintiff in the amount of \$394,033.95, which constitutes: \$75,000 in attorney's fees; supplemental earnings that do not include stock-based compensation; and prejudgment interest

using an interest rate calculation that comports with Section 1961 in effect one week prior to the court's order.

In [\*Jansen v. Lincoln Fin. Grp.\*, No. 4:13-CV-04068-RAL, 2015 WL 4879295 \(D.S.D. Aug. 14, 2015\)](#), the court found that Lincoln Financial did not abuse its discretion in denying "any occupation" long-term disability benefits to Plaintiff, who alleged disability from a combination of heart problems and mental illness. Lincoln relied on medical reviews obtained from cardiologist Dr. Darius Marhamati, internist Dr. Mark Rosen, and psychiatrist Dr. Chris Esguerra.

**Claimant sort of wins.** In [\*Flynn v. Ascension Health Long Term Disability Plan\*, No. 4:13CV2449 HEA, 2015 WL 4429767 \(E.D. Mo. July 20, 2015\)](#), where the Plan denied Plaintiff's claim for long-term disability benefits, the court denied the parties' motions for summary judgment, finding that there was disputed issues of material fact concerning Plaintiff's prednisone usage. Because the court found that it cannot adjudicate whether Defendants' decision to deny Plaintiff's claim for long term disability benefits was arbitrary and capricious, it remanded the case to Sedgwick with directions to reopen the administrative record to either determine the status of Plaintiff's prednisone use as of December 5, 2012, and her treating gastroenterologist's opinions thereon, or to request a revised report from Dr. Alan Altman (peer reviewer specializing in Gastroenterology) which does not rely on his previous assumption that Plaintiff was off of prednisone per Plaintiff's doctor's instructions as of December 5, 2012. Plaintiff's disability stemmed from Crohn's disease.

In [\*Weske v. Hartford Life & Accident Ins. Co.\*, No. CIV.13-3554 DSD/JJK, 2015 WL 627932 \(D. Minn. Feb. 12, 2015\)](#), the court concluded that Hartford abused its discretion in terminating Plaintiff's long-term disability benefits effective March 1, 2013 and ordered reinstatement of her benefits for the period of March 1, 2013 to November 21, 2013, the date consistent with her surgeon's un-rebutted opinion that Plaintiff could not work for the six months following the Physical Capacities Evaluation Form. Based on the record, the court was unable to determine whether Plaintiff was disabled after November 21, 2013, and declined to consider that issue. In ruling on the parties' motions, the court found that Hartford appropriately considered whether Plaintiff could work in a sedentary position in the general workplace, which involves sitting most of the time, occasional walking or standing for brief periods, and occasional lifting, even though her own job required more standing and walking. However, Hartford's finding of no disability was not supported by substantial evidence, where Hartford failed to do the proper due diligence in assessing Plaintiff's disability status before her surgery and Hartford's reviewing physician did not consider the surgeon's opinions which are crucial to the issue of Plaintiff's disability

status. The court was also troubled by the timing of Hartford's decision to terminate benefits, which came on the eve of her scheduled surgery which would render Plaintiff disabled again for at least four weeks. "Hartford's haste to terminate benefits just before the surgery evinces a desire to avoid coverage for the post-surgery period." Accordingly, the court denied Hartford's motion for summary judgment and granted in part Plaintiff's motion for summary judgment.

In [Whitley v. Standard Ins. Co., No. CIV. 13-1335 MJD/LIB, 2015 WL 506323 \(D. Minn. Feb. 6, 2015\)](#), the court found that Standard abused its discretion in concluding that Plaintiff's "Own Occupation" is a family medicine physician, rather than an emergency room physician, and that Plaintiff was not disabled under the Policy. Plaintiff worked as an emergency room physician for many years before her disability, but she was also board certified in family medicine. The court dismissed Plaintiff's claim for breach of fiduciary duty against her employer, Lake Region, for failing to provide CPT codes and by providing false information to Plaintiff regarding her coverage under the long-term disability plan. The court found evidence in the record that Lake Region falsely represented to Plaintiff that, as one of her employment benefits, she would receive "own occupation" disability insurance coverage that defined her "own occupation" as emergency room physician. There is also evidence that Lake Region was, at a minimum, negligent in responding to Standard's simple request for CPT codes. However, the court found that there is no evidence in the record that Lake Region was acting as a fiduciary or plan administrator with respect to Plaintiff's claim. The Policy states that the payment of long term disability claims is solely within the discretion of Standard and when Plaintiff made her claim for long-term disability payments, she submitted the claim directly to Standard, without any assistance from Lake Region. Lake Region was not involved in the decision to approve benefits for Plaintiff under the Policy, nor was it involved in the decision to later discontinue benefits. There is also no evidence that Lake Region had discretionary authority or control over the Plan or over Plan assets or that it had any discretionary responsibility in administering the Plan. While Lake Region did provide information about Plaintiff's benefits to her, and took on administrative functions in forwarding the CPT codes, those acts, alone, do not constitute the type of duty that would make it a fiduciary under ERISA. The court went further to state that,

"While the Court is compelled to dismiss Whitley's ERISA breach of fiduciary duty claims against Lake Region based on her choice of legal theory, its decision should not be seen in any way as condoning Lake Region's conduct in this matter. To the contrary, the Court believes Lake Region acted in a manner wholly inconsistent with principles of professionalism and common courtesy in misrepresenting to Whitley the nature of her disability benefits, and in failing to respond to Standard's request for information. While Whitley's claim cannot be sustained, this is not the type of behavior that should be encouraged, or sanctioned, by the courts."

The court denied Defendant Standard Insurance Company's Motion for Summary Judgment, granted Plaintiff's Motion for Summary Judgment and Defendant Lake Region's Motion for Summary Judgment.

## I. Ninth Circuit

**Denial of long-term disability benefits is an abuse of discretion where insurer committed a number of procedural irregularities in its review of the claim and appeal.** [Yancy v. United of Omaha Life Ins. Co., No. CV14-9803 PSG \(PJWX\), F.Supp.3d , 2015 WL 9311729 \(C.D. Cal. Dec. 18, 2015\)](#) (Judge Philip S. Gutierrez). The court found that Defendant abused its discretion when it denied Plaintiff's claim for long-term disability benefits. Here, Plaintiff had submitted years of medical records showing that she suffers from some combination of systemic lupus erythematosus, fibromyalgia, migraines, and major depression. Regarding the standard of review and Defendant's structural conflict of interest, the court found certain factors warranting increased skepticism: 1) Defendant provided inconsistent reasons for denial, at first claiming lack of proof of cognitive impairment and then later changing the reason to lack of evidence of physical impairment; 2) Defendant failed to adequately investigate Plaintiff's claim or to ask Plaintiff for evidence it deemed necessary to render its decision; 3) Defendant failed to credit reliable evidence; and 4) Defendant chose a reviewing physician who did not believe in awarding disability benefits to claimants with fibromyalgia. The court also found that Defendant engaged in procedural error where it relied on a reviewing doctor's report without affording Plaintiff an opportunity to view and respond to the report. Defendant also offered conflicting construction of plan provisions by its implicit requirement that Plaintiff submit objective evidence of her disability but such requirement is not stated in the LTD policy. The court also found that Defendant erred by failing to develop facts it deemed necessary to making its determination. In sum, the court concluded that there is no evidence which can provide a reasonable basis for Defendant's denial when all of the circumstances of Plaintiff's case are considered in the aggregate.

**Court denies disability claimant relief from local rule prohibiting disclosure of court-sponsored mediation communications.** [Jones v. Life Insurance Company of North America, No. 08-CV-03971-RMW, 2015 WL 8753996 \(N.D. Cal. Dec. 15, 2015\)](#) (Judge Ronald M. Whyte). In matter challenging LINA's offset of dependent Social Security disability insurance benefits, Plaintiff sought permission to disclose to the court for evidentiary purposes things that happened and things that were said in District Court and Ninth Circuit mediation, as well as Defendants' mediation brief. The court denied Plaintiff's motion from ADR confidentiality. It found that Plaintiff did not meet certain narrow exceptions to the general prohibition on disclosure of information from court-sponsored mediation as set forth in ADR Local Rule 6-12. The court rejected Plaintiff's argument that ERISA requires disclosure of mediation

communications, finding that the mediation exchanges are not part of the administrative record simply because the parties may have discussed administrative proceedings at mediation. The court found that no manifest injustice would result by not permitting Plaintiff to disclose the mediation communications, distinguishing this case from *Barnes v. AT&T Pension Benefit Plan-Non-Bargained Program*, 963 F.Supp.2d 950 (N.D. Cal 2013), where the court had permitted consideration of an early neural evaluation for purposes of a collateral issue dealing with notice as it affected attorneys' fees. Lastly, the court found that disclosure for purposes of impeachment would undermine the policy goal of Federal Rule of Evidence 408-encouraging settlement.

**On de novo review, Liberty Life erred in its termination of LTD benefits which it based, in part, on surveillance.** [\*Bigham v. Liberty Life Assurance Company of Boston, No. C15-349RSM, 2015 WL 8489417 \(W.D. Wash. Dec. 11, 2015\)\*](#) (Judge Ricardo S. Martinez). On *de novo* review of Liberty Life's decision to terminated Plaintiff's LTD claim, the court ruled under Rule 52 in favor of Plaintiff. Here, Plaintiff argued that she is disabled under the terms of the LTD Plan due to "chronic intractable pain, fibromyalgia, seronegative spondyloarthropathy, cervical and lumbar degenerative disc disease," and related conditions. Liberty Life argued that medical evidence and post-diagnosis surveillance do not establish that Plaintiff is disabled or otherwise unable to perform her own occupation. The court concluded otherwise and remanded to Liberty Life the issue of extending benefits beyond the 24-month period prescribed for "own occupation" benefits. Specifically, the court found that Plaintiff's job required her to be able to focus her thoughts and interact with others for long periods of time on a daily basis and doctors who personally examined her concluded that her condition made it impossible to for her to reliably perform this essential job function. The court found that subjective evidence has been found in previous cases to be valuable evidence for a disability claim. Liberty Life argued that surveillance showed Plaintiff standing and walking for a total of 42 minutes without any sign of discomfort, let alone chronic and disabling pain. It further argued that Plaintiff did not bend carefully or walk gingerly, grimace or limp. With respect to surveillance, the court found that it neither proves nor disproves Plaintiff's limitations and nothing on surveillance is inconsistent with Plaintiff's self-reports.

**Termination of LTD benefits not an abuse of discretion where in-person and reviewing physicians concluded that Plaintiff could perform normal job and employer confirmed restrictions fell within normal job duties.** [\*Cruz-Baca v. Edison Int'l Long Term Disability Plan, No. 214CV07887JFWMANX, 2015 WL 8490898 \(C.D. Cal. Dec. 9, 2015\)\*](#) (Judge John F. Walter). The court found that the Plan (administered by Sedgwick) did not abuse its discretion in finding that Plaintiff was no longer disabled from performing her normal job as a Customer Specialist 2. Sedgwick had Plaintiff evaluated in person by an independent doctor, Dr. Saleem

Waraich, who concluded that Plaintiff was unable to fulfill the substantial and material duties of her usual occupation but that she should be reassessed in one year because her condition could be controlled by new medication which would take at least six months to show its full effects. Sedgwick later had Plaintiff evaluated in person again but by Dr. Ramachandran Srinivasan, who concluded that Plaintiff could perform her normal job. On appeal, Sedgwick had three reviewing physicians review Plaintiff's medical records, including Rajendra K. Marwah, M.D., Mark Borigini, M.D., and Dennis Payne, Jr., M.D. The restrictions recommended by Dr. Borigini and Dr. Payne were presented to Plaintiff's work location for review and consideration and Sedgwick determined that the restrictions fell within Plaintiff's normal job duties as a Customer Specialist 2 without any accommodations needed. Although Plaintiff had been approved for Social Security disability benefits, Sedgwick acknowledged that it had not been informed of the basis for her approval of SSDI benefits, but noted that it was likely based on a different standard of benefit eligibility than the standards under the Plan, and that there may have been additional underlying medical information submitted in the SSDI process that was not submitted to the Plan, or may have had relatively less rigorous case management than Plaintiff's LTD file.

**Aetna did not abuse its discretion in terminating long-term disability benefits claim.**

[Yaakoubi v. Aetna Life Ins. Company, et al., No. CV-14-01808-PHX-NVW, 2015 WL 8479059 \(D. Ariz. Dec. 9, 2015\)](#) (Judge Neil V. Wake). The court found in favor of Aetna on Plaintiff's motion for judgment on the administrative record requesting review of Aetna's denial of her long-term disability benefits. Viewing the evidence of bias in the light most favorable to Plaintiff, the court found that the evidence does not show that Aetna's conflict of interest improperly influenced its decision to terminate Plaintiff's long-term disability benefits. The court found that the record supports Aetna's determination that Plaintiff could perform "light" work with limited standing and walking and that "reasonable occupations" that Plaintiff was capable of performing existed as of the benefit termination date.

**Administrator abused its discretion by determining there was a reasonable job that the disability claimant could perform that was within the proper zone as required by the terms of the disability plan.** [Barnett v. S. California Edison Co. Long Term Disability Plan, No. 13-16925, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 8056622 \(9th Cir. Dec. 7, 2015\)](#) (Before FERNANDEZ and M. SMITH, Circuit Judges, and SCHEINDLIN,\* District Judge). In dispute over denied long-term disability benefits, the Ninth Circuit vacated the district court's determination in favor of the defendant Plan and remanded for further proceedings. Under the Plan provisions that applied to Plaintiff, "[d]isabled means that, due to illness or injury, you are unable to perform ... any reasonable job for the company after two years." Moreover, "[a] reasonable job is any gainful activity in any job classification for which you are or may reasonably become fitted by education, training, or experience." And that job must be located "at any company within the

zone ... in which you were working on your last day at work.” The court did not find improper Defendant’s determination that there was a reasonable job that Plaintiff could perform, however, Defendant abused its discretion when it implicitly determined that the job in question was within the proper zone.

[Sonia Cruz-Baca, v Edison Int’l Long Term Disability Plan, No. CV147887JFWMANX, 2015 WL 7573624 \(C.D. Cal. Nov. 25, 2015\)](#) (Judge John F. Walter). The court found that the Plan did not abuse its discretion when it terminated Plaintiff’s disability benefits and entered judgment in favor of the Plan.

**Insurer’s decision to pro rate a bonus over twelve months even though the bonus covered only a six-month period is not an abuse of discretion.** [Powell v. Hartford Life & Acc. Ins. Co., No. 13-16529, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 7074859 \(9th Cir. Nov. 13, 2015\)](#) (Before WALLACE, BLACK\*, and CLIFTON, Circuit Judges. WALLACE dissenting). Plaintiff appealed the district court’s grant of summary judgment to The Hartford Life and Accident Insurance Company on Plaintiff’s claim that Hartford abused its discretion in calculating his Monthly Rate of Benefits under his employer’s ERISA Plan by improperly pro rating his “MBO/Key Contributor Bonus.” Specifically, Plaintiff argued that the Bonus, which was awarded for work that he completed between January 1, 1995 and June 30, 1995, should be pro-rated over six months, the period to which it relates, and not over twelve months, which is what Hartford did. The court found that nothing in the Plan states exactly how to pro rate a bonus to get a proper “rate in effect,” and the Plan itself does not define that term. Hartford applied a policy to pro rate any bonuses earned in the year preceding a disability over twelve months, which is consistent with how the plan deals with other variable income sources, like commissions. The court found this method to be a logical interpretation of ambiguous language with regard to non-commissioned employees. The majority affirmed the district court. Judge Wallace dissented and found that Hartford’s blanket application of a one-size-fits-all rule that all compensation will be averaged over twelve months in calculating disability benefits contradicts the plain language of the plan and is an abuse of its discretion.

**Disability Plan cannot offset against long-term disability benefits Cal. Labor Code Section 4850 pay that the disabled firefighter did not actually receive; the Plan did not require the firefighter to retire in a manner to be eligible to receive Section 4850 pay; prejudgment interest awarded at 5% annum.** [Barboza v. California Ass’n of Prof’l Firefighters, No. 2:08-CV-0519-KJM-EFB, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 7273215 \(E.D. Cal. Nov. 17, 2015\)](#) (Judge Kimberly J. Mueller). On remand from the Ninth Circuit Court of Appeals, the district court had to decide whether the California Association of Professional Firefighters Long Term Disability

Plan (“CAPF Plan”) required Plaintiff Barboza to retire in a manner that would entitle him to a full year of Cal. Labor Code Section 4850 benefits. Section 4850 benefits provide up to one year of pay to disabled firefighters (among other professions) who have not been retired. The Plan offsets against long-term disability benefits any Section 4850 pay received, or forfeited or waived. The Plan took a full year of the Section 4850 offset although Barboza did not receive a full year of 4850 pay because he was retired by the City of Tracy. The parties agreed the Ninth Circuit intended “Plan” to mean the written Plan instrument, that the CAPF Plan does not expressly dictate the manner in which a participant must retire from fire service in order to be eligible for long-term disability benefits, and the CAPF Plan does not explicitly require a participant to retire in a manner that would entitle him to a full year of Section 4850 pay in order to be eligible for long-term disability benefits. First, the court found that Defendants may not succeed now by arguing Barboza was eligible for Section 4850 pay and waived or forfeited that pay since this issue is precluded from reconsideration in light of the Ninth Circuit’s decision. (This court previously agreed and granted summary judgment in Defendants’ favor.) The court also disagreed that the Ninth Circuit’s order “left undisturbed” the court’s previous conclusion that Barboza was eligible for and waived 4850 pay, because if it had, it simply would have affirmed the district court’s decision. Second, the court found that certain provisions in the Plan requiring cooperation by Plan members do not require resolution in Defendant’s favor because Defendants did not rely on these sections to reach their decisions. Specifically, CAPF cited no failure to cooperate and described no bad faith, lack of cooperation, or failure to comply. ERISA does not allow an ERISA plan administrator to assert a reason for denial of benefits that it had not given during the administrative process. But even if the court were to reach the Plan’s new argument, the court could not find that Defendants acted within their discretion by interpreting those sections to mandate a retirement consistent with a full year of Section 4850 benefits in this case. Lastly, the court granted Plaintiff’s motion for prejudgment interest at 5% annum. Plaintiff submitted evidence that he paid interest rates of 4.92% to 9.10% on a home equity line of credit to cover his expenses while awaiting benefits payments.

**On de novo review, claimant did not meet his burden of demonstrating entitlement to benefits.** [Lawrence v. Life Insurance Company of North America, No. CV15-170 DSF \(PJWX\), 2015 WL 7013089 \(C.D. Cal. Nov. 12, 2015\)](#) (Judge Dale S. Fischer). The court found that evidence in the Administrative Record did not show that Plaintiff met his burden of demonstrating that he was entitled to the disability benefits sought. First, Plaintiff’s treating physician did not opine that Plaintiff was disabled through the Policy Elimination Period, and prior to the denial of the claim the treating physician stated that Plaintiff was “ready to work.” Second, the court found that the record showed that Plaintiff’s hypertension is generally well-controlled, and even when it is not, there is no evidence that it interferes with his job function or creates an undue risk of a life-threatening event while on the job. Third, apart from self-reported symptoms, the court found no evidence of Plaintiff suffering from a disabling psychological

condition. Lastly, the court found no reason to believe that the muscular issues reported by one doctor rises to the level of disabling conditions.

**Aetna abused its discretion by applying “inconsistent yardsticks” in disability determination and claimant is entitled to “own occupation” benefits.** [Rude v. Intel Corp. Long Term Disability Ben. Plan, No. 13-15834, Fed.Appx. , 2015 WL 6912951 \(9th Cir. Nov. 10, 2015\)](#) (Before SILVERMAN and CHRISTEN, Circuit Judges, and DUFFY, District Judge). In an action challenging a denial of a claim for long-term disability benefits under the Intel Corp. Long Term Disability Plan, the Ninth Circuit vacated and remanded the district court’s decision in favor of the Plan. The court found that Aetna abused its discretion in denying Plaintiff’s benefits because it “applied inconsistent yardsticks when measuring what Rude’s job was and what he was capable of performing.” The court also found that Aetna’s characterization of Plaintiff’s job as sedentary is inconsistent with statements from his supervisor, who stated that Plaintiff’s job involved as much as two hours of walking and one hour of standing per day, and from Plaintiff himself, who stated that his job required three hours of standing and one hour of walking per day. The court vacated the district court’s judgment and remanded for an award of benefits for the six months of long term disability remaining in Plaintiff’s “own occupation” period but disallowed benefits for the subsequent “any occupation.”

**Court found claimant did not prove disability allegedly caused by mental illness worsened by a workplace sexual assault.** [Shaw v. Life Insurance Company of North America, No. CV1407955MMMFFMX, 2015 WL 6755187 \(C.D. Cal. Nov. 4, 2015\)](#) (Judge Margaret M. Morrow). On *de novo* review, the court found that the medical reports in the administrative record are not sufficient to show by a preponderance of the evidence that Plaintiff was unable to perform the material duties of her regular occupation as a legal assistant. The court found that the only reports that support her claim are conclusory, and provide insufficient information concerning Plaintiff’s functional capacity. The court further found that the fact that Plaintiff was denied federal disability benefits, but received disability benefits from the state of California, is non-conclusive, particularly given the lack of evidence in the record that details the rationale for the two decisions or whether those rationales might have informed a decision as to whether she was disabled under the Plan. The court did not place great weight on narratives provided by Plaintiff, her family, and friends which suggested that her mental illness was disabling. The court declined to expand the record to include a declaration from Plaintiff but it did take judicial notice of the GAF scale found in the DSM-IV.

**Disability policy’s choice-of-law provision does not trump California Insurance Code’s ban on discretionary language.** *Hirschkron v. Principal Life Insurance Company*, No. 3:15-cv-

00664-JD (N.D. Cal. Oct. 29, 2015) (Judge James Donato) (Westlaw cite TBA). The parties filed cross-motions on the issue of the standard of review. Plaintiff contended that *de novo* review applies based primarily on the argument that Cal. Ins. Code § 10110.6(a) prohibits discretionary language in disability policies. Principal contended that the disability policy was not governed by the Code because of its choice-of-law provision stating that the laws of Maryland govern. The court found that the arguments regarding the enforceability of this choice of law provision, and about whether or not the undisputed discretionary provisions would be valid under Maryland law, are irrelevant to the question at hand. This is because “on its face, California Insurance Code Section 10110.6, which is ‘self-executing,’ expressly applies to policies, contracts, certificates or agreements that were offered, issued, delivered or renewed ‘whether or not in California.’ The plain language of the Section voids discretionary provisions even if the relevant policy, contract, certificate or agreement contains a choice of law provision that ultimately results in the substantive rights and obligations of the parties being governed by the laws of a state other than California.” The court explained that although choice of law provisions in ERISA contracts should be followed so long as they are not unreasonable or fundamentally unfair, allowing a choice of law provision to trump the Code on the narrow issue of the applicable standard of review for a denial of benefits would subvert the right to a fair review of claims denials that was granted by the California legislature to all California residents.

**Court upholds Unum’s denial of LTD benefits to claimant impaired by Chronic Fatigue Syndrome.** [Hans v. Unum Life Insurance Company; E&J Gallo Winery Long Term Disability Plan, No. CV1402760ABMRWX, 2015 WL 5838462 \(C.D. Cal. Oct. 5, 2015\)](#) (Judge Andre Birotte Jr.) The court found in favor of Unum on Plaintiff’s claim for long-term disability benefits stemming from Chronic Fatigue Syndrome (“CFS”). The court sided with Unum that it relied on a significant improvement in Plaintiff’s condition justifying termination of his benefits. Unum contended that its doctors reviewed Plaintiff’s claims and concluded that the medical record did not support Plaintiff’s CFS diagnosis. Unum’s “independent” medical examiner, Dr. Peter Gannon, examined Plaintiff in-person and confirmed that Plaintiff had no neurological condition or restrictions and limitations. Unum’s vocational analysis concluded that Plaintiff could work in other gainful occupations including computer sales, IT auditor and systems analyst. Lastly, Unum pointed out that the Plaintiff’s CPET (Cardiopulmonary Exercise Test) is very inconsistent with the administrative record and should not be relied upon as objective evidence.

[Healy v. Fortis Benefits Ins. Co., No. 14-CV-00832-RS, 2015 WL 5352742 \(N.D. Cal. Sept. 14, 2015\)](#). On *de novo* review of a long-term disability claim termination, the court found that it was improper for USIC to terminate Plaintiff’s benefits when the definition of disability switched from “own occupation” to “any occupation.” In sum, the court found that the evidence

established that Plaintiff, more likely than not, was disabled under the plan's terms continuing after the change in definition date. Despite a shoulder surgery, Plaintiff's conditions persisted to preclude her from working full time, particularly in an environment requiring heavy keyboard use. Further, the court found a lack of evidence of jobs that Plaintiff could perform paying a "gainful" wage and consistent with her experience and physical limitations. The court also concluded that the evidence does not support a conclusion that Plaintiff's statements, or her treating professionals' observations and conclusions, lack credibility.

In [Mayra Rodas v. Standard Ins. Co., et al. Additional Party Names: UnitedHealth Grp., UnitedHealth Grp. Long-Term Disability Plan, No. EDCV132203JGBSPX, 2015 WL 5156455 \(C.D. Cal. Sept. 1, 2015\)](#), Plaintiff worked as a Broker Agent Service Specialist for ten years before becoming disabled. Following a bench trial on the administrative record, the court concluded that Plaintiff presented persuasive evidence that she suffered from post-polio syndrome, and that this affliction made it difficult for her to move around and caused her to become tired easily. Further, Plaintiff demonstrated that she could not sit for longer than approximately 2 hours at a time—which would make performing her job duties exceedingly difficult, if not impossible. Plaintiff's evidence came from three sources: (1) her treating physicians; (2) close acquaintances; and (3) the SSA's finding that she was disabled. In contrast, none of Standard Insurance Company's reviewing doctors conducted a physical examination or adequately addressed Plaintiff's inability to sit for longer than 2.5 hours a day.

In [YVETTE WILLIBY, Plaintiffs, v. AETNA LIFE INSURANCE COMPANY & DOES 1-10, inclusive, Defendants., No. 214CV04203CBMMRWX, 2015 WL 5145499 \(C.D. Cal. Aug. 31, 2015\)](#), the court conducted a bench trial based on the administrative record on Plaintiff's short-term disability claim that Aetna denied. The court found that Plaintiff's claim for STD benefits beyond February 28, 2013 is supported by relevant medical records and opinions of four treating doctors. In contrast, Aetna's termination of STD benefits is based on findings from three reviewing doctors: (1) neurologist Dr. Vaughn Cohan; (2) occupational medicine specialist Dr. Robert Swotinsky; and (3) neuropsychologist Dr. Elana Mendelsohn. On *de novo* review, the court found that Aetna prematurely terminated Plaintiff's STD benefits.

In [Weston v. Aetna Life Ins. Co., No. CV 14-100-BLG-SPW, 2015 WL 4876829 \(D. Mont. Aug. 13, 2015\) \(Not Reported in F.Supp.3d\)](#), the court found that Aetna did not abuse its discretion in terminating Plaintiff's LTD benefits. Plaintiff was diagnosed and impaired by fibromyalgia, cervical disc disease, facet arthropathy, arthritis, and pseudoseizures. Aetna terminated Plaintiff's LTD claim and she appealed. On appeal, Aetna had Plaintiff's claim reviewed by Dr. Priya Swamy, a pain management specialist, who concluded that Plaintiff could perform sedentary or

light duty work. The court found that there is no evidence that Aetna's conflict of interest improperly influenced Aetna's decision, that there is no evidence that Aetna has a history of biased claims administration, that there is no evidence that Aetna provided inconsistent reasons for denial, and that there is no evidence that Aetna acted with malice. As such, the court found that the conflict-of-interest factor is of minimal significance. The court found that Plaintiff's records failed to supply evidence of restrictions and limitations stemming from Plaintiff's medical conditions that prevent her from working. Second, Aetna's failure to conduct an in-person medical evaluation is insufficient to establish an abuse of Aetna's discretion. Third, Aetna and its independent expert did have all of the relevant evidence and Aetna's expert physician's inability to reach Plaintiff's treating doctor for a peer-to-peer consultation does not support Plaintiff's position that Aetna abused its discretion. Finally, the court found that Aetna gave Plaintiff's SSDI award appropriate consideration.

In [\*Page v. Unimerica Ins. Co., No. 3:12-CV-103, 2015 WL 4549473 \(S.D. Ohio July 27, 2015\)\*](#), Plaintiff is a beneficiary who brought breach of fiduciary duty claims against her deceased spouse's employer and life insurance claims administrator for alleged miscommunications which led her and her husband to believe that he had continued life insurance coverage after he became disabled and stopped working. The court found that the claims administrator did not make the challenged representations upon which Plaintiff's breach of fiduciary duty claim is based, so it could not have been acting in a fiduciary capacity when the representations were made. For this reason, the court found that the claims administrator is entitled to summary judgment on the breach of fiduciary duty claim against it. With respect to the employer, however, the court found that a reasonable fact-finder could conclude that the representations and omissions were material. Here, the employer failed to respond to Plaintiff's letter and sent an enrollment form concerning her husband's "eligibility under a plan" and "the extent of benefits" he was entitled to as his employment terminated. The employer's failure to respond to the participant's inquiry misled him into thinking that his life insurance premium would continue to be paid by the company, which prevented him from making an adequately informed decision about whether to pursue the conversion option under the Plan. The court also found that no evidence supported the employer's claim that they did not rely on the misrepresentations to Plaintiff's detriment, especially where Plaintiff testified that her, "husband died believing that he was taking care of his family through that life insurance, and [the employer] gave us no reason to believe that it was not [in effect]." As such, the court did not grant summary judgment to the employer for the breach of fiduciary duty claim. Lastly, with respect to the equitable estoppel claim against the employer, the court found there is no evidence to support the elements of Plaintiff's equitable estoppel claim against employer, and the company cannot be estopped from denying her claim because the Plan did not give it the right to deny it or obligate it to pay the life insurance benefit she seeks. Accordingly, the court granted summary judgment on the equitable estoppel claim.

**Claimant wins!** In [\*Carrier v. Aetna Life Ins. Co.\*, No. CV1403932BROFFMX, F.Supp.3d](#), [2015 WL 4511620 \(C.D. Cal. July 24, 2015\)](#), on *de novo* review, the court found that Plaintiff, impaired by uterine cancer, neuropathy, and depression, was entitled to long-term disability benefits and Aetna's denial of her benefits was improper. The court declined to consider additional medical records that Plaintiff did not submit to Aetna during the claims and appeals process. The court remanded to Aetna to make a determination on Plaintiff's entitlement to "any occupation" disability benefits. The reviewing physicians involved in this matter are Dr. Tamara Bowman, who specializes in Internal Medicine and Endocrinology and Dr. Malcolm McPhee, who specializes in pain management.

In [\*Withrow v. Bache Halsey Stuart Shield, Inc. Salary Prot. Plan \(Ltd\)\*, No. 13-55812, Fed.Appx.](#), [2015 WL 3757718 \(9th Cir. June 17, 2015\)](#), the Ninth Circuit affirmed the district court's Findings of Fact, Conclusions of Law and Order, finding that Reliance did not err in calculating Plaintiff's "monthly earnings" by including the 24 months of salary preceding Plaintiff's date of disability, even though Plaintiff was disabled for several of those months and received salary continuation pay (but not commissions), because the plain language of the Plan is unambiguous that the "preceding 24 month period" applies to that time period immediately preceding an employee's disability; the only basis for applying a period less than 24 months is if the employee was not employed for the full term.

In [\*Hegarty v. AT&T Umbrella Benefit Plan No. 1\*, No. C-14-1976 EMC, 2015 WL 3638542 \(N.D. Cal. June 11, 2015\)](#) (**Not Reported in F.Supp.3d**), the court found that it was unreasonable for the claims administrator to deny short-term disability benefits on the basis that Plaintiff did not provide "objective" or "measurable" evidence that he was disabled by his migraine pain. Although the Benefit Plan requires "objective medical information" that indicates the severity of a claimant's disability and objectively evidences how the claimant is functionally impaired, in cases where the claimant's disabling condition is not one for which the medical community can provide objective evidence, then an administrator's conditioning an award on the existence of evidence that cannot exist is arbitrary and capricious.

In [\*Hertan v. Unum Life Ins. Co. of Am.\*, No. CV 14-5331 PA SSX, 2015 WL 3632244 \(C.D. Cal. June 9, 2015\)](#) (**Not Reported in F.Supp.3d**), the court determined on *de novo* review that Plaintiff was entitled to reinstatement of her LTD benefits. The court took judicial notice of Unum's interrogatory responses. The court found that Unum consistently focused entirely on the physical requirements of what they concluded was a "sedentary" occupation and not the cognitive demands of Plaintiff's occupation as an attorney. The court found non-compelling Unum's doctor's discounting of Plaintiff's "complaints of persistent pain and use of chronic

narcotics because “no data has been presented to document this possibility.” Unum had never asked Plaintiff for data to support the degree of cognitive impairment she experienced as a result of the pain and narcotic medication. The fact that Plaintiff may have become habituated to Percocet does not establish that Plaintiff is capable of performing her occupation after taking a dose of the narcotics prescribed to her. Even minimal loss of cognitive abilities could prevent her from working full-time as an attorney while under the influence of Percocet. Even if Plaintiff had habituated to the Percocet, the pain alone would decrease Plaintiff’s efficiency and production of work product. The court was not persuaded by Unum’s argument that because Plaintiff worked up to 70% of the time without medication that there is no evidence that she cannot work the additional 30%.

In [Zagon v. Am. Airlines, Inc. Long Term Disability Plan, No. 13-55866, Fed.Appx. , 2015 WL 2405450 \(9th Cir. May 21, 2015\)](#), the Ninth Circuit affirmed the district court’s order granting summary judgment to Defendant, a self-funded long-term disability plan. The court found that the district court properly declined to incorporate California’s notice-prejudice rule into ERISA federal common law.

In [Hinshaw v. Unum Life Ins. Co. of Am., No. CV 14-06157 DDP PLAX, 2015 WL 2127085 \(C.D. Cal. May 6, 2015\) \(Not Reported in F.Supp.3d\)](#), the court found that Unum did not abuse its discretion in terminating the *pro se* plaintiff’s long-term disability benefits. Plaintiff had maintained coaching and tutoring jobs in 2008–2009 and had no post–2011 medical visits. Plaintiff was also not responsive to Unum’s request for further documentation and proof of disability. The court found that Unum reasonably concluded that Plaintiff no longer qualified for benefits under the LTD Plan even though it was based on Unum’s own internal “paper” review conducted by medical personnel. Although the court found that Unum might have conducted a more thorough investigation of Plaintiff’s disability, Unum gave Plaintiff multiple opportunities to provide updated medical documentation of his disability, both during its 2013 review of his eligibility and during his appeal. Unum also requested an in-person visit from a representative, which Plaintiff cancelled.

In [Gordon v. Metro. Life Ins. Co., No. 5:10-CV-05399-EJD, 2015 WL 1940209 \(N.D. Cal. Apr. 29, 2015\) \(Not Reported in F.Supp.3d\)](#), the court determined that abuse of discretion review would apply to MetLife’s disability claim decision, despite that MetLife failed to render a decision on Plaintiff’s appeal. The court explained that Plaintiff did not suffer any substantive harm from MetLife’s conduct, distinguishing this case from *Blau v. Del Monte Corporation*, 748 F.2d 1348 (9th Cir.1984), where the evidence showed that the administrator failed to comply with virtually every applicable mandate of ERISA. However, the court did observe that

procedural violations of ERISA's requirements are evidence of arbitrary and capricious decisionmaking. The court will conduct the review with a heightened degree of skepticism and will consider additional evidence submitted with Plaintiff's notice of appeal.

In [Evans v. Sun Life & Health Ins. Co., No. 13-55601, Fed.Appx. , 2015 WL 1812809 \(9th Cir. Apr. 22, 2015\)](#), the Ninth Circuit affirmed the district court's decision finding that Sun Life abused its discretion in denying Plaintiff's long-term disability benefits application. The court found that the evidence showed that Plaintiff became disabled before his employment was terminated, and that his psychiatric symptoms improved but not enough to return to work as a trial lawyer during the 180-day elimination period. The court also found that Sun Life exhibited bias against Plaintiff, including its failure to conduct another physician review when Sun Life became aware that another patient's record mixed with Plaintiff's medical record, its decision to conduct a pure paper review, its failure to grapple with treating physicians' and its own psychiatrist's earlier contrary determinations, and its purported reliance on objective evidence when none could be adduced for the particular condition.

**Discretionary clause found only in the SPD is not sufficient to alter the standard of review from *de novo*.** In [Prichard v. Metro. Life Ins. Co., No. 12-17355, F.3d , 2015 WL 1783507 \(9th Cir. Apr. 21, 2015\)](#), the Ninth Circuit held that the district court should have reviewed Plaintiff's long-term disability claim *de novo* since the grant of discretion to MetLife was only in the SPD, which is not part of the Plan's "written instrument." The court found that the only document in the record that contains a clear indication that it is a Plan document is an insurance certificate that expressly states that the Plan consists only of (1) the Group Policy and its Exhibits, which include the certificate(s); (2) IBM's application; and (3) any amendments and/or endorsements to the Group Policy. The insurance certificate declares that those documents constitute the "entire contract" between IBM and MetLife. The Ninth Circuit previously held in *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1161 (9th Cir. 2001) that a Plan document's integration clause precluded the administrator from binding insureds to the Summary's discretion-granting clause. Applying that principle to this case, and limiting the analysis to the documents listed in the insurance certificate's integration clause, the court found that no written instrument of the Plan confers discretionary authority to MetLife.

In [Cox v. Allin Corp. Plan, No. C 12-5880 SBA, 2015 WL 1737764 \(N.D. Cal. Apr. 14, 2015\) \(Not Reported in F.Supp.3d\)](#), the court denied the parties' motions for reconsideration on its partial grant of Plaintiff's motion for judgment, finding that Unum had abused its discretion in terminating Plaintiff's benefits and remanding the matter to Unum for further consideration of Plaintiff's claim. The court specifically found that Unum abused its discretion by failing to

properly address the SSA's decision and applying the incorrect standard to assess the applicability of the self-reported limitation. In view of those conclusions, the court found remand is the proper remedy rather than payment of benefits.

In [\*James v. AT&T W. Disability Benefits Program\*, No. 12-CV-06318-WHO, 2015 WL 1190011 \(N.D. Cal. Mar. 13, 2015\)](#) (**Not Reported in F.Supp.3d**), the court determined that Defendant properly withheld income tax from the check it paid to Plaintiff following entry of judgment in her favor. The court found that the Plan was entitled to withhold the income taxes at issue and that the judgment in this case has been fully satisfied.

**Violation of ERISA regulations, absent substantive harm, does not change the standard of review to *de novo*.** In [\*Dimery v. Reliance Standard Life Ins. Co.\*, No. 12-17550, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 1044047 \(9th Cir. Mar. 11, 2015\)](#), the court affirmed the district court's grant of summary judgment in favor of Reliance on Plaintiff's claim for long-term disability benefits. The applicable SPD and the ERISA regulations required Reliance to render a decision on Plaintiff's administrative appeal within forty-five days, or to provide notice that additional time was required due to special circumstances before the initial forty-five day period expired. 29 C.F.R. § 2560.503-1(i)(1)(i), (i)(3)(i). Reliance notified Plaintiff that it was seeking an independent medical evaluation, but did not expressly state that it needed additional time beyond the forty-five day period to render a decision. Reliance denied benefits on the sixty-fourth day. Reliance argued on appeal that the SPD is not part of the plan under *CIGNA Corp. v. Amara*, 131 S.Ct. 1866, 1877-78 (2011), but because the parties proceeded in district court as though the SPD was part of the Plan without objection from Reliance, the court found that Reliance has waived this argument. The court rejected Plaintiff's argument that her claim should have been reviewed *de novo*. First, the denial of Plaintiff's benefits was not "necessarily the mechanical result" of a violation of the terms of the Plan, in that the Plan did not state that a particular result would ensue from a failure to adhere to the time limits for reviewing the denial of benefits. Second, ERISA procedural violations do not alter the standard of review unless the violations cause the beneficiary substantive harm. The court found that Plaintiff does not identify any substantive harm resulting from Reliance's untimely decision. Thus, the district court properly reviewed the denial of Plaintiff's benefits under an abuse of discretion standard.

In [\*Montoya v. Reliance Standard Life Ins. Co.\*, No. 14-CV-02740-WHO, 2015 WL 1056560 \(N.D. Cal. Mar. 10, 2015\)](#) (**Not Reported in F.Supp.3d**), the court found that Plaintiff has not shown that he is entitled to review IME reports prior to Reliance issuing a final decision on his appeal. The court previously required Plaintiff to submit to a physical IME, which Reliance had requested after Plaintiff submitted his appeal. Plaintiff had already undergone a psychiatric IME

prior to filing suit. The court noted, however, that if Reliance uses one or both of the IME reports to insert a new reason for denying Plaintiff's claim, and refuses to provide copies of those IME reports before finally denying Plaintiff's claim, then Plaintiff may re-raise his procedural violation argument in conjunction with an appeal of the denial of benefits.

In [\*Dana v. W. States Insulators & Allied Workers Pension Plan\*, No. C14-0336 RSM, 2015 WL 1037689 \(W.D. Wash. Mar. 9, 2015\)](#), Plaintiff alleged that Defendant must pay retroactive disability pension benefits back to April 1, 2004, which is what he contends is the earliest date upon which Social Security Disability Insurance ("SSDI") benefits became payable to him. Defendant contended that it is only required to pay benefits back to January 2009, which it has already done, because that is the date Plaintiff began receiving SSDI benefits. The Plan provides that benefits shall commence on the date that Social Security disability benefits first become payable. While the Trustees' interpretation of the word "payable" may not be the only interpretation of that word, the court could not say that the interpretation went against the plain meaning of the Plan Document or that it was illogical, implausible or without support from inferences that may be made from the facts in this record. The court granted Defendant's motion for summary judgment.

In [\*Montoya v. Reliance Standard Life Ins. Co.\*, No. 14-CV-02740-WHO, 2015 WL 884643 \(N.D. Cal. Mar. 2, 2015\)](#) (**Not Reported in F.Supp.3d**), the court held that exhaustion should be excused because the plan at issue does not require exhaustion of administrative remedies prior to filing suit. For purposes of determining Defendant's summary judgment motion, the court found that the insurance policy produced in the Administrative Record is the written plan document. Here, the policy implies that the only requirement a claimant must meet before filing suit is to wait at least 60 days after submitting written proof of loss but no longer than three years. The court found that the policy language does not require exhaustion and suggests that exhaustion is not required. However, the court found that it was appropriate for Reliance to require Plaintiff to attend Independent Medical Examinations during his administrative appeal. Although the Ninth Circuit has not yet addressed whether it is procedurally or substantively unfair to require IMEs during the administrative appeal stage, the court was persuaded by the out-of-circuit cases cited by Reliance that have directly addressed this issue in favor of requiring an IME during administrative appeal. The court ordered the parties to proceed with the physical IME that Plaintiff failed to attend.

In [\*Kibel v. Aetna Life Ins. Co.\*, No. CV 14-3861 SVW PLA, 2015 WL 858751 \(C.D. Cal. Feb. 26, 2015\)](#), the court found that Plaintiff was not disabled as of the date she took medical leave in February 2012, but that an MRI demonstrated that her multiple sclerosis had diminished her

mental and physical capacities to such an extent that she could no longer perform her job as of March 19, 2014. The court found that Aetna owed Plaintiff long-term disability benefits as of that date. The court, however, denied that Plaintiff was eligible for a waiver of life insurance premium benefit that had a more stringent definition of disability.

In [\*Baker v. Hartford Life & Acc. Ins. Co.\*, No. 4:14-CV-209-BLW, 2015 WL 769962 \(D. Idaho Feb. 23, 2015\)](#), the court granted Hartford's Motion for Summary Judgment in this matter alleging a wrongful denial of long-term disability benefits. Hartford determined that Plaintiff was disabled by a psychiatric disorder limiting payments to only 24 months of benefits and Plaintiff contended that he was disabled by mycotoxicosis or chemical sensitivity. The court determined that Hartford's decision is reviewed under an abuse of discretion standard tempered by the degree of the severity of any structural conflict of interest. The court found that Hartford has taken steps to reduce potential bias and that Hartford did not take inconsistent positions throughout the claim process, adequately investigated Plaintiff's claim, and its findings were not clearly erroneous. With respect to policy interpretation, the court found that under the terms of the Plan, a mentally ill claimant may still receive the full duration of benefits so long as the claimant is totally disabled as a result of a physical condition.

In [\*Chavez v. Reliance Standard Life Ins. Co.\*, No. CV-13-02512-PHX-GMS, 2015 WL 727929 \(D. Ariz. Feb. 19, 2015\)](#), Plaintiff worked as a Senior Long Term Disability Claims Manager for Defendant Matrix Absence Management, Inc. ("Matrix"), before becoming disabled and receiving short-term and long-term own occupation benefits. Plaintiff alleged disability due to rheumatoid arthritis, Sjogren's disease, hypothyroidism, and migraine headaches. As part of its review for long-term any occupation benefits, Reliance Standard received an anonymous phone call stating that Plaintiff was not disabled. Reliance had Plaintiff undergo an in-person Independent Medical Examination with Dr. Debra Rowse, who opined that Plaintiff was not disabled. Similarly, Dr. Manoj Moholkar, a doctor Reliance hired to perform a medical record evaluation of Plaintiff's claim, also opined that Plaintiff was not disabled. The court found that none of the procedural irregularities alleged by Plaintiff, including reliance on the anonymous phone call, arise to the level of an abuse of discretion.

In [\*Gonda v. The Permanente Med. Grp., Inc.\*, No. 11-CV-01363-SC, 2015 WL 678969 \(N.D. Cal. Feb. 17, 2015\)](#), the court considered whether a settlement agreement bars Plaintiff's claims against TPMG and the TPMG Plan. This dispute involved a denial of long-term disability benefits that are insured and administered by Life Insurance Company of North America ("LINA"). The Settlement Agreement specifically releases TPMG and its agents from any claims

which Plaintiff held (or had previously held), and it specifically mentions ERISA claims. The court found that,

- Although Defendants attempt to raise an untimely affirmative defense, the court permitted Defendants to amend their answer and the proper affirmative defenses are now adequately pled.
- LINA's decision not to use the Settlement Agreement as a basis for denying benefits during Plaintiff's administrative appeals does not preclude assertion of the Settlement Agreement as an affirmative defense in this action.
- LINA's willingness to hear Plaintiff's internal appeals cannot affect TPMG or the TPMG Plan's contractual rights under the Settlement Agreement, particularly where LINA is not a party to this lawsuit and was not a party to the Settlement Agreement.
- Even if TPMG (rather than LINA) had agreed to allow administrative appeals of Plaintiff's claims, that would not have constituted waiver of the release in the Settlement Agreement.
- LINA's willingness to consider Plaintiff's appeals and Defendants' agreement to stay this case during those appeals did not constitute waiver of an affirmative defense.
- Defendants are not barred from raising the Settlement Agreement as a defense by equitable, promissory, and judicial estoppel, because by allowing Plaintiff to pursue his internal appeals, Defendants did not admit that he had a viable cause of action in court, nor did Defendants surrender their contractual right to be released from all ERISA causes of action that Plaintiff held against them.
- On its face, the Settlement Agreement constitutes a knowing and voluntary waiver of Plaintiff's ERISA claims against Defendants.
- California law governs the Settlement Agreement, including the ERISA waiver. This Court is bound by the Ninth Circuit's holding in *Wang Labs., Inc. v. Kagan*, 990 F.2d 1126 (9th Cir.1993) and must give force to the parties' choice of law provision.
- After considering the extrinsic evidence that Plaintiff offered, there is no meaning to which the language of the Settlement Agreement is reasonably susceptible that permits Plaintiff's claims.
- Separate consideration for waiver of the ERISA claims is not required where the writing is plain and explicit and given for the express purpose of effecting a complete release.
- Even though the TPMG Plan is not listed in the Settlement Agreement, the Plan is an entity created and administered by Plaintiff's former employer and the agreement's broad release clause clearly bars Plaintiff's ERISA action against the TPMG Plan.

In [\*Culhane v. Aetna Life Ins. Co.\*, No. 14CV76 BEN KSC, 2015 WL 710722 \(S.D. Cal. Feb. 17, 2015\)](#), on *de novo* review, the court found that Aetna incorrectly denied Plaintiff long-term disability benefits on this basis that Plaintiff's eligibility for coverage ended when he was terminated. Plaintiff was earning his full salary until his termination. Aetna determined that

because his eligibility for coverage ended on the day he was terminated and he was earning his full salary up to that point he could not be covered by the Policy and earning 80% or less at the same time. However, if he was covered by the Policy beyond his last day, then he could meet the second prong of the Test of Disability. The Policy contains a section titled “When Coverage Ends,” with a subheading for “When Coverage Ends For Employees.” It states, in relevant part, that “[y]our coverage under the plan will end if ... [y]our employment stops for any reason, including job elimination or being placed on severance. This will be the date you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below...” Further, “[i]t is your employer’s responsibility to let Aetna know when your employment ends. The limits above may be extended only if Aetna and your employer agree, in writing, to extend them.” Plaintiff argued that his coverage was extended by one week because he paid the premiums for an additional week of coverage beyond his termination. Aetna did not dispute that Plaintiff paid the premiums for an additional week of coverage and that the premium was never returned. Instead, Aetna argued the payment did not extend his coverage because Aetna and the employer did not enter into a written agreement to extend Plaintiff’s coverage. The court found that the policy language is open to numerous reasonable interpretations. Because both interpretations are reasonable, the language is ambiguous and must be construed against Aetna. Plaintiff may have remained eligible for coverage under the Plan beyond when his employment stopped because premium payments were made on his behalf. Although the court found the basis for Aetna’s denial was incorrect, Plaintiff is not necessarily entitled to disability benefits under the Policy since Aetna did not make a determination based on his medical condition. The court found that remand to the administrator is appropriate to evaluate the evidence concerning Plaintiff’s medical condition and to determine, based on that evidence, if Plaintiff was unable to perform his job duties due to illness or injury.

In *Gallego v. Wells Fargo & Company Long Term Disability Plan*, No. 13-CV-04518-VC, 2015 WL 349111 (N.D. Cal. Jan. 23, 2015), the court granted summary judgment to Defendants on the issue as to whether the disability plan permits an offset of workers’ compensation weekly permanent partial disability (“PPD”) payments. The court rejected Plaintiff’s arguments that his PPD payments were not “Other Income Benefits” within the meaning of the Plan. Plaintiff argued that “Other Income Benefits” are limited to benefits paid to compensate for lost income, and that his PPD benefits were instead paid to compensate him for the impairment he suffered as a result of his medical problems. Second, he argued that his PPD benefits were not a periodic benefit. The court found that the Plan does not limit “Other Income Benefits” to only those benefits that compensate for loss of income. The Plan expressly provides that all periodic workers’ compensation payments are counted as “Other Income Benefits,” without regard to whether those payments are benefits for loss of income. The court found that even if the Plan did limit “Other Income Benefits” in such a fashion, Plaintiff’s PPD benefits were paid in part to

compensate for lost income in the form of loss of future earning capacity. Because worker's compensation PPD benefits are calculated in terms of a claimant's entitlement to a certain number of weeks of payment, the court found that they fall within the definition of a periodic benefit.

In *Sliwa v. Allied Home Mortgage Capital Corp.*, No. 2:13-CV-01433-APG, 2015 WL 56044 (D. Nev. Jan. 5, 2015), Lincoln National Life Insurance Company denied Plaintiff's long-term disability claim after determining her disability was within the policy's pre-existing condition exclusion. After Plaintiff filed suit, Lincoln moved for judgment against Plaintiff under Fed.R.Civ.P. 52. However, the evidence Lincoln submitted in support of its motion was not offered or cited during the administrative process. Because the court is bound to the evidence cited in the administrative record, and because the parties are both amenable, the court remanded this case back to Lincoln to make its benefits determination based on the full record.

J. Tenth Circuit

[HAROLD E. MASON, Plaintiff, v. RELIANCE STANDARD LIFE INSURANCE COMPANY, Defendant.](#), No. 14-CV-01415-MSK-NYW, 2015 WL 5719648 (D. Colo. Sept. 30, 2015). On Plaintiff's claim for long-term disability benefits, the court found that Plaintiff demonstrated that Reliance's denial of benefits is not supported by substantial evidence and therefore arbitrary and capricious. Reliance sought to conduct an in-person medical examination of Plaintiff, but he was unable to attend because he was hospitalized on that date. Instead of rescheduling, Reliance retained Dr. Manoj Mehta to conduct a record review of Plaintiff's medical records. The court was critical of Dr. Mehta's medical opinion. The court reversed and remanded for determination by the plan administrator, and with instructions to articulate the interpretation given to Policy terms, fully consider the evidence that was readily available, particularly as it relates to Plaintiff's ability to perform the material duties of his occupation from July 2012 – July 2013.

In [Riley v. Aetna Life Ins. Co.](#), No. 13-CV-01347-REB-KMT, 2015 WL 1726762 (D. Colo. Apr. 13, 2015) (Not reported in F.Supp.3d), the court found that Aetna's decision to deny long-term disability benefits was supported by substantial evidence, including a medical review completed by Dr. Elana Mendelsohn, a psychologist. The court found that Plaintiff can perform the physical demands of sedentary work but rejected his claim that he cannot handle the stress of the managerial positions Aetna identified as ones he can perform. The court found that Dr. Mendelsohn's conclusion that the record justifies no psychologically-related limitations on Plaintiff's ability to work is more than sufficient to support Aetna's conclusion that Plaintiff did not meet the enhanced definition of disability set forth in the plan.

In [\*Messick v. McKesson Corp.\*, No. 2:13-CV-1036 TS, 2015 WL 471643 \(D. Utah Feb. 4, 2015\)](#), the court found that LINA failed to properly address to Plaintiff's counsel Plaintiff's claim file, a letter indicating the deadline for submission of an appeal, a letter acknowledging receipt of appeal, and the appeal determination. These failures resulted in some harm to Plaintiff because he was not afforded the opportunity to appeal his claim determination a second time before filing suit. However, the court found that the error occurred outside the context of the merits of the claim determination and does not rise to the level of a procedural irregularity warranting a de novo review of LINA's claim decision. But, the court did not grant LINA all the deference it would otherwise be entitled under the arbitrary-and-capricious standard. The court found that LINA acted reasonably when making its short-term disability claim determination. As such, the court considered the long-term disability claim moot because long-term disability benefits are only paid if the short-term disability benefits are exhausted.

In *Swanson v. Unum Life Ins. Co. of Am.*, No. 13-CV-4107-JAR, 2015 WL 339313 (D. Kan. Jan. 26, 2015), the court upheld Unum's decision to deny Plaintiff's claim for long-term disability benefits. The court found that it was reasonable for Unum to consider Plaintiff's history of full-time work where she claimed that she "fought through" the pain in order to maintain her full-time schedule since the Fifth Circuit has found that a claimant's decision to work for years despite her pain "permits the inference that she was able to perform the material and substantial duties of her job while experiencing the level of neck and back pain she experienced" prior to the date she stopped working. As such, Unum was reasonable to consider the degree to which Plaintiff's symptoms worsened prior to switching to a part-time schedule. The court found a "complete dearth of objective evidence" in the record supporting Plaintiff's asserted occupational limitations and concluded that the record supplied a "reasoned basis" for Defendant's benefits determination.

In *Barta v. CenturyLink*, No. 13-CV-03030-RM-KLM, 2015 WL 310155 (D. Colo. Jan. 22, 2015), the court denied Plaintiff's motion to strike a declaration submitted by Defendant in opposition to Plaintiff's motion seeking judgment on her denial-of-benefits claim. The court explained that Plaintiff's Opening Brief called into question Defendant's production of vocational data. The declaration offers an explanation of the vocational data, which pertains directly to the procedural issue raised by Plaintiff. The court found that the declaration addresses a purported procedural irregularity raised by Plaintiff and does not pertain to Plaintiff's eligibility for benefits. Allowing the declaration may enable the court to understand and evaluate the decision under review.

In *Williams v. FedEx Corporate Servs.*, No. 2:13-CV-37 TS, 2015 WL 248570 (D. Utah Jan. 20, 2015), the court granted Defendant Aetna Life Insurance Company's ("Aetna") Motion to Dismiss Plaintiff's Breach of Fiduciary Duty Claim for Lack of Subject Matter Jurisdiction and Motion for Partial Judgment on the Pleadings for Failure to State a Claim of Breach of Fiduciary Duty, where Plaintiff filed two ERISA claims against Defendant: a claim for wrongful withholding of short-term disability benefits under 29 U.S.C. § 1132(a)(1)(B) and a claim for breach of fiduciary duty under 29 U.S.C. § 1132(a)(3) seeking injunctive relief. The injunctive relief Plaintiff sought was an order requiring Aetna to inform FedEx that Plaintiff did not have a substance abuse problem, that Aetna was incorrect in making any such statements to FedEx, and that such statements should not be relied upon to require that Plaintiff participate in any type of drug testing or rehabilitation. The court found that Plaintiff lacked Article III standing since he did not allege the type of injury to support the court's jurisdiction. The court allowed Plaintiff to amend his Complaint and instructed him to allege how he has an actual interest in his personnel records and how he is injured by FedEx's maintenance of those records. With respect to the breach of fiduciary duty claim, the court noted that Plaintiff seeks an equitable remedy in addition to the award of disability benefits. The court found that if it determines that Plaintiff was wrongfully denied his disability benefits and that his illness was not related to drug or alcohol abuse, his personnel record at FedEx would contain erroneous and damaging information. Having determined previously that this would be an actual and imminent injury, equitable relief, in addition to his awarded benefits, would be appropriate to make Plaintiff entirely whole. However, because Plaintiff did not sufficiently allege the harm necessary to support simultaneous § 1132(a)(1)(B) and § 1132(a)(3) claims, the court granted Defendant's motion, but without prejudice for Plaintiff to amend his Complaint to allege such an injury.

K. Eleventh Circuit

**Plan dismissed from action since not liable for payment of benefits; abuse of discretion applies because decision was made by agents of the entity with discretionary authority; Plaintiff, impaired following a stroke, is entitled to disability benefits for only a limited period.** [Campbell v. United of Omaha Life Insurance Company & J& B Importers Welfare Plan, No. 2:14-CV-00623-JEO, 2015 WL 5818040 \(N.D. Ala. Oct. 6, 2015\)](#) (Magistrate Judge John E. Ott). In ruling on the parties' motions concerning Plaintiff's short-term and long-term disability claims, the court agreed with the Defendants that the Plan is entitled to judgment in its favor and is due to be dismissed from this action since Plaintiff offered no basis for holding the Plan liable for the STD and LTD benefits he claims are due to him. Regarding the standard of review, the court agreed with Defendant that because the Plan grants United of Omaha discretionary authority to make benefits determinations, and because it exercised that authority through its agents, the arbitrary and capricious standard of review applies. Further, all of the letters to Plaintiff and his counsel communicating the status and resolution of the benefits claims

were from United of Omaha and written on United of Omaha letterhead with a United of Omaha address. The court found no indication that the employees who made the decisions to deny Plaintiff's claims were not acting as United of Omaha's authorized agents. The court found that under the LTD policy, Plaintiff would have been entitled to LTD benefits commencing on or about February 16, 2012, when his 90-day elimination period ended because the evidence from his doctors reflects that he suffered from neurocognitive deficits and memory impairment following his stroke sufficient to prevent him from performing the essential functions of his job through October 2012. Thereafter, United of Omaha had a reasonable basis to deny all LTD benefits to Plaintiff in light of his own self-reporting that he was doing well coupled with the opinion of a physician consultant at University Disability Consortium, Dr. James Bress, that Plaintiff was capable of performing full-time light work.

In [\*Melech v. Life Ins. Co. of N. Am.\*, No. CIV.A. 10-00573-KD-M, 2015 WL 4744356 \(S.D. Ala. Aug. 11, 2015\)](#), on remand from the Eleventh Circuit, the district court granted summary judgment in favor of LINA on Plaintiff's claim for LTD benefits. The court explained that on remand LINA was to consider the evidence in the SSA file and the administrative record from the original decision. The court disagreed with Plaintiff that LINA failed to provide a full and fair review on remand because it did not consider all the evidence reasonably available including the original claim file, Plaintiff's Declaration/affidavit from 2012, and "all other documents exchanged with LINA's lawyers throughout this case either in correspondence or in pleadings over the Court's ECF system." The court also rejected Plaintiff's assertion that her claim was denied on a new basis, that she was unable to perform her Regular Occupation from May to June 2007 but did not meet the 26-week Elimination Period, instead of a denial based on lack of objective evidence to support her doctor's opinion of total disability as found in LINA's original claim denial decision. Giving deference to LINA's decision-making and consideration of conflict of interest as a factor in deciding whether the decision was arbitrary and capricious, the court found that LINA's decision to deny benefits was reasonable based on the record before it, and not arbitrary or capricious. Lastly, the court granted Defendants' motion to strike Plaintiff's Exhibit 2, the Hertz Company Overview downloaded from the Hertz website, Plaintiff's Exhibit 7, her Declaration/affidavit signed in 2012 and previously submitted in this action, and Plaintiff's Exhibit 8, the Targeted Market Conduct Examination Report, because they were not before LINA when it made the benefits decision.

**Claimant wins!** In [\*Wilson v. Walgreen Income Prot. Plan for Pharmacists & Registered Nurses\*, No. 6:13-CV-1840-ORL, 2015 WL 4528962 \(M.D. Fla. July 27, 2015\)](#), the court adopted the Magistrate Judge's report and recommendation and granted Plaintiff's motion in part as follows:  
a. Sedgwick failed to follow the claim procedures established by the IPP and the regulations; no later than November 8, 2013, Plaintiff is deemed to have exhausted the administrative remedies

available under the IPP; Plaintiffs appeal is deemed denied by operation of law on that date; and Plaintiff's November 25, 2013 Complaint is ripe for review; the applicable standard of review is de novo; the denial of Plaintiff's appeal is de novo wrong and Plaintiff is entitled to judgment as a matter of law; Plaintiff's LTD benefits is reinstated from April 9, 2011 through November 25, 2013, the date the operative complaint was filed, with prejudgment interest on each monthly payment from the date due until the date paid; and the parties must meet and confer in a good faith attempt to resolve the Plaintiff's claims for attorneys' fees and costs.

**Claimant loses.** In [Oliver v. Aetna Life Ins. Co., No. 14-15259, Fed.Appx. , 2015 WL 4153628 \(11th Cir. July 10, 2015\)](#), the court found that Aetna's denial of "any occupation" long-term disability benefits to Plaintiff was not *de novo* wrong. Plaintiff worked as a courier for FedEx and became impaired by a combination of longstanding back and knee problems and an on-the-job injury. Aetna had Plaintiff's claim reviewed by an orthopedic surgeon, Dr. Lawrence Blumberg, who found that Plaintiff could engage in some compensable employment for a minimum of 25 hours per week. Another orthopedic surgeon hired by Aetna, Dr. Martin Mendelssohn, agreed with Dr. Blumberg's conclusion. The court rejected Plaintiff's argument that judicial estoppel operates to require Aetna to follow the SSA's determination that Plaintiff is totally disabled. The court explained that based on precedent and the "manifestly different criteria of the SSA and the Plan," Plaintiff cannot simply rely on the determination by SSA in challenging Aetna's denial of benefits.

In [Garrett v. Prudential Ins. Co. of Am., No. 8:14-CV-686-T-27AEP, 2015 WL 2169249 \(M.D. Fla. May 8, 2015\)](#), the court determined that Prudential's decision to terminate Plaintiff's long-term disability benefits was neither *de novo* wrong nor an abuse of discretion. Plaintiff claimed disability as a result of a myriad of conditions, including Klippel–Feil Syndrome (bone disorder characterized by abnormal joining of two or more spinal bones in the neck), cervical disk disease and herniated discs at C5–6 and C6–7 with radiculopathy, migraines, lumbar disc disease, fibromyalgia, anxiety and depression, thoracic radiculitis, carpal tunnel syndrome, adhesive capsulitis, hepatitis C, adrenal fatigue & depressed immune system, asthma, hypertension, GERD, and gastroparesis. Her disability was supported by her treating physicians and an independent medical examiner who all opined that she is disabled and unable to work. However, Prudential's peer-reviewing physicians contrarily opined that she had no medically necessary restrictions or limitations and that the treating physicians' opinions regarding her inability to work were unsupported by objective clinical evidence.

In [Nolley v. Bellsouth Long Term Disability Plan For Non-Salaried Employees, No. 14-13470, Fed.Appx. , 2015 WL 1947390 \(11th Cir. May 1, 2015\)](#), the court affirmed the district

court's decision granting summary judgment in favor of Defendant on the *pro se* plaintiff's ERISA claims because Sedgwick's (the third-party administrator) decision to terminate her LTD benefits was not "*de novo* wrong." Although Plaintiff's psychiatrist concluded that she was incapable of working due to her depression, his progress notes indicate that the majority of her cognitive processes were within normal limits. Multiple independent physician advisors concluded that there were no objective findings substantiating the conclusion that Plaintiff was unable to work. The court found that Sedgwick's benefits decision was not wrong simply because it denied Plaintiff's claim based on her failure to furnish objective medical evidence of her disability. The relevant Plan document specifically provided that LTD benefits would terminate if Plaintiff failed to furnish objective medical evidence demonstrating the continuing nature of her disability, and the claims administrator may rely on such a provision in making its determination to terminate benefits.

In [\*Denney v. Aetna Life Ins. Co.\*, No. 2:14-CV-1519-JHH, 2015 WL 1734337 \(N.D. Ala. Apr. 16, 2015\)](#), the court granted summary judgment in favor of Aetna on Plaintiff's claim for "any occupation" disability benefits, where Plaintiff previously worked as a ramp agent for Southwest Airlines, a heavy duty-strength occupation. The court found that Aetna's benefits decision, based on the FCE, an "independent" review of Dr. Ephraim Brenman, Plaintiff's neurosurgeon's medical records and release of Plaintiff to return to work, a CT myelogram and MRI scans, and transferable skills analysis, was correct.

In [\*Glenn v. Am. United Life Ins. Co.\*, No. 14-13945, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 1638919 \(11th Cir. Apr. 14, 2015\)](#), the court concluded that Plaintiff did not carry his burden to prove that he suffers from a disabling physical impairment for which he is entitled to receive long-term disability benefits. First, the court found that he did not submit evidence sufficient to indicate that his cognitive impairments result from side effects of his pain medications, as the record shows that his physicians previously believed that the impairments stem from his Bipolar Disorder and depression. The court also found that Plaintiff did not demonstrate that he suffers disabling pain that precludes him from performing the material and substantial duties of his regular occupation because the record contains ample evidence that he could adequately perform his duties. Because it found that the administrator's decision was not "wrong," the court did not reach Plaintiff's argument on appeal that the Administrator did not possess the authority to compel him to undergo a neuropsychological examination. The court also did not reach Plaintiff's argument that the district court erred in considering Plaintiff's refusal to undergo a neuropsychological examination.

In *Smith v. Cox Enterprises, Inc.*, No. 1:13-CV-00834-TCB, \_\_\_F.Supp.3d\_\_\_, 2015 WL 331116 (N.D. Ga. Jan. 27, 2015), the court granted summary judgment to Defendant in this matter where Plaintiff sought to recover long-term disability benefits under an employer welfare benefit plan administered by Aetna Life Insurance Company. The court applied the modified Rule 56 standard set forth in *Curran v. Kemper Nat'l Servs., Inc.*, No. 04-14097, 2005 WL 894840, at \*7 (11th Cir. 2005) (in an ERISA benefit denial case the district court sits more as an appellate tribunal than as a trial court, does not take evidence, but rather, evaluates the reasonableness of an administrative determination in light of the record compiled before the plan fiduciary) and *Crume v. Metro. Life Ins. Co.*, 417 F.Supp.2d 1258, 1272 (M.D. Fla. 2006) (finding that a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exist, do not apply). Applying the 11<sup>th</sup> Circuit's six-step framework for evaluating an ERISA denial of benefits claim, the court first found that it cannot conclude that Aetna's denial was *de novo* wrong. The court found that there is a lack of clinical evidence supporting Plaintiff's claim that she is prevented from performing her job due to Meniere's disease, migraines, vertigo, and hypoactive labyrinth. The burden in an ERISA case is on the claimant to establish her disability and her entitlement to benefits and the record reflects only one audiology report from December 2005, more than six years prior to Plaintiff's long-term disability claim, one VNG data analysis report from March 2010, and clinical notes from both her otolaryngologist and neurologist, none of which the court found to present substantial objective evidence of long-term disability. The court concluded that the preponderance of the medical records and statements from Plaintiff's health care providers do not support the conclusion that her medical conditions are severe enough to support a finding of total disability. The court found notable that Plaintiff claims to have been symptomatic and diagnosed with Meniere's disease in 2005, and yet she continued to successfully work full-time for the next six years. The court readily acknowledged the possibility that Plaintiff does in fact suffer from such severe conditions and that she is wholly incapable of working but without sufficient objective evidence, test results, and supporting medical opinions, the court cannot conclude that Aetna's decision to deny Plaintiff benefits was wrong. The court found that it is clear from the record that Aetna's denial of benefits was reasonable and a reasonable decision cannot be arbitrary and capricious. Nonetheless, the court considered each of Plaintiff's arguments attacking the reasonableness of the decision and found them to be without merit.

In *Law v. Aetna Life Ins. Co.*, No. 2:13-CV-2267-JHH, 2015 WL 260833 (N.D. Ala. Jan. 21, 2015), the court found that Aetna's decision to deny long-term disability benefits due to a pre-existing condition exclusion in the Plan was not an abuse of discretion. The Plan defines pre-existing condition as "an illness, injury or pregnancy-related condition for which, during the 12 months before ... coverage ... became effective" one of the following three things have occurred: (1) claimant was diagnosed or treated for the condition; (2) claimant received diagnostic or

treatment services for the condition; or (3) claimant took drugs that were prescribed or recommended by a physician for the condition. Further, the Plan states that it “does not pay benefits for a disability that is caused, or contributed to, by a pre-existing condition, if the disability starts within the first 24 months after your coverage goes into effect.” Plaintiff’s disability occurred within the first 24 months of coverage. The court found that during the 12–month look-back period the evidence in the administrative record is “crystal clear” that Plaintiff’s disabling condition was caused by, or was contributed to, by a pre-existing condition under the terms of the Plan. Plaintiff claims to be disabled due to back pain from degenerative spinal problems, diagnosed as spondylosis. In the relevant medical records, Plaintiff’s doctor repeatedly notes a long history of back pain, Plaintiff underwent a posterior lumbar interbody fusion after an earlier lumbar MRI noted “moderate L4–5 stenosis and possible spondylosis,” and Plaintiff was prescribed various pain medications. From these medical records, the court found that it is clear that Plaintiff was diagnosed and treated for chronic back pain and “lumbar derangements,” received diagnostic and treatment services for the condition, and was prescribed pain medication for back pain and back spasms during the look-back period. Each of those, separately and in combination, qualified under the Plan to exclude Plaintiff’s disabling condition.

In *Johnson v. Liberty Life Assur. Co. of Boston*, No. 2:13CV916-WHA, 2015 WL 248944 (M.D. Ala. Jan. 20, 2015), a matter involving a termination of long-term disability benefits, the court granted summary judgment in favor of Liberty Life on the basis that Plaintiff failed to exhaust administrative remedies. The court rejected Plaintiff’s argument that exhaustion would have been futile and that he was denied meaningful access to the administrative procedures in place. Specifically, the court found that the claim denial letter informed Plaintiff of how to proceed with an administrative review of his claim. With respect to the *Watts* exception – a rule that if a plan claimant reasonably interprets a summary plan description as permitting him to file a lawsuit without exhausting administrative remedies, his lawsuit is not barred if he fails to exhaust administrative remedies – the court found it inapplicable to Plaintiff’s claim. The court also granted summary judgment to Liberty Life on the alternative basis that the benefits decision was not an abuse of discretion, where Liberty Life had determined that Plaintiff voluntarily retired even though his employer continued to make available to him a light duty position at the same pay, and his doctor had stated that he was able to perform a light duty position on a full-time basis.

**Court affirmed denial of long-term disability benefits in action brought by pro se plaintiff.**

In *Cook v. Aetna Life Ins. Co.*, No. 14-10473, \_\_\_Fed.Appx.\_\_\_\_, 2015 WL 75191 (11th Cir. Jan. 7, 2015), the 11<sup>th</sup> Circuit, in a per curiam opinion, affirmed the district court’s grant of summary judgment in favor of Aetna on the *pro se* Plaintiff’s denied long-term disability claim. The court found that the records showed Plaintiff was not disabled, and that thus the administrator’s

decision to deny benefits was not wrong. The district court was entitled to rely on the Independent Medical Evaluation (“IME”) performed by Dr. Richard Wilson, which did not reveal any medical conditions causing disability. Moreover, although Plaintiff’s treating physician concluded that Plaintiff was disabled, Dr. Robert Swotinsky, a board-certified specialist in occupational medicine, reviewed the basis for the treating doctor’s assessment, and concluded that “[t]he documentation [did] not corroborate impairment.” Aetna was not required to accord extra respect to the treating physician. Because the court determined that Aetna’s decision to deny benefits was not wrong, it did not need to move on to the next step of the analysis. However, the court found that even if Aetna’s decision was wrong, it was not arbitrary and capricious in light of the medical opinions in the record.

L. D.C. Circuit

**Court enters judgment in favor of disability claimant impaired by hypercoagulable thrombosis, portal vein thrombosis, status post splenorenal shunt, and renal cell carcinoma.** [Marcin v. Reliance Standard Life Ins. Co., No. CV 13-1308 \(ABJ\), .F.Supp.3d , 2015 WL 5996341 \(D.D.C. Oct. 14, 2015\)](#) (Judge Amy Berman Jackson). In this matter involving long-term disability benefits, the court previously remanded the matter to Reliance for further consideration on no less than two occasions. Upon the third time that Reliance concluded Plaintiff was capable of performing all of the material duties of her regular occupation on a full time basis when her coverage for benefits ended, the court determined that it would enter in judgment in favor of Plaintiff. The court noted, however, that the entry of judgment for Plaintiff is not a judicial determination that plaintiff was “totally disabled” at the time she stopped working, but rather, based on the finding that Reliance’s denial of benefits to Plaintiff was not reasonable. In sum, the court found that Reliance’s decision reflects: (1) a selective review of the medical evidence that omits any mention of three relevant records that undermine the conclusion that Plaintiff could work full-time; (2) reliance on a mischaracterization of a doctor’s report; and (3) a failure to meaningfully engage with the undisputed fact that Plaintiff never actually worked full time. Taken together, Reliance’s determination was not supported by “substantial evidence.”

**Cost of medical insurance for employee with multiple sclerosis was not a motivating factor in her termination.** In [Giles v. Transit Employees Fed. Credit Union, No. 14-7055, F.3d , 2015 WL 4217787 \(D.C. Cir. July 14, 2015\)](#), the D.C. Circuit held that the cost of insuring Plaintiff, who suffered from multiple sclerosis, was not a motivating factor in the employer’s termination decision, and affirmed summary judgment in favor of the employer on Plaintiff’s

ADA, DCHRA, and ERISA § 510 claims. The thrust of Plaintiff's claims is that the cost of treating her MS was causing the monthly premium for the Blue Preferred Option 1 plan to rise and that TEFCU dismissed her to reduce its health care costs. The court found that TEFCU asserted a legitimate, non-discriminatory reason for terminating Plaintiff: she was a poor employee. Although Plaintiff had an overall high rating, testimony from her supervisors showed that she performed record maintenance duties associated with her scanning specialist position inadequately. The court found that no reasonable jury could conclude the real reason for her discharge was that TEFCU believed her medical expenses were driving up the insurance premium. There was no evidence Plaintiff's insurance claims had any effect on the premium or that her supervisors thought they did or could. Thus, the court concluded that the record does not permit an inference that the cost of insuring Plaintiff was a motivating factor in the decision to terminate her.

## VII. *Discovery*

### A. First Circuit

In [\*Adele E. v. Anthem Blue Cross & Blue Shield\*, No. 2:15-CV-01-DBH, 2015 WL 4715753 \(D. Me. Aug. 7, 2015\)](#), a matter challenging the denial of a medical benefit claim, Plaintiff sought to modify the record to add (i) benefit plan and related documents, (ii) documents regarding the denial of her second-level appeal, and (iii) information regarding medical reviewers. She also sought discovery regarding the first and third categories. The court granted, with modifications, Plaintiff's request to supplement the record as to the benefit plan and related documents, grant, without objection, her request to supplement the record with materials pertaining to her second-level appeal, and grant her request to supplement the record with medical reviewer information only insofar as it implicates documents responsive to a proposed request for production of medical reviewers' curriculum vitae, and otherwise denied it. With respect to Plaintiff's proposed discovery, Plaintiff sought to serve 11 interrogatories and 9 requests for production of documents bearing generally on (i) the documents used to decide her claim and (ii) information on the physicians who reviewed it. The court granted Plaintiff's request to propound RPDs related to information relevant to her claim for benefits. But, the court denied most of Plaintiff's proposed discovery regarding the medical reviewers.

In [\*Wilson v. Pharmacia Corporation Long Term Disability Plan\*, No. CV 14-CV-12345-LTS, 2015 WL 4572833 \(D. Mass. July 29, 2015\)](#), the court previously ordered Aetna to produce certain categories of documents. Aetna filed a motion seeking a protective order for four categories of documents: (1) internal guidelines regarding Aetna's 24 month limitation policy;

(2) information surrounding the firewall Aetna has in place to eliminate any conflict of interest between those who administer plans and those who make benefits determinations; (3) information surrounding Aetna's financial arrangements with the MES Group, Inc. ("MES"), a third-party vendor providing medical consultant services; and (4) information surrounding Aetna's financial arrangements with individual physicians retained as medical consultants. Aetna argued that the information is confidential and that its dissemination to others outside of the present litigation could give Aetna's competitors and other medical service providers sensitive information which could in turn be used to Aetna's financial detriment. Plaintiff urged the court to view Aetna as a fiduciary of the employee benefits plan who should not be able to shield its decision-making or process from any plan participants. Based on an *in camera* review, the court found that internal guidelines regarding the 24-month limitations policy does not reveal any specific business strategies, cost saving measures, or specific issues relating to mental disabilities triggering the limitation. The court denied the protective order as to this category. The court also found that Aetna did not demonstrate how disclosure of information regarding its structural conflict of interest is likely to harm Aetna in the marketplace and denied a protection order with respect to that information. However, the court agreed with Aetna that public disclosure of documents involving Aetna's dealings with MES may indeed harm both Aetna and/or MES in the marketplace and granted a protective order as to that information. Lastly, Aetna sought to protect documents surrounding its dealings with independent individual physicians as medical consultants. In support of its motion, Aetna submitted an affidavit from Michael A. Corarito, a business consultant with Aetna Review Consultant Services ("ARCS"). The court agreed with Aetna that public disclosure of its financial arrangement with an individual medical consultant could cause another consulting physician to underbid the consultant to take his or her business or demand more money from Aetna upon seeing what the other physician is being paid. As such, the court granted Aetna's motion as to this information.

**Aetna must respond to discovery requests relevant to its conflict of interest in administering long-term disability claim.** In [\*Wilson v. Pharmerica Corp. Long Term Disability Plan\*, No. CIV.A. 14-12345-LTS, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 1962812 \(D. Mass. May 1, 2015\)](#), a dispute involving a denial of long-term disability benefits, Plaintiff filed a discovery motion which included requests for documents and responses to interrogatories. Plaintiff sought: (1) documents which relate to Aetna's adjudication of her claim; and (2) documents and responses to interrogatories which relate to Aetna's conflict of interest, as Aetna both insures and administers claims for LTD benefits. The court ordered Aetna to produce the portion of the instruction manual, policy manual, and internal interpretations or guidance pertaining to the Plan's twenty-four month limitation exception. The court also ordered Aetna to respond to certain interrogatories, and for experts it identifies in one interrogatory, to report the total number of evaluations each expert performed for Aetna in 2011 and 2012 and, for each year, a breakout of the number of times in which the expert concluded the insured was disabled and not disabled.

The court further ordered Aetna to: (1) report the total compensation it paid to MES (a third-party medical review vendor) in 2011; (2) explain Aetna's basis for determining how much to compensate MES in 2011; (3) explain the basis or method for compensating the experts it identifies; and (4) produce documents showing its procedures, if any, to prevent or to mitigate the effect of structural conflicts.

## B. Second Circuit

In [\*Liyan He v. Cigna Life Ins. Co. of New York\*, No. 14 CIV. 2180 AT GWG, 2015 WL 4114523 \(S.D.N.Y. July 8, 2015\)](#), the court granted Cigna's motion for a protective order, which requires Plaintiff to maintain the confidentiality of sections of Cigna's Policies and Procedures manual (the "P & P") produced in this action. Cigna submitted a sworn declaration of Richard M. Lodi, Cigna's Senior Operations Representative Cigna, to support its argument that the P & P is not publicly available and it would be valuable to Cigna's competitors, because it would give them information that they could not otherwise obtain. Although Cigna previously disclosed ten sections of the P & P to other claimants, the court was satisfied that the statements from Lodi show that Cigna takes reasonable steps to maintain the confidentiality of the P & P and that competitive harm would result from its disclosure. The court noted that the protective order requires that the materials be used only for this litigation and not for "attorney's eyes only" treatment or other arrangements that would significantly restrict Plaintiff's counsel's conduct of this litigation.

**Discovery on conflicts and procedural irregularities is permitted in cases subject to *de novo* review.** In [\*Liyan He v. Cigna Life Ins. Co. of New York\*, No. 14 CIV. 2180 AT GWG, \\_\\_\\_F.R.D.\\_\\_\\_\\_, 2015 WL 249832, at \(S.D.N.Y. Jan. 20, 2015\)](#), a matter involving review of a denial of long-term disability benefits, the court concluded that discovery in cases that will ultimately be subject to *de novo* review should normally be designed to cast light on conflicts and procedural irregularities that might have affected the completeness of the administrative record. The court explained that the 2<sup>nd</sup> Circuit made clear in two *de novo* review cases that the decision whether to consider material outside the administrative record turns on the existence of a conflict of interest and procedural regularities. Thus, the relevance of conflicts and procedural irregularities in *de novo* review cases should derive from their potential to impact the development of a proper administrative record. In considering what specific discovery should be ordered here, the court recognized that there are a number of cases holding that there is a special test for obtaining discovery in ERISA benefit determination cases that is, whether the plaintiff has shown a "reasonable chance that the requested discovery will satisfy the good cause requirement." However, the court found that the use of this phrasing as a special standard to govern ERISA cases is "unwarranted." Instead, Fed.R.Civ.P. 26(b)(1)—limiting the scope of discovery to material that is "relevant to any party's claim or defense"—applies. Discovery

should be limited if the burden or expense of the proposed discovery outweighs its likely benefit. In addition, courts must recognize the significant ERISA policy interests of minimizing costs of claim disputes and ensuring prompt claims-resolution procedures. With these principles in mind, the court determined that since Cigna does not dispute that it has an inherent conflict of interest, there is no need for discovery into the issue of Cigna's structural conflict of interest. Further, the existing record provides a sound basis on which to evaluate the existence of procedural irregularities and other nonstructural conflicts that might have affected the completeness of the record. As such, the court is "skeptical" that Plaintiff needs much more discovery beyond what is already contained in the administrative record in order to attempt to make her "good cause" showing. In light of the above factors, the court limited Plaintiff to a single deposition of a Cigna employee as to the procedural administration of Plaintiff's claim and denied all document discovery with the exception of the examination of the written evaluations of some key employees involved in the decision making on Plaintiff's claim. The court reiterated that the goal of this discovery will be only to determine whether there are conflicts or procedural irregularities that bear on the question of whether the existing administrative record is incomplete.

### C. Third Circuit

In [\*Calabree v. Eaton Med. Plan for Retirees & Other Eligible Individuals\*, No. 13-CV-00828, 2015 WL 3903499 \(E.D. Pa. June 25, 2015\)](#), a matter involving a denial of medical plan benefits, the court denied Plaintiff's discovery requests aimed at determining whether the SPD is an operative plan document, including whether Defendant ever took formal corporate action to adopt the SPD. The court found that Defendant already provided the materials Plaintiffs require to determine if the SPD in fact provides an enforceable Plan term: the Wrap Plan and the SPD. The court did grant Plaintiff discovery into whether Defendant used inadequate or inappropriate information in denying Plaintiff's claim and ordered Defendant to respond to an interrogatory seeking the identity of each Operative Agreement governing any health plan sponsored by Eaton Corporation under which Plaintiff was covered as a participant or beneficiary. The court had not yet determined which standard of review is applicable to Plaintiff's claim.

In [\*Spear v. Fenkell\*, No. CIV.A. 13-02391, 2015 WL 3822138 \(E.D. Pa. June 19, 2015\)](#), the plan fiduciaries in this case had the extraordinary task of investigating and then litigating against a former trustee accused of fiduciary violations, who also happened to be an ESOP participant. The court declined to apply the fiduciary exception to the attorney-client privilege in this matter where Defendant, the former Trustee of the ESOP, CEO of Alliance, and also ESOP participant, sought documents and information subject to the attorney-client privilege. Applying the divergence of interests test, the court found a pronounced conflict of interest between the parties. The fiduciaries were put on notice at least at the time of the *Chesemore* decision of fiduciary

violations by Defendant. The court found that the presence of this conflict weighs decisively in favor of rejecting the fiduciary exception and retaining the evidentiary privilege.

In [\*Felker v. USW Local 10-901\*, No. CIV.A. 13-7101, 2015 WL 1867910 \(E.D. Pa. Apr. 23, 2015\)](#), the court permitted Plaintiffs to conduct limited discovery only into the Plan Administrator's potential conflict of interest. The court rejected Defendant's argument that its concession of a financial conflict of interest makes discovery beyond the administrative record unnecessary. The court also found that Plaintiffs need only make a "minimal showing of bias or irregularity" sufficient to establish a "good faith" allegation of a procedural conflict. In this case, Plaintiffs alleged that the Plan Administrator may not have made the decision to deny the claim for benefits because letters written by Sunoco's outside labor counsel and Sunoco's Assistant General Counsel are very similar to the letters signed by the Plan Administrator that denied Plaintiffs' claim for benefits.

In [\*Greene v. Hartford Life & Acc. Ins. Co.\*, No. 13-6033, 2015 WL 533257 \(E.D. Pa. Feb. 6, 2015\)](#), Plaintiff sought discovery concerning an altered form that suggests a procedural irregularity in the administration of his claim for life insurance benefits. The court found Hartford's explanation regarding the alteration to be "speculative." As such, the court found that the potential structural conflict of interest coupled with the procedural irregularity of the altered form warrants further discovery. The court permitted Plaintiff to depose an employee of the life insurance plan sponsor who submitted both versions of the forms and the Hartford employee who had discussions about the forms with this employee. The depositions were limited to the circumstances surrounding the submission of the initial claim form and subsequent alteration of the claim form.

#### D. Fourth Circuit

In [\*Lockard v. Unum Life Ins. Co. of Am.\*, No. 3:15-CV-21, 2015 WL 4730089 \(N.D.W. Va. Aug. 10, 2015\)](#), a matter challenging the denial of long-term disability benefits, Plaintiff sought leave to take depositions and to serve the Defendant with interrogatories and requests for production of documents, for the limited purpose of determining the existence and extent of any conflict of interest on Unum's part. The court denied the motion because Plaintiff did not identify any facts that serve to indicate that Unum's decision to deny disability benefits was improperly affected by Unum's conflict of interest. The court explained that discovery is not mandated in every case, regardless of the circumstances, merely because a structural conflict of interest exists. The court concluded that it will be able to sufficiently determine Unum's motives and its conflict of interest, without requiring the requested discovery. However, the court explained that it does not hold that references to facts relevant to a defendant's conflict of interest are always necessary

when a plaintiff moves for extra-record discovery in an ERISA case. Just in this case, Plaintiff's "general statements concerning the existence of a conflict of interest are insufficient to warrant extra-record discovery."

In [\*Greenbrier Hotel Corp. v. Unite Here Health\*, No. CIV.A. 5:13-11644, 2015 WL 1637754 \(S.D.W. Va. Apr. 13, 2015\)](#), Plaintiffs filed a complaint alleging entitlement to excess contributions made to Plan 155, which Defendant refused to remit. The counts remaining following a motion to dismiss involve breach of fiduciary duty under ERISA. Plaintiff filed a motion to compel concerning several interrogatories and 56 different requests for production of documents, which the court granted in part. The category of documents Plaintiff sought included: 1) trust agreements, plan rules, SPDs, amendments, and communications concerning these documents; 2) termination of Plan unit 155; 3) documents related to the agreement between UNITE HERE and SEIU; 4) reserves; 5) collective bargaining negotiations and 2004 and 2009 plan documents; and 6) information on other Plan units.

E. Fifth Circuit

[\*Perez v. Louisiana Health Servs. & Indem. Co.\*, No. 15-MC-61-BAJ-RLB, 2015 WL 5444009 \(M.D. La. Sept. 15, 2015\)](#). Louisiana Health Services & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") must produce documents in response to an administrative subpoena issued by the Employee Benefits Security Administration relating to possible violations of HIPAA and the ACA. The court declined issue any ruling regarding whether the doctrine of equitable tolling would apply to any future action commenced by the Secretary against BCBSLA.

**Defendant must make Rule 26(a) initial disclosures in denial-of-benefits matter.** In [\*Bruce v. Anthem Ins. Companies, Inc.\*, No. 3:15-CV-0353-D-BK, F.R.D. , 2015 WL 4127337 \(N.D. Tex. July 6, 2015\)](#), an ERISA action involving a denial of health benefits, the court overruled Defendants' objections to making initial disclosures required by Rule 26(a)(1), rejecting Defendants' argument that the court's review is limited to the administrative record and it is "exempt from initial disclosures" under Rule 26(a)(1)(B)(i). The court found that Defendants did not proffer any specific reasons why the initial disclosures would be inappropriate under the facts and circumstances of this case, especially where there is no blanket prohibition against discovery in actions under 29 U.S.C. § 1132(a)(1)(B). Because the court must determine whether the administrator abused its decision, some evidence other than that contained in the record may be relevant to judicial review.

In [\*Thomason v. Metro. Life Ins. Co.\*, No. 3:14-CV-00086-P-BF, 2015 WL 1914557 \(N.D. Tex. Apr. 27, 2015\)](#), Plaintiff challenges Defendants' decision to offset his long-term disability benefits by \$1,250/month as a result of his direct rollover of his pension benefits into an IRA. Plaintiff moved to compel MetLife to respond to certain discovery requests. The court determined that MetLife's responses to request for admissions seeking information regarding the rollover of Plaintiff's pension benefits to an IRA and whether the rollover was accomplished by a "direct trustee-to-trustee transfer" were not evasive. The RFA concerning whether Plaintiff's rollover was a direct trustee-to-trustee transfer improperly asks MetLife for a legal conclusion. The court denied Plaintiff's motion to compel MetLife to fully answer RFPs seeking "[a]ll correspondence, guidelines, policies, procedures, forms, manuals and other written instructions" that governed the denial letter authors' "role as a fiduciary" with respect to their handling of Plaintiff's claim and "[a]ll correspondence, guidelines, policies, procedures, forms, manuals and other written instructions" that govern a claims administrator's "role as a fiduciary." The court also denied Plaintiff's challenges to MetLife's responses to discovery requests seeking information about the application of pension offsets on other occasions. However, the court did grant Plaintiff's motion with respect to interrogatories which seek information regarding other claims under the same LTD plan that governs Plaintiff's claim or other plans with the same language, determining that evidence of how MetLife has interpreted the governing LTD plan and/or identical offset provisions in other plans is relevant, or reasonably likely to lead to other relevant information, and therefore discoverable.

In [\*Thomason v. Metro. Life Ins. Co.\*, No. 3:14-00086-P-BF, 2015 WL 1914527 \(N.D. Tex. Apr. 27, 2015\)](#), the court denied Plaintiff's motion to compel against Defendant Verizon Employee Benefits Committee ("VEBC") to produce discovery in this matter. Here, it is undisputed that Plaintiff's claims are governed by the 2008 summary plan description for the LTD plan for Verizon's management employees so Plaintiff's requests concerning the 2005 summary plan description for the LTD plan governing non-management employees is not applicable to Plaintiff's claims, and discovery regarding the development of language used in the 2005 summary plan description is not relevant.

#### F. Sixth Circuit

**Plaintiff did not provide facts that show he has a colorable procedural or bias claim such that he is entitled to discovery.** [\*Corey v. Sedgwick Claims Mgmt. Servs., et al.\*, No. 1:15 CV 1736, 2015 WL 9206490 \(N.D. Ohio Dec. 17, 2015\)](#) (Judge Patricia A. Gaughan). Plaintiff moved to compel discovery on conflict of interest with respect to his denied claim for disability benefits. Specifically, he claimed that it was unclear who actually made the decision to deny his claim, under what authority, and based on what evidence. He also claimed that it was unclear whether Defendants followed Plan protocol for allowing him to bring his long term disability claim. Finally, Plaintiff claimed that portions of the Administrative Record are redacted as "Restricted Proprietary Information." The court denied Plaintiff's motion, finding that he

offered no evidence to suggest that the Plan's decision was the result of bias, conflict, or procedural irregularity such that discovery is warranted in this case: 1) nothing in the final denial letter suggests that Defendants' actions were based on any irregularities; 2) the denial letter is also clear as to who made the final decision to deny plaintiff benefits and identifies what evidence the Committee relied on in making the determination to deny benefits, and that evidence is a part of the Administrative Record; 3) Defendants provided plaintiff and the Court with a copy of the medical review referenced in the denial letter, and Plaintiff has produced no evidence that indicates Defendants deliberately withheld this or any other medical review. The court also found that no discovery is necessary on the long term disability claim because the Plan documents define all Plan procedures and Plaintiff can rely on the evidence in the Administrative Record to support this claim. Finally, the court found that Defendants' act of marking some documents as "proprietary information" does not show that Defendants acted out of bias or procedural irregularity.

[Davis v. Hartford Life & Accident Insurance Company, No. 3:14-CV-00507-TBR, 2015 WL 7571905 \(W.D. Ky. Nov. 24, 2015\)](#) (Judge Thomas B. Russell). In matter involving disability claim, Plaintiff served Hartford with a set of interrogatories and requests to produce documents as well as requests to depose several of Hartford's employees. The court granted in part and denied in part Plaintiff's motion to compel discovery.

[RANDY HATFIELD, Plaintiff, v. LIFE INSURANCE COMPANY OF NORTH AMERICA d/b/a CIGNA GROUP INSURANCE, Defendant., No. 5: 14-432-DCR, 2015 WL 5722791 \(E.D. Ky. Sept. 29, 2015\)](#). The court granted Plaintiff's motion to compel Defendant Life Insurance Company of North America ("LINA") to furnish more complete responses to discovery requests limited to issues addressing the conflict of interest issue. Specifically, LINA must provide the following information: payments made from 2005 to the present by LINA to third-parties who reviewed Plaintiff's claim for the purpose of his most recent denial and appeal (and supporting documentation for those payments); statistical data for the years 2005 to the present for those individuals and entities who handled Plaintiff's most recent denial and appeal; employee compensation, bonuses, and awards; and policies or procedures on which LINA relied in its most recent denial of Plaintiff's claim.

In [Austin-Conrad v. Reliance Standard Life Ins. Co., No. CV 4:10CV-00127-JHM, 2015 WL 4464103 \(W.D. Ky. July 21, 2015\)](#), a matter involving a denial of long-term disability benefits, Plaintiff sought discovery related to bias in the evaluation process, including the following topics: (1) incentive, bonus, or reward programs or systems, formal or informal, for an employee involved in reviewing disability claims; (2) contractual connections between the conflicted

administrator/payor and the vendors/reviewers utilized in plaintiff's claim; (3) statistical data regarding the number of claims files sent to the vendors/reviewers and the number of denials which resulted; (4) statistical data concerning the number of times the vendors/reviewers found claimants unable to work in at least a sedentary occupation or found that the claimants were not disabled; and (5) documentation of administrative processes designed only to check the accuracy of grants or claims. The court permitted this discovery but limited number 3 and 4 to a 10-year period. Plaintiff also sought discovery of the claims manual and related internal policies, which the court granted. Plaintiff sought permission to issue subpoena duces tecum to independent medical examiners, seeking to discover: (1) the number of IMEs they perform in comparison to the number of non-IME patients they see, with particular emphasis on those relating to complaints of fibromyalgia, chronic fatigue syndrome, polyneuropathy and associated depression and anxiety; (2) the compensation they receive for conducting IMEs in comparison to what they receive in other aspects of their medical practices; (3) IRS 1099 forms for work for insurance companies or medical examination companies; (4) lists of publications related to IMEs; (5) lists of previous testimony; (6) their schedules for the week surrounding her IME; and (7) production of copies of IMEs on other patients, with redaction to protect patient privacy. The court denied numbers 4, 5, 6, and 7 for venturing "too far afield." The court permitted the other topics but stated that the amount paid by Reliance to the physicians is more appropriately sought by interrogatory to Reliance than subpoena to a non-party.

In [\*Patton v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA\*, No. 1:15-CV-43, 2015 WL 4068051 \(S.D. Ohio July 2, 2015\)](#), a matter involving denial of accidental death benefits, the court granted Plaintiff's request to conduct discovery on Defendants' conflict of interest/bias, finding that Plaintiff made more than a "mere allegation" that a conflict of interest exists. Plaintiff alleged that Defendants' lack of impartiality is demonstrated on the face of the administrative record because they failed to conduct a due diligence investigation. The court also found that Plaintiff is entitled to discovery because she alleged sufficient facts to maintain a due process violation by the plan administrator. Plaintiff alleged that the administrative record did not include all documents that were relevant to the claim.

In [\*Sun Life Assur. Co. of Canada v. Jackson\*, No. 3:14-CV-41, 2015 WL 566940 \(S.D. Ohio Feb. 9, 2015\)](#), a matter brought by Sun Life to determine the proper beneficiary of a life insurance policy, the court found that the daughter of the decedent made a colorable procedural challenge that justifies granting her request for discovery outside of the administrative record. Here, the daughter pointed to several pieces of evidence that suggested that Sun Life was on notice of her claim months before it paid benefits to the other party, during the period that it processed his claim, and, at the same time, refused or ignored her attempts to make a claim. The Administrative Record does not address what steps, if any, Sun Life took to address the

daughter's claim and that information is relevant to her counterclaims. The court allowed the daughter to conduct limited discovery relevant to the allegations of procedural irregularities and bias raised by her counterclaims.

G. Seventh Circuit

**Discovery in long-term disability case denied because Plaintiff did not satisfy threshold burden.** [Weddington v. Aetna Life Ins. Co., No. 15 C 1268, 2015 WL 6407764 \(N.D. Ill. Oct. 21, 2015\)](#) (Magistrate Judge Sidney I. Schenkier). Plaintiff propounded five interrogatories and five requests to produce upon Aetna, seeking information that she describes as falling into three categories: (1) Aetna's internal procedures and protocols applicable to her claim, including certain definitions as to terms she describes as "cryptic;" (2) processes related to Aetna's engagement of certain medical consultants, and definitions relating thereto; and (3) protocols Aetna uses for reviewing claims when illegible handwritten medical records are involved. The court found that Plaintiff is not entitled to the discovery she seeks because she is unable to satisfy the first threshold burden of identifying a specific conflict or instance of misconduct on Aetna's part. Specifically, Plaintiff's assertion of an incomplete administrative record falls short of suggesting that some form of misconduct or bias has occurred. The court went on to find that even if limited discovery were appropriate, many of the discovery requests Plaintiff propounded are improper because they go to the "mental processes" of the Plan's administrator or do nothing to expose a larger strategy on Aetna's party to deny claimants their benefits.

In [Spano v. Boeing Co., No. 06-CV-0743-NJR-DGW, 2015 WL 4941698 \(S.D. Ill. Aug. 19, 2015\)](#), a matter involving an ERISA class action in which Plaintiffs assert Defendants breached fiduciary duties owed to Plaintiffs in operating and administering their 401(k) plans, the court granted Plaintiffs' motion to exclude documents that Defendant produced less than three months before trial. The documents Defendants produced relate to Plaintiff's Company Stock Fund claim and should have been disclosed much earlier in the litigation, which has been pending for nine years.

In [OSF Healthcare Sys. v. Sivyver Steel Corporation Health Care Plan, No. 1:14CV01102, 2015 WL 4778352 \(C.D. Ill. Aug. 13, 2015\)](#), a matter where Plaintiff sought reimbursement from the defendant Plan for medical services provided to a plan participant, the court granted Plaintiff's motion for discovery. In this case, Plaintiff argued that the contents of an email demonstrates that the Plan considered impermissible factors when deciding how and to what extent to pay on the claim in question, and they should at least be allowed discovery to explore the issue further. In the email, plan administrators considered whether Plaintiff would actually take the time to "balance bill" the member's estate in evaluating the claim, but such consideration had nothing to

do with making an appropriate determination of what the plan documents required the Plan to pay to OSF; it was an overt reference to paying as little as possible without too many “cons.” The court explained that this conduct is precisely why limited discovery is allowed in cases where a specific instance of misconduct like this can be identified by a plaintiff. As such, the court concluded that Plaintiff is entitled to discovery to explore just how much of a role this issue played in the Plan’s decision to pay what it did.

#### H. Eighth Circuit

**Medical provider entitled to conflict of interest discovery related to reasonableness of Defendant’s interpretation of plan permitting cross-plan offsetting.** [Peterson v. Unitedhealth Grp. Inc., No. 14-CV-2101 \(PJS/BRT\), 2015 WL 5776138 \(D. Minn. Oct. 1, 2015\)](#) (Judge Patrick J. Schiltz). In an action where a medical provider alleged that United withheld payments in order to offset alleged overpayments that United had made to Plaintiff on behalf of different patients enrolled in different plans, on the parties’ cross-motions for summary judgment, the court found that Plaintiff should be afforded the opportunity to conduct discovery to determine whether there are other factors —such as a history of biased claims administration on United’s part—that could help to persuade the Court that United’s interpretation of the plans is an abuse of discretion. The court denied the motions and directed the parties to meet with the discovery judge to develop a discovery plan.

In [Greater St. Louis Const. Laborers Welfare Fund v. Ability Bldg. & Restoration, LLC, No. 4:14-CV-63 RLW, 2015 WL 631012 \(E.D. Mo. Feb. 12, 2015\)](#), the court set a hearing on the Fund’s motion for sanctions related to post-judgment discovery violations, including appearance at a deposition. At the hearing, the court instructed Defendant Ability Building & Restoration, LLC and its representative Ms. Mays–Adkins to show cause why civil contempt sanctions should not be imposed against them for failure to comply with this court’s Orders. Because incarceration is a possible civil contempt sanction, the court advised that Ms. Mays–Adkins has the right to representation by counsel and failure to appear for the hearing as ordered may subject Ms. Mays–Adkins to arrest by the United States Marshals Service. The court also ordered Ms. Mays–Adkins to bring with her to the hearing on March 4, 2015 all of the documents and records listed in Plaintiffs’ Notice of Deposition.

In [Iron Workers St. Louis Dist. Council Annutiy Trust v. Miller Bldg. Grp., LLC, No. 4:14-CV-01298-JAR, 2015 WL 153810 \(E.D. Mo. Jan. 12, 2015\)](#), Plaintiffs sought to take a post-judgment deposition in aid of execution of their judgment in this matter involving delinquent fringe benefit contributions. The court found that this procedure is appropriate pursuant to Rules 69(a) and 30 of the Federal Rules of Civil Procedure.

*Greater St. Louis Const. Laborers Welfare Fund v. Town & Country Masonry*, No. 4:13-CV-00696-JAR, 2015 WL 65074 (E.D. Mo. Jan. 5, 2015) is an action involving delinquent fringe benefit contributions. Plaintiffs filed a motion to compel seeking to take a post-judgment deposition in aid of execution of their judgment. The court found that this procedure is appropriate pursuant to Fed.R.Civ.P 69(a) and 30. Based on the affidavit of Plaintiffs' counsel, the Custodian of Records of Defendant Town & Country was properly noticed for deposition but failed to appear. The court granted Plaintiffs' motion and ordered the Custodian of Records of Defendants to appear for deposition at the offices of Plaintiffs' counsel, and produce the requested documents at the same time.

## I. Ninth Circuit

**Fiduciary exception to attorney-client privilege applies to emails and testimony responsive to Plaintiff's discovery requests.** [Haigh vs. Construction Industry and Laborers Joint Pension Trust for Southern Nevada, Plan A and Plan B, et al. No. 2:14-CV-1545-JAD-VCF, 2015 WL 8375150 \(D. Nev. Dec. 9, 2015\)](#) (Magistrate Judge Cam Ferenbach). Plaintiff brought suit challenging the suspension of his pension benefits. On Plaintiff's motion to compel, the court considered (1) whether Haigh's Motion to Compel meets the threshold requirements for a motion to compel, (2) whether the "fiduciary exception" to the attorney-client privilege applies to the contested emails, (3) whether Deponent Danley may be compelled to answer questions regarding legal opinions given during the June 18, 2014 benefits termination meeting, and (4) whether Haigh is entitled to costs and fees associated with bringing the instant motion to compel. The court ruled as follows: (1) Plaintiff's request seeks information within the scope of discovery under Rule 26 and they are proportional to the needs of the case; (2) the "fiduciary exception" to the attorney-client privilege applies to some of the emails described in the privilege log; (3) the "fiduciary exception" requires Deponent Danley to answer Haigh's questions regarding legal advice and opinions given during the June 18th benefits termination meeting; (4) and Haigh is not entitled to costs and fees for bringing the motion.

**Conflict of interest discovery denied in LTD case subject to *de novo* review.** [Nguyen v. Sun Life Assurance Company of Canada, No. 314CV05295JSTLB, 2015 WL 6459689 \(N.D. Cal. Oct. 27, 2015\)](#) (Magistrate Judge Laurel Beeler). Plaintiff sought to discover material outside of the administrative record, including: 1) The completeness of the administrative record; 2) The "policies and guidelines" that Sun Life followed (or should have followed) in assessing his claim; and 3) The relationship between Sun Life and its four outside medical reviewers. The court concluded that, under governing Ninth Circuit law, Plaintiff is not entitled to most of this

discovery because he has not “clearly established” that evidence outside the existing administrative record is “necessary to conduct an adequate *de novo* review of the benefit decision.” The court ordered that documents relied on in making the benefit determination and generated in the course of making the benefit determination must be produced. The court also ordered that “policies and guidelines” must be produced but Plaintiff is not entitled to extra-record discovery into whether and why Sun Life followed, or failed to follow, its own policies and guidelines. The court denied discovery concerning the bias of Sun Life’s medical reviewers although noted that may be an “exceptional” case where such discovery would be appropriate.

**Fiduciary exception to attorney-client privilege applies to attorney communications on remand determination.** [Jones v. Life Insurance Company of North America, No. 08-CV-03971-RMW, 2015 WL 5770797 \(N.D. Cal. Oct. 2, 2015\)](#) (Judge Ronald M. Whyte). Plaintiff sought the production of certain attorney communications and documents which Plaintiff contends are relevant to her claim on the theory that Defendants’ attorneys (in-house or litigation counsel) either made the underlying substantive decision to reject Plaintiff’s appeal regarding the computation of her benefits, or provided advice regarding that decision. The court found that the scope of the documents Defendants must produce to Plaintiff as part of the administrative record is limited to documents that relate to LINA’s remand determination and which were created prior to the date of the final determination on Plaintiff’s ERISA claim. Defendants are required under the Federal Rules of Civil Procedure to produce privilege logs when they withhold information on the basis of privilege that is sought by Plaintiff through discovery. The court will conduct an *in camera* review of all documents and communications between LINA and in-house counsel that relate to the remand determination.

In [Colaco v. Asic Advantage Simplified Employee Pension Plan, No. 5:13-CV-00972-PSG, 2015 WL 4734950 \(N.D. Cal. Aug. 10, 2015\)](#), a matter seeking benefits under a SEP plan, Plaintiffs moved to compel production of documents authored or created by Microsemi’s attorney, Harley Bjelland, in relation to the SEP plan based on the fiduciary exception to the attorney-client privilege. Plaintiffs also moved to compel information relating to other former ASIC SEP plan participants. The court found that Plaintiffs failed to demonstrate that Bjelland acted as a fiduciary in the capacity of a claims administrator. First, Bjelland was not hired until after the plan terminated, which underscores Microsemi’s contention that it—not the plan, not the plan sponsor, not the plan trustee—hired Bjelland to provide legal advice about its legal liability to Plaintiffs, and nothing more. Second, the court found that there is no evidence that Bjelland’s functions involved the exercise of discretionary authority or control over the SEP plan. The court did find that information regarding other former ASIC SEP plan participants is relevant to this action and granted Plaintiffs’ motion to compel with respect to that information only. The court denied Plaintiffs’ motion for sanctions.

In [Haigh v. Constr. Indus. & Laborers Joint Pension Trust For S. Nevada, Plan A & Plan B, No. 2:14-CV-1545-JAD-VCF, 2015 WL 1886666 \(D. Nev. Apr. 24, 2015\)](#), the court denied Plaintiff's discovery requests because the complaint did not plead any facts in support of a breach of fiduciary duty, or allege that the administrative process experienced a conflict of interest. The court found that it will limit its abuse of discretion review to the administrative record.

In [Zavislak v. Google Inc. Welfare Benefit Plan, No. 14-CV-04802 NC, 2015 WL 909518 \(N.D. Cal. Feb. 27, 2015\) \(Not Reported in F.Supp.3d\)](#), Plaintiff sought an order allowing him to conduct limited discovery aimed at uncovering the impact of an apparent conflict of interest on the part of the Google Inc. Welfare Benefit Plan administrator, where Google acts as both the Plan administrator and funding source for benefits. The Court found that Plaintiff made a sufficient showing of a possible conflict to justify discovery limited to whether and to what extent the Plan administrator, Google, participated in or influenced the formulation, adoption, or revision, of the rule that resulted in the denial of Plaintiff's claim, where: 1) Plaintiff's declaration submitted in support of his discovery request states that he had a telephone conversation with Anthem's Account Executive for Google who revealed that the change in Plaintiff's claims processing between 2013 and 2014 was due to a claims audit; 2) Plaintiff's declaration summarizes a discussion with Google's U.S. Health Plan Program Manager who stated that Google does randomly audit certain claims and he planned to seek reimbursement from Anthem for amounts that he believed were incorrectly paid on Plaintiff's claims in 2013; and 3) an internal email exchange at Anthem discussing Plaintiff's appeal of the denial of his claims noted that a decision favorable to Plaintiff was an "option [that] increases the likelihood that Google will have to pay claims under the member's coverage under the wife's plan" and asked Anthem's Senior Associate General Counsel if she thinks that "because of that we'd need Google's consent before offering up that second option." The court approved the following discovery requests:

***Document Requests:***

1. The agreement between Google and Anthem referenced in Dkt. No. 28 ¶ 10 (stating that "Anthem acted pursuant to a written agreement with Google").
2. All documents that relate to the rule(s) that was used by Anthem to deny Zavislak's claims.

***Interrogatories:***

1. Describe in detail all communications between Google and Anthem relating to the rule(s) that was used by Anthem to deny Zavislak's claims, including but not limited to

any communications on the subject raised by Anthem's Managing Associate General Counsel in his email to Anthem's Senior Associate General Counsel at Dkt. No. 22-2 at 3.

2. Describe in detail all communications between Google and Anthem relating to Zavislak's claims and/or appeals.

In [Bryant v. Colonial Sur. Co., No. 1:13-CV-00298-BLW, 2015 WL 672314 \(D. Idaho Feb. 17, 2015\)](#), a non-ERISA matter, the court ordered Defendant Colonial Surety Company to produce evidence of other bad-faith claims made against it since January 2005 involving similar ERISA Fidelity Bonds.

J. Eleventh Circuit

**Request for special master to oversee corporate representative deposition is denied.** [United Surgical Assistants, LLC v. Aetna Life Insurance Company & Aetna Health, Inc., No. 8:14-CV-211-T-30JSS, 2015 WL 777535 \(M.D. Fla. Dec. 3, 2015\)](#). In a previous order, the court permitted inquiry regarding the following: (1) the exact nature of the information considered by the fiduciary in making the decision; (2) whether the fiduciary was competent to evaluate the information in the administrative record; (3) how the fiduciary reached its decision; (4) whether, given the nature of the information in the record, it was incumbent upon the fiduciary to seek outside technical assistance in reaching a "fair and full review" of the claim; and (5) whether a conflict of interest existed. Defendant moved the court to appoint a special master to preside over the deposition of the Defendant's corporate representative and to clarify the scope of the deposition. The court denied Defendant's motion, finding that this case does not present circumstances that would justify court-ordered supervision or intervention, as the facts of the case are relatively straightforward, the legal issues under ERISA are not unusually complex, only a single deposition remains to be taken, and guidance has already been provided by the Court as to the issues raised in Defendant's Motion. The Federal Rules of Civil Procedure sufficiently outline the process of conducting depositions and Defendant's request to preemptively limit the topics of examination before the deposition takes place on the basis of the parties' differing interpretations of the Court's order is premature.

In [Blake v. Union Camp Int'l Paper, No. 14-14275, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 4646763 \(11th Cir. Aug. 6, 2015\)](#), a matter involving a denial of pension benefits, the Eleventh Circuit held that the district court did not abuse its discretion in denying Plaintiff's motion to compel discovery. The court found that the district court properly limited discovery to the evidence that the ERISA plan administrator had before it in making its decision regarding Plaintiff's benefits. Further, the court found that the district court did not make a clear error of judgment in denying the motion

since Union Camp produced the entire administrative record and certified that the record included everything that had been compiled for the administrator's review of Plaintiff's claim. Because Plaintiff's pension never vested because he worked for less than the requisite 10 years before he left his job at Union Camp, the additional documents he requested would not have changed the district court's decision regarding his benefits claim, and denial of the motion could not have harmed his case.

In [Everson v. Zurich Am. Ins. Co., No. 5:14-CV-613-OC-37PRL, 2015 WL 1708453 \(M.D. Fla. Apr. 15, 2015\)](#), a lawsuit challenging the denial of accidental death benefits, the court denied Plaintiff's motion to order Zurich to supplement the administrative record with documents submitted after it issued a decision on Plaintiff's appeal. However, the court did permit Plaintiff to conduct limited discovery regarding the scope and impact of Zurich's admitted conflict of interest.

K. D.C. Circuit

**Employer defending delinquent contribution suit failed to satisfy criteria for additional time to conduct discovery under FRCP 56(d).** [Serv. Employees Int'l Union Nat'l Indus. Pension Fund, et al. v. Castle Hill Health Care Providers, LLC, et al., No. 14-CV-00334 \(APM\), 2015 WL 8023909 \(D.D.C. Dec. 4, 2015\)](#) (Judge Amit P. Mehta). In suit seeking delinquent contribution payments to the pension fund and provide remittance reports, the court denied Defendants' request for additional time to conduct discovery under Rule 56(d) and entered judgment in Plaintiffs' favor. The court found that Plaintiffs provided sufficient evidence establishing the amounts of the unpaid and late contributions, interest, and liquidated damages. Defendants' claimed that they lack sufficient information to respond to Plaintiffs' factual contentions but the declaration supporting the Rule 56(d) request did not satisfy all three criteria articulated in *Convertino v. DOJ*, 684 F.3d 93 (D.C. Cir. 2012) (*Convertino* criteria). First, Defendants made no effort to explain why they could not produce facts to oppose summary judgment. Indeed, for three months before Plaintiffs filed their motion, another judge issued an order directing the parties to meet and confer in order to initiate the discovery process but they did not. Second, Defendants did not outline the facts they intend to discovery or describe why such facts are necessary to the litigation. Defendants complain that Plaintiffs fail to specify the months for which Defendants were delinquent in making contributions and claim that they need discovery but Plaintiffs' summary spreadsheet shows precisely for which months in which years Defendants were delinquent in making contribution payments to each facility. Defendants did not explain why the spreadsheet is "meaningless" or what facts they hope to obtain to dispute Plaintiff's calculations. And last, Defendants did not demonstrate that the information they seek is in fact discoverable. The court found it unclear why Defendants do not already possess the records needed to determine what, if any, amounts are actually owed to Plaintiffs.

## VIII. *Exhaustion of Administrative Remedies*

- A. First Circuit
- B. Second Circuit
- C. Third Circuit

In [\*Mallon v. Trover Solutions Inc.\*, No. 14-3189, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 2372729 \(3d Cir. May 19, 2015\)](#), the Third Circuit affirmed dismissal of a putative class action contesting the Appellees' subrogation rights under a health insurance plan and seeking declaratory and injunctive relief pursuant to §§ 502(a)(1)(B) and 502(a)(3) due to failure to exhaust administrative remedies. The court rejected Plaintiff's argument that exhaustion was not required for claims of breach of fiduciary duties since the court found that this involved a claim for benefits due. The court also found that exhaustion was not excused for Appellees' failure to meet the notice requirements for an adverse benefits determination since Appellees substantially complied with the notice requirements by providing Plaintiff's counsel with the document setting forth the subrogation rights and the procedures and timeline for filing an administrative complaint and appeal. Lastly, the court rejected Plaintiff's argument that exhaustion was satisfied because there were no administrative remedies available to resolve subrogation disputes. Administrative appeals under the benefits program cover "disputes or objections regarding a Claims Administrator decision that concerns coverage terms," and the benefits program outlines a complaint procedure by which plan participants can lodge any complaint with the Claims Administrator.

In [\*Lewis-Burroughs v. Prudential Ins. Co. of Am.\*, No. 14-CV-1632 KM, 2015 WL 1969299 \(D.N.J. Apr. 30, 2015\)](#), Plaintiff submitted an administrative appeal to Prudential and then supplemented her appeal with the results of a functional capacity evaluation that Prudential had not specifically requested. When Prudential did not render a decision within 90 days of the date Plaintiff submitted her appeal, Plaintiff filed suit and Prudential filed a motion to dismiss based on a failure to exhaust, arguing that it had 90 days after Plaintiff supplemented her appeal to make a decision. The court determined that the parties are bound by the appeal process set forth in the Plan, which states that Prudential "shall" decide an appeal no later than 90 days after "the receipt of [the plan holder's] appeal request." The court explained that this literal reading of the Plan is strongly supported by 29 C.F.R. § 2560.503-1(i), which expressly states that the deadline

for deciding an appeal begins when the “appeal is filed”...“without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.” The court rejected Prudential’s argument that the Plan and the ERISA regulations allow for tolling of the 90-day deadline in this circumstance. Both the Plan and the Regulations require that: (1) the plan holder must have failed to provide information “necessary” to the resolution of the appeal; (2) before the initial 45–day period expires, Prudential must send the participant written notice that it is claiming the extension; and (3) that notice must list the “necessary” information that Prudential requires from the participant. Also, even if these conditions were met, the 90-day clock does not restart from zero, rather the clock is suspended from the date that Prudential sends the notification of extension until the date the participant furnishes the “necessary” information. The court also found that the substantial compliance doctrine does not affect Plaintiff’s right to commence this action. Accordingly, the court denied Prudential’s motion to dismiss.

D. Fourth Circuit

E. Fifth Circuit

*Glenn v. L. Ray Calhoun & Co.*, No. A-13-CA-701-SS, 2015 WL 363262 (W.D. Tex. Jan. 27, 2015), a matter involving a denial of benefits under an Occupational Accident insurance policy, the court granted summary judgment to Defendant OneBeacon for Plaintiff’s failure to exhaust administrative remedies. Plaintiff asserted that exhaustion is not mandated because the terms of the Policy do not explicitly require exhaustion. However, the court noted that the origins of the exhaustion requirement are based on judicial interpretations of the ERISA statutory scheme and Congressional intent. Plaintiff further argued that exhaustion is not required because the claim for coverage falls outside the exhaustion requirement, but the court found that the issue before the court is clearly an attack on a denial of benefits under an ERISA plan. Thus, Plaintiff was required to exhaust.

F. Sixth Circuit

**Failure to notify healthcare provider with derivative standing of time limit for initiating an administrative review results in remand.** [Lucia Zamorano, M.D., P.C. v. Roofers Local 149-Sec. Benefit Trust Fund, No. 14-10565, 2015 WL 9478024 \(E.D. Mich. Dec. 29, 2015\)](#) (Judge Arthur J. Tarnow). Plaintiffs sought to recover benefits allegedly owed to it pursuant to a patient’s assignment of medical benefits under an ERISA-governed insurance plan. The court agreed with the Third Circuit and concluded that a plan participant or beneficiary’s authorization of payment of her benefits directly to a healthcare provider as reimbursement for medical services confers on the provider derivative standing as a beneficiary to bring an ERISA claim for the benefits. Since the Plaintiff here obtained derivative standing as a beneficiary, it was entitled

to notice of the procedure for appealing Defendant's denial of its claim for benefits. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(g)(1)(iv). Since Defendant did not provide such notice, Plaintiff's failure to appeal the denial of its claim within the 180-day deadline does not warrant dismissal of its claim. But because Plaintiff was denied the right to complete administrative review and Defendant failed to notify it of the time limit for initiating an administrative appeal, the court remanded Plaintiff's claim to the administrative process, to be treated as if Plaintiff timely appealed the denial of benefits.

**Dismissal for failure to exhaust is without prejudice where deadline for administrative appeal has not yet passed.** [Watkins v. Matrix Absence Mgmt., Inc., No. 3:15-CV-00716-JHM, 2015 WL 6480145 \(W.D. Ky. Oct. 27, 2015\)](#) (Judge Joseph H. McKinley, Jr.). In granting Defendant's motion to dismiss, the court concluded that Plaintiff did not meet his burden of proving that the administrative appeals process would have been clearly futile. The court declined to dismiss the case with prejudice because the court did not have the Plan document before it and the time for Plaintiff to appeal the denial of his claim for LTD benefits had not yet passed.

**Failure to exhaust administrative remedies not excused and case dismissed without prejudice.** [Hues v. Fed. Ins. Co., et al., No. 2:15-CV-84, 2015 WL 6107644 \(S.D. Ohio Oct. 16, 2015\)](#) (Judge James L. Graham). Plaintiffs did not file an administrative appeal of Defendant's denial of accidental death benefits. The court found that the complaint should be dismissed for failing to exhaust administrative remedies provided by the Plan. The court rejected Plaintiffs' estoppel argument based on the decision letter which stated that they "have the right to appeal" but did not inform them that they were required to appeal. Defendant, as claims administrator, had no obligation to provide Plaintiffs with the SPD that states the requirement to appeal. The court also rejected Plaintiffs' argument that exhaustion would have been futile because Plaintiffs were actively involved in the claims process, they had nothing further to submit in support of the claim, and they were certain that Defendants would deny the appeal. The court declined to dismiss the case with prejudice since the court could not say definitively that the claims administrator in this case would reject Plaintiffs' reasons for not filing a timely appeal as opposed to waiving the time limits, and Plaintiffs should have the opportunity to make those arguments to the administrator.

In [Farm Bureau Gen. Ins. Co. of Michigan v. Blue Cross Blue Shield of Michigan, No. 1:14-CV-58, 2015 WL 4874611 \(W.D. Mich. Aug. 13, 2015\)](#), Plaintiff, a no-fault insurer, filed this case seeking coverage/payment from Defendant, an ERISA plan administrator, for services provided by a medical facility to a participant covered by both plans. The court found that this case was

not a “priority” dispute because BCBSM concedes that its plan is first in priority. Second, the court found that Plaintiff has not shown a legal or factual basis for an independent action for reimbursement or recoupment. Rather, the court determined that this case, at its core, is a challenge to BCBSM’s denial of benefits under an ERISA welfare benefit plan. As such, Plaintiff is required to exhaust administrative remedies, which it did not do. The court rejected Plaintiff’s argument that exhaustion would be futile. Accordingly, the court dismissed Plaintiff’s Complaint for failing to exhaust the administrative remedies.

In [\*Jammal v. Am. Family Ins. Grp.\*, No. 1:13 CV 437, 2015 WL 1810304 \(N.D. Ohio Apr. 21, 2015\)](#), the court found that Defendants provided no evidence or reason to convince the court that any attempt by Plaintiffs to pursue a claim for benefits under ERISA administrative procedures would have been anything other than futile, where Defendants had designated the Plaintiffs as independent contractors and not employees.

In [\*Hammonds v. Aetna Life Ins. Co.\*, No. 2:13-CV-310, 2015 WL 1299515 \(S.D. Ohio Mar. 23, 2015\)](#), the court concluded that Defendants waived the 180-day time limitation for Plaintiff to submit an appeal and implicitly granted a requested 30-day extension by considering the appeal on its merits. Even assuming that the untimely exhaustion argument has not been waived, Plaintiff effectively exhausted her administrative remedies because Aetna addressed her appeal on the merits, and Aetna has presented an administrative record adequate for review by the court, thus satisfying the purposes underlying the exhaustion requirement. The court denied Defendants’ request for judgment based on the alleged untimeliness of Plaintiff’s appeal.

In [\*Schra v. Metro. Life Ins. Co.\*, No. CIV. 13-13650, 2015 WL 806955 \(E.D. Mich. Feb. 26, 2015\)](#), the court granted Defendant’s Motion to Uphold the Administrative Decision. Here, MetLife terminated Plaintiff’s short-term disability claim beyond April 17, 2011 and Plaintiff fully exhausted her administrative remedies under the plan with respect to these benefits. However, when Plaintiff filed suit, she sought to recover long-term disability benefits. Defendant argued that Plaintiff cannot maintain its claim for LTD benefits because Plaintiff never filed a claim for such benefits, and because Plaintiff failed to exhaust administrative remedies available had such claim for LTD benefits been denied. During the motion hearing, Plaintiff requested that the Court allow her to amend the complaint to seek entitlement to STD benefits, rather than LTD benefits. Defendants contended that the STD plan is a payroll practice plan not governed under ERISA and the court lacks subject matter jurisdiction. The court found that the STD plan is not an ERISA plan; rather, the STD plan is a payroll practice plan. Thus, amending the complaint would be futile. Plaintiff raised a new argument, contending that an application for LTD benefits would have been futile, and that, in accordance with *Dozier v. Sun Life Assurance Co. of*

*Canada*, 466 F.3d 532 (6th Cir. 2006), the court should excuse Plaintiff's failure to exhaust the administrative review process prior to bringing the instant action. The court found that the issue of futility is waived, given that Plaintiff did not raise this new argument until his post-hearing responsive brief.

G. Seventh Circuit

**Exhaustion of administrative remedies is excused and would have been futile.** [Knigge v. the Dorothy Prusek 401\(k\) Plan, et al., No. 14-CV-0542, 2015 WL 8986326 \(N.D. Ill. Dec. 16, 2015\)](#) (Judge Sharon Johnson Coleman). In this case Plaintiff alleged that Defendants failed to deposit portions of Plaintiff's elected deferred compensation into the 401(k) plan and did not make their employer contribution to the Plan after 2005. In 2012, upon learning that the Plan was being terminated because of the inactivity of Defendants, Plaintiff asked Prusek to reinstate the plan and deposit the missing contributions, but Prusek refused to do so. Defendants moved to dismiss based on failure to exhaust administrative remedies. The court denied Defendants' motion, finding that exhaustion was excused because Plaintiff was denied meaningful access to review procedures as she was never provided copies of Plan documents and was not informed how to pursue an appeal. Although Defendants attempted to introduce contradictory evidence, the court found Plaintiff's allegation that she was not informed of the available review procedures as adequate to survive the motion to dismiss. Further, exhaustion would have been futile since the decisionmaker, a solo practitioner, would be the ultimate arbitrator of any administrative proceeding and would be reviewing her own prior refusal to remedy the situation.

**Inference that the exhaustion requirement is excused where participant sent multiple requests and inquiries about his pension benefit and did not receive any response.** [Lange v. The University of Chicago & the University of Chicago Retirement Income Plan for Employees, No. 15 C 7303, 2015 WL 7293588 \(N.D. Ill. Nov. 19, 2015\)](#) (Judge Jorge Alonso). Plaintiff filed suit seeking a determination of entitlement to pension benefits that included pre-2009 service where he worked part-time for approximately 1,000 hours a year. Plaintiff alleged that before he retired he asked the Benefits Office for an estimate of his monthly pension benefit and was told that he was only eligible to recover benefits starting from his full-time employment in November 2009. Plaintiff then asked a Benefits Analyst, to include all of his years of employment in his pension calculation and sent numerous emails to the Benefits Analyst and the Benefits Department, but never received a determination of his benefits eligibility, or an explanation for the denial of the benefits he accrued during his 40 years of employment with the University. As of August of 2015, when this suit was filed, Plaintiff had yet to receive an explanation from Defendant as to why his pension benefits do not include his pre-2009 service. Defendant moved to dismiss for failure to exhaust. The court found that because Plaintiff's

complaint supports the inference that the exhaustion requirement is excused, his purported failure to exhaust is not a basis for dismissing this suit.

H. Eighth Circuit

I. Ninth Circuit

**Notice-prejudice rule does not extend to 180-day administrative appeal deadline.** [\*Dietz-Clark v. HDR, Inc.\*, No. 3:15-CV-00035 JWS, 2015 WL 6039587 \(D. Alaska Oct. 15, 2015\)](#) (Senior Judge John W. Sedwick). The court granted United of Omaha's motion to dismiss for Plaintiff's failure to exhaust administrative remedies in connection with her denial of long-term disability benefits claim because she did not file an appeal of the denial within 180 days. Plaintiff alleged that she did not file an appeal because she hoped to rehabilitate herself. Plaintiff's attorney requested that United of Omaha reopen her claim, arguing that the missed deadline was not fatal to her request because of Alaska's "notice-prejudice rule," which is not preempted by ERISA based on *UNUM Life Insurance Co. v. Ward*. United of Omaha declined to reopen the claim. The court declined to extend the notice-prejudice rule to cover contractual administrative appeal deadlines.

J. Tenth Circuit

K. Eleventh Circuit

In [\*Watson v. Teledyne Technologies Inc. Pension Plan\*, No. CIV.A. 14-0452-WS-M, 2015 WL 2097610 \(S.D. Ala. May 5, 2015\)](#), the plan administrator denied Plaintiff Smith an additional retirement benefit of \$96/month. Plaintiff Smith appealed the administrator's decision and was awarded this additional amount prospectively, but not retroactively to the date Plaintiff took early retirement. The Plan administrator also notified Plaintiff Watson that he was eligible for the additional \$96 monthly benefit but he had to waive the joint and survivor annuity in order to receive the benefit. Without a further claim or appeal to the administrator, Plaintiffs filed suit, alleging two counts under 29 U.S.C. § 1132(a)(1)(B). Defendants filed a motion to dismiss for failure to exhaust administrative remedies. The court granted Defendants' motion and dismissed Plaintiffs' complaint without prejudice. The court found that Plaintiffs are seeking Plan benefits in excess of those they were awarded by the plan administrator and the Plan plainly requires them to file a claim with the Committee for those benefits. If the Committee denied the benefits, then Plaintiffs are first required to appeal that decision to the Committee before filing suit.

## IX. *Governmental Plans*

### A. Second Circuit

**Government sponsored health plans are exempted from ERISA regulation and anti-assignment language did not operate to strip healthcare provider of standing to sue.**

[Semente v. Empire Healthchoice Assurance, Inc., No. 14CV5823DRHSIL, F.Supp.3d 2015 WL 7953939 \(E.D.N.Y. Dec. 4, 2015\)](#) (Judge Hurley). Chiropractic provider brought suit against Defendants to recover money allegedly wrongfully withheld by Empire Blue Cross Blue Shield and the health plans it administers for Verizon and Suffolk employees. Count II asserts claims for breach of the Employee Medical Health Plan (“EMH Plan”) administered by Empire and sponsored by Suffolk as well as for violations of 29 C.F.R. § 2560.503–1. Suffolk moved to dismiss for lack of standing and for failure to state a claim. The court granted in part and denied in part Suffolk’s motion. The court found that the ERISA claim stems from Plaintiff’s assertion that the Patient Protection and Affordable Care Act (“PPACA”) incorporated the ERISA claims procedures set forth at 29 C.F.R. § 2560.503–1. The court found that government sponsored health plans are specifically exempted from application of the Regulation under 29 U.S.C. § 1003(b) (providing that “[t]he provisions of this subchapter shall not apply to any employee benefit plan if such plan is a government plan”). Because the EMH Plan is government-sponsored, it is not covered by the Regulation, and the court dismissed Count II with prejudice. With respect to Defendants’ argument that the alleged assignments Plaintiff proffers from his patients are ineffective to confer standing, the court explained that under New York law an assignment is valid even where an agreement generally prohibits assignment, unless the agreement specifies that an assignment would be invalid or void. Here, the court declined to dismiss Plaintiff’s claim on the basis of the anti-assignment language in the EMH Plan Booklet since the language does not state that any assignments would be “void.” However, the court ordered the parties to brief whether or not the court should retain supplemental jurisdiction over the state law claims against Suffolk since it dismissed the federal claims.

### B. Sixth Circuit

**Governmental plan exemption does not apply to University Medical Center since it is not a political subdivision, agency, or instrumentality of Kentucky.** In [Milby v. Liberty Life Assur. Co. of Boston, No. 3:13-CV-00487-CRS, F.Supp.3d , 2015 WL 1968840 \(W.D. Ky. Apr. 30, 2015\)](#), the court denied Plaintiff’s motion to remand her state law claims related to the denial of her employer-provided long-term disability benefits, finding that University Medical Center (“UMC”) is not a political subdivision, agency, or instrumentality of Kentucky under ERISA’s

governmental plan exemption. UMC is not a political subdivision under the *Hawkins County* test because neither Kentucky nor its arm, University of Louisville (“U of L” –a state institution), directly created UMC. Further, no special act of the legislature or a public official brought UMC into existence and UMC does not bear sufficient indicia of sovereignty to be deemed a political subdivision. The court also found that UMC is not an agency or instrumentality of Kentucky according to the multi-factor test created by the IRS for the following reasons: (1) U of L does not control the everyday operations of UMC; (2) no specific legislation created UMC; (3) UMC maintains a financial separation from U of L; (4) U of L lacks the removal power to control and discipline Board members once they are appointed or elected; and (5) UMC’s employees are not considered employees of U of L, and UMC’s employees are not entitled to public employee benefits. Finally, UMC is not an agency or instrumentality of Kentucky under the employment-relationship test since UMC clearly functions as a private enterprise in relating to its employees. Because UMC does not meet the “governmental plan” exception, the court found that all of Plaintiff’s claims are preempted by ERISA.

### C. Ninth Circuit

**A Plan is not “established” or “maintained” by a government entity based on school districts’ participation in the Plan that was established by a union.** In [\*Wilson v. Provident Life & Acc. Ins. Co.\*, No. C14-1479RSL, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 1941334 \(W.D. Wash. Apr. 29, 2015\)](#), the court found that the “Washington Education Association Group Plan W-138 Plan 11,” a group insurance plan underwritten by Provident and “established and maintained” by the Washington Education Association (“WEA”) is not a governmental plan exempt from ERISA. Provident issued the Plan to the WEA, and the Plan covers (a) employees of the WEA and its affiliates and (b) employees of Washington public school districts that elect to participate in the Plan. The Plan was not the product of collective bargaining, but the result of a separate negotiation between the WEA and Provident; the District merely “elected” to participate in the Plan. The court found that the Plan was independently created by the WEA for the benefit of its employees along with government employees, and the evidence does not suggest that school districts played any direct role in the Plan’s creation. Private plans do not become public plans merely through the participation of public employers. Because the Plan is not a governmental plan, the court denied Plaintiff’s Motion to Remand.

### X. *Interpleader Actions*

A. Fourth Circuit

*Unum Life Ins. of Am. v. Witt*, No. 1:14CV00005, 2015 WL 72099 (W.D. Va. Jan. 6, 2015) involved an interpleader action where Unum paid into court the death benefit proceeds of a life insurance policy and requested the court to determine who is entitled to those proceeds—either the named beneficiaries of the policy or a bank that obtained an assignment of the policy as collateral for a loan to the insured. The bank moved for summary judgment, which the court granted. The court found that it is settled that where the insured assigns the proceeds of a life insurance policy as security for a debt, the creditor’s right is superior to that of the beneficiary of the policy. The Beneficiaries contended that there is no present evidence that the assignment in question in this case was properly filed, but the court explained that life insurance policy provisions requiring an assignment to be filed with the insurance company are solely for the benefit of the insurer, and not the beneficiary. If the insurer does not insist on such provisions, the beneficiary cannot complain, and by filing an interpleader action, an insurance company waives compliance with such provisions. The court also rejected the Beneficiaries’ argument that the life insurance company ought to have notice of an assignment prior to the insured’s death because Group Policy contains no such requirement and neither Unum nor the Beneficiaries were prejudiced by the timing of notice of the Assignment.

B. Seventh Circuit

C. Eighth Circuit

D. Ninth Circuit

In [\*Minnesota Life Ins. Co. v. Gomez\*, No. CV-14-00866-PHX-JZB, 2015 WL 4638351 \(D. Ariz. Aug. 4, 2015\)](#), Plaintiff filed a Complaint in interpleader requesting that the court determine the right beneficiaries of the decedent’s basic life insurance and accidental death and dismemberment policy. The spouse was named a beneficiary but is being investigated for murdering the decedent. On a default judgment, the court granted Plaintiff’s request for relief in the form of an order (1) discharging Plaintiff from further liability for the funds, (2) requiring Defendants to interplead their claims to the benefits, (3) permanently enjoining Defendants from bringing any claim or action against Plaintiff relating to the benefits, and (4) dismissing Plaintiff with prejudice.

E. Eleventh Circuit

In [\*Prudential Ins. Co. of Am. v. Davidson\*, No. 1:14-CV-1879-WSD, 2015 WL 4734746 \(N.D. Ga. Aug. 10, 2015\)](#), the court granted Prudential's motion requesting the court to enter an order directing it to deposit the sum of a life insurance benefit with the Clerk of Court where the beneficiary (and spouse of decedent) is being investigated for murdering the decedent. The spouse's right to the death benefits is forfeited under Georgia Law if it is shown that she murdered or conspired to murder her husband and benefits would be paid to the surviving children in equal shares.

XI. *Life Insurance & AD&D Benefit Claims*

A. First Circuit

B. Second Circuit

In [\*Thomas v. CIGNA Grp. Ins.\*, No. 09-CV-5029 SLT RML, 2015 WL 893534 \(E.D.N.Y. Mar. 2, 2015\)](#), the court previously granted Plaintiff's motion for summary judgment to the extent of remanding the matter for further factfinding and a new eligibility determination. Specifically, the Court directed that LINA investigate whether Countrywide furnished the SPD in accordance with the relevant regulations and whether the SPD placed participants in the Basic Life Insurance Plan on notice of certain "Waiver of Premium" provisions. After conducting its investigation, LINA determined that the decedent was appropriately informed of her Waiver of Premium rights under the life insurance plans, but failed to timely exercise those rights within the allowable timeframes. The court denied LINA's motion for summary judgment, finding that the Administrative Record in this case does not contain evidence that the decedent was ever furnished with an SPD in accordance with the statutes and regulations; there is not enough information to ascertain whether the decedent was the sort of participant who could be furnished with an SPD through electronic means; there is no evidence concerning the decedent's duties and whether access to Countrywide's electronic information system was "an integral part" of the decedent's duties; and the Administrative Record establishes that the SPDs were not furnished in accordance with the requirements of § 2520.104b-1(c)(1)(iii).

C. Third Circuit

**Administrator's determination that decedent was not eligible for life insurance benefits was reasonable and administrators are not bound by Federal Rules of Evidence.** [Malishka v. MetLife, No. 14-4195, Fed.Appx. \\_\\_\\_, 2015 WL 9311399 \(3d Cir. Dec. 23, 2015\)](#) (Before CHAGARES, RENDELL, and BARRY, Circuit Judges). The court affirmed the district court's grant of summary judgment in favor of MetLife on Plaintiff's denied claim for life insurance benefits for her deceased son. The court found that MetLife reasonably determined from the administrative record that the decedent lost eligibility for coverage under the Boilermakers National Health and Welfare Fund in the third Eligibility Quarter in 2011 and did not regain eligibility prior to his death. MetLife relied upon detail summaries of the decedent's hours which were provided by the union. The union advised that the hours attributed to the decedent were accurate and had been confirmed by the employer. The court rejected Plaintiff's objection that MetLife relied on hearsay evidence since an ERISA plan administrator is not bound by the Federal Rules of Evidence.

In [Guthrie v. Prudential Ins. Co. of Am., No. 14-3282, Fed.Appx. \\_\\_\\_, 2015 WL 5138091 \(3d Cir. Sept. 2, 2015\)](#), the Third Circuit affirmed the district court's order granting summary judgment in favor of Prudential on its determination to deny accidental death and dismemberment benefits to Plaintiff based on a legal intoxication exclusion in the policy. Here, the police report stated that the insured ran off the road towards an embankment on a dry road with no adverse weather conditions and was last seen alive drinking alcohol at a local bar. According to the toxicology report, the insured's blood alcohol level was 0.14% and his vitreous humour alcohol level was 0.13%. Prudential's reviewing expert, Dr. Albert Kowalski, opined that the insured's blood alcohol level at the time of the accident could be determined within a reasonable degree of medical certainty through retrograde extrapolation and that it was between 0.10 and 0.12% at the time of the accident.

In [Reg'l Employers' Assurance Leagues Voluntary Employees' Beneficiary Ass'n Trust v. Castellano, No. CV 03-6903, 2015 WL 5025446 \(E.D. Pa. Aug. 25, 2015\)](#), a declaratory judgment action brought by the REAL VEBA Trust and other defendants, the court ordered that the Trust must pay \$750,000.00 to Defendant. The court did not order Koresko or the Koresko entities pay the benefits to Defendant because in another case the court ordered them to pay restitution for losses and disgorgement of profits to the Trusts in an amount over \$19 million. Because the court granted Defendant benefits under the Plan, it denied Defendant's motion for summary judgment on its equitable ERISA claim, common law counterclaims, and the civil RICO claims.

In [Minchella v. Sun Life Assur. Co. of Canada, No. CIV.A. 14-4024, 2015 WL 4578902 \(E.D. Pa. July 29, 2015\)](#), Plaintiff alleged that Defendant failed to make a decision on Plaintiff's claim for basic accidental death benefits, pursuant to a policy issued to the decedent, Jason Minchella, despite Plaintiff's repeated requests that Defendant do so. Defendant moved to dismiss the claim on the grounds that Plaintiff's claim is precluded under the doctrine of *res judicata* and that Plaintiff has failed to exhaust his administrative remedies as required under ERISA. The court denied Defendant's motion. The court determined that it was better to decide the *res judicata* issue stemming from a settlement agreement between the parties and prior court action relating to a claim for general life insurance benefits on a complete factual record rather than on a motion to dismiss. With respect to exhaustion of remedies, the court found that Defendant failed to plead any specific language in the Policy regarding available or required administrative remedies. Further, the express reservation of the accidental death benefit claim in the release and settlement agreement appears to evince Plaintiff's intent to exhaust administrative remedies. Plaintiff's allegation that Defendant repeatedly ignored Plaintiff's request to reach a final claim decision raises a potential issue as to whether any further attempt to exhaust administrative remedies would have been futile. Because the current state of the record does not permit any determination as to the affirmative defense of exhaustion of administrative remedies, the court denied the motion but permitted Defendant to raise the issue again in any motions for summary judgment.

In [Woerner v. Fram Grp. Operations, LLC, No. CIV.A. 12-6648 SRC, 2015 WL 3970199 \(D.N.J. June 30, 2015\)](#), the court granted summary judgment to Defendant on Plaintiff's claim for life insurance benefits. At the time that the decedent enrolled in the life insurance plan he was on sick-leave and not an "active" employee. The plan was also not formally established until after the decedent's death. Neither the employee nor his wife was provided with the insurance plan document that set forth the eligibility criteria. Notwithstanding, the court found that it had to follow the governing ERISA plan documents that contain an active-service requirement even though they were not disclosed to Plaintiff or her husband.

In [Locklear v. Sun Life Assur. of Canada, No. 4:14-CV-00401, 2015 WL 1964675 \(M.D. Pa. May 1, 2015\)](#), Sun Life denied Plaintiff AD&D benefits for her deceased husband, taking the position that his death occurred during the commission of a crime. The decedent died from injuries sustained in a collision after he attempted to pass a construction vehicle in a no-passing zone. Sun Life believed that violations of Pennsylvania Vehicle Code, 75 Pa.C.S. §§ 3301, 3714, and 3736 were properly classified as crimes. The court noted that in Pennsylvania, an offense must carry the possibility of imprisonment or death in order to constitute a crime. Offenses for motor vehicle violations are not contained in the Pennsylvania Crimes Code, but in the Vehicle

Code. Under this straight-forward definition of a crime under Title 18, the court found that none of the decedent's Vehicle Code violations constitute a crime. With respect to Sun Life's argument that the decedent's actions constitute reckless endangerment, the court found that Sun Life failed to raise this issue at the administrative level and cannot provide *post hoc* rationales for its denial of benefits, especially where it had possessed adequate facts to deny benefits on the ground of reckless endangerment. Regardless, the court found that a denial of benefits on this basis would not be appropriate. Sun Life failed to carry its burden that the decedent possessed the *mens rea* necessary to commit reckless endangerment of another person and therefore be excluded from coverage. As such, the court denied Sun Life's motion for summary judgment and granted Plaintiff's motion for summary judgment.

In [\*Diener v. Renfrew Centers, Inc.\*, No. CIV.A. 11-4404, 2015 WL 567339 \(E.D. Pa. Feb. 10, 2015\)](#), a dispute involving a group term life insurance policy issued by the Life Insurance Company of North America ("LINA"), the court dismissed the breach of contract claim because Plaintiff did not meet his burden of establishing the elements of breach of contract. Plaintiff failed to demonstrate that the decedent had an active life insurance policy in effect at the time of her death. The court dismissed the breach of fiduciary duty claim against LINA, finding that it cannot be held liable for failing to disclose material facts to parties with whom it never communicated about the life insurance plan. The court also dismissed the breach of fiduciary duty claim against the employer because the record was devoid of evidence of any actual material misrepresentation or omission of material information by the employer that had a substantial likelihood of misleading a reasonable employee into making a harmful decision regarding benefits.

#### D. Fourth Circuit

[\*Ervin v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.\*, No. CIV.A. WMN-15-201, 2015 WL 5567318 \(D. Md. Sept. 21, 2015\)](#). The court granted summary judgment in favor of the insurer on Plaintiff's claim for accidental death benefits, where the insurer determined that the insured suffered a heart attack prior to falling out of a boat and landing face down in the water. The report on the autopsy concluded that the insured "died of Atherosclerotic Cardiovascular Disease complicated by Drowning." The policy does not pay benefits for deaths resulting from heart attacks.

[\*Bostic v. Bostic\*, No. CIV.A. 6:14-2130-BHH, 2015 WL 5178163 \(D.S.C. Sept. 3, 2015\)](#). In dispute between deceased insured's wife and ex-wife (who was designated beneficiary of deceased's life insurance policy), the court granted Defendant's motion to dismiss, finding that the ex-wife is the proper beneficiary of the insurance policy.

In [Winburn v. Progress Energy Carolinas, Inc., No. 4:11-CV-03527-RBH, 2015 WL 505551 \(D.S.C. Feb. 6, 2015\)](#), the court found that Prudential's decision to deny the AD&D claim on the basis of the legal intoxication exclusion was reasonable and that Plaintiff received a full and fair review. At the time of Mr. Winburn's death in 2008, the terms of the AD&D Plan then in effect contained the "legally intoxicated" exclusion and Mr. Winburn's blood alcohol level rose to the level of legal intoxication.

E. Fifth Circuit

[Metro. Life Ins. Co. v. Scott, No. CIV.A. 15-362, 2015 WL 5165556 \(E.D. La. Sept. 2, 2015\)](#).

This civil interpleader action called on the court to determine whether a widow murdered her husband without justification such that she is disqualified from receiving his life insurance proceeds. The court denied the decedent's son's motion for summary judgment. Although the father's death was ruled a homicide and that Mr. and Ms. Scott were the only two people in the house at the time of the homicide, this alone is insufficient for the court to enter judgment as a matter of law that Ms. Scott intentionally and without justification killed Mr. Scott. Further, there is no final judgment that Ms. Scott is criminally responsible for her husband's death.

In [Singletary v. Prudential Ins. Co. of Am., No. CIV.A. 14-2648, 2015 WL 4661774 \(E.D. La. Aug. 5, 2015\)](#), applying the plain words of an exclusion in a dependent life insurance benefit policy, the court found that Prudential's determination that the decedent was not a qualified dependent because he was on "active duty" as a member of the United States Army at the time of his death was supported by evidence in the administrative record and falls on a continuum of reasonableness. The decedent died as a result of injuries sustained in a motor vehicle collision. He was a member of the United States Army, but he was stationed stateside and was off-duty at the time of his death. The "off duty" notation on the Report of Casualty was merely an internal code for the Army's administration area regarding the decedent's location at the time of his death and did not change the fact that he was on "active duty."

In [James v. Life Ins. Co. of N. Am., No. CIV.A. H-12-2095, 2015 WL 4126580 \(S.D. Tex. July 8, 2015\)](#), the court granted summary judgment in favor of Plaintiff in this matter involving a denial of AD&D benefits. LINA denied benefits because the decedent had been driving with a blood alcohol concentration of .19% (more than two times above the legal limit in the Commonwealth of Virginia) when he died as a result of "inhalation of combustion products and thermal injury" after his car collided with a tree and caught fire. The policy's AD&D benefits were triggered when "the Covered Person suffer[ed] a Covered Loss resulting directly and independently of all

other causes from a Covered Accident ....” A “Covered Accident” was defined as a “sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or a Covered Loss.” LINA found that the crash was not “unforeseen” as required by the policy, because the insured was driving under the influence and studies have shown that individuals with BACs between 0.11 and 0.20 percent suffer serious physical impairments including slowed reaction time and gross motor control. LINA concluded that serious injury or death would be highly likely to occur while operating a vehicle with a BAC of .19% and would not be an unforeseen event. The court disagreed that the accident was foreseeable or highly likely where statistics that compared the amount of alcohol impaired trips that were taken to the amount of people who died showed less than a one percent chance of death.

F. Sixth Circuit

**Partial denial of life insurance benefits not arbitrary and capricious where insured did not submit required evidence of insurability form that was a condition precedent for excess coverage.** [Van Loo v. Cajun Operating Co., et al., No. 14-CV-10604, 2015 WL 7889034 \(E.D. Mich. Dec. 4, 2015\)](#) (Judge Laurie J. Michelson). Plaintiffs filed this lawsuit after Defendant Reliance Standard Life Insurance Company partially denied their claim for life insurance benefits following the death of their daughter, Donna Van Loo. Donna was an employee of Defendant Cajun Operating Company d/b/a/ Church’s Chicken and purchased life insurance coverage through Church’s, which held a Reliance policy, and named her parents as beneficiaries. Because Van Loo never submitted proof of good health, Reliance determined that Plaintiffs cannot recover life insurance benefits in excess of \$300,000. The court granted Reliance’s motion for judgment on the administrative record, finding that its decision to deny Plaintiffs’ claim for benefits was not arbitrary and capricious. The information in the Administrative Record indicated that Van Loo was mailed an evidence of insurability form (“EIF”) by Reliance in 2010, but never returned it to Church’s or Reliance. The court found that Reliance’s structural conflict did not influence its conduct—before 2010, it was Church’s responsibility to mail EIFs to insureds, and the Administrative Record indicates that once Reliance took responsibility for this task, it did mail the form to Van Loo. Moreover, the court found that Reliance’s interpretation of a disputed Policy provision was the only reasonable interpretation of the unambiguous Policy language and declined to apply the principle of *contra proferentum*. The court rejected Plaintiffs’ argument that the incontestability clause prevents Reliance from disputing the Policy’s effectiveness since coverage never became effective in the first place. The court also found that Reliance did not waive its ability to assert the lack of an EIF in its decision to deny coverage despite the fact that it had accepted life insurance premiums from the insured for six years.

**Change in beneficiary designation made by guardian of legally incapacitated participant is void.** [Metropolitan Life Insurance Company v. Austin, et al., No. 14-CV-12005, 2015 WL 7770659 \(E.D. Mich. Dec. 3, 2015\)](#) (Judge Linda V. Parker). MetLife initiated this interpleader action to determine the disposition of the proceeds of a life insurance policy owned by Clara Austin. Defendant Laura Brown, the adult great niece of Clara Austin, was named the primary beneficiary of the policy in March 2008. At that time, Michelle Austin, Clara Austin's adult granddaughter, was removed as the primary beneficiary. Ms. Brown and Ms. Austin each claim entitlement to the insurance proceeds. The court concluded that the beneficiary designation naming Ms. Brown as the beneficiary of the life insurance benefits is void, as Clara Austin lacked the competency to complete the change. Clara Austin was deemed legally incapacitated and Ms. Brown was appointed as her guardian in November 2007. Ms. Brown submitted the beneficiary designation form making herself the primary beneficiary allegedly to comport with Clara Austin's wishes. The court found that Ms. Brown lacked authority to make this change.

**In interpleader action, beneficiary designation controls notwithstanding allegations that beneficiary took advantage of the decedent.** [Metropolitan Life Insurance Company v. Thomason, et al., No. 15-12256, 2015 WL 6955412 \(E.D. Mich. Nov. 10, 2015\)](#) (Judge Avern Cohn). In an interpleader action, the court found that the decedent's most recent beneficiary designation was valid and that 50% of the benefit is payable to the decedent's caregiver/girlfriend. The decedent's sister challenged the designation, claiming that the caregiver took advantage of decedent, that decedent was suffering from dementia, that she was not aware that the caregiver was decedent's girlfriend, and that the caregiver did not take good care of decedent. However, the court found that there is no evidentiary support in the record for these allegations and in the absence of any basis in the record for questioning decedent's most recent designation of beneficiary form, the court concluded that the final designation made by the decedent is controlling.

In [Stockman v. GE Life, Disability & Med. Plan, No. 13-4450, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 5061425 \(6th Cir. Aug. 28, 2015\)](#), the court affirmed the district court's decision in favor of Plaintiff on his claim for dismemberment benefits due to the permanent and total loss of his left foot for one year. A series of surgeries partially restored Plaintiff's use of the foot, but it remains permanently damaged. The district court concluded that Plaintiff's injury fell within the Plan's promise that "the permanent and total loss of function of the hand or foot as a result of an accident after the loss has continued for at least 12 consecutive months" would be covered. The Sixth Circuit determined that the meaning of the term "permanent" is ambiguous because it is subject to two reasonable interpretations. Using Webster's definition of "permanent" which means something that is "continuing or enduring without fundamental or marked change," the court found that although Plaintiff was able to walk without an assistive device after 12 months,

this does not mean that the loss of the use of his foot was not “continuing or enduring without fundamental or marked change.” Applying MetLife’s interpretation would create an insurmountable requirement to claim benefits. Judge Boggs penned a dissenting opinion.

G. Seventh Circuit

**Insured’s death while legally intoxicated not payable under terms of accidental death & dismemberment policy.** [Fleming v. Reliastar Life Insurance Company, No. 14-1482, 2015 WL 7853847 \(C.D. Ill. Dec. 1, 2015\)](#) (Judge James E. Shadid). The court granted summary judgment in favor of Reliastar on Plaintiff’s claim for denied accidental death & dismemberment benefits, for which she claimed following the death of her son. The evidence showed that her son had been drinking prior to a motor vehicle accident where the cause of death was stated to be “blunt force trauma to the head and chest” and “accidental.” Her son’s blood ethanol level was .401% and urine ethanol level was .503%. Reliastar’s doctor, Dr. Brad Heltemes, opined that legal intoxication is defined as .08% ethanol so the insured’s level was 5 times above the legal limit. The AD&D policy excludes payment for deaths caused directly or indirectly by the insured’s intoxication. The court found that the administrative record contains adequate, uncontradicted evidence that the insured’s accident and injuries were caused directly or indirectly by his intoxication and ReliaStar’s denial of Plan benefits pursuant to the Intoxication Exclusion was proper.

[Giacomini v. Standard Ins. Co., No. 14-CV-533-WMC, 2015 WL 5440664 \(W.D. Wis. Sept. 15, 2015\)](#). Standard Insurance Company did not abuse its discretion in denying accidental death benefits for the death of an insured that it determined was fatally injured as a result of operating an ATV while intoxicated. Standard’s decision was based on law enforcement reports and opinions from multiple physician consultants.

In [Urlacher v. Life Ins. Co. of N. Am., No. 14-CV-0952, 2015 WL 1898286 \(E.D. Wis. Apr. 27, 2015\)](#), Plaintiffs filed suit against LINA and Landmark (decedent’s employer) related to group life insurance benefits under a policy that the insured had not converted after her coverage terminated. The policy allows participants to convert their group coverage to individual coverage by submitting a conversion application and paying a premium within 31 days of coverage ending but if a participant does not receive timely notice of her conversion rights, “the conversion period will be extended,” but “[i]n no event will the conversion period be extended beyond 90 days.” The parties dispute on when the 90-day period starts. The court determined that resolution of this issue did not matter since even under Plaintiffs’ interpretation they are not entitled to benefits.

The policy provides benefits if a participant dies after the 31-day period (but during the extended conversion period) if the participant filed a conversion application and paid the required premium, which the insured did not do. The court dismissed the claim against LINA but did not dismiss the claim of breach of fiduciary duty against Landmark. Plaintiffs alleged that they contacted Landmark twice during the conversion period to request beneficiary forms and to confirm the dollar amount of the life insurance benefits but Landmark failed to advise Plaintiffs of the need to convert the life insurance coverage. The court found that the facts alleged in the complaint state a plausible claim that Landmark, in its capacity as plan administrator, breached its fiduciary duty to communicate material information regarding the need to convert and its breach caused the insured's conversion period to lapse.

#### H. Eighth Circuit

[Hall v. Metro. Life Ins. Co., No. CIV. 13-3163 MJD/BRT, 2015 WL 5472551 \(D. Minn. Sept. 16, 2015\)](#). In a lawsuit against MetLife for its denial of accidental death and dismemberment benefits, the court found that MetLife failed to provide Plaintiff with the opportunity for a full and fair review and remanded the matter to MetLife for further proceedings. The court found that MetLife's denial letters were a confusing amalgam of shifting bases for denial, particularly in light of Plaintiff's pro se status during the administrative process.

**Denial of life insurance benefits based on plan participant's failure to notify insurer of cancer diagnosis is not unreasonable.** In [Huang v. Life Ins. Co. of N. Am., No. 14-3401, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5155365 \(8th Cir. Sept. 3, 2015\)](#), Plaintiff, a life insurance beneficiary, brought suit against Life Insurance Company of North America (LINA), when it denied benefits for her deceased husband based on his failure to notify LINA of the cancer diagnosis he received after applying for benefits but before the policy was issued. The court held that the administrator reasonably determined that the delivery of the plan application to the beneficiary during the claims process satisfied the plan's delivery requirement. The court further held that reliance on an oral representation made by a LINA representative that the husband would qualify for coverage upon submission of the application was not reasonable, and thus administrator did not breach its fiduciary duty. Lastly, the court held that the application and summary plan description adequately and fairly presented the requirements for supplemental insurance, and thus the application did not amount to breach of LINA's fiduciary duty. Here, the application was a short, 2½-page document that stated that an applicant "may need to provide more medical info," "may need to take medical tests and report the results," and "must report any change in ... health that happens before the insurance is effective." The court noted that this duty was not buried in a lengthy document nor hidden in text smaller than the balance of document.

In [\*Mitchell v. Robinson\*, No. 1:11CV130 SNLJ, 2015 WL 1650871 \(E.D. Mo. Apr. 14, 2015\)](#), the court held that MetLife's decision to pay the decedent's husband death benefits was supported by substantial evidence and granted summary judgment in its favor. In this case, Plaintiffs allege a claim of wrongful death against Robinson for killing the decedent; however, MetLife paid benefits to Robinson following an investigation where a police captain informed MetLife that Robinson was not the aggressor and inadvertently shot the decedent while trying to shoot at the person breaking into the residence.

#### I. Ninth Circuit

In [\*SUSAN SALYERS, Plaintiff, v. METROPOLITAN LIFE INSURANCE COMPANY, Defendant.\*, No. CV 14-7490 PA \(JCX\), 2015 WL 4779243 \(C.D. Cal. Aug. 14, 2015\)](#), Plaintiff brought suit for payment of supplemental life insurance benefits for her now-deceased spouse in the amount of \$250,000. The Plan specified that Evidence of Insurability (statement of health) was required for any insurance over \$50,000. The employer deducted premiums from Plaintiff's paycheck based on the higher level of coverage but the spouse never completed a statement of health. MetLife paid only \$30,000 in death benefits and denied Plaintiff's claim for the \$250,000 benefit. The court concluded that because there is no ambiguity in the Plan documents such that reasonable persons could disagree as to their meaning or effect, MetLife is not estopped from asserting the evidence of insurability requirement. Although the court found the collection of premiums in these circumstances was unjust to Plaintiff, absent some additional showing that MetLife acted knowingly and intentionally to allow for coverage regardless of the requirements for evidence of insurability, Plaintiff's waiver argument must fail.

**Death from Deep Vein Thrombosis developed after a long flight is not an "accident" under accidental death benefit policy.** In [\*Williams v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA\*, No. 13-55719, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4080909 \(9th Cir. July 7, 2015\)](#), the Ninth Circuit affirmed the district court's grant of summary judgment in favor of the life insurance company, where it denied accidental death benefits for the sudden death of Jack Williams as a result of Deep Vein Thrombosis ("DVT") shortly after he completed roughly 28 hours of air travel in a five-day period. Defendant determined that Williams' death did not result from an "accident" under the terms of the policy. The plan defines Injury as bodily injury: "(1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body ... (2) which occurs under the circumstances described in a Hazard applicable to that person; and (3) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss under a Benefit applicable to such Hazard." The court concluded that no person of average intelligence and experience would find that Williams died "as a direct result of an unintended, unanticipated accident that is external to the body."

In [\*Life Ins. Co. of N. Am. v. Sorilla\*, No. CV-14-01797-PHX-DGC, 2015 WL 3407468 \(D. Ariz. May 27, 2015\)](#) (Not Reported in F.Supp.3d), the insured had completed a beneficiary designation form which contained a box for designating a beneficiary for the basic life insurance and a separate box for designating a beneficiary for the voluntary life insurance. The insured designated Sylvia Sorilla as the beneficiary of his basic life insurance, but left the beneficiary designation for the voluntary life insurance blank. Based on that form, LINA concluded that the insured had not designated a beneficiary for the voluntary life insurance and determined that the insured's brother, Jose Matus, was entitled to the benefits according to the policy's preference clause. The court found as a matter of law that LINA's decision to award the benefits to Jose Matus was proper under the life-insurance policy.

**Insurer can rescind an ERISA policy based on a material misrepresentation about a participant's employee status.** In [\*Guardian Life Ins. Co. of Am. v. Gabrielian & Associates Ins. Servs., Inc.\*, No. 13-55217, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 576831 \(9th Cir. Feb. 12, 2015\)](#), the Ninth Circuit Court of Appeals found that the district court did not err in finding that Guardian Life had the right to rescind an ERISA policy based on material misrepresentation of a participant's status as an employee. The participant failed to qualify as an ERISA employee under the *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318 (1992), factors, because the employer did not "control the manner and means by which" she worked: she worked in a separate physical location and appeared to control her work hours; the employer did not provide her with any tools or instrumentalities; they worked together for at most only four months; and the participant was paid only by commission. Because the participant was not an ERISA employee, the employer's claim to the contrary constituted a material misrepresentation. Had Guardian Life known that the participant was not an "employee" for ERISA purposes, it likely would not have issued the policy in the first instance. Appellants argued for the first time on appeal that California law, not ERISA, should govern the policy at issue, but the court found this choice-of-law question waived since it was not timely raised in the district court.

In *Becker v. Mays-Williams*, No. 13-35069, \_\_\_F.3d\_\_\_, 2015 WL 348872 (9th Cir. Jan. 28, 2015), the 9<sup>th</sup> Circuit Court of Appeals considered an issue of first impression: whether beneficiary forms constitute "plan documents" described in 29 U.S.C. § 1104(a)(1)(D). In this case, the decedent had previously designated his then wife as a beneficiary under two benefit programs that Xerox maintained for its employees. Following his divorce, he attempted to change his designated beneficiary to his son from an earlier marriage. Specifically, on a few occasions the decedent "telephonically undesignated" his ex-wife as his beneficiary and indicated that he wanted his son as beneficiary instead. In each instance, following the telephone

conversation with Xerox, the decedent, received, but did not sign and return, beneficiary designation forms requesting that he confirm his selection of his son as beneficiary. After he died, the ex-wife and son put in competing claims for benefits. Xerox interpleaded the two parties and the district court found in favor of the ex-wife since the decedent had not completed and returned the designation forms.

In reversing the grant of summary judgment to the ex-wife, the court found that nothing in the record indicates that the beneficiary designation forms themselves constituted, or were in any way incorporated into, governing plan documents. Therefore, the district court erred in determining that the decedent was required to abide by the language contained in the forms—but not in the governing plan documents—to change his beneficiary designation to his son. Because the Plan filed an interpleader action and declined to exercise any discretionary authority, the court reviewed *de novo* whether the ex-wife or son is entitled to plan benefits—a question answered by reference to the governing plan documents. The inquiry for the court was whether the decedent strictly or substantially complied with the governing plan documents. The court noted that such an inquiry is one of state law and one that implicates the decedent’s intentions. Nothing in the governing plan documents prevents unmarried participants from designating beneficiaries by telephone call and the Plans’ SPDs instruct unmarried participants to call the Xerox Benefits Center or to visit the Xerox website in order to change or to complete a beneficiary designation. The court found that the governing plan documents permit unmarried participants to change their beneficiary designations by telephone. The court concluded that a reasonable trier of fact could determine that the decedent intended to change his beneficiary and his phone calls to Xerox constituted substantial compliance with the governing plan documents’ requirements for changing his beneficiary designation.

#### J. Tenth Circuit

In [\*The Claudia Nelson Family Trust v. Hartford Life & Accident Ins. Co.\*, No. 14-CV-2092-WJM-KLM, 2015 WL 4113764 \(D. Colo. July 8, 2015\)](#) (**Not Reported in F.Supp.3d**), the court held that Hartford did not exercise its discretion arbitrarily or capriciously by interpreting “regularly scheduled vacation day” to exclude individuals on medical leave and thus finding that the participant did not meet the supplemental life insurance policy definition of “Actively at Work.” Because the Plaintiff Trust did not establish an unbroken chain of regularly scheduled vacation days or holidays (i.e., non-medical leave days) from September 7, 2012, until January 1, 2013, the court upheld Hartford’s denial of supplemental life benefits.

In [\*Shafer v. Metro. Life Ins. Co.\*, No. 14-CV-00656-RM-KMT, 2015 WL 4055473, at \\*7 \(D. Colo. July 2, 2015\)](#) (**Not Reported in F.Supp.3d**), the court found that the decedent had notice of the 2012 MetLife Policy’s Actively at Work requirement and MetLife did not arbitrarily and

capriciously deny Plaintiff's claim for benefits under the 2012 MetLife Policy in excess of \$873,000 plus interest.

K. Eleventh Circuit

In [Lubin v. AT&T Ret. Sav. Plan, No. CV1481263CIVSCOLA, 2015 WL 4397703 \(S.D. Fla. July 17, 2015\)](#), the court found that AT&T Retirement Savings Plan's decision to follow its ERISA plan's default beneficiary rules in paying life-insurance benefits to the daughter of a deceased employee was correct. The employee's sisters challenged that decision because the employee's daughter had been adopted by her step-father. When interpreting ERISA plans, courts turn to the law of trusts, within which is the principle of contract interpretation known as *expressio unius est exclusio alterius* (the express mention of one thing excludes all others). This doctrine instructs "that when certain matters are mentioned in a contract, other similar matters not mentioned were intended to be excluded." Here, the Plan documents state that a child is a person "related by birth or by adoption and not through marriage." Plaintiffs asked the Court to read this passage as stating that a child is a person related by birth or by adoption and not through marriage, unless the person related by birth was later adopted away from the plan participant. The court declined to do so and found that the Plan provides a complete list of who is, and who is not considered a child. Since the category of persons who are not children is limited to persons related through marriage, the Court may not read in an additional category of persons who are not children (i.e., persons who are related by birth but who are later adopted away).

In [Moceri, estate of v. Ratner Companies, LC, No. 2:14-CV-579-FTM-29CM, 2015 WL 1538109 \(M.D. Fla. Apr. 7, 2015\)](#), MetLife did not notify the employee of her right to continue her life insurance policy following termination of employment until months after her termination and two days after the employee passed away. The court granted MetLife's motion to dismiss the estate's breach of fiduciary duty claim, finding that there is no statutory basis for MetLife's duty to inform the employee of her continuance rights. Further, the policy also does not require that MetLife issue written notice of continuance rights. The court dismissed the claim without prejudice and with leave to amend.

In [Bruce-Thomas v. Hartford Life & Acc. Ins. Co., No. 6:14-CV-1194-ORL-37, 2015 WL 736350 \(M.D. Fla. Feb. 20, 2015\)](#), the court granted Hartford's motion for summary judgment on Plaintiff's claim for life insurance benefits, where the insured died due to an overdose of Oxycodone and Alprazolam and the policy provides death benefits if the insured dies from an "injury." The policy excludes payment of death benefits where the death results from sickness or disease or medical or surgical treatment of a sickness or disease. The court found that medical

treatment of a condition includes death caused by accidentally overdosing on a drug prescribed by a doctor for a medical condition. Here, it was uncontested that the insured died from an accidental overdose of medications prescribed by the insured's doctor to treat his chronic pain, cervical radiculopathy, and anxiety. Further, the conditions for which the insured was prescribed medication—chronic pain, cervical radiculopathy, and anxiety – constitute a “sickness or disease.”

## XII. *Medical Benefit Claims*

### A. U.S. Supreme Court

**Affordable Care Act tax credits are available in States that have a Federal Exchange.** In [\*King v. Burwell\*, No. 14-114, \\_\\_\\_ S.Ct. \\_\\_\\_, 2015 WL 2473448 \(U.S. June 25, 2015\)](#), Virginia residents who did not want to purchase comprehensive health insurance brought an action challenging the IRS final rule implementing the premium tax credit provision of the Patient Protection and Affordable Care Act (ACA). The rule authorized tax credits not only for purchases on state-established health insurance exchanges, but also purchases on exchanges established by federal government if States did not establish exchanges. Virginia has a Federal Exchange. Petitioners argued that Virginia's Exchange does not qualify as “an Exchange established by the State under [42 U.S.C. § 18031],” so they should not receive any tax credits. Without the tax credits, the cost of buying insurance would be more than eight percent of their income, which would exempt them from the Act's coverage requirement. The question presented was whether the Act's tax credits are available in States that have a Federal Exchange. The Court held that the Supreme Court would not give Chevron deference to the IRS interpretation of the ACA, and the ACA authorized tax credits for health insurance purchased from federally-established exchanges.

The majority explained that Congress based the Affordable Care Act on three major reforms: first, the guaranteed issue and community rating requirements; second, a requirement that individuals maintain health insurance coverage or make a payment to the IRS; and third, the tax credits for individuals with household incomes between 100 percent and 400 percent of the federal poverty line. In a State that establishes its own Exchange, these three reforms work together to expand insurance coverage, minimize adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. Under petitioners' reading, without the tax credits, the coverage requirement would apply to significantly fewer individuals and only one of the Act's three major reforms would apply in States with a Federal Exchange. The Court explained that this “could well push a State's individual insurance market into a death spiral” and it “is implausible that Congress meant the Act to operate in this manner.”

B. First Circuit

In [Stephanie C. v. Blue Cross, No. CIV.A. 13-13250-DJC, 2015 WL 1443012 \(D. Mass. Mar. 29, 2015\)](#), the court determined that BCBS's decision to deny residential treatment was supported by substantial evidence. The Plan clearly requires that: (1) treatment be furnished in the "least intensive" type of medical care setting that is appropriate; (2) no benefits will be provided for services "furnished along with [a] non-covered [service],"; and (3) coverage of acute residential treatment does not include residential "educational" programs or psychotherapy services provided along with such programs. The court found that there is substantial evidence in the administrative record to support BCBS's conclusion that Gateway provided its mental health services in an educational setting. As such, denial of the Gateway residential treatment claims was rational even if only based on the fact that the Plan did not allow for benefits performed at educational facilities. The treatment was also not "medically necessary," because the reviewing doctors each concluded independently that at the time the patient was admitted to Gateway he did not have acute symptoms or severe impairment and was not a chronic or persistent danger to himself or others.

C. Second Circuit

**Denial of mental health treatment is not a violation of Plan terms and Plan can recoup overpayment.** [Tedesco v. I.B.E.W. Local 1249 Ins. Fund, No. 14-CV-3367 KBF, 2015 WL 6509039 \(S.D.N.Y. Oct. 28, 2015\)](#) (Judge Katherine B. Forrest). The court found that Defendants' denial of coverage for certain providers (for treatment of OCD and mental illnesses) was not a violation of Plan terms. The court also found that Plaintiff did not demonstrate that Defendants' requirement that Plaintiff recertify the need for continued visits to her psychiatrist violates the Mental Health Parity and Addiction Equity Act of 2008. Further, Plaintiff did not exhaust her claim that Defendants' recouping of "overpayment" funds from Plaintiff is an unlawful set-off because it violates Plan terms. With respect to Defendants' counterclaim, the court found that the Plan plainly states that the Fund is entitled to recoupment of overpayments.

**Denial of residential treatment for substance abuse affirmed.** [Tansey v. Anthem Health Plans, Inc., No. 14-3931, Fed.Appx. \\_\\_\\_, 2015 WL 5999320 \(2d Cir. Oct. 15, 2015\)](#) (DENNIS JACOBS, RAYMOND J. LOHIER, JR., Circuit Judges and GEOFFREY W. CRAWFORD,\* District Judge). The court affirmed the grant of summary judgment in favor of Defendant on Plaintiff's claim for residential treatment in a substance abuse facility. The court found that the denial of benefits was not arbitrary and capricious where four physicians opined that residential rehabilitation treatment was not medically necessary—including one outside consultant and one

consultant retained by an independent, impartial review organization, with no connection to Anthem.

[\*Biller v. Excellus Health Plan, Inc.\*, No. 3:14-CV-0043 GTS/DEP, 2015 WL 5316129 \(N.D.N.Y. Sept. 11, 2015\)](#). The court dismissed Plaintiff's ERISA claim for benefits and breach of fiduciary duty claims against Defendants for their denial of her health insurance claim for \$16,419.15 for an air ambulance to transport her from Robert Packer Hospital in Sayre, Pennsylvania, to the Cleveland Clinic in Ohio.

D. Third Circuit

**Contraceptive mandate does not substantially burden non-religious pro-life organization's freedom of religion.** [\*Real Alternatives, Inc. v. Burwell\*, No. 1:15-CV-0105, 2015 WL 8481987 \(M.D. Pa. Dec. 10, 2015\)](#) (Judge John E. Jones III). Plaintiff Real Alternatives is a non-profit, non-religious, pro-life organization that has excluded contraceptive care from its health insurance plan. The plan to which it subscribed was cancelled by its insurance provider and it alleges that the ACA's Contraceptive Mandate caused its insurer to no longer be willing to omit contraceptive care from coverage. Real Alternatives sought a judgment declaring the Contraceptive Mandate and its application to Plaintiffs to be a violation of the Fifth Amendment, the APA and Religious Freedom Restoration Act ("RFRA"). Plaintiffs also sought a permanent injunction ordering Defendants to offer the religious employer exemption to organizations such as Real Alternatives that hire employees who share their beliefs. The court denied Plaintiffs' motion for summary judgment, finding that their RFRA claim fails. Even if Plaintiffs have standing to bring the claim, they have not alleged a substantial burden to their exercise of religion. Even if they had, the government has articulated a compelling interest in a broadly applicable system of health care, in order to advance public health and gender equality. The court found that Plaintiffs have proposed no less restrictive means to administer that system, but even if a less restrictive means existed, it would substantially hamper the government's ability to most effectively achieve compelling interests.

In [\*Prof'l Orthopedic Associates, PA v. CareFirst BlueCross BlueShield\*, No. CIV.A. 14-4486 MAS, 2015 WL 4025399 \(D.N.J. June 30, 2015\)](#), a claim by a healthcare provider, a professional medical association, and an individual patient, to recover medical benefits under a health insurance plan, the court concluded that the anti-assignment provision in the benefit plan is valid and enforceable. Because the assignments upon which Plaintiffs rely are void, the provider and association are not beneficiaries under the Plan, and they lack standing to bring their claims. With respect to the individual's claims, the court found no indication that, to the extent that Count I attempts to assert both a breach of fiduciary duty claim and section 502(a)(1)(B) claim

for benefits, the fiduciary duty claim is distinct from the benefits claim. Because the fiduciary duty claim does not seek any additional relief otherwise not provided for by section 502(a)(1), the court found that it cannot stand.

E. Fourth Circuit

**Procedural irregularities in claims decision results in remand to the claims administrator to begin the review process anew.** [Boyd v. Sysco Corp., et al., No. 4:13-CV-00599-RBH, 2015 WL 7737966 \(D.S.C. Dec. 1, 2015\)](#) (Judge R. Bryan Harwell). In this matter where Plaintiff seeks coverage for mental health/substance abuse benefits under the Sysco Corporation Group Benefit Plan for treatment he received at a residential rehabilitation program, the court remanded to the claims administrator to consider the administrative record and the relevant plan provisions and internal guidelines for the correct year and begin the review process anew. The Court agreed with the defendants that the effect of any procedural irregularities would be to excuse a failure by a claimant to exhaust administrative remedies and possibly to remand the case, rather than to change the standard of review to *de novo*. The court found that an abuse of discretion standard would apply to a review of the matter on its merits but due to the court's concern regarding irregularities in the administrative review process by the claims administrator, UBH, it remanded the matter. The court found that the claims administrator did not process the claim on time, denied Plaintiff a full and fair review by omitting documents from the administrative record, and failed to comply with the procedural requirements of ERISA.

**Court grants in part and denies in part motion to dismiss lawsuit and addresses issues of preemption, breach of fiduciary duty, exhaustion, and standing.** [Rogers v. Unitedhealth Grp., Inc., No. 2:15-CV-01736-DCN, 2015 WL 6462716 \(D.S.C. Oct. 26, 2015\)](#) (Judge David C. Norton). In a lawsuit brought by a plan participant and his spouse against United for payment of rehabilitative care to treat septicemia, the court ruled on United's motion to dismiss all claims as follows: (1) Plaintiffs' state law claims are preempted by ERISA; (2) Plaintiffs failed to state a claim for breach of fiduciary duty under 29 U.S.C. § 1109 because they only seek individual recovery rather than monetary relief on behalf of the group health plan; (3) although the participant did not exhaust his administrative remedies, it would have been futile under the circumstances and because it is not apparent from the face of the complaint that the affirmative defense applies, the motion is denied; and (4) because the court dismissed the state law claims and counsel conceded that the spouse would no longer have standing to pursue the ERISA claims, the court granted United's motion with respect to the spouse's claims.

[Dewhurst v. Century Aluminum Co., No. CV 2:09-1546, 2015 WL 5304616 \(S.D.W. Va. Sept. 9, 2015\)](#). In a certified class action challenging the termination of retiree medical benefits, the

court granted summary judgment in favor of Defendant. The relevant CBAs provide materially as follows:

The Group Insurance Benefits shall be set forth ... in booklets entitled Employees' Group Insurance Program and Retired Employees' Group Insurance Program, and such booklets are incorporated herein and made a part of this ... Labor Agreement by such reference.... It is understood that this Agreement with respect to insurance benefits is an agreement on the basis of benefits and that the benefits shall become effective on [the various CBAs' effective dates], except as otherwise provided in the applicable booklet, and further that such benefits shall remain in effect for the term of this ... Labor Agreement.

The court found that the language is clear and unambiguous that the retirees' healthcare benefits remained in effect for the term of the applicable CBA. The court found no basis to conclude those benefits vested beyond the term of each CBA. The court also found support of this reading of the CBA in the collective bargaining history.

In [\*Bryson v. United Healthcare Ins. Co.\*, No. 3:15-CV-00142-FDW, 2015 WL 4026009 \(W.D.N.C. July 1, 2015\)](#), Plaintiff brought ERISA and non-ERISA claims against Defendants for their refusal to pay \$82,419.24 in medical expenses incurred by Plaintiff during a time in which he was employed by Defendant Connexions and was the named insured under a health insurance policy with Defendant United Healthcare. The court declined to dismiss the non-ERISA claims because the Complaint contains sufficient factual material, which, if true, may support Plaintiffs' claims that the Plan is not covered by ERISA. The court dismissed the ERISA breach of fiduciary duty claim because adequate relief is available for Plaintiffs' injury through review of Plaintiff's individual benefits claim under § 1132(a)(1)(B). The court also dismissed Plaintiff's claim under § 1133 for denying him a full and fair review since this provision does not provide for a separate cause of action for a violation of administrative remedies.

#### F. Fifth Circuit

**Waiver under Settlement Program is valid and precludes claims related to workplace injury.** [\*Castillo v. Tyson Foods, Inc.\*, No. CIV.A. H-14-2354, 2015 WL 6039236 \(S.D. Tex. Oct. 15, 2015\)](#) (Judge Lee H. Rosenthal). The court found that Plaintiff's claims against Tyson are precluded by her participation in Tyson's Workplace Injury Settlement Program and her agreement to accept benefits under that program. Plaintiff was born in Mexico, has a sixth-grade education, and cannot speak English. She was injured at a Tyson food-processing plant in Houston, Texas when a machine fell on her hand and pulled it into a vat while she held a nylon bag underneath a dumper (a machine that deposits chicken into a vat for processing). The court declined to strike an affidavit by a Tyson nurse, wherein she attested that she provided Plaintiff with the Program's SPD and acceptance-and-waiver form in Spanish and thoroughly explained

the terms to her before Plaintiff signed the waiver without any questions. The court found that the waiver was knowing and voluntary, specified the true intent of the parties, and was conspicuous and on the face of the agreement. The court also found that it was statutorily and contractually valid and that there was no procedural or substantive unconscionability.

[Brooks v. Ryder Sys., Inc., No. CIV.A. H-14-2153, 2015 WL 5734704 \(S.D. Tex. Sept. 30, 2015\)](#). In a suit challenging the denial of medical and wage replacement benefits, the court found that PartnerSource did not abuse its discretion in finding on the record before it that Plaintiff had missed two appointments and that his medical benefits should therefore be terminated based on the Plan's requirements. The court also found that no Plan provision or any legal authority establishes that Plaintiff would be entitled to wage replacement benefits under the Plan if his termination was wrongful. Instead, under the plain language of the Plan, Plaintiff's entitlement to wage replacement benefits only lasted until termination of his employment.

In [Hamsher v. N. Cypress Med. Ctr. Operating Co., No. 14-20576, Fed.Appx. , 2015 WL 4547720 \(5th Cir. July 29, 2015\)](#), the self-funded health plan required "prior-authorization" as an absolute precondition to reimbursement for certain services. Both inpatient and outpatient hospital services must be prior-authorized. The Plan defines "[h]ospital" to include "[a] facility operating legally as a psychiatric [h]ospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates. The court found that the administrative record is essentially silent as to the nature of the participant's treatment at a facility called Timberline Knolls Residential Treatment Center. Further, there was no information as to whether Timberline is a "hospital" as defined under the Plan. Although, the name is suggestive, the title alone does not constitute the type of "substantial evidence" that Defendant must put forward. The court found that Defendant had its chance to create a record showing that the participant received services at a "hospital" but failed to do so. As a result, the court reversed the judgment of the district court and remanded for entry of judgment in favor of Plaintiff.

**Religious Freedom Restoration Act's requirement regarding contraceptive services is not a substantial burden.** In [E. Texas Baptist Univ. v. Burwell, No. 14-10241, F.3d , 2015 WL 3852811 \(5th Cir. June 22, 2015\)](#), a consolidated matter challenging the Religious Freedom Restoration Act ("RFRA")'s requirement that religious organizations either offer their employees health insurance that covers certain contraceptive services or submit a form or notification declaring their religious opposition to that coverage, the Fifth Circuit reversed the district courts' holding that the requirement violates RFRA or, in one case, that Plaintiffs had demonstrated a substantial likelihood of establishing that it does. The Fifth Circuit found that Plaintiffs have not

shown and are not likely to show that the requirement substantially burdens their religious exercise under established law. The court considered the extent to which the courts defer to a religious objector's view on whether there is a substantial burden. The inquiry has three components: (1) What is the adherent's religious exercise? (2) Does the challenged law pressure him to modify that exercise? (3) Is the penalty for noncompliance substantial? With respect to the second question, the court agreed with its sister circuits that have considered contraceptive-mandate cases: the court makes the decision as to whether the challenged law pressures him to modify that exercise. The court found that although Plaintiffs have identified several acts that offend their religious beliefs, the acts they are required to perform do not include providing or facilitating access to contraceptives. Further, Plaintiffs have no right under RFRA to challenge the independent conduct of third parties. Because the court did not find substantial burden, the court did not reach the strict-scrutiny prong or the other requirements for an injunction.

G. Sixth Circuit

H. Seventh Circuit

[Perry v. Toyota Motor Engineering & Manufacturing Health and Welfare Benefit Plan, No. 315CV00072RLYWGH, 2015 WL 7454669 \(S.D. Ind. Nov. 23, 2015\)](#) (Judge Richard L. Young). The court found that Defendant's decision denying Plaintiff medical benefits for the period of January 1, 2012 to November 20, 2014 was not an abuse of discretion. Plaintiff's long-term disability benefit claim was terminated in July 2009 and reinstated November 2014. At the time his benefits were terminated, Plaintiff and his dependents had been entitled to continued medical benefits by virtue of his eligibility for disability benefits. The medical benefit plan was amended in 2012 to exclude medical benefit coverage for when LTD benefits are awarded retroactively. The court found that it is undisputed that Plaintiff was not eligible for medical benefit coverage at the time the 2012 Plan was published and that he was awarded LTD Benefits retroactively. Thus, under the plain language of the 2012 Plan, Plaintiff is not entitled to medical benefits for the period January 1, 2012 to November 20, 2014 and his medical benefits did not vest during that time period.

**Court rejects Catholic university's ERISA arguments in action seeking to enjoin part of ACA which requires contraceptive coverage.** In [Univ. of Notre Dame v. Burwell, No. 13-3853, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 2374764 \(7th Cir. May 19, 2015\)](#), the Seventh Circuit held that nonprofit Catholic university that brought suit against the Secretary of Health and Human Services to enjoin enforcement of part of the Affordable Care Act (ACA) requiring employers to provide employees with health insurance that covered contraceptive services failed to establish likelihood of success on the merits. The ACA states that "if the eligible organization provides a copy of the

self-certification [EBSA Form 700] of its objection to administering or funding any contraceptive benefits ... to a third party administrator [Meritain], the self-certification shall be an instrument under which the plan is operated, [and] shall be treated as a designation of the third party administrator as the plan administrator under section 3(16) of ERISA for any contraceptive services required to be covered under § 2590.715–2713(a)(1)(iv) of this chapter to which the eligible organization objects on religious grounds.” 29 C.F.R. § 2510.3–16(b). Notre Dame argued that had it not filled out the EBSA Form 700, Meritain wouldn’t have been authorized to provide contraceptive services because it would have been a “plan administrator” under section 3(16), and thus not a plan fiduciary entitled to make expenditures (as for contraception coverage) on behalf of the plan. Notre Dame further argued that it alone is authorized to designate a plan fiduciary, and that it made that designation in the form that it mailed to the company and thus is complicit in the provision of contraceptives to the university’s staff. The court found that Notre Dame’s “triggering” argument does not apply to Aetna, which is the students’ health insurer and so already a plan fiduciary required by the ACA to provide contraceptive coverage to plan members whether or not Notre Dame signs the form. The court also found that Notre Dame has not been ordered to name Meritain as a plan fiduciary. Rather, the signed form “shall be treated as a designation of the third party administrator as the plan administrator under section 3(16) of ERISA for any contraceptive services required to be covered.” 29 C.F.R. § 2510.3–16(b). The treatment and designation is by the government, not the university.

In *King v. Blue Cross and Blue Shield of Illinois*, Case No.: 3:13-CV-1254-CAB-JMA (S.D. Cal. May 14, 2015), the court determined, among other things, that the medical plan’s Lifetime Maximum Benefit does not violate the Patient Protection and Affordable Care Act. (This opinion has not been picked up by Westlaw but I can email you a PDF of the Order upon request.)

In [\*Burnick v. Office & Prof’l Employees Int’l Union\*, No. 14-C-1173, 2015 WL 1898310 \(E.D. Wis. Apr. 27, 2015\)](#), Plaintiff brought suit against both Local 35 and the Office and Professional Employees Union (“OPEIU”) to enforce her right to life, dental, vision, and health insurance coverage. OPEIU filed a motion to dismiss, which the court granted. The court determined that the Plan was created by the collective bargaining agreement between Local 35 and the Employees Union, and possibly also a 2008 letter agreement. OPEIU was not a party to any of these agreements and OPEIU never assumed any obligations created by those agreements. Thus, OPEIU’s payment of some of Plaintiff’s insurance premiums without assuming any continuing obligation to do so did not transform it into a plan sponsor that is liable for continuing to provide vested benefits.

I. Eighth Circuit

**Blue Cross did not abuse discretion by denying coverage of autologous stem-cell transplantation for multiple sclerosis.** [Wenzel v. Blue Cross Blue Shield of Minnesota, No. CV 14-4739\(DSD/HB\), 2015 WL 6549594 \(D. Minn. Oct. 28, 2015\)](#) (Judge David S. Doty). Blue Cross denied Plaintiff with relapsing/remitting multiple sclerosis (MS) coverage for a medical procedure known as autologous stem-cell transplantation (ASCT). ASCT is not approved for FDA marketing and is currently in phase III clinical trials. Blue Cross’s medical director reviewed the MPM II–121, which notes that ASCT “is not established in MS.” The court found that the MPM II–121 reasonably explains why ASCT is too underdeveloped to be considered non-investigative for any patient. The court also found that Blue Cross did not have to defer to the treating doctor’s conclusions about ASCT as applied to Plaintiff. The court concluded that Blue Cross’s interpretation of the Plan and subsequent classification of Plaintiff’s ASCT treatment as “investigative” was reasonable. The court rejected Plaintiff’s argument that Blue Cross inconsistently applied the Plan terms because other Blue Cross entities that approved ASCT for MS. Plaintiff did not demonstrate that those entities approved ASCT under the same plan terms.

In [Spizman v. BCBSM, Inc., No. 14-CV-3568MJD, 2015 WL 4569249 \(D. Minn. July 27, 2015\)](#), Plaintiffs asserted six causes of action. In Count I, Plaintiffs seek a declaration that BCBSM had an affirmative duty to notify Plaintiffs in writing of a substantial reduction in coverage from 2012 to 2013; that BCBSM’s failure so to notify rendered the 2013 reduction in coverage void; and therefore, the 2012 Certificate provides coverage for Mrs. Spizman’s home health care needs. With Count II, Plaintiffs seek declaratory judgment that the 2013 Certificate provides coverage for Mrs. Spizman’s home health care needs and requirements. Count III is a claim for benefits under ERISA based on the terms of the basic group term life insurance plan. With Count IV, Plaintiffs allege that BCBSM breached its fiduciary duty “[b]y failing and refusing to pay benefits to Plaintiffs and engaging in deceptive and fraudulent conduct.” Plaintiffs seek separate monetary compensation resulting from Defendant’s breach of fiduciary duties and other equitable relief, including future home health care coverage, as a “restitutionary monetary reward in the form of a constructive trust,” and judicial reformation of the Plan. With Count V, Plaintiffs seek a \$110–per–day penalty for BCBSM’s failure to provide relevant materials for Plaintiffs’ appeal. With Count VI, Plaintiffs seek equitable relief in the form of enforcement of the reformed plan and separate monetary compensation, asserting that statements made by BCBSM’s agent and claim representative, estop BCBSM from denying benefits to Plaintiffs. The court granted Defendant’s motion to dismiss with respect to Counts I, II, V, and VI and denied to all other counts.

J. Ninth Circuit

**Denial of initial placement of dental implants under medical benefit plan that excluded only restorative work to dental implants is an abuse of discretion.** [Dragu v. Motion Picture Indus. Health Plan for Active Participants, No. 14-CV-04268-RS, F.Supp.3d , 2015 WL 7274202 \(N.D. Cal. Nov. 16, 2015\)](#) (Judge Richard Seeborg). The court ruled in favor of Plaintiff on her claim for dental implants that the defendant health plan denied as not being a covered medical benefit. Plaintiff mangled her jaw, mouth, teeth, and gums when she tumbled down a rocky creek while hiking. She sought medical treatment for her various injuries from an oral surgeon who recommended extracting the damaged teeth, inserting bone grafts where possible, implanting fixtures for implantation of abutments and crowns, and—lastly—installing abutments and crowns as replacements for the missing teeth. Plaintiff requested coverage for the medical procedures from her medical benefit plan, which initially denied coverage for dental implants, including the implantation of fixtures and placement of abutments and crowns, on the basis that “Dental services are not covered under the Plan.” After Plaintiff appealed this determination, the Appeals Committee paid her oral surgeon for the installation of fixtures at a reimbursement rate of 50%, which was the rate available to out-of-network providers under the terms of the 2013 plan. But, with respect to her claim for the placement of crowns and abutments, the Plan offered a different reason to deny the claim: “Dental implants may be covered in cases of trauma, ablative surgery or congenital anomalies. Prosthetic rehabilitation of dental implants including abutments and crowns are not covered under the medical benefit.” The court found that the Plan misinterpreted the plain language of the medical benefit plan when it denied Plaintiff coverage for the initial placement of abutments and crowns and reimbursed her doctor at the lower rate as required by the plain language of the medical benefit agreement. The court found persuasive Plaintiff’s argument that the 2013 SPDs, which apply here, do not, in fact, exclude from the medical benefit the initial placement of abutments and crowns. The 2013 SPDs exclude “[p]rosthentic rehabilitation of dental implants including abutments and crowns,” but are silent about the initial placement of abutments and crowns. The language of the plan plainly excludes coverage for *restorative* work to existing crowns and abutments, thus the Plan’s reliance on the exclusion of prosthetic rehabilitation of dental implants was illogical and an abuse of discretion.

The Ninth Circuit affirmed the district court’s decision that Blue Cross did not abuse its discretion in interpreting the Plan as excluding coverage for treatment that it deemed “Experimental/Investigational.” The treatment was provided as part of a phase three clinical trial. [Robertson v. Blue Cross, No. 15-35304, Fed.Appx. 2015 WL 5239572 \(9th Cir. Sept. 9, 2015\)](#).

In [Barling v. UEBT Retiree Health Plan, No. 14-CV-04530-VC, 2015 WL 4623611 \(N.D. Cal. July 31, 2015\)](#), Plaintiff brought a putative class action against a health plan and related defendants alleging that they violated the terms of the ERISA plan by requiring him to pay deductibles and coinsurance during a time when Medicare served as Plaintiff's "primary payer" and the Plan served as his "secondary payer." Plaintiff also brought an individual ERISA penalties claim for the plan administrator's failure to respond promptly to his document requests. The court found that under either standard of review, Plaintiff wins because the Plan language is susceptible to only one meaning: coinsurance and deductibles are part of "Covered Expenses" and therefore the Plan could not make retirees pay them when the Plan serves as the secondary payer. The court found that the Plan improperly required him to pay deductibles but that there is no evidence that the Plan required Plaintiff to pay coinsurance. Because Plaintiff is no longer a participant in the Plan, the Plan's improper interpretation will not harm him in the future and he lacks standing to pursue a benefits claim with respect to coinsurance. The court awarded a total of \$10,000 in statutory document penalties for the Plan's year-long delay in producing the CBA and LLC Agreement and Contract.

In [Lisa O. v. Blue Cross of Idaho Health Serv. Inc., No. 1:12-CV-00285-EJL, 2015 WL 3439847 \(D. Idaho May 28, 2015\) \(Not Reported in F.Supp.3d\)](#), the court found that Defendants' conclusion that a patient's treatment was for correction of *behavioral modification*, and not *behavioral abnormality*, was reasonable given the nature of the conditions and the types of treatments provided. As such, the treatment came under an exclusion in the plan. The therapy and programming the patient participated in were geared towards modifying her behaviors arising from her anorexia, depression, self-harming, and self-harm/violent conduct. The court found that it was reasonable to conclude that those treatments were not for the purpose of addressing a mental disorder or illness as much as they were to correct behavior. The court concluded that Defendants did not abuse their discretion in denying the claim based on the exclusion and granted Defendants' Motion for Summary Judgment.

In [Lisa O. v. Blue Cross of Idaho Health Serv. Inc., No. 1:12-CV-00285-EJL, 2015 WL 3439847 \(D. Idaho May 28, 2015\) \(Not Reported in F.Supp.3d\)](#), Plaintiff sought reimbursement for expenses she incurred for her minor daughter's attendance at two boarding schools under a health benefits plan provided by her then employer. Plaintiff had signed a release agreement with her employer, which stated the following carve out, "This General Release of Claims, however, does not affect any vested rights I might have for benefits under any group medical insurance, disability, workers' compensation, unemployment compensation, or retirement program." The court agreed with the Magistrate Judge's conclusion that the "vested rights" language of the Release is ambiguous and there are disputed facts which preclude entry of summary judgment for either side on this question. Specifically, it was ambiguous whether the claims had "vested"

at the time the expenses were incurred – before the Release was signed – and there was excluded from the Release’s waiver. The court could not ascertain whether the claims sought to be recovered in this case are “vested” as defined and/or intended in the Release and whether Plaintiffs knowingly and voluntarily waived those claims as a matter of law.

In [\*Robertson v. Blue Cross & Blue Shield of Texas\*, No. CV 14-224-M-DWM, 2015 WL 1715072 \(D. Mont. Apr. 15, 2015\) \(Not Reported in F.Supp.3d\)](#), Blue Cross denied preapproval for a hemapoietic stem cell transplant to treat Plaintiff’s diffuse systemic sclerosis, a rare autoimmune disease that causes the skin and other connective tissues in the body to tighten and harden. Without treatment, the disease can attack tissues in internal organs and is fatal once it infiltrates the tissues of the lungs or heart. Blue Cross determined that the procedure is “experimental, investigational, and unproven.” The evidence in the record showed that the procedure is not “standard therapy” for severe systemic sclerosis, is still under investigation, and is associated with treatment-related mortality, but is not “in general use in the medical community” for the treatment of systemic sclerosis. The court affirmed Blue Cross’s decision but, finding that it “was legally, but perhaps not morally, reasonable.”

#### K. Tenth Circuit

**Denial of residential treatment for eating disorder affirmed.** [\*M.K. v. Visa Cigna Network POS Plan\*, No. 14-4143, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 5933591 \(10th Cir. Oct. 13, 2015\)](#) (BRISCOE, HOLMES and MORITZ, Circuit Judges). The court affirmed the district court’s determination that Defendant’s denial of coverage for residential treatment for an eating disorder was not arbitrary and capricious. Cigna’s physician, Dr. Narendra Patel, determined that inpatient residential treatment of the eating disorder was not medically necessary and that a partial hospitalization program is available to assist Plaintiff to learn coping skills to deal with bingeing, purging, and restricting. The court found that the Visa Plan Document gave the plan administrator and any appointed claims administrators, including Cigna, full power, discretion, and authority to administer the Plan and apply all of its provisions. Although the Plan required decisions regarding medical necessity to be made by “the Medical Director” and there was no evidence that a Medical Director made the decision, the court found that this procedural irregularity was nothing more than a “technicality” and Cigna substantially complied with ERISA regulations and the terms of the Plan and Summary Plan Description. In considering all of the factors, the court found that immediate admission to residential treatment was not necessary.

L. Eleventh Circuit

In [Lesnick-Oakes v. Am. Airlines, Inc., No. 15-10777, Fed.Appx. , 2015 WL 4488499 \(11th Cir. July 24, 2015\)](#), the Eleventh Circuit affirmed the district court's grant of summary judgment in favor of Defendant, finding that based on the claims record, the Plan was not "de novo wrong" in refusing to refund Plaintiff medical insurance premiums for her daughter. The Plan guidelines required Plaintiff to file a life event requesting that her daughter's medical coverage be waived within 60 days of Plaintiff's return to work. Plaintiff returned to work in 2010 and the benefits she had in place prior to her 2006 leave-of-absence, which included medical coverage for herself and her daughter, were automatically reinstated. The guidelines provide that benefit elections made during a leave-of-absence only apply for the duration of the leave-of-absence. Although Plaintiff waived medical coverage in February 2011, that waiver only applied to the duration of her January 2011 leave-of-absence; when she returned to work in March 2011, the benefits that she had in place prior to her January 2011 leave-of-absence were automatically reinstated.

In [Faison v. Donalsonville Hosp. Inc., No. 14-14939, Fed.Appx. , 2015 WL 3372192 \(11th Cir. May 26, 2015\)](#), the 11<sup>th</sup> Circuit denied affirmed the district court's denial of the Hospital's Rule 60(b) motion. Defendant denied Plaintiff insurance benefits based on an Illegal Acts exclusion from coverage and the court previously affirmed the district court's entry of judgment in favor of Plaintiff. Defendant sought relief from the judgment based on newly discovered evidence that showed that one hospital "wrote off" Plaintiff's entire medical bill to charity. The court found that Defendant did not show that Plaintiff was not still liable to the hospital for his full medical bill. The hospital explained that the charitable credit would become null and void if Plaintiff became entitled to payment from "an employee benefit plan."

XIII. *Pension Benefit Claims*

A. First Circuit

**Terms of settlement agreement and pension plan do not provide Plaintiff with the right to accrue benefit service while on disability leave.** [Vendura v. Northrop Grumman Corp., et al., No. 14-10943-WGY, 2015 WL 6085698 \(D. Mass. Oct. 16, 2015\)](#). The core dispute in this case is whether the Northrop Grumman Space & Mission Systems Corp. Salaried Pension Plan Administrative Committee properly assessed the amount of Benefit Service Plaintiff had accrued. The court found that no explicit terms of a settlement agreement grants Plaintiff any Benefit Service for time spent on disability leave and its guarantee of continued employee status

until retirement does not on its own give Plaintiff any right to Benefit Service credit during this period. The pension plan terms create a sixty-month cap on the amount of Benefit Service a Participant can receive for long term disability leave beginning after January 1, 2000. Because Plaintiff had started his leave in June 2000 and had been on leave for more than five years, this five-year maximum was added to his seven years of actual service to make up twelve years of Benefit Service. The Summary Plan Description also does not entitle Plaintiff to more years of Benefit Service and even if the SPD is ambiguous, the Plan controls and the SPD cannot alter the Court's construction of the Plan. Lastly, the court found that Defendant did not misrepresent the fact that Plaintiff could not accrue Benefit Service under the Plan.

In [\*O'Shea v. UPS Ret. Plan\*, No. CIV.A. 14-10377-WGY, 2015 WL 4205307 \(D. Mass. July 10, 2015\)](#), the court found that the Plan's determination to deny a participant's children any benefits from the retirement plan was not an abuse of discretion. O'Shea worked as a UPS employee for nearly four decades. After falling ill, he elected to retire and chose a retirement plan that would guarantee monthly payments to his children for ten years. Unfortunately, he died just one week before the date on which his retirement annuity was slated to start. Under the terms of UPS's retirement plan, because O'Shea was not actually retired at the time of his death, the court agreed with UPS that his children are not entitled to benefits.

#### B. Second Circuit

**Employer may not withhold payment of SERP benefits on the ground that they are excessive or unreasonable under New York law, federal law, or employer's articles of incorporation and by-laws.** [\*Levy v. Young Adult Inst., Inc.\*, No. 13-CV-2861 \(JPO\), 2015 WL 7820497 \(S.D.N.Y. Dec. 2, 2015\)](#) (Judge J. Paul Oetken). Defendants moved for summary judgment on the legal question of whether Plaintiff's former employer, Youth Adult Institute ("YAI") may withhold payment of Plaintiffs' ERISA benefits on the ground that they are excessive or unreasonable under New York law, federal law, or YAI's articles of incorporation and by-laws. YAI began reducing Plaintiff's SERP benefits prior to issuing payments in January 2010. In August 2011, the New York Times published an article about Plaintiff's compensation and the New York State Office for People with Developmental Disabilities signaled that it might pursue remedial action against YAI. YAI stopped making payments and hired Mercer LLC to determine whether Plaintiff's compensation was reasonable. Mercer concluded that Plaintiff's compensation was excessive and YAI contacted the IRS to report that it had paid an excess benefit to Plaintiff. The IRS sent YAI two letters disagreeing with its analysis but did not issue a decision on Plaintiff's compensation. The magistrate judge's Report and Recommendation determined that YAI could not withhold Plaintiff's compensation and recommended that the court deny its motion for partial summary judgment. Judge Netburn concluded, specifically, that (1) neither the New York Not-for-Profit Corporation Law nor the

Internal Revenue Code authorizes YAI's unilateral decision to withhold Plaintiff's benefits payments, and (2) public policy considerations do not authorize YAI to set aside the SERP as unenforceable. The court rejected YAI's objections and adopted the report in full.

**Offset of Workers' Compensation benefits from disability pension benefits proper notwithstanding subsequent repayment of WC due to third-party settlement.** [Caban v. Employee Sec. Fund of the Elec. Products Indus. Pension Plan, No. 14-4593-CV, Fed.Appx. , 2015 WL 6684688 \(2d Cir. Nov. 3, 2015\)](#) (ROBERT A. KATZMANN, Chief Judge, ROSEMARY S. POOLER, DENNY CHIN, Circuit Judges). The Second Circuit affirmed the decision of the district court granting summary judgment in favor of Defendants' on Plaintiff's claim for disability pension benefits. For the period of time Plaintiff received Workers' Compensation benefits, the Plan paid Plaintiff zero in benefits, notwithstanding that Plaintiff later had to reimburse his Workers' Compensation carrier from settlement proceeds from a third-party lawsuit. The court found that the Plan required the WC offset "in all cases," and the Joint Board's decision was neither arbitrary nor capricious; to the contrary, it was consistent with the written terms of the PTF Plan. The court also found that the Joint Board's calculation of Plaintiff's disability pension was not in error. Plaintiff contended that the Joint Board should have used the pension credit rate applicable to "A"-rated journeypersons because he was highly skilled, performed the same work as an "A"-level employee, and occasionally worked jobs that paid the "A" rate. The court agreed with the district court that the most natural reading of the Plan language is that the participant's pension benefits depend on his rate of pay and employer contribution at the time he separated from covered employment. Lastly, the court rejected Plaintiff's argument that the Joint Board failed to provide adequate notice of the reasons for its decision.

**Participant did not satisfy burden of establishing eligibility for pension benefits; no document penalty claim against Plan Administrator; and no abuse of discretion by district court in denying further discovery.** [Whelehan v. Bank of Am. Pension Plan for Legacy Companies-Fleet-Traditional Ben., No. 14-3438-CV, Fed.Appx. , 2015 WL 6603417 \(2d Cir. Oct. 30, 2015\)](#) (AMALYA L. KEARSE, RALPH K. WINTER and JOSÉ A. CABRANES, Circuit Judges). Plaintiff-Appellant asserted that genuine issues of material fact preclude a judicial determination that the denial of her claim for pension benefits by the Bank of America Benefits Appeals Committee ("Appeals Committee") was not arbitrary and capricious. The Second Circuit affirmed, finding that Plaintiff failed to establish that she became eligible for Plan benefits, participated in the Plan, and accrued a vested benefit. Rather, Plaintiff demands that Defendants produce evidence supporting her claim but this "misapprehends ERISA's assignment of burdens and the scope of judicial review." The court also found that the district court properly dismissed the breach of fiduciary duty claim under Section 502(a)(2) since she only seeks

individual relief and not relief on behalf of the plan. The court denied Plaintiff's document penalty claim because there was no evidence that Plaintiff requested documents from the Plan Administrator during the claim and appeals process. Lastly, the court found that the district court did not abuse its discretion in denying Plaintiff's request for further discovery. Plaintiff did not submit an affidavit in responding to Defendant's summary judgment motion, she just asked for it in her responsive filing. That was reason alone to deny Plaintiff's request but the court also found that the documents Plaintiff sought could not have given rise to a genuine issue of material fact since the review was limited to the administrative record.

In [\*Sullivan v. Stanadyne Corp.\*, No. 3:13-CV-01288 JAM, 2015 WL 3674751 \(D. Conn. June 12, 2015\)](#), the court found that Plaintiff's claims contending that defendants (1) wrongfully excluded certain stock option payouts and bonuses from his pensionable earnings, and (2) denied him full, unreduced early retirement benefits to which he is entitled, are barred by a release that Plaintiff signed which generally purported to discharge Defendants from liability for alleged violations of ERISA. With respect to the second claim, since it appeared to the court that a correctly pleaded claim would not be barred by the release, it permitted plaintiff to file an amended complaint.

**Divorce settlement agreement does not constitute a QDRO.** In [\*Yale-New Haven Hosp. v. Nicholls\*, No. 13-4725-CV, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3498771 \(2d Cir. June 4, 2015\)](#), the Second Circuit found that a divorce settlement agreement does not constitute a Qualified Domestic Relations Order ("QDRO") because the agreement fails to comply with the requirements of 29 U.S.C. § 1056(d)(3)(C). The "substantial compliance" rule announced in *Metropolitan Life Insurance Co. v. Bigelow*, 283 F.3d 436 (2d Cir. 2002) does not apply to domestic relations orders issued after January 1, 1985. However, the court found that two *nunc pro tunc* orders constitute valid QDROs that assign funds to the former spouse from the three retirement and pension plans named in the orders. The court rejected the argument that domestic relations orders entered after the death of the plan participant can be QDROs. Because the *nunc pro tunc* orders do not clearly specify the fourth plan, the court concluded that the orders do not assign funds from that plan to the former spouse.

**SSA's determination to review disability award every 3 years justifies denial of permanent-disability pension.** In [\*Ocampo v. Bldg. Serv. 32B-J Pension Fund\*, No. 14-0877, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3448856 \(2d Cir. June 1, 2015\)](#), the Second Circuit affirmed the district court's grant of summary judgment dismissing the complaint on the ground that the plan at issue conferred on Defendants discretion to determine eligibility for benefits and that Defendants' reliance on Social Security Administration ("SSA") determinations, policies, and procedures was not arbitrary or capricious. Plaintiff was a pension plan participant seeking a pension on the basis of permanent

disability. Defendants determined that her disability was not permanent on the sole basis that the SSA, in awarding her Social Security disability benefits, had stated that her eligibility for such benefits must be reviewed at least once every three years, rather than once every five years. 20 C.F.R. § 404.1590(d), which regulates the frequency of SSA reviews, provides that “if your disability is not considered permanent . . . we will review your continuing eligibility for disability benefits at least once every 3 years.” The court found that the Trustees’ denial of Plaintiff’s claim was subject to review under the arbitrary-and-capricious standard since the Plan conferred the Trustees discretionary authority. The court rejected Plaintiff’s contention that *de novo* review should apply because the real decision maker on her benefits application was the SSA and that the Trustees exercised no discretion but simply rubber-stamped SSA’s decisions.

**MetLife did not abuse its discretion in refusing to include approximately 2.4 million of an arbitral award as wages for purposes of calculating pension benefits.** In [\*Roganti v. Metro. Life Ins. Co.\*, No. 13-4532-CV, F.3d, 2015 WL 2251503 \(2d Cir. May 14, 2015\)](#), the 2<sup>nd</sup> Circuit reversed the district court’s grant of summary judgment in favor of the plaintiff-plan participant, in this matter where Plaintiff contended that the administrator’s failure to include an award by an arbitral panel of \$2,492,442.07 million in his favor and against his employer in his historical income when tabulating his pension violated ERISA. Plaintiff had brought arbitration proceedings against MetLife before the Financial Industry Regulatory Authority (“FINRA”), seeking, among other things, wages that he would have been paid but for the retaliatory pay reductions, as well as compensation for the decreased value of his pension, which was tied to his wages. The FINRA panel awarded Plaintiff “compensatory damages,” but its award did not clarify what that sum was compensation for. MetLife denied Plaintiff’s claim for a pension benefits adjustment because the FINRA award did not say that it was, in fact, back pay. The court held that the administrator’s refusal to include the award in Plaintiff’s historical income when tabulating his pension was not arbitrary or capricious. MetLife was not required to comb through thousands of pages of arbitration testimony in order to reverse-engineer an explanation for an arbitral award. As such, the district court erred by using this as a reason to grant less deference to MetLife’s determination on remand. The court also held that the administrator’s “categorical” conflict of interest was not entitled to any weight in the court’s assessment because there was no evidence that the conflict actually affected the decision and MetLife submitted an un rebutted affidavit that averred, among other things, that MetLife’s business and finance departments are kept completely separate from the administration of the Plans.

In [\*Sanford v. TIAA-CREF Individual & Institutional Servs., LLC\*, No. 14-1496-CV, Fed.Appx., 2015 WL 1881396 \(2d Cir. Apr. 27, 2015\)](#), the court affirmed the district court’s grant of summary judgment in favor of TIAA-CREF on Plaintiff’s claim for benefits under his deceased wife’s retirement and annuity plans. The court found that the district court did

not abuse its discretion in declining to consider evidence outside of the administrative record, where Plaintiff contended for the first time in his cross-motion for summary judgment that TIAA-CREF did not inform his then-attorney of the need to submit documents into the administrative record, but there was no affirmative evidence of a failure to notify. The court rejected Plaintiff's argument that TIAA-CREF should not have accepted the change-of-beneficiaries form reducing his percentage of benefits because his wife lacked mental capacity at the time she signed the power-of-attorney authorizing the change of beneficiaries. Further, nothing in the Plan or ERISA proscribes the use of an agent to execute any change of beneficiaries.

In [\*Hamilton v. Gen. Motors Hourly-Rate Employee's Pension Plan\*, No. 7:14-CV-00777, 2015 WL 1820686 \(N.D.N.Y. Apr. 22, 2015\)](#), Plaintiff alleged that an MOU between GM and his union, which stated that transferred employees shall bring with them their entire personnel record as though their full period of service had been at Saginaw, entitled him to additional credited service for employees who work at designated foundry locations (which included Saginaw). Defendants denied Plaintiff's claim, taking the position that the MOU was not intended to amend the Plan, the MOU language is specific to employment seniority and the employment record, and there is nothing in this or other MOU language that suggests that Plaintiff would be provided with additional foundry service for time worked at a non-foundry location. The court took into consideration the purpose of the MOU in conjunction with the MOU's noted silence on the terms of the Plan and found that Defendants' conclusion that the MOU does not alter the terms of the Plan is valid and reasonable. The court found that Defendants' characterization of the MOU as essentially a human resources agreement designed to ease employee transition between two operations is clearly reasonable under the circumstances. The court granted Defendants' motion for summary judgment as to Plaintiff's claim for improper denial of benefits. The court denied Plaintiff's breach of fiduciary duty claim as merely a restatement of his unpaid benefits claim and also denied Plaintiff's promissory estoppel claim since the MOU could have not have materially misrepresented the method by which his pension benefits would be calculated.

In [\*Pension Benefit Guar. Corp. v. Renco Grp., Inc.\*, No. 13-CV-621 RJS, 2015 WL 997712 \(S.D.N.Y. Mar. 6, 2015\)](#), the asserted a claim for ERISA reachback liability under 29 U.S.C. § 1369(a). Section 1369(a) assigns reachback liability to companies or persons who evade pension obligations by, *inter alia*, selling ownership interests in subsidiaries in order to reduce their ownership below 80%. The court determined that the inquiry relevant to determining whether Renco must face reachback liability here is whether a principal purpose of entering the Cerberus transaction was to evade liability by removing itself from RG Steel's controlled group, through a reduction of its ownership of RG Steel below 80%. In denying the cross-motions for summary

judgment, the court found that there are disputed issues of material fact precluding summary judgment in favor of either PBGC or Renco.

In [Mercedes v. Bldg. Serv. 32BJ, No. 14 CIV. 713PAC SN, 2015 WL 845729 \(S.D.N.Y. Feb. 26, 2015\)](#), court dismissed a *pro se* plaintiff's lawsuit seeking an early distribution of benefits from the defendant, a retirement savings fund. The Fund permits a payment of benefits under three circumstances: (1) upon the participant's retirement; (2) upon the participant's death; or (3) upon participant's disability or "separation from service." The Summary Plan Description also identifies these three circumstances as the only events that permit a payment of benefits and states that an employee "may not withdraw money from [his] account while [he] work[s] in covered employment. There are no loans, hardship withdrawals or other in-service withdrawals."

In [McCarthy-O'Keefe v. Local 298/851 IBT Employer Grp. Pension Trust Fund, No. 13-CV-4785 JMF, 2015 WL 783352 \(S.D.N.Y. Feb. 24, 2015\)](#), the court granted Defendants' summary judgment motion against Plaintiff, proceeding *pro se*, in this matter where Plaintiff claimed that the Fund and the Board incorrectly calculated her pension benefits. The issue was whether a 1996 settlement awarded Plaintiff a higher pension rate retroactive to her hiring date. The court found that the Board's conclusion that the settlement did not provide for such retroactive relief is likely correct, and certainly reasonable, as the text of the settlement merely stated that Plaintiff's pension "will be rolled over to the union plans effective as soon as practical" and gave no indication that the new pension rate should apply back to Plaintiff's date of hire in 1988. The court also denied Plaintiff's motion to supplement the administrative record.

### C. Third Circuit

[Crawford v. Hertzberg, et al., No. CV 15-240, 2015 WL 9304509 \(W.D. Pa. Dec. 22, 2015\)](#) (Judge Cathy Bissoon). A divorce decree, entered well before either ex-spouse filed a bankruptcy petition, is sufficient to exclude ERISA-plan proceeds from the bankruptcy estate.

[Sikora v. UPMC, et al., No. 2:12-CV-01860, 2015 WL 9288174 \(W.D. Pa. Dec. 22, 2015\)](#) (Judge Mark R. Hornak). Plan that is unfunded and maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees is a top hat plan exempt from the substantive provisions of ERISA.

**Plaintiffs sufficiently alleged anti-cutback claims with respect to pension plan amendments seeking to eliminate right to grow into “beefed up” early retirement benefits and to no longer count as “service” time spent working as an independent contractor.** [Tabor v. Allstate Insurance Company, et al., No. CV 15-2602, 2015 WL 7756188 \(E.D. Pa. Dec. 1, 2015\)](#)

(Judge S.J. Buckwalter). The court found that the complaint sets forth a sufficiently plausible claim that Allstate cut back subsidized early retirement benefits that fall within the ambit of § 204(g). The complaint alleged that prior to November of 1991, any employee agent who completed twenty years of continuous service with Allstate could receive “beefed up” early retirement benefit upon reaching age 55. The court found that the pension plan’s provision of a “benefit greater than the actuarial equivalent of the normal retirement benefit,” that was to last beyond retirement age was an accrued benefit upon its creation for purposes of § 204(g). Allstate decided to phase out and ultimately eliminate the “beefed up” benefits. While Plaintiffs may not have been eligible to receive the “beefed up” benefits until they completed twenty years of service with Allstate and reached the age of 55, that fact did not mean that their entitlement to those benefits had not accrued over time relative to their age and years of service. The court found that while Allstate could have phased out and eliminated those benefits for agents who had not yet begun working for Allstate as of the time of the November 1991 amendment, they could not deny Plaintiffs, who were employed before and remained employed after the amendments, the opportunity to “grow into” those benefits. Plaintiff also alleged that under the Pension Plan prior to the amendments, any employee agent who completed twenty years of “service” with Allstate and who attained the age of 55 was entitled to receive early retirement benefits in the event he or she retires before reaching normal retirement age. Prior to its amendments, creditable “service” included any time as either an employee agent of Allstate under a contract, or as an exclusive agent independent contractor of Allstate. The amendments purported to alter the definition of “service” to exclude any time spent as an exclusive agent independent contractor. Because the right to receive certain money on a certain date may not be affected by a condition imposed after a benefit has accrued, the court found that this claim also sufficiently pleads a claim under ERISA § 204(g).

In [O’Blenis v. Nat’l Elevator Indus. Pension Plan, No. 13-CV-5842 SRC, 2015 WL 4773092 \(D.N.J. Aug. 12, 2015\)](#), Plaintiff did not contend that he is entitled to additional pension benefits under the terms of the Plan, but rather, that he should receive additional funds due to principles of (1) equitable estoppel and (2) fiduciary duties. The court granted summary judgment to Defendants. With respect to his equitable estoppel claim, Plaintiff alleged that a union official told him he was entitled to receive his full pension benefits. However, pension calculation sheets accurately stated the amount of Plaintiff’s reduced entitlement and were not misleading. The court rejected Plaintiff’s argument that the SPD and Plan documents could have been clearer, particularly where he did not identify any ambiguity in the documents or contended that he relied on any of them when he decided to begin withdrawing pension benefits. The court also found

that Plaintiff could not reasonably rely on misinformation if he received documents that contain accurate, corrective information. Any reliance on the union official's representation was independently rendered unreasonable by each of the subsequent communications Plaintiff received from the Plan. Lastly, with respect to "extraordinary circumstances," the court found that the alleged unauthorized estimate by a union official falls far short of the extraordinary circumstances required; the record presents no indicia whatsoever of affirmative fraud, active concealment, or a long-term network of misrepresentations. On the breach of fiduciary duty claim, the court found that Plaintiff failed to demonstrate that the union official exercised any discretion over or represented the Plan. Even if Plaintiff satisfied the threshold inquiry, he would also need to demonstrate detrimental reliance, which he did not given the unambiguous and clear calculations from the Plan.

In [\*Flick v. Chartwell Advisory Grp. Ltd.\*, No. CIV.A. 14-06953, 2015 WL 4041969 \(E.D. Pa. July 2, 2015\)](#), the court dismissed Plaintiff's claim for the present value of the 401k matching payments that Defendant allegedly failed to make since his claim is premised exclusively on the terms of the Employee Handbook, which is not the plan or the summary plan description. The Employee Handbook's language does not describe plan benefits that are enforceable under ERISA. The court also dismissed Plaintiff's breach of fiduciary duty claim since Plaintiff did not show that the fiduciary's breach of its duty was a proximate cause of Plaintiff's injury. Thus, even if he was entitled to a 25% matching contribution for the first 6% he saved, he did not allege that he satisfied the precondition necessary to receive matching contributions. From his allegations, the court could not infer that Plaintiff was injured as a result of the alleged misrepresentations. Lastly, the court dismissed Plaintiff's equitable estoppel claim because he did not allege any facts suggesting he was diligent and engaged in persistent questioning about the significant benefits at stake. Because of this, the court found that he did not plausibly allege the existence of extraordinary circumstances.

**Plan administrator's interpretation of Plan resulting in actuarial reduction of benefits contrary to Plans' text violates ERISA and anti-cutback rule.** In [\*Cottillion v. United Ref. Co.\*, No. 13-4633, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 1219640 \(3d Cir. Mar. 18, 2015\)](#), Plaintiff, on behalf of a class of other terminated vested participants (TVPs) (collectively "Employees"), brought suit against United for actuarially reducing benefits they received before normal retirement age of 65. They brought a claim for benefits under ERISA Section 502(a)(1)(B) and an anti-cutback claim under Section 204(g). As a preliminary matter, the court found that the Employees were properly excused from exhausting Plan remedies because exhaustion would have been futile. Here, United had a fixed policy denying benefits as evidenced by correspondence between the Plan Administrator and many of the TVPs.

The court found that the relevant plans unambiguously afforded TVPs retirement benefits with actuarial reduction. Specifically, no provision treats TVPs differently from people who retire directly from United, and no provision requires actuarial adjustment (reduction) for taking retirement benefits early. The court found that the Plan Administrator's interpretation of the Plan improperly denied accrued benefits to the Employees. In 1988, United's understanding of the Plans accorded with the plain reading of the Plans, but by 2005, United had reinterpreted the Plans and decided that they required actuarial adjustments to the amounts paid to TVPs who took early retirement. This resulted in the improper denial of TVPs' accrued early retirement benefits and thus violated ERISA's anti-cutback rule.

The court found that United waived its objection to the district court's order to pay interest at 7.5% on the Employees' damages, but because there is some evidence that the Plan provided 7.5% as a default rate, the district court's order was not clearly erroneous. The court also found that the district court properly concluded that class members who had not yet elected to receive their benefits were entitled only to an option to start receiving properly computed benefits at the appropriate age under the Plan. If they were older than 59½ or 60, they were not entitled to receive damages in the amount of benefits they would have received had they elected to receive (properly computed) benefits as early as possible plus interest.

In [\*Silvaggio v. Cement Masons Local 526 Pension Fund\*, No. 2:12CV1605, 2015 WL 877763 \(W.D. Pa. Mar. 2, 2015\)](#), Plaintiff sought to recover the benefit of the 100% Joint and Survivor Annuity under Local 526's Pension Plan, contending that the Fund denied her benefits by reducing her survivor benefit to 50% of her husband's benefit after his death. The court granted the Fund's motion for summary judgment, finding that the Fund did not have an affirmative duty to confirm that the selections Plaintiff's husband made on the Application were in fact the selection she intended. Here, the 50% Option was checked on the Pension Application and the Plan documents require the Fund to select the 50% Option absent an election by the participant. Moreover, Domenic accepted the higher benefit paid under the 50% Option for almost twenty years without complaint.

**Summary judgment reversed and remanded where triable issue of fact remains as to whether a top-hat plan is unenforceable for lack of consideration.** In [\*Campbell v. Sussex Cnty. Fed. Credit Union\*, No. 13-4141, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 690435 \(3d Cir. Feb. 19, 2015\)](#), Plaintiff began working for Diamond State in 1983 and became a Manager/President in 1998. In 2005, she engaged a lawyer to draft a supplemental retirement-benefits plan on her behalf (the "Plan"), whose stated purpose was to reward Plaintiff for her loyal and continuous service to the Company. The Plan, which was approved by the board of directors, required Diamond State or its successor to provide lifetime health insurance benefits to Plaintiff and her

husband at its sole cost and expense upon Plaintiff's retirement from the Company. In the fall of 2007, Plaintiff resigned from Diamond State to accept a position at Sussex and Diamond State covered her health insurance benefits. In November 2008, Sussex and Diamond State entered into a merger agreement under which Sussex assumed all liabilities of Diamond State on March 31, 2009. Sussex later fired Plaintiff for alleged performance reasons and offered her COBRA coverage. Plaintiff and Sussex dispute whether or not Sussex was obligated to honor the Plan as the successor to Diamond State.

In granting Sussex's motion for summary judgment, the district court ruled that the Plan is unenforceable for lack of consideration because Plaintiff was not required to work for any additional period of time after the Plan was adopted and her past performance as an employee of Diamond State could not have served as consideration to support the formation of a contract. The 3<sup>rd</sup> Circuit disagreed and found that a reasonable trier of fact could find that the consideration for the Plan took the form of Plaintiff's continuous services and loyalty up until her actual date of retirement. Sussex made four arguments supporting affirmance of the district court's decision, each of which the court rejected as follows:

- Exhaustion of Administrative Remedies. Plaintiff was not required to exhaust any additional administrative remedies before bringing suit where Sussex never complied with the Plan because it failed to advise Plaintiff of, among other things, (1) the specific reason or reasons for its denial of the claim, (2) the specific reference to pertinent provisions of the Plan on which such denial is based, (3) appropriate information as to the steps to be taken to submit the claim for review, and (4) the time limits for requesting a review.
- Statute of Limitations. The district court did not erroneously apply the doctrine of equitable tolling to conclude that Plaintiff's ERISA claim was time-barred. Equitable tolling applies to situations like here where a plan administrator has failed to comply with regulatory notice requirements in denying a plan participant's claim for benefits.
- Successor Liability. Although Sussex asserts that it did not assume liability for the Plan when it merged with Diamond State, the court declined to determine Sussex's equitable defense to successor liability in the first instance because Sussex never moved for summary judgment in the district court on this ground.
- Compliance with Contractual Obligations. Sussex argued that it is not required to pay for Plaintiff's health insurance because its current BCBS plan bars coverage for all but full-time employees. Construing the Plan as a whole, the court concluded that a plausible (if not more reasonable) interpretation of the Plan is that Diamond State was required to provide coverage at least equivalent to what Plaintiff enjoyed at the time of her Plan's adoption. Because a factfinder must weigh this conflicting evidence at trial, we court declined to use this alternative ground to affirm the district court's judgment.

For the above reasons, the court reversed the district court's entry of summary judgment and remanded for further proceedings consistent with this opinion.

In *Hendrian v. AstraZeneca Pharm. LP*, No. 3:13-CV-00775, 2015 WL 404533 (M.D. Pa. Jan. 29, 2015), Plaintiff retired and began receiving benefits under the AstraZeneca Defined Benefit Pension Plan. After more than three years he was notified that his benefits were miscalculated resulting in a \$72.18 monthly overpayment. The Plan advised Plaintiff that he could either return the cumulative overpayment amount of \$2,309.61 or allow his future payments to be further reduced. Plaintiff disputed his liability for any overpayments and objected to any reduction in his monthly benefits. The court found that for purposes of Section 502(a)(1)(B), Plaintiff cannot recover the \$3,828 monthly amount stated in his Election Package because he was not entitled to that amount under the terms of the Plan. However, Defendants are not entitled to summary judgment because they have not sufficiently demonstrated the amount of benefits Plaintiff is entitled to under the Plan. Also, with respect to Defendants' recoupment efforts, the court determined that whether Defendants' decision to recoup Plaintiff's overpayments was erroneous under the arbitrary and capricious standard is an issue for trial. With respect to Plaintiff's breach of fiduciary duty claim, the court made the following findings: 1) AstraZeneca acted as a fiduciary with respect to the conduct at issue when its agent, with actual or apparent authority, communicated with Plaintiff about his benefits and options under the Plan; 2) reasonable minds could differ as to whether the miscalculation of Plaintiff's benefits was immaterial as a matter of law; and 3) there is a genuine issue for trial as to whether Plaintiff detrimentally relied upon the miscalculated pension estimates. The court denied Defendants' summary judgment motion on Plaintiff's estoppel claim, finding that the multiple alleged miscommunications such as pension estimates, a benefit election package, and a benefit commencement verification letter, created an issue for trial as to whether Plaintiff can demonstrate the requisite extraordinary circumstances required to succeed on his estoppel claim. The court also denied Defendants' motion for summary judgment on Plaintiff's waiver and equitable restitution claims.

#### D. Fourth Circuit

**Court denies reconsideration and declines to apply fraud exception to ERISA's pension plan antialienation provision and QDRO process.** [Dahl v. Aerospace Employees' Ret. Plan of the Aerospace Corp., No. 1:15CV611 JCC/IDD, 2015 WL 6604799 \(E.D. Va. Oct. 29, 2015\)](#) (Judge James C. Cacheris). A Virginia court issued a divorce decree between Dahl and Goetz. The court incorporated their divorce settlement agreement, which gave Dahl the option to elect a fifty, seventy-five, or one hundred percent survivor annuity benefit under Goetz's pension plan, the Aerospace Employees' Retirement Plan. AERP permits a plan participant to designate a beneficiary to receive a survivor annuity after the participant has died. Goetz continued to work for The Aerospace Corporation for eleven years after the divorce, during which time he

remarried. When Goetz retired on July 31, 2014, Dahl still had not elected the survivor benefits. Goetz gave Dahl no notice of his intent to retire nor informed AERP of the divorce settlement. In fact, he affirmatively marked on his retirement application that there were no court orders requiring his benefits to be paid to another person. Goetz designated his current wife as his survivor beneficiary and the AERP would not recognize the draft Qualified Domestic Relations Order because the survivor annuity vested in Goetz's current wife at the time of Goetz's retirement. The court previously ruled that under Forth Circuit law, the benefits vested in Goetz's current wife at that time and cases relied on by Plaintiff do not void Goetz's beneficiary designation as an act of fraud or breach of good faith. The court denied Plaintiff's motion for reconsideration. The court declined to create a fraud or breach of trust exception to Goetz's pension plan beneficiary designation because doing so would likely conflict with ERISA's antialienation provision and create uncertainty in pension plan administration. Further, recognizing alleged fraud to void Goetz's designation would violate the terms of the AERP benefit plan.

[BRYAN DONALD MURPHY, Plaintiff, v. INTERNATIONAL PAINTERS AND ALLIED TRADES INDUSTRYPENSION FUND, et al., Defendants., No. 3:13-CV-28760, 2015 WL 5722809 \(S.D.W. Va. Sept. 29, 2015\).](#) Plaintiff challenged Defendants' interpretation of the pension plan, which they interpreted as allowing them to use the date of disability onset as determined by the SSA. Plaintiff also contended that they misinterpreted the plan by not awarding him a 501-hour credit for each year that he has been absent from employment due to his disability. The court found that Plaintiff's proposed interpretation of the plan asks the Trustees to comb through and interpret complex administrative law decisions, medical records, and state agency findings rather than look to the date of onset explicitly set by the SSA. The court found that Plaintiff offered no viable explanation to support his conclusion that this interpretation is reasonable yet Defendants' simpler interpretation, which is consistent with the overall language of the plan, is not.

[Surface v. Boilermaker Black Smith Nat. Pension Trust, No. 7:14CV00528, 2015 WL 5553739 \(W.D. Va. Sept. 18, 2015\).](#) In this action seeking to recover pension benefits from the Boilermaker-Blacksmith National Pension Trust, Plaintiff claims that the Trust improperly denied his claim for pension benefits and breached its fiduciary duties. The court denied both motions for summary judgment without prejudice and remanded the claim to the Trust for a full and fair review of Plaintiff's claim for pension benefits.

In [Dahl v. Aerospace Employees' Ret. Plan of the Aerospace Corp., No. 1:15CV611 JCC/IDD, 2015 WL 4874706 \(E.D. Va. Aug. 13, 2015\)](#), Plaintiff, the former spouse of retirement plan participant, brought suit against the retirement plan for survivor benefits to which she was

allegedly entitled as a result of a written settlement agreement with the plan participant. The plan participant retired but did not inform Plaintiff. Upon retirement, his current wife became vested in a 50% survivor annuity. Upon learning of the retirement, Plaintiff submitted a QDRO to the Plan. The Plan determined that the QDRO could not operate to assign a survivor annuity to Plaintiff upon the current wife's vesting. The court agreed. The court explained that to conclude otherwise would undermine ERISA's preemption of state law by causing a DRO, rather than a QDRO, to have some effect on the alienation of benefits under ERISA—a result that ERISA itself clearly prohibits. The court also found no basis to apply the fraud/breach of trust exception recognized in *Yiatchos v. Yiatchos* and *Free v. Bland* to ERISA.

In [\*United States v. Wilson\*, No. 3:09-CR-00161-FDW, 2015 WL 3633644 \(W.D.N.C. June 10, 2015\)](#), the court held that the Federal Debt Collections Procedures Act ("FDCPA"), 18 U.S.C. § 3613 is an express statutory exception to the anti-alienation provision of ERISA (29 U.S.C. § 1056(d)(1)) as well as the corresponding provision in the Internal Revenue Code (26 U.S.C. § 401(13)(A)). The court found that the government may enforce a criminal restitution order and is entitled to a writ of garnishment against Defendant's interest in the United Brotherhood of Carpenters Pension Fund.

In [\*Setzer v. Michelin Ret. Plan\*, No. 3:13-CV-00192-MGL, 2015 WL 1643422 \(D.S.C. Apr. 14, 2015\)](#), the court held that the Plan did not abuse its discretion by denying Plaintiff's benefit claim to change the Joint and Survivor (50%) form of pension benefit payment elected under the Plan after his retirement and the Annuity Commencement Date. Plaintiff divorced his wife after his retirement benefit payments commenced and sought the right to change the spouse beneficiary should he remarry. The court found that ERISA and Fourth Circuit case law preclude Plaintiff's request. The Plan required that Plaintiff, with his former wife's consent, elect to forgo the Joint and Survivor form of benefit payment during the Election Period. Plaintiff did not divorce his wife until more than five years after his Annuity Commencement Date and the Fourth Circuit has held that unless the form of benefit is properly changed prior to retirement, a participant is locked into the joint and survivor annuity upon retirement and cannot change the form of benefit even with the spouse's consent.

#### E. Fifth Circuit

[\*McKinney v. Line Const. Ben. Fund\*, No. 1:14-CV-066-NBB-SAA, 2015 WL 5692809 \(N.D. Miss. Sept. 28, 2015\)](#). The court considered whether an employer's requirement of a written statement repealing the plaintiffs' interest in filing a workers' compensation claim constitutes an abuse of discretion by the administrator. The court found no abuse of discretion as the employer is within reason to require written confirmation of a plan participant's disavowed interest in

filing a workers' compensation claim after the administrator received contradictory notice that the same participant intended to file a workers' compensation claim. The health plan contains a workers' compensation limitation.

In [Repass v. AT & T Pension Benefit Plan, No. 3:14-CV-2686-L, 2015 WL 5021405 \(N.D. Tex. Aug. 25, 2015\)](#), Plaintiff seeks pension credit for time spent working at AT&T affiliates. Her complaint alleged ERISA violations, breach of fiduciary duty, and promissory estoppel, the latter two on which Defendants' moved to dismiss. The court found that Plaintiff has alleged sufficient facts, at this stage, to assert a claim for promissory estoppel. Specifically, Plaintiff alleged misrepresentations for which Defendants would be liable irrespective of the existence of her benefits under her pension plan. The court did dismiss the breach of fiduciary duty claim upon determining that Plaintiff's claim for wrongful denial of benefits under 29 U.S.C. § 1132(a)(1)(B) precludes her from asserting a claim for breach of the fiduciary duty under section 29 U.S.C. § 1132(a)(3).

**Fund has standing to bring declaratory judgment action and court has subject matter jurisdiction to adjudicate this claim.** In [Bd. of Trustees of the Plumbers & Pipefitters Nat. Pension Fund v. Fralick, No. 13-10711, Fed.Appx. , 2015 WL 680522 \(5th Cir. Feb. 18, 2015\)](#), Defendant appealed the district court's declaratory judgment in favor of the Board of Trustees of the Plumbers and Pipefitters National Pension Fund (the "Board") and the dismissal of her counterclaim for benefits under ERISA. The Board initiated this declaratory judgment action seeking a declaration that Defendant was not entitled to a preretirement surviving spouse pension benefit and it sought an order that it only owed Defendant an additional payment of \$36,722 based on the remaining payments due under her late husband's retirement pension. Defendant argued that the district court lacked subject matter jurisdiction because the Board's ERISA claim falls outside the remedies provided to it in § 1132(a) because only a beneficiary may make such a claim under § 1132(a)(1)(B). The court found that this argument does not bear on whether the court has subject matter jurisdiction over the Board's claim and concluded that the district court correctly held that it had subject matter jurisdiction to adjudicate this declaratory judgment claim under its federal question power in 28 U.S.C. § 1331. Further, the Board has standing to bring the claim because the Board presents a long-standing actual controversy between the parties that is capable of judicial resolution. It is of no moment that the Board filed this action before Plaintiff counterclaimed for benefits. The court found that the district court's conclusion that Defendant was judicially estopped from challenging the earlier decision in her husband's case was not an abuse of discretion. The court further found that Defendant was disqualified from preretirement surviving spouse benefits because her husband did *not* die before his Effective Date of Benefits. Accordingly, the court affirmed in part, vacated

in part, and remanded the case for entry of an amended judgment awarding Defendant the remaining payment of \$36,722 due under her late husband's retirement pension.

**Plan Administrator did not abuse its discretion in distributing Savings Plan benefits.** In [Hall v. Lockheed Martin Corp., No. 14-10471, Fed.Appx. , 2015 WL 676850 \(5th Cir. Feb. 18, 2015\)](#), a matter involving the distribution of savings plan benefits, Plaintiff alleged that Lockheed Martin Corp. ("LMC") was negligent and breached its fiduciary duty by recognizing a power of attorney in favor of her late husband's daughter. The district court granted summary judgment in favor of LMC and found that Plaintiff's state law claims were preempted by ERISA and that there was no genuine issue of fact that LMC, as Plan administrator, had abused its discretion in administering her late husband's account in the Plan. The court found that Plaintiff presented nothing on appeal that would create a question of material fact that the Plan administrator's actions were arbitrary and not supported by substantial evidence.

F. Sixth Circuit

**Retirement plan's conservative interpretation of maximum contribution limits is not arbitrary and capricious.** [Gerber v. Ohio N. Univ., et. al, No. 3:14 CV 2763, 2015 WL 9206584 \(N.D. Ohio Dec. 17, 2015\)](#) (Judge Jack Zouhary). The *pro se* plaintiff challenged ONU's interpretation of the ONU's Defined Contribution Retirement Plan's maximum contribution limits for the years 2002-06, contending that he was not allowed to make the maximum voluntary contribution. The Plan required participants to defer 7.5% of their compensation while also allowing voluntary contributions. The Plan stated a participant's total contributions could not exceed the limits set forth in 26 U.S.C. §§ 415 and 402(g). During the period in question, the Plan did not distinguish between mandatory and elective deferrals in calculating the maximum amount, combining them to determine the 402(g) limit, which it did so in part based on advice from TIAA-CREF. The IRS did an audit of the Plan per Plaintiff's urging and it concluded that "reducing allowable elective deferrals by the amount of mandatory contributions did not result in any violation of IRC section 403(b) for the 2002 through 2006 tax years." The court determined that ONU's conservative interpretation of the limits was reasonable. Further, Plaintiff's dispute concerning ONU's interpretation made years before was basically a breach of fiduciary duty claim under the guise of a denial of benefits claim and the statute of limitations for such a claim has long since passed. The court denied Plaintiff's motion to amend his complaint to include a breach of fiduciary duty claim and to supplement the administrative record with information that the court deemed either irrelevant or duplicative of documents already in the administrative record.

[Fred Michael Reed, Plaintiff, v. Int'l Painters And Allied Trades Indus. Pension Plan, Defendant., No. 2:12-CV-72, 2015 WL 7450891 \(S.D. Ohio Nov. 24, 2015\)](#) (Judge James L. Graham). In this matter, the issue was whether Plaintiff's pension vested before he left the employ of union painting companies and became an over-the-road truck driver. The court denied Defendant's motion for summary judgment on Plaintiff's benefit claim, finding that its determination was arbitrary and capricious, but remanded the claim to the administrator for further findings. The court granted summary judgment in favor of Defendant on Plaintiff's equitable estoppel claim.

**Right to lifetime pension benefits under Supplemental Executive Retirement Plan was superseded by an agreement.** [Schempp v. GC Acquisition, LLC, No. 14-4076, Fed.Appx. , 2015 WL 7003396 \(6th Cir. Nov. 12, 2015\)](#) (Before GUY, BATCHELDER, and GIBBONS, Circuit Judges). The Sixth Circuit affirmed the district court's ruling that Plaintiff waived his rights to benefits under Glastic Corporation's Supplemental Executive Retirement Plan A ("SERP A") because he entered an agreement that superseded SERP A. The district court held that a 2006 Agreement, on its face, replaces any rights Plaintiff may have had under SERP A. The following provision from the Agreement's recitals provision was dispositive for the district court: "It is the intent of the parties that this Agreement, a modification of [SERP A], and all deferrals of compensation and distributions made pursuant to it, complies with Section 409A of the Internal Revenue Code of 1986, as amended." Assuming without deciding that the knowing-and-voluntary requirement applies in this case, the court was convinced that a rational trier of fact would conclude that Plaintiff both knowingly and voluntarily waived his rights under SERP A.

**District court did not abuse discretion in appointing receiver over assets disputed in litigation.** [Pension Ben. Guar. Corp. v. Evans Tempcon, Inc., No. 15-1388, 2015 WL 6685319 \(6th Cir. Nov. 2, 2015\)](#) (BATCHELDER, MOORE, and ROGERS, Circuit Judges). PBGC received notice that the Estate of Victor Posner ("the Estate") had failed to make required contributions to the APL/NVF Consolidated Pension Plan. In response, PBGC filed notices of a federal tax lien against the Estate and its entities, including Evans Tempcon, Inc. Thereafter, Evans Tempcon transferred \$1.8 million to the other entities as well as to individuals associated with the Estate. Following a foreclosure action against Evans Tempcon, the PBGC and Evans Tempcon entered into a joint stipulation restraining Evans Tempcon from transferring any additional assets without PBGC's approval. When PBGC learned that Evans Tempcon had violated the stipulation, it filed a motion to appoint a receiver, which the district court granted. The Sixth Circuit determined that the district court did not abuse its discretion in granting PBGC's motion and affirmed.

**Denial of lump sum pension benefits not arbitrary and capricious where participant did not submit an *accurate* election form before his death.** [Fife v. Ford Motor Company, et al., No. 14-CV-14586, 2015 WL 6467626 \(E.D. Mich. Oct. 27, 2015\)](#) (Judge Matthew F. Leitman).

Here, the pension plan participant began receiving monthly pension benefits under the retirement plan and then sought to receive the benefits as a lump sum. He was required to complete an election form that accurately reflected both (1) his personal information that was used to calculate the amount of his lump-sum payment and (2) the amount of the lump-sum payment to which he was entitled under the Plan. The participant completed an election form, but the form included an inaccurate lump-sum payment amount that was based upon the company's erroneous belief that his wife (who had been entitled to survivorship benefits under the Plan) was still alive. The retirement plan committee deemed the election ineffective but the participant died before he received the corrected election form. The committee found that he never effectively elected to receive the lump-sum payment. His estate brought suit and the court granted Defendant's motion for judgment, finding that its decision was not arbitrary and capricious since the committee required timely submission of an accurate election form and the participant did not comply. The court rejected the estate's argument that common-law contractual principles apply or that Defendant was equitably estopped from denying benefits.

**ERISA's anti-forfeiture and anti-cutback provisions do not protect disability pension benefits.** [Myers v. Bricklayers & Masons Local 22 Pension Plan, No. 14-4234, 2015 WL 6218994 \(6th Cir. Oct. 22, 2015\)](#) (BOGGS, SUTTON, and COOK, Circuit Judges). In this case the Defendants revoked Plaintiff's disability pension when they discovered that he violated an eligibility condition—working in “noncovered masonry employment.” Plaintiff claimed the amendment adopting the disqualifying eligibility condition violates ERISA's anti-forfeiture provision, which protects normal retirement benefits from forfeiture, and anti-cutback provision, which prevents amendments that decrease accrued benefits. The Sixth Circuit found that its decision in *McBarron v. S & T Industries, Inc.*, 771 F.2d 94 (6th Cir. 1985) controls and affirmed the decision of the district court dismissing Plaintiff's suit for failure to state a claim.

[DAVID M REES & WENDY REES, Plaintiffs, v. IRON WORKERS' LOCAL NO. 25 PENSION FUND, et al., Defendants., No. 14-CV-12401, 2015 WL 5729087 \(E.D. Mich. Sept. 30, 2015\).](#)

The court found that the Pension Fund was equitably estopped from revoking special retirement benefits, where Plaintiff's decision to retire was influenced by a trustee's representation that Plaintiff could retire earlier than anticipated and use his “banked hours.” Plaintiff detrimentally relied on the fact that the Pension Fund did not take any action within 90 days to revoke his benefits, despite the Pension Plan requiring decisions to be made on pension applications within

90 days (120 for unusual circumstances). Because Plaintiff's pension application was approved and his benefits were being paid, he did not have an opportunity to return to work and obtain the necessary hours without using the "banked hours." Further, Plaintiffs suffered financial damage from the revocation of benefits and future reduction to the amount of benefits. The court found that these adverse changes in position as a result of Plaintiffs' reliance on the Pension Fund's representations amount to detrimental reliance.

[Robbennolt v. Washington, No. 14-2433, Fed.Appx. , 2015 WL 5637563 \(6th Cir. Sept. 25, 2015\).](#) Although the Sixth Circuit acknowledged that ERISA's anti-alienation provision should prohibit Michigan from obtaining state-court orders forcing prisoners to receive pension benefits at their prison addresses, because the state court issued such an order, the court must leave it undisturbed. Since the district court lacked authority to alter or amend the state court's judgment, the Sixth Circuit reversed and remanded.

[JAMES RUSSELL SMITH PLAINTIFF v. INTEGRAL STRUCTURES, INC. DEFENDANT, No. 3:14-CV-419-GNS, 2015 WL 5570042 \(W.D. Ky. Sept. 22, 2015\).](#) The court denied Defendant's motion for judgment on the pleadings on Plaintiff's claim for retirement benefits under a salary continuation agreement stemming from the sale of the company. The court found that a time period of three years from the date of change of ownership to termination does not so clearly indicate a lack of vesting as to render Plaintiff's claim implausible.

[Estep v. United Mine Workers of America 1974 Pension Plan & Trust, No. CV 15-44-ART, 2015 WL 5443865 \(E.D. Ky. Sept. 15, 2015\).](#) The court granted the defendant pension plan's motion to dismiss the claim of a surviving spouse who was not entitled to benefits because she was not married to the plan participant nine months before he retired. The plan paid benefits to the first wife, who was married to the plan participant during the time frame defined in the Plan. "But federal law recognizes that, although the second wife was with him when he died, the first was with him when he worked to earn his benefits."

**Alter-ego doctrine does not apply in circumstance where union association negotiated, signed, and received the benefit of the agreement with the employer.** In [Bd. of Trustees of the Local 17 Iron Workers Pension Fund v. Harris Davis Rebar LLC, No. 14-3997, F.3d , 2015 WL 5131853 \(6th Cir. Sept. 2, 2015\),](#) the Sixth Circuit affirmed the district court's dismissal of the Trustees' claims, where they allege that one of the defendant employers, Harris Davis Rebar LLC, signed a labor agreement as a device to allow the other defendant employer, Davis JD Steel

LLC, to evade its obligations under a different labor agreement. The court declined the Trustees's invitation to treat the two companies as one under a judge-made doctrine known as the "alter-ego" doctrine. Essentially, the Trustees seek a determination that Davis Rebar is bound by the terms of JD Steel's labor agreement, which requires JD Steel to make contributions to the Trustees' pension fund rather than to union defined-contribution plans, which is what Davis Rebar is required to contribute to. In this case, the same association of iron-workers unions negotiated and signed both agreements with the two employers and the court declined to set aside the union association's judgment regarding its members' best interests in favor of the Trustees' judgment or the court's judgment. The court rejected the Trustees' separate argument that Davis Rebar is required to make contributions to the fund under the Pension Protection Act, which imposes various obligations on plan sponsors. The court explained that Davis Rebar is not a sponsor of the fund under its contract with the Iron Workers.

In [\*Frisky-Watson v. Ford Motor Co.\*, No. 1:15-CV-00083, 2015 WL 4496291 \(N.D. Ohio July 23, 2015\)](#), the court granted Defendant's motion for judgment on the administrative record on Plaintiff's claim for surviving spouse benefits. At the time that the deceased spouse retired from the Ford Motor Company he was not married, and therefore did not elect surviving spouse benefits. He did contact Ford's National Employee Services Center, a call center run by Ford and separate from the Defendant Board, to inform Ford of his marriage, and indicated a desire to add survivor benefits for Plaintiff. The call center representative gave him the Board's telephone number and the UAW Retiree Medical Benefits Trust's telephone number but there is no indication that he ever called either of these numbers or completed a survivor benefits election form. The most relevant Plan language is as follows: "No election provided hereunder shall become effective under any circumstance for any retired employee whose completed election form is received by the Board .... On or after October 1, 1999, such election must have been received by the Board before the first day of the month in which the retiree has been married 18 months." The court determined that the Board reasonably interpreted the Plan to require a completed election form to elect survivor benefits.

In [\*Pearce v. Chrysler Grp., L.L.C. Pension Plan\*, No. 13-2374, Fed.Appx. \\_\\_\\_\\_\\_, 2015 WL 3797385 \(6th Cir. June 18, 2015\)](#), an action to recover supplemental retirement ("30-and-Out") benefits from Defendant-Appellee Chrysler Group L.L.C. Pension Plan ("Plan"), the Sixth Circuit reversed and remanded the district court's finding that the Summary Plan Description did not materially conflict with the Pension Plan, and therefore any motion to amend the complaint to seek equitable relief under ERISA § 502(a)(3) would be futile. The court affirmed the district court's grant of summary judgment to the Plan, denial of Plaintiff's request for discovery, and striking of Plaintiff's reply brief filed in opposition to the Magistrate Judge's Report and Recommendation.

In [\*Donati v. Ford Motor Co. Gen. Ret. Plan\*, No. 13-CV-14496, 2015 WL 2405613 \(E.D. Mich. May 20, 2015\)](#), the Plan denied the participant's request to pay a lump sum distribution of a retirement benefit the participant was receiving as an alternate payee of her ex-spouse. But, the Plan did approve a cash out that applied to the participant's own retirement benefit. The court found that the cash out unambiguously applies only to the participant's own retirement benefit. As such, the court found that discovery into the uniform application of plan provisions was not necessary. Lastly, because the language of the Plan is unambiguous, Plaintiff's estoppel claim must fail.

In [\*Pokorny v. Excavating Bldg. Material & Const. Drivers Union Local No. 436 Pension Fund\*, No. 1:14-CV-02821, 2015 WL 2250881 \(N.D. Ohio May 13, 2015\)](#), Plaintiff filed suit against the Fund for payment of pension benefits and for breach of fiduciary duty, where the Fund represented to Plaintiff in writing that he was vested and would receive a pension benefit but then informed Plaintiff after he retired that he in fact did not have enough eligible service to vest in any pension benefit. The court dismissed Plaintiff's Section 502(a)(1)(B) claim because the Board decided that the records did not support that Plaintiff had accumulated enough years of employment under the Plan to receive pension benefits. However, the court permitted Plaintiff's Section 502(a)(3) breach of fiduciary duty claim to proceed, finding that Plaintiff established that Defendants were acting in their fiduciary capacity when they generated the letter informing him of his entitlement to benefits and that the letter constituted a material misrepresentation that he relied upon to his detriment. Lastly, the court found that Plaintiff properly plead the elements of an equitable estoppel claim against Defendants, explaining that the balance of equity strongly favors the application of estoppel to prevent Plaintiff from being left with no disability pension benefits for the remainder of his life.

In [\*Corley v. Commonwealth Indus., Inc. Cash Balance Plan\*, No. 14-5789, Fed.Appx. \\_\\_\\_, 2015 WL 2151837 \(6th Cir. May 8, 2015\)](#), the Sixth Circuit held that the law of the case doctrine precludes the court from reconsidering Plaintiff's appeal, where the court ruled previously that Plaintiff is not entitled to a larger lump-sum pension payment and his second appeal is based on the same arguments.

In [\*Dobroski v. Ford Motor Co.\*, No. 1:14-CV-02111, 2015 WL 1880378 \(N.D. Ohio Apr. 24, 2015\)](#), Plaintiff requested retirement benefits from Ford in April 2013, and on September 19, 2013, submitted a benefits election form requesting retirement benefits to commence on May 1, 2013. He also requested a buy out and a payment of retirement benefits dating back to March

2007. Ford granted his request for prospective retirement benefits, effective May 1, 2013, but denied his other requests based on Article V, Section 2(k) of the Plan, which states that early retirement benefits become payable “on the first day of the first month after (i) the employee shall have become eligible for such a benefit, and (ii) the employee shall have filed application for such benefit with the Board. The court found that the Board’s interpretation of the Plan was reasonable and granted Defendant’s motion for judgment on the administrative record.

In [\*Paul v. Detroit Edison Co.\*, No. 13-14256, 2015 WL 1469314 \(E.D. Mich. Mar. 30, 2015\)](#), the court found that Plaintiff satisfied the requisite elements of equitable estoppel in an ERISA context and granted Plaintiff’s Motion for Summary Judgment. The court ordered that Defendants shall be estopped from reducing Plaintiff’s retirement benefits and shall return Plaintiff to “the same position he would have been in had the representations been true.” The court dismissed the Plan’s counterclaim seeking repayment of the excess lump sum paid to Plaintiff as a result of Defendants’ miscalculations.

In *Sanders v. Chrysler Grp., LLC UAW Pension Plan*, No. 13-CV-11046, 2015 WL 349185 (E.D. Mich. Jan. 26, 2015), the court granted Defendant’s motion for judgment on Plaintiff’s claim seeking to recover surviving-spouse benefits allegedly due to her pursuant to her decedent husband’s employer-sponsored plan. The husband had retired under the terms of that plan on May 31, 2007, with payments effective June 1, 2007. He elected to enroll in a surviving-spouse option and had designated his former wife as beneficiary. His former wife died in August of 2008 and he submitted the death certificate to the plan but did not complete and submit the forms cancelling his surviving spouse coverage. Plaintiff and her decedent husband married on September 13, 2009 and he died a little over a year later. Plaintiff filed a claim for benefits as the surviving spouse but her claim was rejected because her husband never cancelled his surviving-spouse coverage in favor of his former wife after her death; and he never re-elected the surviving-spouse coverage, designating Plaintiff as the new beneficiary. The Board, who reviewed Plaintiff’s appeal, upheld the denial for the same reasons but later the parties agreed that the husband’s purported failure to cancel his existing surviving-spouse coverage upon his former wife’s death was not a proper basis for denying Plaintiff spousal benefits. The plan provides that any retiree who marries or remarries, subsequent to the earliest date surviving spouse coverage was in effect may elect, or re-elect, surviving spouse coverage. The plan states that “[s]uch coverage shall become effective on the first day of the third month following the month in which the Board of Administration receives a completed election form, but in no event before the first day of the month following the month in which the retired employee has been married one year.” However, “[n]o election provided [t]hereunder shall become effective under any circumstances for any retired employee whose completed election form is received by the Board of Administration after the first day of the month in which the retired employee has been

married one year,” or 18 months if on or after October 1, 1999. The court observed that the plan language is not ambiguous. The terms of the plan spell out precisely what a retiree must do to elect coverage and, given those terms, the court found that the Board’s decision to deny Plaintiff benefits is reasonable, and therefore not arbitrary or capricious.

In *Humes v. Elec. Workers’ Pension Trust Fund of Local Union No. 58, I.B.E.W., Detroit, Mich.*, No. 13-10385, 2015 WL 249330 (E.D. Mich. Jan. 20, 2015), the court denied Defendant’s motion for relief from the court’s previous order in favor of Plaintiff in his claim seeking pension credit for work he claimed to have performed for French Electric in 1985. The court found that it did not commit a mistake of law in holding that Defendant operated under a conflict of interest, because although some courts have held that multi-employer plans cannot have a conflict of interest, this position is not uniform. Moreover, even if the court did commit a mistake of law, such mistake does not qualify as a substantive mistake of law so as to merit relief under Rule 60(b)(1) because the conflict of interest did not drive the court’s holding that Defendant abused its discretion in denying Plaintiff’s appeal. Instead, the court’s holding centered on the actions of the Plan Administrator in summarizing some of the evidence to the Board, while failing to account for Plaintiff’s contrary evidence. Further, the court had explained that the conflict of interest factor alone was not determinative.

**PBGC determination of benefit liabilities was not an abuse of discretion.** In *Pension Ben. Guar. Corp. v. Kentucky Bancshares, Inc.*, No. 14-5573, \_\_Fed.Appx.\_\_, 2015 WL 221621 (6th Cir. Jan. 15, 2015), the 6<sup>th</sup> Circuit affirmed the district court’s grant of summary judgment to the Pension Benefit Guaranty Corporation (“PBGC”) under 29 U.S.C. § 1303(e) to enforce its determination that Kentucky Bancshares, Inc., in terminating its Retirement Plan and Trust (“Plan”), violated Title IV of ERISA, in particular 29 U.S.C. § 1341, and a PBGC regulation. Kentucky Bancshares allegedly failed to pay all benefit liabilities due under the terms of the Plan and the PBGC found that a post-termination amendment of the Plan did not alter Kentucky Bancshares’ obligations at the time of termination. The court found that the district court correctly recognized that PBGC’s resolution of the controversy is subject to deferential review and its final determination will be upheld unless it is shown to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. PBGC reasonably concluded that Kentucky Bancshares’ compliance with PPA § 1107 did not obviate its obligation to also comply with ERISA’s standard termination requirements. Specifically, the Plan’s qualifying status under IRC §§ 401 and 411 does not compel the conclusion that the resultant decrease in the value of benefits was necessary to maintain Plan qualification under §§ 401 and 411, for purposes of 29 C.F.R. § 4041.8(a)(1) and (c)(1).

G. Seventh Circuit

**Fund abused its discretion in not recognizing terms of posthumous QDRO.** [Cingrani v. Sheet Metal Workers' Local No. 73 Pension Fund, No. 15 C 6430, 2015 WL 8780620 \(N.D. Ill. Dec. 15, 2015\)](#) (Judge Harry D. Leinenweber). Plaintiff filed a motion for judgment on the pleadings on his ERISA claim for benefits challenging the Fund's decision to revert back to the Plan his ex-spouse's 50% interest in his pension benefit where she died before he retired, the QDRO was silent as to what would happen if the ex-spouse predeceased him, and Plaintiff obtained an amended QDRO that provided that the benefit would revert back to him if the ex-spouse predeceased him. The court granted the motion, finding that under the facts of this case the Plan Administrator's refusal to recognize the fact that the ex-spouse's interest terminated on her death and reverted to Plaintiff as required by the amended QDRO was arbitrary and capricious. "It is obvious that where the QDRO is silent, and there is no default rule, and a beneficiary dies prior to her interest vesting, there is nothing to revert to the Fund." The court found that there was no reason to not apply the amended QDRO even though it was entered after the ex-spouse's death, explaining that courts have held that ERISA does not prohibit application of posthumous QDROs.

**Interim agreement following expiration of CBA validly eliminated the employer's obligation to contribution to the pension fund.** In [Michels Corp. v. Cent. States, Se., & Sw. Areas Pension Fund, No. 14-3726, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5138576 \(7th Cir. Sept. 2, 2015\)](#), the Seventh Circuit considered when the employer's obligation to contribute to the pension funded ended, where the governing collective bargaining agreement (CBA) between the multiemployer group and the union terminated and there were a series of temporary "extensions" of the CBA. The court concluded that the parties to the CBA terminated it in accordance with its terms effective January 31, 2011. Thereafter, a series of short-term agreements that had the effect of extending the CBA's terms for the designated periods while the parties negotiated but the interim agreement that took effect on November 15, 2011 eliminated the employers' duty to contribute to the pension fund and extended all other terms of the CBA. The court reversed the district court's grant of summary judgment for the pension fund, where it held that the interim agreement was not sufficient to end the employers' duty to contribute. The Seventh Circuit determined that the CBA imposing the duty to contribute had long since expired by November of 2011, and there was nothing to prevent the parties from agreeing to the new arrangement.

In [Cocker v. Terminal R.R. Ass'n of St. Louis Pension Plan for Nonschedule Employees, No. 12-1239-DRH, 2015 WL 3623584 \(S.D. Ill. June 10, 2015\)](#) (**Not Reported in F.Supp.3d**), Defendants argued that the Terminal Railroad Association of St. Louis Pension Plan provided

that Plaintiff's gross benefit should be reduced by the amount that was payable to him under the Union Pacific Pension Plan at his normal retirement age (\$2,311.73). Plaintiff argued that the term "payable" refers to the benefit the participant is actually receiving, either his reduced early retirement benefit or his unreduced benefit at Normal Retirement Age as the case may be, meaning that the offset should be the amount actually paid to him as an early retirement benefit under the Union Pacific Pension Plan (\$1,022.94). The court found in favor of Plaintiff. Specifically, the plain reading of Section 5.5(b) requires resolution of what was the amount of retirement income payable from the Union Pacific Plan, in February 2010 when Plaintiff retired from Terminal Railroad and started his pension from the Terminal Pension Plan. Plaintiff's Union Pacific Plan early retirement of \$1,022.94 per month is the amount of "retirement income payable." Since Plaintiff retired early from Union Pacific, he will never be eligible for normal retirement benefits. Thus, the higher normal retirement benefits from the Union Pacific Plan are not payable and will never be payable to Plaintiff.

**District court award of monthly defined benefit payment based on unexplained calculation in benefit statement is reversed and remanded.** In [\*Reilly v. Cont'l Cas. Co.\*, No. 14-2888, F.3d](#), 2015 WL 2081418 (7th Cir. May 6, 2015), the court reversed and remanded the district court's decision ordering Continental to pay Plaintiff a \$5,400 monthly defined pension benefit based on a 1999 benefit statement. In 2012, Continental sent Plaintiff a different calculation, showing lower compensation and entitlement to roughly \$4,200 a month. The district court concluded that Continental's decision was arbitrary and capricious and ordered it to pay monthly benefits at the \$5,400 level. Continental appealed, contending that its calculation should have been sustained, and if not that the district court should have remanded for a new calculation rather than ordering payment at the rate projected in 1999. The district court found Continental's 2012 decision to be arbitrary and capricious because it was not based demonstrably on the Plan's definition of "compensation." Continental asserted that the 1999 statement reflected Plaintiff's qualifying compensation plus a "benefit salary," but "benefit salary" is not a term used or defined in the Plan. Continental did not explain why \$164,747.16 is the right number for 1994 and did not show how it had ascertained Plaintiff's top 60-months' compensation. However, the court determined that to show that \$164,747.16 is an unexplained number does not justify a judicial award of a \$5,400 monthly pension. The district court needed to determine, or allow the administrator to determine, the right number, and not just to assume that whatever had been estimated in 1999 is Plaintiff's entitlement. Plaintiff also did not offer a calculation in support of the pension to which he claims entitlement and the only way to reach a reliable decision is to apply the Plan's terms to Plaintiff's qualifying compensation, one month at a time, to find the top-60-month average. If the parties cannot agree, then the district court must remand this matter to Continental so that the administrator can make a fresh calculation, which then could be subjected to another round of judicial review.

## H. Eighth Circuit

In [\*Crouch v. Bussen Quarries, Inc.\*, No. 4:14CV1733 CDP, 2015 WL 4959517 \(E.D. Mo. Aug. 19, 2015\)](#), the court found that Defendants did not violate ERISA (as amended by the Pension Protection Act of 2006) when they eliminated Plaintiff's early-retirement benefits consistent with the Central States Rehabilitation Plan, which permitted the elimination of certain types of adjustable benefits. The court also found that Bussen Quarries was not acting as Plaintiff's fiduciary when it negotiated a new collective bargaining agreement with his union such that it withdrew from the Central States Pension Plan. "It is well settled that an employer is not acting as a fiduciary when it is acting in its role as a sponsor making a decision about what benefits to offer its employees." Bussen Quarries termination of its participation in a pension plan, which had the effect of reducing Plaintiff's benefits, is not enough to make Bussen legally responsible for that result under ERISA.

In [\*Tussey v. ABB Inc.\*, No. 2:06-CV-04305-NKL, 2015 WL 4159983 \(W.D. Mo. July 9, 2015\)](#), on remand from the Eighth Circuit, the court determined that the ABB Defendants did abuse their discretion when they removed the Vanguard Wellington Fund from the PRISM Plan and mapped its assets into the Fidelity Freedom Funds. The court found that a non-conflicted fiduciary could have chosen the Freedom Funds since although all target funds carry high fees, they were becoming popular in 2000 and there were not many target funds to choose from. It would not be unreasonable for a fiduciary to make an exception to the rule that a sustained track record was needed to at least put the investment on the platform. However, the removal of the Wellington Fund from the PRISM platform and the mapping of its assets to the Freedom Funds was an abuse of discretion because it was motivated in large part to benefit Fidelity Trust and ABB, not the Plan participants. With respect to damages, the court explained that even if the performance of the alternative target fund that had the highest rate of return would be the proper measure of damages, Plaintiffs presented no evidence of what that figure would be. Therefore, the court found that Plaintiffs failed to satisfy their burden of proof on the issue of damages.

In [\*Knowlton v. Anheuser Busch Co., LLC\*, No. 4:13-CV-210 SNLJ, 2015 WL 4131817 \(E.D. Mo. July 8, 2015\)](#), the court granted partial judgment on the pleadings to Plaintiff class members – former employees of Busch Entertainment Corporation ("BEC"), a member of the "Controlled Group" of Anheuser-Busch Companies, LLC ("ABC") – in this matter where they were denied certain enhanced retirement benefits. Following reasoning from a Sixth Circuit decision based on the same plan language, the court determined that there is no need to go beyond the words of the Plan to decide Plaintiffs' motion. Section 19.11(f) states that individuals "whose employment with the Controlled Group is involuntarily terminated within three (3) years after the Change in

Control” would be entitled to certain enhanced benefits. The court found that when each term in the provision is understood according to its ordinary meaning, and no term is ignored, eligibility for enhanced pension benefits requires satisfaction of five elements: (1) that the recipient be a plan participant (2) whose employment with the Controlled Group (3) is involuntarily terminated (4) within three years after (5) a change in control. The court found that the phrase is unambiguous and has only one plausible interpretation: the individual’s employment with the Controlled Group must be involuntarily terminated. A job loss or some otherwise undefined period of unemployment is not required. As such, the court concluded that there is no reason for the court to wait until the full “administrative record” is before it because to look beyond the words of Section 19.11(f) itself would be improper.

In [Carter v. Gen. Motors Hourly-Rate Pension Plan, No. 1:14-CV-00564-JMS, 2015 WL 3867661 \(S.D. Ind. June 23, 2015\)](#), prior to 2007, Plaintiffs were employees of Allison Transmission, a division of GM. They all qualified for either normal or early retirement from GM in 2007 but after GM sold GM–Allison to Clutch, Plaintiffs all continued employment with Clutch–Allison. Several years later they each requested to retire from GM and to begin receiving GM Plan benefits, but to continue their employment with Clutch–Allison. The Plan denied their request because of their employment with a “successor company.” Based on a *de novo* review of the administrative record, the court determined that Plaintiffs have not been wrongly denied benefits under the GM Plan. The court explained that the Plan’s successor provision refers to “a successor company,” not just “GM’s successor.” The Plan provides that a successor can arise “through divestiture.” Accordingly, under the plain terms of the GM Plan, Plaintiffs must terminate employment with Clutch–Allison, the successor company, in order to begin receiving benefits under the GM Plan.

**Use of IRA funds to pay wages is a prohibited transaction.** In [Ellis v. C.I.R., No. 14-1310, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3513519 \(8th Cir. June 5, 2015\)](#), the taxpayers formulated a plan whereby the taxpayer would use his retirement savings as startup capital for a used car business and then use the business as his primary source of income. The 8<sup>th</sup> Circuit affirmed the district court’s decision that the taxpayer engaged in a prohibited transaction with respect to his IRA when he directed his business to pay him a salary. The court rejected the argument that the Plan Asset Regulation, 29 C.F.R. § 2510.3–101(c) (providing that the underlying assets of an “operating company” in which a plan invests are not considered plan assets for determining whether a prohibited transaction occurred), applies to this case since the plain language of § 4975(c) prohibits both “direct and indirect” self-dealing of the income or assets of a plan. The court also rejected the argument that the payment of wages is exempt under § 4975(d)(10) (excludes from the list of prohibited transactions the “receipt by a disqualified person of any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually

incurred, in the performance of his duties with the plan.”) Here, the company compensated the taxpayer for his services as general manager of the company, not for any services related to his IRA.

## I. Ninth Circuit

**Account levied by creditors is exempt under the anti-alienation provision of ERISA.** [Bay Area Painters v. Torben Hansen Enterprises, Inc., No. 14-CV-00182-WHO, 2015 WL 9453646 \(N.D. Cal. Dec. 28, 2015\)](#) (Judge William H. Orrick). Plaintiffs Bay Area Painters moved for an order determining that an account opened by Defendant, a judgment debtor of Plaintiffs, was not exempt under the anti-alienation provision of ERISA. The court found that because the account was set up in the name of an ERISA-governed profit sharing plan name and contained plan assets as part of the winding up of the Plan, the account was exempt. The court found that Defendant met its burden to show that the disputed funds are exempt under Cal. Civil Proc. Code Section 704.115 and ordered \$55,380.09 to be returned to the Plan, plus interest.

**Pensioners who elected a lump sum pension benefit at first retirement are not entitled to additive benefits at second retirement.** [Barnes v. AT&T Pension Ben. Plan-Nonbargained Program, No. 13-16005, Fed.Appx., 2015 WL 7074850 \(9th Cir. Nov. 13, 2015\)](#) (WALLACE, SILVERMAN, and CHRISTEN, Circuit Judges). The Ninth Circuit in a cursory opinion affirmed the district court’s grant of summary judgment in favor of the pension plan on Plaintiff’s and the Class’s claim that they were entitled to restore, upon bridging and second retirement, a discount applied to their pension when they first retired. The court found that the procedural irregularities and failure to exercise discretion alleged by Plaintiff did not change the standard of review to *de novo*. The Plan determined that lump sum payees like Plaintiff were eligible to receive only cash balance benefits upon their second retirement pursuant to Section 3.4(a) of the Plan. These payees were not “eligible to receive” a monthly pension at first termination because of their lump sum election and thus not eligible for greater benefits under Section 3.4(d)(3) which applies to participants who elected to receive an annuity. The court found this to be a reasonable interpretation of the relevant plan provisions.

**Plan did not abuse discretion in interpreting plan document where scrivener’s error caused an internal inconsistency/ambiguity and the interpretation was supported by extrinsic evidence.** [Davis v. Pension Trust Fund for Operating Engineers, No. 14-CV-00853-JSC, 2015 WL 6664639 \(N.D. Cal. Nov. 2, 2015\)](#) (Magistrate Judge Jacqueline Scott Corley). When Plaintiff applied for Plan disability benefits he had accrued 9 years of credited service and 9 years of future credited service. Plaintiff contended he was due a higher benefit than that determined by the Plan. The Trust Fund’s legal counsel informed the Appeals Committee that

certain relevant provisions contained typographical errors as a result of an amendment to the Plan. The scrivener's error caused an internal inconsistency/ambiguity in the plan document. The court found that given that the Plan does not state which of three benefit levels applies to a participant in Plaintiff's circumstances, and given that the Plan read literally does not provide any benefits to a participant disabled after July 2008 with more than ten years, and only provides benefits to those with more than five but less than ten years of credited service, the court cannot conclude that the Trustees' interpretation was an abuse of discretion. The court also found that extrinsic evidence showed that the Trustees intended to provide disabled participants with more than five but less than ten year of service with a benefit amount equal to the actuarial equivalent. The court found that *contra proferentum* and equitable estoppel does not apply.

[STEPHEN COLACO, et al., Plaintiffs, v. THE ASIC ADVANTAGE SIMPLIFIED EMPLOYEE PENSION PLAN, et al., Defendants. Additional Party Names: ASIC Advantage, Inc., David Lichtenstein, David Robertson, Michael Mullen, Microsemi Corp., Moddy Wong, Nhan Tran, Quy Lau, Sina Ma, Stephen Thomas, Terry Jones, Tom Gammon, Trinh Nguyen, No. 5:13-CV-00972-PSG, 2015 WL 5655465 \(N.D. Cal. Sept. 24, 2015\).](#) In a lawsuit involving denial of Simplified Employee Pension (SEP) plan benefits, the court found that Defendants may not argue that separation agreements are a basis for denying Plaintiffs' right to SEP benefits, but they may argue that the separation agreements bar this lawsuit.

In [Dresel v. Pension Plan of Pac. Nw. Labs., No. C14-1665 MJP, 2015 WL 4164827 \(W.D. Wash. July 9, 2015\)](#), the court determined that it was an abuse of discretion for Defendant to deny Plaintiff's request for Early Retirement Benefits following attainment of his Early Retirement Date. Defendant argued that because Plaintiff never returned to active employment following the commencement of his leave of absence, he was "terminated" from employment, and thus his failure to reach age 55 while still actively employed disqualifies him from the early retirement benefit. The court found that the Plan nowhere defines what constitutes "termination" or under what circumstances (other than the obvious situation of being fired from the job) an employee is considered "terminated." Further, it does not matter, for purposes of determining eligibility for early retirement benefits, when Plaintiff was terminated. The provision regarding Early Retirement Age contains no requirement of active employment.

In [Leicht v. Sw. Carpenters Pension Plan, No. 13-55715, Fed.Appx. , 2015 WL 3452079 \(9th Cir. June 1, 2015\)](#), the court reversed the district court's ruling, finding that the Plan abused its discretion when it arbitrarily interpreted the term "building inspector" to mean only publicly-employed building inspectors without any rational justification and suspended Plaintiff's benefits on this basis.

**Non-qualified top hat plan is exempted under ERISA from spousal consent requirements.** In [\*E & J Gallo Winery v. Rogers\*, No. 13-55327, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 738265 \(9th Cir. Feb. 23, 2015\)](#), an interpleader action to determine the designated beneficiary under the Key Executive Profit Sharing Retirement Plan (the “ERP”) belonging to a now-deceased former Gallo employee, the 9<sup>th</sup> Circuit Court of Appeals affirmed the district court’s decision that Mark Rogers was the proper beneficiary of the ERP benefits. The Gallo Qualified Plan provides that benefits would be paid a) to the surviving spouse, or b) to the designated beneficiary, but only if there was no surviving spouse or if the surviving spouse had consented to the designated beneficiary, and would pass to the estate only if there were no surviving spouse or the surviving spouse had consented to the designated beneficiary. The district court correctly concluded that Robert unambiguously designated his former wife, Audrey Rogers, as his primary beneficiary under the ERP, and his brother, Mark, as his secondary beneficiary. First, nothing in the ERP governing documents provided that Robert’s marriage void his prior beneficiary designation. Second, the ERP is a non-qualified, top hat plan, exempted under ERISA from spousal consent requirements. Third, the primary beneficiary waived her right to the benefit.

**Denial of benefits under health and pension plan affirmed.** In [\*LeBlanc v. Motion Picture Indus. Health Plan\*, No. 13-55291, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 736941 \(9th Cir. Feb. 23, 2015\)](#), the court affirmed the district’s denial of Plaintiffs’ claim for benefits under the Defendants Motion Picture Industry Health Plan and Motion Picture Industry Pension Plan and the denial of Plaintiffs’ motion for attorney fees. The court found that Defendants gave specific and legitimate reasons for rejecting non-contemporaneous records and records other than payroll records to demonstrate the requisite employment and hours and Plaintiffs received a “full and fair” review as required by 29 U.S.C. § 1133(2). The district court did not abuse its discretion in denying Plaintiffs’ motion for attorneys’ fees.

In [\*Finley v. N. CA. Carpenters Pension Fund Trustees\*, No. 2:13-CV-1132-GEB-EFB, 2015 WL 692242 \(E.D. Cal. Feb. 18, 2015\)](#), the *pro se* Plaintiff alleged that defendants wrongfully denied him benefits and that he is “totally disabled” as that term is defined by the pension plan. Plaintiff worked as a carpenter and joined the carpenters union in San Francisco, Carpenters Local # 22, in 1978. Between 1979 and 1980, plaintiff worked as a union carpenter in Palm Springs, California, before taking a short break from carpentry to work as a locksmith. In 1982, plaintiff joined the carpenters union in San Bruno, California, and continued to work as a union carpenter without a break in service until his retirement. As a union member, he participated in a pension plan that was governed by the Pension Fund. The crux of Plaintiff’s complaint is that Defendants wrongfully removed the previously-granted Future Service Eligibility (“FSE”) credits for which

he had previously been credited. The court found that Plaintiff's amended complaint contains allegations sufficient to assert an ERISA claim that he was entitled to receive FSE credits under the plan due to his disability, but that such credits were wrongfully removed in violation of the plan. But, Plaintiff's complaint fails to allege that several of the defendants engaged in any wrongful conduct and the complaint references several purported claims, including breach of contract, theft of pension credits, bad faith, fraud, collusion, and oppression, which are not supported by any factual allegations. The court recommended that the remaining Defendants who have appeared in this action be dismissed, and this matter proceed on Plaintiff's ERISA claim brought pursuant to 29 U.S.C. § 1132(a)(1)(B) against the Carpenters Funds Administrative Office of Northern California and the Pension Fund.

In [\*Giannini v. Carpenters Pension Trust Fund for N. California\*, No. C 14-05227 LB, 2015 WL 498726 \(N.D. Cal. Feb. 5, 2015\)](#), a matter brought by a *pro se* plaintiff, the court found Plaintiff's claim to recover \$17,500 under an ERISA-covered pension plan could have been brought under ERISA § 502(a)(1)(B) and is completely preempted by ERISA. As such, the court granted the Fund's motion to dismiss.

#### J. Tenth Circuit

**Plan participant is not entitled to convert previously elected early retirement benefit into a disability claim under the unambiguous terms of defined benefit pension plan.** In [\*Martinez v. Plumbers & Pipefitters Nat. Pension Plan\*, No. 14-1315, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4547570 \(10th Cir. July 29, 2015\)](#), the Tenth Circuit affirmed the Fund's denial of Plaintiff's claim for disability benefits under a multiemployer defined benefit pension plan. Plaintiff had retired from plumbing in 2004 at age 56 and took advantage of the Plan's early retirement pension. After a few years he resumed work and his pension was suspended during that time according to rules that prohibit retirement benefits during disqualifying employment. When he retired again in 2009, he requested the Fund to allow him to convert the pension benefits he previously elected from an early retirement pension to a disability pension—a change that would entitle him to higher monthly payments. The Fund denied the conversion and the district court upheld the denial. The Tenth Circuit agreed that the Plan language is unambiguous and allows Plan participants to apply for and receive only one type of pension benefit for life absent several clearly delineated exceptions, none of which apply to Plaintiff. With respect to the standard of review, the court declined to determine whether the Fund in fact violated ERISA's procedural requirements or whether any of the alleged violations would be serious enough to warrant *de novo* review because, even considering the Fund's denial of benefits *de novo*, the court would affirm. Plaintiff argued that the Fund was equitably estopped from denying his benefits because correspondence misled him into believing that he would be able to convert his retirement to a disability pension, including statements that he could “re-retire.” The court determined that because the Plan

language is unambiguous and the representations cited by Plaintiff are not the type that rise to the requisite level of egregiousness, his equitable estoppel claim fails.

**Colo.Rev.Stat. § 13–54–102(1)(s) does not apply to funds once paid out from a retirement plan.** In [\*In re Gordon\*, No. 14-1257, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3916597 \(10th Cir. June 26, 2015\)](#), the Gordons sought relief under Chapter 7 of the Bankruptcy Code. Their assets included a 401(k) retirement account with a \$16,700 balance and a savings account holding \$2,051, which was the balance remaining from a lump-sum distribution from the retirement account. These funds were not commingled with money from other sources. The Tenth Circuit affirmed the district court’s holding that the Colorado exemption for “[p]roperty ... held in or payable from any pension or retirement plan or deferred compensation plan,” (Colo.Rev.Stat. § 13–54–102(1)(s)) does not apply to funds once paid out from a retirement plan.

In [\*Richardson v. Kellogg Co.\*, No. 14-CV-2372-DDC-JPO, 2015 WL 474320 \(D. Kan. Feb. 4, 2015\)](#), the *pro se* Plaintiff asserted that Defendants discriminated against him and breached his retirement contract by denying him retirement and medical benefits that he is entitled to receive under his retirement plan. Because Plaintiff did not exhaust his administrative remedies, and the court found no evidence in the summary judgment record showing that exhaustion would have been futile, the court granted summary judgment against Plaintiff on his ERISA claim.

In *United States v. Wyatt*, No. 96-CR-00468-RBJ, 2015 WL 148677 (D. Colo. Jan. 12, 2015), the court dismissed an application for a writ of garnishment where the government sought to garnish benefits from an ERISA-governed retirement account. The retirement plan sponsor objected that the pension plan funds cannot be released without spousal consent. Under ERISA, retirement benefits of married participants must be paid in the form of a qualified joint and survivor annuity. The government argued that under the FDCPA, co-owned property interests are determined by state law, and that to the extent the garnishment affects the property interest of a third party, that individual must intervene in the action and prove her interest. The court agreed with the garnishee that because the pension plan is governed by ERISA, the spouse’s property interest would be based in federal law and she does in fact have such an interest. The court determined that without spousal consent, the funds cannot be garnished. The court also determined that the garnishee has standing to adjudicate whether the funds can be garnished without spousal consent and the spouse did not need to intervene in the matter.

K. Eleventh Circuit

**Plan administrator abused its discretion in denying Plaintiff “Male direct owner” classification under pension plan.** [Lee v. Equity Properties Asset Management, Inc., et al., No. 8:13-CV-2239-T-30EAJ, 2015 WL 6956556 \(M.D. Fla. Nov. 10, 2015\).](#) The court found that Defendants’ decision to deny Plaintiff the advantageous “Male direct owner” classification under the Equity Properties Asset Management, Inc. Defined Benefit Pension Plan was arbitrary and capricious. The court found that under the terms of the Plan, “Male direct owners” is undefined and ambiguous and the ambiguity must be construed in Plaintiff’s favor for purposes of *de novo* review. Under Plaintiff’s interpretation, he fits the description of “Male direct owners” because he held an option to purchase 50% of EPAM’s stock. Because the administrator was *de novo* wrong, the court next determines whether the administrator was vested with discretion in interpreting the provisions of the Pension Plan. The court found that the plan administrator was vested with discretion but that its decision was unreasonable given a number of procedural irregularities. The procedural irregularities that the court found most notable included Defendants’ admitted failure to compile an administrative record, failed to timely and properly provide Plaintiff with election forms, and never provided Plaintiff with a final determination on his claim. The court found that a close review of the record suggests that Defendants were, at the very least, partners in a scheme to obscure Plaintiff’s control over the company to their mutual advantage.

[Taylor v. NCR Corp., No. 1:14-CV-2217-WSD, 2015 WL 5603040 \(N.D. Ga. Sept. 23, 2015\).](#) The court granted Defendant’s motion to dismiss based on its arguments that (1) statutory penalties under ERISA Section 104 do not apply to top hat plans, and (2) a tax impact is not part of an accrued benefit under ERISA.

L. D.C. Circuit

**PBGC did not act arbitrarily or capriciously in declining to provide shutdown benefits or insure a participant’s individual account.** In [Deppenbrook v. Pension Benefit Guar. Corp., No. 13-5254, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 728062 \(D.C. Cir. Feb. 20, 2015\)](#), the D.C. Circuit affirmed the district court’s decision that the PBGC properly interpreted ERISA and did not act arbitrarily or capriciously in declining to provide shutdown benefits to a participant in a terminated pension plan, and the PBGC properly interpreted ERISA and did not act arbitrarily or capriciously in failing to insure the participant’s individual account. The court held that the PBGC properly interpreted ERISA and its own regulations by insuring only benefits that were nonforfeitable on the plan termination date. Plaintiff was not entitled to shutdown benefits because he was not

terminated until approximately six weeks after the plan terminated on June 14, 2002. The court rejected the argument that the plan termination date was the same as the date on which Plaintiff received the notice of plant closure pursuant to the WARN Act. The WARN Act's 60-day notice requirement, 29 U.S.C. § 2102(a), was not a "required waiting period" under ERISA, and therefore did not cause shutdown benefits to vest on May 1. The court also found that the PBGC properly declined to administer the individual account portions of the pension plan. Plaintiff's pension-plan benefit included "a defined benefit pension determined in accordance with Article 5" of the pension plan, as well as an "Individual Account Benefit based on the balance of the Individual Account of the Participant." Each individual account was simply "an account maintained on behalf of a" plan participant and the PBGC is statutorily prohibited from insuring this account. Lastly, Plaintiff argued that the PBGC unlawfully amended his pension plan by requiring him to accept a distribution of his individual account. Assuming arguendo that the PBGC in fact amended the plan, the court found that Plaintiff cannot identify a statutory provision that bars the PBGC from doing so.

**Fund did not abuse its discretion in denying claims of former spouse and awarding death benefits to beneficiaries designated by an emergency fiduciary.** [\*Fanning v. Bell, No. CV 13-1937 \(CKK\), F.Supp.3d\*](#), 2015 WL 572248 (D.D.C. Feb. 11, 2015) involves a Rule 22 interpleader action to resolve a dispute between Defendants over the proper beneficiaries entitled to a death benefit payable from Plaintiff. Plaintiff sought summary judgment that the Central Pension Fund did not abuse its discretion in awarding the death benefit to the decedent's four grandchildren, who were designated as beneficiaries on the decedent's behalf. In opposition, Defendant argued that she is entitled to benefits paid by the Central Pension Fund for two reasons: (1) she was still legally married to the decedent at the time of his death, and (2) she was named as a beneficiary of the decedent's pension during their marriage and that designation was never validly changed. The court found that the Central Pension Fund did not abuse its discretion in rejecting both of these arguments. First, ten years prior to his death, a court in Kentucky entered an "Interlocutory Decree of Dissolution of Marriage." Bell argued that the decree ended the marriage but did not address the marital assets, and as such, it was not final at the time of his death. However, the court found that Bell cited to no authority to support the conclusion that her divorce was not final at the time of death ten years later. Second, Bell was never affirmatively designated as the Beneficiary of the decedent's pension and was only listed as the Beneficiary, per operation of the Plan, because she was his spouse. Upon their divorce, Bell was no longer a beneficiary, and she did not have a QDRO entitling her to a surviving spouse annuity. Lastly, the designation form naming the decedent's four grandchildren was signed by an emergency fiduciary who had full and complete emergency guardianship including the ability to make medical and financial decisions and had the power to "execute instruments." The court found that it was not unreasonable for the Fund to accept the terms of the emergency fiduciary Order on its face even though there was an ongoing criminal investigation related to the Beneficiary

form since the court order appeared valid on its face and the Central Pension Fund was not aware of any actual criminal charges or any conviction resulting from the criminal investigation. Accordingly, the court granted Plaintiff's Motion for Summary Judgment.

**Ex-spouse not entitled to pension plan survivor benefits.** In *Musgrove v. Inst.*, No. CV 13-1794 (ABJ), \_\_\_F.Supp.3d\_\_\_, 2015 WL 393242 (D.D.C. Jan. 30, 2015), the court granted Defendants' motion for judgment on the pleadings in this matter where Plaintiff brought suit challenging the denial of survivor benefits from her former husband's pension plan. Plaintiff also claimed that TIAA-CREF and the Brookings Institution violated ERISA by failing to provide her with all of the documents and information she requested. In addition, she argued that even if she is not a beneficiary of the plan, Defendants should be estopped from denying her the survivor benefit because they previously informed her that she would receive it. The court found that Plaintiff is not a beneficiary of the Plan because the plain language of a 2009 amendment to the Plan excludes Plaintiff since she is an ex-spouse. With respect to her request for documents, Plaintiff did not contest Defendants' assertion that she received all of the documentation and information that was relied on or "submitted, considered, or generated in the course of making the benefit determination." Rather, she sought further documentation in order "to ascertain what, if any, notification was provided to the decedent that an amendment had been made to the Plan." The court found that Plaintiff is not entitled to information relating to notice to the decedent unless it relates to the benefits determination, and she did not allege that it does. Lastly, the court found that Plaintiff did not establish a claim for equitable estoppel because she failed to allege that she relied to her detriment on the initial letters she received and that she has suffered prejudice as a result.

**PPA § 1107 does not provide relief from 29 C.F.R. § 4041.8.** In *Royal Oak Enterprises, LLC v. Pension Benefit Guar. Corp.*, No. CV 13-1040 (GK), \_\_\_F.Supp.3d\_\_\_, 2015 WL 364336 (D.D.C. Jan. 28, 2015), the court granted summary judgment to the Pension Benefit Guaranty Corporation ("PBGC") in a matter where Plaintiff challenged the PBGC's determination that it had improperly decreased the value of plan benefits after its pension plan's termination and ordered Plaintiff to make additional payments to Plan participants. After the Plan's termination date, Plaintiff changed the method it used to calculate certain payments to Plan participants which resulted in them receiving approximately \$2.1 million less than they would have been paid under the terms of the Plan as previously written.

In its analysis, the court noted that 29 U.S.C. § 1341 provides the "[e]xclusive means" for terminating single-employer pension plans and requires plan administrators to distribute assets "in accordance with the provisions of the plan and any applicable regulations." 29 U.S.C. § 1341(a)(1) & (b)(3)(A). Further, resolution of this matter rests primarily on the PBGC's regulation codified at 29 C.F.R. § 4041.8, which provides that a "participant's or beneficiary's plan benefits are determined under the plan's provisions in effect on the plan's termination date."

29 C.F.R. § 4041.8(a). Through PPA § 1107, Congress explicitly provided relief from any violations of ERISA’s anti-cutback provisions that occurred from a Plan’s compliance with required plan amendments. Under PPA § 1107, if a plan administrator amends a pension plan in order to comply with the PPA, the pension plan or contract shall be treated as being operated in accordance with the terms of the plan during the grace period and such pension plan shall not fail to meet the requirements of IRC and ERISA by reason of such amendment. Any amendment must be made on or before the last day of the first plan year beginning on or after January 1, 2009. Second, the amendment must apply retroactively to the grace period and the plan must have been operated as if such amendment were in effect during the grace period.

Plaintiff argued that PPA § 1107, accords with § 4041.8, and was in effect on the Plan termination date although it was not adopted until after the Plan’s termination. Second, Plaintiff argued that even if the PPA Amendment was not in effect on the termination date, it is permissible under § 4041.8’s exceptions for amendments that do not decrease benefits or are necessary to meet certain tax code requirements.

In rejecting Plaintiff’s arguments, the court found that the PPA Amendment was not “in Effect” on the Plan’s termination date because the PBGC’s interpretation of “in effect” is entitled to deference and § 1107 of the PPA does not provide relief from 29 C.F.R. § 4041.8. The court also found that the PPA Amendment is not a permissible post-termination amendment under Title IV of ERISA and 29 C.F.R. § 4041.8 because the PPA Amendment decreases the value of the participants’ or beneficiaries’ plan benefits under the plan’s provisions in effect on the termination date and the “decrease” in the value of plan benefits caused by the PPA Amendment was not necessary to meet a qualification requirement under section 401 of the IRS Code.

#### XIV. *Plan Status*

##### A. Second Circuit

[Hailoo v. Disability RMS, First Unum Life Insurance Company, No. 14-CV-1992\(ADS\)\(ARL\), 2015 WL 7575906 \(E.D.N.Y. Nov. 25, 2015\)](#) (Judge Arthur D. Spatt). ERISA does not apply to policy where insured is self-employed, the sole owner of her dental practice, and none of her employees are entitled to disability benefits under the Policy.

**Long-term incentives plan is not an ERISA plan.** [Timian v. Johnson & Johnson, No. 6:15-CV-06125 MAT, 2015 WL 6454766 \(W.D.N.Y. Oct. 26, 2015\)](#) (Judge Michael A. Telesca). Defendant maintained a Long-Term Incentive Plan to provide “long-term incentives” for its employees, including Restricted Stock Unit awards, which are award(s) of a right to receive an amount based on the Fair Market Value of a share of Common Stock of Defendant, subject to

such terms and conditions as the Administrator may establish. The court found that this Plan is neither an employee welfare benefit plan nor employee pension benefit plan governed by ERISA. The Plan is not a welfare benefit plan because it is discretionary and has the stated purpose of providing long-term incentives to those employees with responsibility for the success and growth of the Company. It is not established or maintained for the purpose of providing for its participants medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, prepaid legal services, or similar benefits. The Plan is not a pension plan because although it contemplates the possibility of the deferral of awards, the deferral lies in the sole discretion of the plan administrator. Further, the deferral period cannot extend past the termination of employment. Even if some payments under the Plan may be made after the employee has retired or left the company, it does not result in ERISA coverage.

[Smith v. City of New York, No. 14 CIV. 2690 NRB, 2015 WL 5231366\(S. D.N.Y. Sept. 8, 2015\)](#) ERISA Section 510 claim brought by New York City schoolteacher dismissed because teachers' pension and retirement plan benefits are exempt from ERISA.

In [Forte v. BNP Paribas, No. 14-CV-8556 JPO, 2015 WL 3604317 \(S.D.N.Y. June 8, 2015\)](#), the court held that the "2012 Deferred Compensation Scheme" is a bonus plan exempt from ERISA's definition of a plan, which excludes payments made by an employer to some or all of its employees as bonuses for work performed, unless such payments are systematically deferred to the termination of covered employ or beyond, or so as to provide retirement income. Under the Scheme, a percentage of an employee's bonus for work performed in 2011 is paid immediately, in 2012, and the remainder is retained by BNPP to be disbursed over the course of three years, from 2013 to 2015, in the form of cash and BNPP stock units. The Plan also provides rules for payment of a deferred bonus in the event that an employee leaves the company prior to the full issuance of that bonus, i.e., prior to 2015.

#### B. Third Circuit

In [Hayes v. Reliance Standard Life Ins. Co., No. CIV.A. 3:14-0714, 2015 WL 1219277 \(M.D. Pa. Mar. 17, 2015\)](#), Plaintiff is a self-employed, independent general contractor with no employees who is a member of the Pennsylvania Builders Association (PBA). The PBA established and sponsored a disability plan and offered its members the opportunity to apply for short and long term disability insurance and life insurance through an advertisement it sent to its members. Plaintiff applied for benefits and he was issued STD, LTD, and life insurance policies, for which he timely paid premiums. When Plaintiff became disabled, Reliance denied his claim

because he was not an employee of the PBA and did not submit proof that he was a PBA member. Plaintiff brought suit for breach of contract, bad faith, and negligence in state court. Defendants removed arguing that the policies in question are covered by ERISA. After a lengthy analysis, the court determined that the PBA is an employee organization under ERISA because it has a “bona fide” organizational relationship among its members and is not simply an association for the purpose of qualifying for benefits. As such, the court found that Plaintiff’s state law claims are preempted by ERISA and denied Plaintiff’s motion to remand. The court also found that the PBA members Plan is outside of ERISA’s safe harbor protection and that Plaintiff’s complaint must be dismissed for his failure to exhaust.

In [\*Hershan v. Unum Grp. Corp.\*, No. CIV. 2:14-6120 WJM, 2015 WL 502154 \(D.N.J. Feb. 5, 2015\)](#), the court found that a disability policy remained an ERISA plan even though the employer ceased operations and Plaintiff opted to continue his coverage as an individual and pay premiums directly rather than through the employer. The court rejected the argument that since the employer no longer exists, the policies no longer involve an “employer” and are therefore no longer governed by ERISA. While the Third Circuit has not addressed this issue head on, numerous courts have held that an employee welfare benefit plan does not lose its ERISA status merely because the employer who once established or maintained the plan subsequently goes defunct. The court distinguished *In re Lowenschuss*, 171 F.3d 673, 680 (9th Cir.1999) since it involved a pension plan, the definition of which focuses on the present rather than the past.

In *McLaughlin v. Jones*, No. CIV.A. 14-3430 JAP, 2015 WL 404913 (D.N.J. Jan. 29, 2015), Plaintiff sought access to the grievance procedure set forth in the collective bargaining agreement Dow Jones had negotiated with the Independent Association of Publishers’ Employees (“IAPE”), a labor union representing Dow Jones employees at its Monmouth Junction, New Jersey facility, among other locations. Plaintiff argued that a denial of access to this grievance procedure deprived him of benefits due to him under an employee benefit plan in violation of Section 502(a)(1)(B) of ERISA. The court found that Plaintiff failed to allege that he is seeking relief under an ERISA-covered employee welfare benefit plan, because the grievance procedure under the CBA, as well as the CBA itself, do not qualify as employee welfare benefit plans. The court granted Defendant’s motion to dismiss.

#### C. Fourth Circuit

**Onetime lump sum payment obligations do not create benefit plans under ERISA.** [\*Hayes v. Bayer Cropscience, LP, et al.\*, No. 2:15-CV-07588, 2015 WL 5840215 \(S.D.W. Va. Oct. 5, 2015\)](#) (Judge Joseph R. Goodwin). The court found that Plaintiff’s claim cannot be preempted by ERISA because the benefit to which he is claiming entitlement does not require an ongoing

administrative plan to satisfy the employer's obligation. Plaintiff in this case is not alleging a claim under Bayer's Separation and Retention Agreement, Letter Agreement IX, which the record demonstrates allows for a qualifying employee to choose among several plan options. Instead, Plaintiff alleges that he is entitled to a one-time, lump-sum severance payment. While Plaintiff appears to intentionally avoid direct reference to the CBA's layoff allowance provisions, the court found that the origins of any promise to pay a lump sum severance amount upon the manifestation of a triggering event is of no consequence under an ERISA preemption analysis because the Supreme Court has determined that such onetime, lump sum obligations do not create "benefit plans" under ERISA.

**Plan's suit against participant for declaratory judgment is not authorized by ERISA.** In [Ret. Comm., Plan Adm'r of Executive Ret. Plan of Thermal Ceramics Latin Am. v. Magasrevy, No. 5:14-CV-408-FL, F.Supp.3d](#), 2015 WL 5042896 (E.D.N.C. Aug. 26, 2015), Plaintiffs brought suit seeking a declaratory judgment under ERISA concerning Defendant's entitlement to retirement benefits under two different plans. The court concluded that since the plans at issue in this case are administered in Raleigh, North Carolina, and defendant has been served in the Southern District of Florida, this court would have personal jurisdiction over Defendant under § 1132(e)(2) if this is a proper ERISA enforcement action. However, the court found that it does not have subject matter jurisdiction over the action under § 1132(a)(3). Plaintiffs did not identify any particular provision of ERISA that they are enforcing through the instant action. The court noted that although the Fourth Circuit has not addressed directly the issue presented in this case, the Eleventh Circuit in *Gulf Life Insurance Co. v. Arnold*, 809 F.2d 1520 (11th Cir.1987) held that a fiduciary's declaratory judgment action to determine the extent of its liability is not an action that enforces ERISA. All Plaintiffs need do to enforce the terms of the plan, assuming it contends the claim for benefits is invalid, is deny payment. Here, Plaintiffs did not bring suit to compel Defendant to do anything. Their claim seeking a declaration as to the status of the Top Hat Plan as an ERISA plan does not enforce or remedy a violation of ERISA or the plan. Therefore, the instant action does not constitute an action to "enforce" ERISA or the terms of the plan within the meaning of § 1132(a)(3)(B) or a suit to obtain "appropriate equitable relief." The court found that Plaintiffs attempt to use the declaratory judgment action for "procedural fencing" since Defendant indicated that he was going to file suit in the Southern District of Florida where he resides. Plaintiffs filed this action in a district where Defendant would not otherwise be subject to personal judgment absent ERISA's nationwide service of process provision. ERISA does not permit Plaintiffs to gain a procedural advantage over Defendant in this manner. Accordingly, the court dismissed the action.

In [Green v. Baltimore City Bd. of Sch. Comm'rs, No. CIV.A. WMN-14-3132, 2015 WL 1258414 \(D. Md. Mar. 17, 2015\)](#)(**Not Reported in F.Supp.3d**), the court granted Plaintiffs' motion to

withdraw the Court's Memorandum Opinion and Order granting summary judgment in their favor based on the fact that the parties had operated under the misapprehension that ERISA, as amended by COBRA, governed Defendant Baltimore City Board of School Commissioners' administration of its health insurance plan. However, the governmental plan exception to ERISA applies to the health insurance plan.

In [Buser v. Eckerd Corp., No. 5:12-CV-755-FL, 2015 WL 418172 \(E.D.N.C. Feb. 2, 2015\)](#), the court found that Rite Aid's uninsured, self-funded short-term disability benefit program is not governed by ERISA because it is a "payroll practice." The "payroll practice" exemption excludes payment of an employee's normal compensation, out of the employer's general assets, on account of periods of time during which the employee is physically or mentally unable to perform his duties, or is otherwise absent for medical reasons. Here, Rite Aid paid all short-term disability claims out of their general assets.

#### D. Fifth Circuit

[Martin v. Trend Personnel Services, No. 3:13-CV-3953-L, 2015 WL 7424757 \(N.D. Tex. Nov. 23, 2015\)](#) (Judge Sam A. Lindsay). The court concluded that Plaintiffs are not entitled to recover on their breach of fiduciary duty claim under ERISA against Defendants because the Bonus Agreement at issue fails to satisfy all of the requirements for an ERISA plan. Facts relevant to the court's decision was that Trend Personnel agreed to pay the annual premium on the policies, but it was not involved in the administration of the policies or submission of claims; did not employ a benefits administrator; and did not issue a booklet or provide information to employees regarding the life insurance benefits offered by Penn Mutual. Further, Defendants had no discretion under the Bonus Agreement to determine whether an employee was eligible for life insurance benefits.

**Employee welfare benefit plan maintained by Transit Management of Southeastern Louisiana is a "governmental plan" exempt from ERISA.** [Smith v. Reg'l Transit Auth., No. CIV.A. 12-3059, 2015 WL 6442337 \(E.D. La. Oct. 23, 2015\)](#) (Judge Carl J. Barbier). In this case Plaintiffs allege that Defendants denied them premium-free medical insurance, quarterly Medicare premiums, and deductible reimbursements as guaranteed by their employee welfare benefits plan. Plaintiffs also assert that Defendants breached their fiduciary duties under ERISA in violation of § 1132(a)(2). The court had to decide whether the benefit plan in this case is a "governmental plan" and therefore exempt from ERISA. The court determined that the Regional Transit Authority ("RTA") is a political subdivision under the two-prong *Hawkins* test. The court also found that the Transit Management of Southeastern Louisiana, Inc. ("TMSEL") fits the description of an agency or instrumentality under ERISA and declined to analyze whether

TMSEL is a political subdivision. The court concluded that when Plaintiff's cause of action arose in March 2006, TMSEL was an agency or instrumentality of a political subdivision, it maintained the Plan for its employees, and the Plan is a governmental plan excluded from ERISA's coverage. The court also concluded that because TMSEL was an agency or instrumentality of the RTA, any claim against TMSEL for which Plaintiffs allege the RTA is responsible does not arise under ERISA.

E. Sixth Circuit

**Employer executed written agreements binding itself to CBA's fringe benefit obligations and is required to make delinquent contributions.** [Bd. of Trustees of the Plumbers, Pipe Fitters & Mech. Equip. Serv., Local Union No. 392 Pension Fund v. B&B Mech. Servs., Inc., F.3d , 2015 WL 9466618 \(6th Cir. Dec. 29, 2015\)](#) (COLE, Chief Judge; GIBBONS (dissenting) and STRANCH, Circuit Judges). Five multi-employer fringe benefit funds ("the Funds") filed suit to collect delinquent employee fringe benefit contributions from B & B Mechanical Services, Inc. ("B & B"), an Ohio commercial plumbing contractor. The Funds were established for the benefit of contractors' employees who perform work under a collective bargaining agreement (CBA) negotiated between the Union and the Mechanical Contractors Association (MCA) as agent for its member employers. B & B argued that it made ten years of contributions on a voluntary basis and that its principal did not independently sign the CBA. The district court agreed and granted summary judgment in favor of B&B. The district court held that the Funds failed to produce evidence to prove that B & B signed the CBA or entered into any written agreement binding B & B to the CBA. The panel majority reversed the district court's grant of summary judgment and remanded the case for further proceedings. The court concluded that as a matter of law that B & B entered a number of written agreements setting out its obligation to contribute as required by the Labor Management Relations Act (LMRA) § 302(c)(5)(B) and is bound to pay delinquent contributions that are owed to the Funds in accordance with the terms of the CBA and the trust agreements. The majority did not address whether B & B's multi-year contributions to the Funds are void for illegality because the undisputed evidence supports the conclusion that B & B executed written agreements binding itself to the CBA's fringe benefit obligations. The majority also did not decide whether an employer's course of conduct alone is sufficient to demonstrate that the employer is bound to a written agreement requiring the payment of contributions.

**Voluntary pre-retirement attrition program is not an ERISA Plan.** In *Buchanan v. Gen. Motors, LLC*, No. 13-1664, \_\_Fed.Appx.\_\_, 2015 WL 105892 (6th Cir. Jan. 7, 2015), the 6<sup>th</sup> Circuit Court of Appeals affirmed the district court's grant of judgment on the pleadings in favor

of Defendant General Motors on all of Plaintiffs' four claims: (1) equitable estoppel under federal common law and ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); (2) breach of fiduciary duty under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3); (3) enforcement of substantive rights under ERISA § 502(l)(1)(B), 29 U.S.C. 1132(l)(1)(B); and (4) recovery of benefits (denial of benefits) under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). The dispute concerns an "UAW–GM–Delphi Special Attrition Program" ("SAP") entered into by GM, Delphi, and the United Autoworkers union. The SAP created a voluntary pre-retirement program under which Delphi employees that had accrued between twenty-seven and thirty years of service would cease reporting to work, but continue to receive monthly wages and accumulate credited service toward their pensions under the Delphi Pension Plan. When the assets and liabilities from the Delphi Pension Plan were transferred to the GM Pension Plan, GM determined that it would count Plaintiffs' time employed at Bosch toward their eligibility for pension benefits, but it would not count that time in calculating the amount of the benefits due. Thus, it had "revised" Plaintiffs' pension benefits downward and Plaintiffs allege that this reduction in their pension benefits was done in violation of the SAP.

The panel majority determined that the gravamen of Plaintiffs' complaint is that "GM made a written representation to all of the named Plaintiffs in the form of the SAP that the pension amount would be calculated using a formula that included their years of service at Bosch as well as Delphi and GM." The court did not construe the complaint as making any claim against GM under the GM Pension Plan. Because the court determined that Plaintiff's claims are rooted in the SAP, the threshold question presented on appeal is whether the SAP is an ERISA Plan. The court determined that the SAP cannot be classified as an ERISA pension benefits plan in the first instance because it does not provide "retirement income" as defined in 29 U.S.C. § 1002(2)(A)(i). The SAP is a self-described "pre-retirement program" that incentivizes retirement by providing certain monthly wages for participating employees. Upon retirement, the SAP payments end, and the former employee receives pension benefits pursuant to the Delphi or GM Pension Plan. The SAP does not provide for pension benefits separate from or in addition to those provided by Delphi or GM. By its plain terms, the court found that the SAP does not provide for pension benefits at all. Because the SAP is not an ERISA plan, the court found that Plaintiffs fail to state a claim. The dissent contended that Plaintiffs are making a claim against the GM Pension Plan and Plaintiffs must exhaust their administrative remedies before the federal court rules on the motion for judgment on the pleadings—just as the GM Pension Plan requires.

#### F. Seventh Circuit

In [OWENS v. ST. ANTHONY MEDICAL CENTER, INC., No. 14-CV-4068, 2015 WL 3819086 \(N.D. Ill. June 18, 2015\)](#) (Not Reported in F.Supp.3d), the court stayed Defendant's motion to dismiss Plaintiffs' claim challenging the retirement plan's "church plan" status pending the

Seventh Circuit's decision in *Stapleton v. Advocate Health Care Network*, No. 14-cv-01873, 2014 WL 7525481 (N.D.Ill.Dec. 31, 2014), where the court certified the following question for interlocutory appeal: In order for an employee benefit plan to qualify as a "church plan" under ERISA, 29 U.S.C. § 1003(b)(2) and § 1033, must the plan be established by a church (or by a convention or association of churches)?

In *Schwartz v. Opportunity Int'l, Inc.*, No. 14-CV-5775, 2015 WL 300591 (N.D. Ill. Jan. 21, 2015), Plaintiff alleged, among other claims, that a separation agreement and vacation and sick day benefit plans are governed by ERISA and that Defendants intended to interfere with her benefits under those plans by terminating her employment. An ERISA-governed welfare plan requires five elements: (1) a plan, fund or program, (2) established or maintained, (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits, (5) to participants or their beneficiaries. The court found that Plaintiff has not sufficiently alleged that there was a welfare plan established or maintained by Defendants for the purpose of sick days and vacation benefits. Plaintiff merely alleged a legal conclusion that "the Separation Agreement and vacation and sick day benefit plans" are governed by ERISA. Further, a severance plan falls under ERISA's coverage when the plan requires an ongoing administrative program to meet the employer's obligation. Severance packages do not fall under ERISA when the only determination for receiving severance is whether a participant was fired with or without cause, as that does not require multiple decisions and does not require decisions to be made on an ongoing basis. Here, the only determination of whether Plaintiff would receive a severance benefit was if she was terminated without cause. Plaintiff did not allege that this severance plan required an ongoing administrative program or multiple decisions on an ongoing basis. Accordingly, the court dismissed this claim without prejudice.

#### G. Eighth Circuit

In [\*Lanpher v. Unum Life Ins. Co. of Am.\*, No. CIV. 14-2560 JRT/HB, 2015 WL 5157519 \(D. Minn. Sept. 2, 2015\)](#), the court determined that the long-term disability policy at issue was not an ERISA plan, where the employer, Merrill Lynch, did not maintain a separate administrative scheme or exercised discretion over eligibility or benefits levels for the Unum Policy. Merrill Lynch did not invite Unum to offer a policy to employees or even conduct a presentation about the Unum Policy; it simply acquiesced to Unum's request to make a presentation to its employees. Merrill Lynch did not play any role in the Policy application process, as the employees submitted their applications directly to Unum. Merrill Lynch merely received the bills from Unum, to which Unum had already applied a 15% discount, and then passed the

premium bills on directly to the employees without taking any other administrative actions. Nothing in the record indicated that Merrill Lynch undertook any financial obligations with respect to the Policy, received any material benefit from Unum for facilitating premium bills, or engaged in any practices beyond automatic forwarding of bills immediately to employees. For these reasons the court concluded that Merrill Lynch's activities did not reach the threshold of establishing or maintaining an ERISA employee welfare benefit plan.

#### H. Eleventh Circuit

In [\*Wallace v. Curwen\*, No. CV 114-236, 2015 WL 510129 \(S.D. Ga. Feb. 5, 2015\)](#), the court found that Curwen did not prove that a relevant ERISA plan exists as it relates to a Solomon Smith Barney IRA account and a disputed change of beneficiary. Because Curwen did not meet her burden of proving that federal question jurisdiction exists, the court granted the motion to remand.

In *Rosen v. Provident Life & Acc. Ins. Co.*, No. 2:14-CV-0922-WMA, 2015 WL 260839 (N.D. Ala. Jan. 21, 2015), a matter involving a denial of benefits under a disability insurance policy, the court denied Defendant's Rule 56 motion seeking a dismissal of all of Plaintiff's claims brought under Alabama law. Defendant took the position that the non-RICO claims are preempted by ERISA. The court explained that it "well understands why Provident wants to place the ERISA fence around Rosen's state law claims... If super-duper-preemption forces Rosen to pursue the limited ERISA remedy, the first defense Provident would likely interpose is his failure to exhaust. He has already pretty much exhausted himself, if his complaint can be believed." The court analyzed a number of cases that found an ERISA plan did not exist under circumstances similar to this case, or that the "plan" was entitled to the "safe harbor" exemption. Here, the benefit policy provided benefits only to Plaintiff, who is the sole owner of Northeast Alabama Urology Center, P.C. ("NEAUC"), and the only doctor in its employ. Plaintiff was insured under individually underwritten form 337 and 1737 disability policies and other NEAUC employees were insured under individually underwritten form 297N disability policies. The court found insignificant that the various policies were issued under the same risk number, # 0077866 since the policies were individually underwritten. There remains genuine issues as to the material fact of whether the form 337, 1737 and 297N policies constitute a single "employee welfare benefit plan." The court found that even if the policies under forms 337, 1737, and 297N could be grouped into a single "employee welfare benefit plan," which they cannot, such a plan would fall within the Department of Labor's "safe harbor" provision. The said regulation provides:

For purposes of title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program

offered by an insurer to employees or members of an employee organization, under which (1) No contributions are made by an employer or employee organization; (2) Participation the program is completely voluntary for employees or members; (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or checkoffs.

29 C.F.R. § 25210.3–1(j). Although NEAUC remitted the premiums, it deducted them from the salaries of the insured employees. Construing the facts and the language in the light most favorable to Plaintiff, the court found that summary judgment is inappropriate on the basis of the very first safe harbor requirement. Further, under the first, third, and fourth safe harbor requirements, Provident’s application of a “12% premium discount” does not place the plan outside the safe harbor definition. Although some courts have determined that a premium discount constitutes a contribution because it is a benefit an employee cannot receive as an individual, the court found that this construction is contrary to the text of the regulation and would swallow the third and fourth safe harbor requirements.

#### I. D.C. Circuit

**Rule 59(e) motion for reconsideration denied where Plaintiff sought to advance new legal arguments, including whether short-term disability plan is governed by ERISA.** [Foster v. Sedgwick Claims Mgmt. Servs., Inc., No. CV 14-1241 \(JEB\), F.Supp.3d , 2015 WL 7737305 \(D.D.C. Dec. 1, 2015\)](#) (Judge James E. Boasberg). Here, Plaintiff moved for reconsideration of the court’s previous grant of summary judgment in favor of Defendants. The court determined that the short-term disability (“STD”) plan is not governed by ERISA and that Sedgwick did not abuse its discretion in denying Plaintiff’s long-term disability (“LTD”) claim. The LTD Plan requires that claimants be eligible for STD benefits or Workers’ Compensation. In her motion, Plaintiff advanced two new theories about the STD Plan, including that it is governed by ERISA and alternatively, that the STD Plan is so “related” to the ERISA-covered LTD Plan that ERISA preempts any state-law remedies and her claim lies only under ERISA. Plaintiff also renewed her arguments that the court should have reviewed Sedgwick’s decision to deny her LTD benefits under a *de novo* standard, and that Sedgwick improperly labored under a conflict of interest as the claims administrator for both Plans. Plaintiff also sought permission to amend her Complaint to include a claim that Defendants interfered with her rights under these Plans, in violation of ERISA § 510. The court found that Plaintiff did not meet the exacting Rule 59(e) standard for altering the judgment for Defendants. First, Plaintiff previously conceded that

the STD plan was a payroll practice not governed by ERISA and there was no change in the law or discovery of new evidence that would support a change in Plaintiff's position. Second, because eligibility for STD benefits is not at all affected by the LTD Plan, no state-law cause of action based on the STD Plan "relates" to the LTD Plan in such a way that it would be preempted by ERISA. The court found that there was no newly discovered evidence or any intervening change in the law meriting reexamination of the court's earlier resolution of the LTD claim. Lastly, the court denied Plaintiff leave to amend her Complaint to assert a § 510 claim.

## XV. *Pleading Issues & Procedure*

### A. First Circuit

**Court grants plaintiff's motion to proceed in pseudonym in lawsuit for disability benefits based on mental illness.** [Doe v. Standard Ins. Co., No. 1:15-CV-00105-GZS, 2015 WL 5778566 \(D. Me. Oct. 2, 2015\)](#) (Magistrate Judge John C. Nivison). In a dispute involving long-term disability benefits for a disability based on mental illness, the court granted Plaintiff's motion to proceed in pseudonym. The court found that the sole focus of the litigation is Plaintiff's serious mental health condition and her attempt to recover disability benefits for that condition. "To deny Plaintiff's request under the circumstances of this case might not only prevent Plaintiff from proceeding on her claim, but might also discourage others who suffer from a serious mental health condition from asserting their claims for mental health related benefits to which they are entitled, or otherwise seeking the assistance of professionals and others in their effort to treat and address their condition." Because the public will have access to the facts relevant to the parties' arguments and the Court's ultimate decision in the case, an order permitting Plaintiff to proceed under a pseudonym will not unreasonably interfere with the public's interest in access to judicial records.

In [Langone v. Son, Inc., No. CIV.A. 12-11717-GAO, 2015 WL 3744419 \(D. Mass. June 15, 2015\)](#), Plaintiff Charles Langone, the manager of a pension fund, brought an ERISA action to enforce an arbitrator's decision that Defendant Son, Inc., is jointly and severally liable with others for amounts due because of a subscriber's withdrawal from the fund. Langone also sued two of Son, Inc.'s shareholders, ("the Hudson defendants") under the New Jersey Uniform Fraudulent Transfer Act, to recover proceeds from sales of Son Inc.'s property. The court agreed with Defendants that regardless of whether the ERISA claim against Son Inc. and the Fraudulent Transfer claim against the Hudson defendants share a "nucleus of operative fact," pendant personal jurisdiction is inapplicable here because the fund did not bring a federal claim against the Hudson defendants. (The pendent personal jurisdiction doctrine, where a federal statute

authorizes nationwide service of process, and the federal and state claims derive from a common nucleus of operative fact, the district court may assert personal jurisdiction over the parties to the related state law claims even if personal jurisdiction is not otherwise available.) The court dismissed the claims against the Hudson defendants for lack of personal jurisdiction.

In *Newman v. Metro. Life Ins. Co.*, No. 12-CV-10078, 2015 WL 275703 (D. Mass. Jan. 21, 2015), Plaintiff brought this action against twenty defendants under ERISA and the whistleblower provisions of the Sarbanes–Oxley Act of 2002 (“SOX”), 18 U.S.C. § 1514A. The Lehman Brothers Holdings Inc. Group Benefits Plan (“the Plan”), the Neuberger Berman Defendants and Individual Defendants Amato, Coviello, Fox, Komaroff, Rado and Uvino (collectively, the “LBHI Defendants”) moved to dismiss the claims against them in Plaintiff’s second amended complaint pursuant to Fed.R.Civ.P. 12(b)(2) for lack of personal jurisdiction; 12(b)(5) for insufficient service of process; and Fed.R.Civ.P. 12(b)(6) for failure to state a claim. MetLife joined the motion as to Count III for equitable relief. Plaintiff had obtained leave from the Court to file an amended complaint specifically “limited to those ERISA claims against the Plan [ ] and a SOX claim against the remaining LBHI Defendants.” The court struck the addition of Count III for equitable relief for being beyond the scope of the court’s grant of leave to amend. The court had already concluded that Plaintiff may press her ERISA claim against the Plan and Metlife but Plaintiff appeared to assert the ERISA claim in the SAC against the individual Defendants. The court struck the ERISA claim as to the individual Defendants, granted the motion, and allowed the case to proceed only as to Plaintiff’s ERISA claim against MetLife and the Plan.

## B. Second Circuit

**Claim dismissed for failure to allege exhaustion of administrative remedies but COBRA notice violation claim is adequately pled.** [Mayer v. Joint Industry Board of the Electrical Industry, et al., No. 15-CV-1460\(JS\)\(ARL\), 2015 WL 9581821 \(E.D.N.Y. Dec. 30, 2015\)](#) (Judge Joanna Seybert). The court dismissed without prejudice Plaintiff’s claim for benefits because she did not allege anything with respect to whether she exhausted or even pursued administrative remedies prior to filing suit. The court declined to dismiss Plaintiff’s COBRA claim in her amended complaint, finding that she stated a claim under 29 U.S.C. § 1132(c)(1)(A) for a violation of COBRA’s statutory notice requirements. Specifically, she alleged that her husband disappeared on June 14, 2013 and that Defendants were fully informed about his disappearance, and the Defendants made a determination that a qualifying event had occurred at some point and it would most likely have been a reduction of hours under 29 U.S.C. 1163, since he never returned to work following his June 14 disappearance. Accepting these allegations as true, the court found that the spouse’s failure to return to work was a termination or reduction of hours and, accordingly, a “qualifying event” as set forth in 29 U.S.C. § 1163(2). Lastly, the court

dismissed as a defendant the treasurer of the Joint Industry Board of the Electrical Industry. The court declined to address whether the treasurer is an appropriate defendant since Plaintiff did not proffer any specific allegations regarding whether he is the administrator or otherwise possessed control or discretion with respect to the Plan's denial of benefits.

**Allegation of disparate treatment by union member does not state a claim under ERISA.**

[Trieste v. Graphic Commc'ns Teamsters Local 503, No. 14-CV-6413, 2015 WL 6872482 \(W.D.N.Y. Nov. 9, 2015\)](#) (Judge Michael A. Telesca). Plaintiff alleged that Defendants made false representations to him that as a union member, he was required to make monetary contributions to the Pension fund as a condition of his employment. The court granted Defendants' motion to dismiss, finding that Plaintiff did not plead a cognizable ERISA claim. The court explained that Plaintiff's claim that Local 503, in requiring his participation in the Pension Fund as a condition of employment, engaged in disparate treatment and acted in a manner that was arbitrary and capricious, if proven true, would be a breach of Local 503's duty of fair representation, not a breach of ERISA.

**District court erred by denying motion to vacate default judgment without consideration of the Rule 60(b) factors.** [Gesualdi v. Quadrozzi Equip. Leasing Corp., No. 13-3018-CV, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 6642681 \(2d Cir. Nov. 2, 2015\)](#) (DENNY CHIN, CHRISTOPHER F. DRONEY, Circuit Judges, EDWARD R. KORMAN, Senior District Judge). The Second Circuit vacated and remanded the district court's decision denying Defendants' motion to vacate a default judgment entered against them in this funds collection case. Here, Plaintiffs allege that Defendants are liable for unpaid and delinquent contributions based on single employer and alter ego theories. The court found that the district court did not explain its conclusion that the complaint "established" Defendants' liability. In denying the motion to vacate the default judgment, the district court addressed the timeliness of Defendants' motion and whether their default was willful, but it did not opine on the sufficiency of the complaint, nor did it address the merits of Defendants' defense or the issue of prejudice to Plaintiffs if the default judgment were vacated. In the absence of explanations, the Second Circuit cannot properly review the district court's exercise of its discretion. Accordingly, it remanded to give the district court an opportunity to consider these issues and provide fuller explanations.

In [McCulloch Orthopedic Surgical Servs., PLLC v. United Healthcare Ins. Co. of New York, No. 14-CV-6989 JPO, 2015 WL 3604249 \(S.D.N.Y. June 8, 2015\)](#), the court held that the 30-day period for removal began when Oxford's true agent – CT Corporation – received the pleadings. Removal was timely. Also, for purposes of a motion to remand, the court considers only the original Complaint although the Amended Complaint is operative for all other purposes.

In [\*Managing Directors' Long Term Incentive Plan ex rel. Comm. v. Boccella\*, No. 14 CIV. 7033 PAC, 2015 WL 2130876 \(S.D.N.Y. May 6, 2015\)](#), the court dismissed Plaintiff's declaratory judgment action against Defendant that she has engaged in prohibited competition activity as defined in the Top Hat Plan and accordingly is not entitled to any benefits under the Plan. The court found that Plaintiff, as a fiduciary, does not have standing under ERISA to bring this action. Specifically, fiduciaries do not have standing under Section 1132(a)(3) to seek clarification of their obligations under ERISA-governed contracts and that such suits are not actions to "enforce" ERISA plan terms. The court also decided to abstain from whatever jurisdiction it has in this case.

**Bankruptcy courts do not have jurisdiction to award compensation to a Chapter 7 bankruptcy trustee and his retained professionals out of assets in a 401(k) plan.** In [\*In re Robert Plan Corp.\*, No. 14-1144, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 467707 \(2d Cir. Feb. 5, 2015\)](#), the 2<sup>nd</sup> Circuit considered the issue of whether bankruptcy courts have jurisdiction to award compensation to a Chapter 7 bankruptcy trustee and his retained professionals out of assets in a 401(k) plan governed by ERISA. In concluding that they do not and affirming the decision of the district court, the 2<sup>nd</sup> Circuit explained that a bankruptcy court's power to adjudicate matters in a bankruptcy case turns in part on whether the proceedings are "core" or "non-core." Core proceedings are those that are found to be "arising under" the Bankruptcy Code or "arising in" a bankruptcy case. The court found that no "arising under" jurisdiction exists here because § 704(a)(11) of the Bankruptcy Code merely dictates that if the debtor (or an entity designated by the debtor) served as the administrator of an ERISA plan at the commencement of the debtor's bankruptcy case then the trustee must continue to perform the obligations required of the administrator upon his appointment. Section 704(a)(11) neither alters the substantive duties of ERISA plan administrators nor establishes substantive rights regarding ERISA plans. Similarly, no "arising in" jurisdiction exists here because payment of compensation for ERISA plan administrators is typically an issue that arises outside bankruptcy. It does not depend upon bankruptcy for its existence, nor does it involve an administrative matter that arises only in bankruptcy cases. Finally, the court found that no "related to" jurisdiction exists because 11 U.S.C. § 541(b)(7) explicitly excludes ERISA plan assets from a debtor's bankruptcy estate. Therefore, the outcome of the proceeding relating to compensation could not conceivably have had any effect on the Debtors' estates.

C. Third Circuit

**ERISA claims dismissed where plaintiff did not plead status as a plan participant.** [\*Pursell v. Spence-Brown, et al.\*, No. 13-1571\(FLW\), 2015 WL 9216598 \(D.N.J. Dec. 17, 2015\)](#) (Judge

Freda L. Wolfson). Plaintiff alleged that Local 1033 violated the CBA by failing to include all full and part-time non-managerial, non-officer employees under the provision of the 401(k) plan; that the Local Defendants violated their responsibility under ERISA and the CBA by failing to operate the 401(k) plan prudently and for the exclusive benefit of participants; and that he was discriminated and retaliated against by defendants for exercising rights to which he was entitled under the provisions of the employee benefit plan. The court found that to the extent Plaintiff seeks to represent other Local 1033 employees for alleged ERISA violations, he does not have standing to do so. But more importantly, Plaintiff failed to allege that he was a participant of an employee benefit plan and failure to plead the most basic element of his ERISA claims results in dismissal.

**Section 1132(e)(2) confers personal jurisdiction on the basis of defendant's national contacts; disgorgement claim dismissed because it's a remedy not an independent cause of action; ERISA violations claim dismissed where knowledge of wrongful transfer of plan assets not adequately pled.** [Kalan v. Farmers & Merchants Trust Company of Chambersburg, et al., No. CV 15-1435, 2015 WL 7887893 \(E.D. Pa. Dec. 3, 2015\)](#) (Judge Wendy Beetlestone).

In suit alleging that co-defendants' payment to SYK, a law firm, improperly transferred ERISA plan assets and that SYK committed legal malpractice and breach of fiduciary duty, SYK moved to dismiss for lack of personal jurisdiction and failure to state a claim. SYK also moved to sever. Although the Third Circuit has not addressed the reach of Section 1132(e)(2), it has held in other contexts that a federal court's personal jurisdiction may be assessed on the basis of the defendant's national contacts when the plaintiff's claim rests on a federal statute authorizing nationwide service of process. Thus, it is reasonable to conclude that in ERISA cases, personal jurisdiction is not limited to a defendant's contacts with a particular federal judicial district. The court determined that given the Third Circuit's specific recommendation that a single district judge handle the related litigation, its rulings in other nationwide service of process cases, and SYK's failure to demonstrate a significant hardship if compelled to litigate in the Eastern District of Pennsylvania, SYK's motion to dismiss for lack of personal jurisdiction is denied. The court also found that the claims against it are properly joined because they share common questions of law and fact arising from "the Koresko arrangement" and denied the motion to sever. The court dismissed Count IV (disgorgement) since it is a remedy and not an independent cause of action. Plaintiffs contend that SYK is a non-fiduciary alleged to have accepted payments from trust accounts while it had actual or constructive notice that the payments were in breach of Koresko's fiduciary duties. The court dismissed Count III (ERISA violations) because the allegations fall short of establishing that funds rightfully belonging to an ERISA plan were wrongfully transferred and that SYK had actual or constructive knowledge of the circumstances that rendered the transfer wrongful.

[Communications Workers of America v. Alcatel-Lucent USA Inc., et al., No. 15-CV-8143, 2015 WL 7573206 \(D.N.J. Nov. 25, 2015\)](#) (Judge Claire C. Cecchi). The court denied Plaintiffs' motion to enter a temporary restraining order against Defendants from making two separate transfers of participants, liabilities, and assets from the overfunded Lucent Technologies Pension Plan to the two other underfunded plans, the Alcatel Lucent Retirement Income Plan and the Lucent Technologies, Inc. Retirement Plan, effective December 1, 2015.

**Language of ERISA policy does not explicitly authorize rescission when there is fraud or intentional misrepresentation.** [Salvatore v. Blue Cross of Northeastern Pennsylvania, No. 3:13-CV-02975, 2015 WL 7069334, at \(M.D. Pa. Nov. 12, 2015\)](#) (Judge Robert D. Mariani). The court denied Blue Cross's motion to dismiss Plaintiff's second amended complaint. The issue the court considered but did not fully resolve is whether an insurer is entitled to rescind an ERISA policy based on material misrepresentations in a policy application. The court noted that district and circuit courts around the country have applied ERISA's common law to conclude that material misrepresentations made in an application for a benefits policy may lead to rescission. The Eighth Circuit does not require retroactive rescission for innocent material non-disclosures but requires the decision-maker to act in accordance with its duties as an ERISA fiduciary. With this background, the court denied Defendant's motion to dismiss because: 1) it is not clear from the face of the Second Amended Complaint and supporting materials that Plaintiff either attempted or committed fraud in her application for benefits or that she made an intentional misrepresentation of material fact; and 2) even if it could be established that Plaintiff committed fraud or made intentional misrepresentations of material fact, the Policy does not explicitly authorize rescission. Because Defendant has not shown that Plaintiff's second amended complaint fails to state an ERISA claim on the basis of the language of Plaintiff's policy, the court found it unnecessary to address the other issues raised.

**Court grants in part and denies in part motion to amend complaint and for discovery in action concerning an ESOP.** [Hoover v. Besler, No. CV145786MASDEA, 2015 WL 5854248 \(D.N.J. Oct. 5, 2015\)](#) (Magistrate Judge Douglas E. Arpert). On Plaintiff's Proposed Amended Complaint which alleges various breaches of fiduciary duty and/or co-fiduciary duty claims under ERISA relating to an Employee Stock Ownership Plan, the court granted Plaintiff's motion to amend the complaint with two exceptions. On one proposed claim, the court concluded that on its face it falls outside of the six-year limitations period of § 413(1) and is therefore futile. The court also denied the motion to the extent it purports to being claims against the ESOP, which was previously dismissed from the action. The court also granted Plaintiff's discovery request seeking agreements from 2003-2004 but denied the request as to a defendant's review of the agreement since the court dismissed the claim alleging that this defendant approved the transactions without adequate consideration.

[\*Prof'l Orthopedic Associates, Pa., Cohen v. Horizon Blue Cross Blue Shield of New Jersey\*, No. CIV.A. 14-4731 SRC, 2015 WL 5455820 \(D.N.J. Sept. 16, 2015\)](#). In this lawsuit brought by both the patient and the provider against the insurer for payment of benefits, the court dismissed the claims brought by the patient since, through an assignment of her right to sue; she relinquished her right to bring the cause of action. Both assignor and assignee cannot proceed with the claim. The court also found that Plaintiffs' allegations regarding Horizon's role in analyzing the claim at issue and making the challenged benefits determination are sufficient to state a § 502(a) claim against it.

[\*IUE Multi-Employer Pension Fund v. M & C Vending, Inc.\*, No. CIV. 11-4335 WJM, 2015 WL 5305978 \(D.N.J. Sept. 10, 2015\)](#). The court denied Defendant's motion to vacate a default judgment for withdrawal liability under Rule 60(b)(1) since it was made more than a year after the entry of judgment. The court found that the delay was not justified where Defendant claimed that it could not afford to hire an attorney until after the company's President received an inheritance since Defendant didn't move for default for several months after the President received the inheritance.

In [\*Makwana v. Express Scripts, Inc.\*, No. CIV.A. 14-7096, 2015 WL 4078048 \(D.N.J. July 6, 2015\)](#), the court denied Plaintiffs' motion to remand to state court based on the argument at the court lacks subject matter jurisdiction on their breach of contract claim. The court found that in order to demonstrate that they were entitled to a severance package, Plaintiffs necessarily will have to prove a violation of a term in the Severance Plan which is governed by ERISA. The court rejected Plaintiffs' argument that the loss of a severance package is merely an element of damages.

In [\*Robinson v. Laneko Eng'g Co.\*, No. CIV.A. 14-05036, 2015 WL 4000145 \(E.D. Pa. July 1, 2015\)](#), the court determined that Plaintiff lacked statutory standing to sue for pension benefits purportedly owed to his father since he is neither a participant nor a beneficiary. As a result, the court lacks subject matter jurisdiction over Plaintiff's claims and therefore has no authority to rule on Defendant's arguments that go to the merits of those claims. The court dismissed the complaint for lack of subject matter jurisdiction.

In [\*Piscopo v. Pub. Serv. Elec. & Gas Co.\*, No. CIV.A. 13-552 ES, 2015 WL 3938925 \(D.N.J. June 25, 2015\)](#), the court dismissed Plaintiff's ERISA claims with prejudice after giving him two

opportunities to amend his complaint. The court found that Section 503 of ERISA does not confer a private right of action. As to Plaintiff's Section 502(a) ERISA claim for pension and retirement benefits, Plaintiff did not allege any facts regarding the details of his pension benefit plan. With respect to Plaintiff's document penalty claim, the court found that Plaintiff failed to plead facts sufficient to state a cause of action under section 502(c)(1) (B). Plaintiff did not allege anywhere that Defendant failed or refused to comply with the requests by not mailing the material within 30 days after such request. Additionally, the court found that Plaintiff did not allege sufficient facts demonstrating that Defendant was a plan administrator and hence subject to liability under section 502(c)(1)(B).

In [Gidley v. Reinhart Foodservice, L.L.C., No. 4:14-CV-0800, 2015 WL 1136447 \(M.D. Pa. Mar. 12, 2015\)](#), Plaintiff became disabled and started receiving long-term disability benefits under his employer's plan, which had been insured by MetLife. After he began receiving disability benefits, he learned that Defendants had cancelled the MetLife policy just before his disabling injury and replaced it with a new policy from Reliance Standard, which unlike the MetLife policy, did not provide an Index Adjustment over time. In his First Amended Complaint, Plaintiff alleged that the plan amendment replacing the MetLife policy with the Reliance policy was never disclosed to him by Defendants and the nondisclosure constitutes a breach of fiduciary duty. He also asserted a claim for equitable estoppel on the grounds that the statement of benefits contained material misrepresentations on which he detrimentally relied and that Defendants actively concealed the amendment which was a material change to his policy. His third cause of action seeks benefits due under the MetLife policy; specifically, Defendants owe him the money he would have received under the MetLife policy. Plaintiff also requested that the court strike the plan amendment as it pertains to him because of Defendants' active concealment of material facts upon which he detrimentally relied. The court dismissed the breach of fiduciary duty claim with prejudice because Plaintiff requests only monetary relief which is not equitable in nature. The claim seeking benefits due under the plan was dismissed without prejudice with leave to amend to certify exhaustion of his administrative remedies. The court denied dismissal of Plaintiff's equitable estoppel claim and request to strike the plan amendment as to Plaintiff.

In [Sacchi v. Luciani, No. CIV.A. 14-3130 FLW, 2015 WL 685853 \(D.N.J. Feb. 18, 2015\)](#), Plaintiff brought suit against Defendants recover, *inter alia*, damages for Defendants' failure to send timely notice for coverage under COBRA, in violation of Section 502(c) of ERISA. Plaintiff was never employed by, nor did he ever have health insurance through, Meridian; rather, Plaintiff's claims are based upon his spouse's health insurance coverage when his spouse was employed by Meridian. The court found that Plaintiff lacks standing under ERISA to pursue his claims because Plaintiff did not allege, nor could he allege, that he is a participant or

beneficiary under the benefit plan. Plaintiff argued that ERISA confers standing in his circumstances because he was “eligible to join the Plan,” and but for Defendants’ wrongful conduct, he would have been designated as a beneficiary by his spouse. The court found that it is entirely speculative that the spouse would have ever elected COBRA coverage for Plaintiff given that he was provided the opportunity to do so, yet he did not so act. The court concluded that ERISA simply does not permit any person to sue because he/she could be an eligible beneficiary—without having been so designated by the plan participant in the first instance. Accordingly, the court granted Defendants’ motions to dismiss.

D. Fourth Circuit

**Health and dental plans have standing to sue Insurance Commissioner over enforcement of West Virginia Prompt Pay Act.** [Ohio Valley Health Services & Education Corp. Health Plan, et al. v. Michael D. Riley, et al., No. 5:15CV65, 2015 WL 8494000 \(N.D.W. Va. Dec. 10, 2015\)](#) (Judge Frederick P. Stamp). Here, health and dental plans filed suit against the West Virginia Insurance Commissioner challenging the West Virginia Prompt Pay Act “the Act”) regarding (a) the requirement to pay claims for medical services within 30 days of submitting a clean claim; (b) imposing 10% prejudgment interest on such claims that remain unpaid; (c) automatically awarding attorney’s fees in an action enforcing the Prompt Pay Act or seeking payment for such claims; and (d) that the Prompt Pay Act creates a private cause of action for non-processing or non-payment of claims within the time limits stated in that Act. In denying the Commissioner’s motion to dismiss, the court found that: 1) Riley and the Insurance Commissioner are proper parties because they are the government officials charged with administering and enforcing the Act; 2) Plaintiffs have standing to sue because they have alleged a judicially cognizable injury caused by the threat of Defendants enforcing the Act. Specifically, Defendants have declined to agree that it does not interpret the Act as applying to ERISA covered plans such as the Plaintiffs.

**Service of original complaint satisfies § 1132(h) notwithstanding failure to serve amended complaint.** [Longo v. Trojan Horse Ltd., No. 5:13-CV-418-BO, 2015 WL 7015841 \(E.D.N.C. Nov. 12, 2015\)](#) (Judge Terrence W. Boyle). In an action alleging that Defendants failed to make contributions to a defined contributions plan, or 401(k) plan, Defendant Ascensus Trust moved to dismiss on the basis that the court lacked subject matter jurisdiction because the Secretaries of Labor and Treasury were not served with the amended complaint by certified mail as required by 29 U.S.C. § 1132(h). However, the court found that they were served with the original complaint and Section 1132(h) requires only that a “copy of the complaint” be served. Here, the Secretaries were served with the original complaint, which named the company now known as Ascensus Trust as a party and raised identical claims against it as are listed in the amended complaint. While service of an amended pleading that first asserts claims available to both plan participants and the Secretaries may be required, the court found that the notice requirement and

purposes of § 1132(h) clearly were satisfied by service of the original complaint. The court denied Defendant's motion to dismiss for lack of subject matter jurisdiction pursuant to FRCP 12(b)(1).

[GREENBRIER HOTEL CORPORATION, et al., Plaintiffs, v. UNITE HERE HEALTH, et al., Defendants., No. 5:13-CV-11644, 2015 WL 5626514 \(S.D.W. Va. Sept. 24, 2015\)](#). With respect to the issue of standing to sue as an ERISA fiduciary, the court concluded that the Greenbrier has presented evidence that it is a fiduciary because it (i) exercised fiduciary control over plan assets—contributions—before they were remitted to the Fund, (ii) regularly audited employment rolls to ensure that correct amounts of contributions were being remitted and that only participants and their beneficiaries were receiving benefits from the Fund, and (iii) had a continuing duty to monitor the Trustees of the Fund once it became a party to the Trust Agreement. Although the court found that this evidence would not automatically result in fiduciary status for the Greenbrier for all aspects of Plan Unit 155, it is enough to bestow fiduciary status on the Greenbrier because the Greenbrier is suing the Trustee-Defendants in relation to its (and their) responsibilities to ensure adequate funding for the Plan, and the Greenbrier's employees, themselves participants in the Fund, were remitting appropriate contributions.

[Patterson v. Duke Univ., No. 14CV1062, 2015 WL 5608126 \(M.D.N.C. Sept. 23, 2015\)](#). In granting unopposed motion to dismiss, the court dismissed Plaintiff's second claim for relief under § 1132(a)(3), finding that Plaintiff has an adequate remedy for her claimed denial of disability benefits under § 1132(a)(1)(B). The court also found that ERISA preempts any claims that Plaintiff made under the North Carolina Declaratory Judgment Act.

In [Glass v. BAE Sys., Inc. Unfunded Welfare Ben. Plan, No. CIV. WDQ-14-181, 2015 WL 4878275 \(D. Md. Aug. 13, 2015\)](#), Plaintiff's Complaint alleges ERISA §§ 1132(a)(1)(B) and (a)(3) claims based on Defendants improper calculation of her LTD benefit. Defendants moved to dismiss the (a)(3) for being impermissibly duplicative of the (a)(1)(B) claim. Plaintiff agreed that a § 1132(a)(3) claim "would be duplicative and impermissible under controlling case law" but sought leave to amend the complaint to consolidate "the various allegations of impropriety" into a single count under § 1132(a)(1)(B). Finding that there has been no showing of prejudice, bad faith, or futility, the court granted Defendants' motions to dismiss without prejudice and granted Plaintiff leave to amend.

In [Treadway v. Walgreen Co., No. 5:15-CV-04109, 2015 WL 3949484 \(S.D.W. Va. June 29, 2015\)](#), Plaintiff asserted in her complaint that she "was retaliated against for blowing the

whistle” and Defendants “violated the West Virginia Human Rights Act entitling the Plaintiff to attorney’s fees and costs . . .” The complaint does not include multiple counts for violations of separate statutes or alternative theories of recovery but included allegations regarding her FMLA leave and the denial of her short-term disability claim. The court found that these allegations were just “incidents” in which the Defendants allegedly retaliated against Plaintiff for providing testimony for a former manager, rather than separate claims for relief pursuant to the FMLA or ERISA. Because Plaintiff’s legal theory does not appear to require proof of violation of a federal statute as an element of her claim for relief, the court found that the complaint does not raise questions of federal law or otherwise support federal question jurisdiction. The court found that remand to state court is appropriate.

In [\*Green v. Baltimore City Bd. of Sch. Comm’rs\*, No. CIV.A. WMN-14-3132, 2015 WL 3795908 \(D. Md. June 17, 2015\)](#), the court granted Plaintiffs’ motion to amend their complaint to reflect the following changes: (1) to substitute the Public Health Services Act, 42 U.S.C. § 300bb–1 et seq. (PHSA) rather than the Employee Retirement Income Security Act of 1974 as the foundation for their claims and (2) to include a class action claim against the Board (Count III). The court also granted Plaintiffs’ request for a limited class discovery period of 45 days, after which they may seek class certification. The court found that Plaintiffs adequately plead a class that could survive a Motion to Dismiss and it declined to reach the merits of Plaintiffs’ class claim in the absence of a fully briefed motion to certify a class.

**Filing a complaint is appropriate procedure for seeking review of arbitration award in MPPAA proceeding.** In [\*Freight Drivers & Helpers Local Union No. 557 Pension Fund v. Penske Logistics LLC\*, No. 14-1464, F.3d , 2015 WL 1787776 \(4th Cir. Apr. 21, 2015\)](#), the Fourth Circuit considered the question of how a party to an arbitration proceeding under the Multiemployer Pension Plan Amendments Act of 1980 (“MPPAA”) can obtain review of the arbitration order, as provided in 29 U.S.C. § 1401(b)(2). Specifically, the court addressed whether § 1401(b)(2) and § 1451 require the dissatisfied party to commence a civil action in a district court by filing a complaint, or whether § 1401(b)(3) requires the dissatisfied party to file an application for review of the arbitration order by filing a motion, as provided in the Federal Arbitration Act (“FAA”). In this case, the multiemployer pension plan sought to vacate or modify an arbitration order that rejected the Plan’s assessment of withdrawal liability with respect to two participating employers. The district court dismissed the action and denied reconsideration. The Fourth Circuit held that commencing an action by filing a complaint is the appropriate procedure for seeking review of an arbitration award entered pursuant to the MPPAA, and the amended complaint filed by the multiemployer pension plan related back to filing date of original complaint, thus rendering it timely.

E. Fifth Circuit

In [\*Infectious Disease Doctors, P.A. v. Bluecross Blueshield of Texas\*, No. 3:13-CV-2920-L, 2015 WL 4992964 \(N.D. Tex. Aug. 21, 2015\)](#), the court denied BCBC's motion to dismiss Plaintiff's 29 U.S.C. § 1132(a)(1)(B) claim simply because Plaintiff did not include the terms of the insurance plan in the complaint. Plaintiff asserted that: (1) IDD's patients assigned their benefits to IDD; (2) IDD submitted these patients' claims to BCBSTX; and (3) BCBSTX's failure to pay violated the terms of these plans. Plaintiff also attached tables identifying the patient name, the policy number, the group number, the name of the physicians, the home state, the billed amount, and the medical record number. The court found these allegations to be sufficiently detailed to permit the reasonable inference that Defendant is liable for the alleged misconduct.

In [\*Greenbaum v. Sedgwick Claims Mgmt. Servs., Inc.\*, No. 5:15-CV-127 RP, 2015 WL 3457660, at \(W.D. Tex. May 29, 2015\)](#), Plaintiff brought suit against the HCA Health and Welfare Benefits Plan and its claims administrator, Sedgwick Claims Management Services, Inc., for the denial of her short-term disability claim. The Plan moved to dismiss it from the action, arguing that it is not a proper defendant because the Plan has no discretion or authority to adjudicate the disputed claim and is not liable for the payment thereof. The court denied the Plan's motion, finding that the express language of ERISA's remedial provision provides that an employee benefit plan is a proper defendant under the statute.

In [\*Mora v. Albertson's, L.L.C.\*, No. EP-15-CV-00071-FM, 2015 WL 3447963 \(W.D. Tex. May 28, 2015\)](#), the court found that Plaintiff failed to adequately plead a claim for denial of benefits, where the complaint alleges specific benefits she was denied, but fails to indicate how she was entitled to those benefits under the Plan's terms. The court declined to dismiss Plaintiff's ERISA estoppel claim, finding that it is not duplicative of her section 1132(a)(1)(B) claim since the estoppel claim is based on "material misrepresentations" and do not depend on an entitlement under the Plan's terms. The court dismissed without prejudice Plaintiff's request for extracontractual and punitive damages for her ERISA estoppel claim. The court acknowledged that there does not appear to be Supreme Court or Fifth Circuit authority directly addressing this issue. Plaintiff will be allowed to replead such damages and demonstrate they are available for her ERISA estoppel claim.

In [\*Bruce v. Anthem Ins. Companies, Inc.\*, No. 3:15-CV-0353-D, 2015 WL 1860002 \(N.D. Tex. Apr. 23, 2015\)](#), the court ordered Anthem to file an amended answer to correct deficiencies under Rule 8(b). The court found that the answer that a document "speaks for itself," does not

comport with Rule 8(b)'s requirements. Anthem also improperly pleaded that certain parts of the complaint "consists of legal conclusions to which no response is required." For some of the allegations Plaintiff did not state a legal conclusion, but regardless, the court found that it is "insufficient" under Rule 8(b) to deny an allegation on the basis that it is a "legal conclusion." Anthem also failed to respond substantively to some of the allegations, stating that "Defendants admit only that the administrative record in this case speaks for itself. Otherwise, denied." This type of pleading is insufficient. Plaintiff also challenged certain of Anthem's affirmative defenses, including that:

- Plaintiff's claims are barred, in whole or in part, because Plaintiff's previous disk replacement was completed with a non-FDA approved device and was investigational;
- Plaintiff's claims are barred, in whole or in part, because the efficacy of the device could not be established within the medical literature;
- Plaintiff's claims are barred, in whole or in part, due to Plaintiff's own fault;
- Plaintiff's claims are barred, in whole or in part, by a disclaimer provided; and
- Plaintiff's claims are barred, in whole or in part, due to waiver and/or estoppel.

The court concluded that the first listed affirmative defense gives Plaintiff fair notice, but that the other affirmative defenses do not.

In [\*Davis v. Metro. Life Ins. Co.\*, No. 1:13-CV-2741, 2015 WL 574616 \(M.D. Pa. Feb. 11, 2015\)](#), Plaintiff brought suit against MetLife stating claims for breach of contract, breach of the implied covenant of good faith and fair dealing, and bad faith under the Pennsylvania Unfair Insurance Practices Act ("UIPA"), and, alternatively, denial of benefits and breach of fiduciary duty under ERISA, in connection with MetLife's termination of Plaintiff's long-term disability benefits. MetLife filed a motion seeking to set aside the default that the Clerk of Court entered against MetLife and Plaintiff's motion for default judgment. The court granted MetLife's motion, finding that Plaintiff will not be prejudiced if the court sets aside the default since a delay in receiving LTD benefits is indistinguishable from a "delay in realizing satisfaction on a claim" and not sufficient to constitute prejudice. Additionally, MetLife's proposed defenses, including ERISA preemption of the state law claims, if proved, would constitute a complete defense to Plaintiff's claims. The court found that they are sufficiently meritorious-in the present procedural context-and counsel in favor of setting aside the entry of default. The court also found that MetLife's submissions evidence grossly negligent behavior but not an intentional or strategic decision to refrain from defending itself in this litigation. However, the court found that a monetary sanction is appropriate under the circumstances and ordered MetLife to compensate Plaintiff for the reasonable fees and costs incurred in obtaining the entry of default, moving for default judgment, replying to MetLife's response to the court's show cause order, and opposing MetLife's motion to set aside the entry of default.

In [Winburn v. Progress Energy Carolinas, Inc., No. 4:11-CV-03527-RBH, 2015 WL 505551 \(D.S.C. Feb. 6, 2015\)](#), the court found that Progress (employer and plan sponsor) is not a proper defendant under the Section 502(a)(1)(B) claim for benefits because Prudential, not Progress, administered claims under the Plan.

F. Sixth Circuit

**Plaintiff lacks constitutional and statutory standing to pursue claim against insurer of former employer’s welfare benefit plan.** [Bonewitz v. Cigna Corp., No. 3:14-CV-02281, 2015 WL 5794549 \(M.D. Tenn. Oct. 2, 2015\)](#) (Magistrate Judge John S. Bryant). Plaintiff alleges that Cigna is making health care premiums rise artificially by strategically accepting claims for Male Hypogonadism or “Low-T” [testosterone treatments] based on known unstable testing and interpretation methods, and using a faulty and inadequate coding system. The court found that Plaintiff failed to establish constitutional standing because Plaintiff did not plead facts to show that Cigna had any discretionary authority or control over the Plan such that the injunctive relief Plaintiff seeks would not redress the injury alleged. Any action or inaction by Cigna could not be a breach of fiduciary duty. Additionally, Plaintiff is not a “participant” as defined by ERISA: Plaintiff is not currently, and is not reasonably expected to be, in covered employment; Plaintiff does not reasonably expect to return to covered employment; Plaintiff does not seek benefits under the Plan, but rather he seeks to recoup the difference between the services he paid for and the services he received.

[Cox v. Blue Cross Blue Shield of Michigan, No. 14-CV-13556, 2015 WL 5302819 \(E.D. Mich. Sept. 10, 2015\)](#). Plaintiffs, participants in ERISA-governed health plans, initiated a putative class action alleging that Defendant Blue Cross Blue Shield of Michigan (“BCBSM”) breached its fiduciary duty by charging Plaintiffs’ respective ERISA plans “hidden” fees. BCBSM filed a motion to dismiss, which the court granted, finding that Plaintiffs lack standing to bring this action. With respect to statutory standing, what Plaintiffs seek – disgorgement of the hidden fees – amounts to legal restitution not available under Section 502(a)(3). As such, Plaintiffs failed to set forth sufficient allegations to establish statutory standing to pursue their requested relief. Plaintiffs also failed to establish constitutional standing since the only injunctive relief sought would pertain to the enforcement of a favorable judgment and it is purely speculative that BCBSM would not comply with a court order.

In [PAUL AND LINDA PRACHUN, Plaintiffs, v. CBIZ BENEFITS & INSURANCE SERVICES, INC., et al., Defendant., No. 2:14-CV-2251, 2015 WL 5162522 \(S.D. Ohio Sept. 3, 2015\)](#), the

court found that an arbitration provision in an employment agreement that Plaintiff signed during the course of his employment required arbitration of his ERISA preempted claim that Defendant breached its duty to properly advise Plaintiff with respect to medical coverage. The court determined that Plaintiffs did not meet their burden to show that the ERISA claims are non-arbitrable. As such, the court concluded that Plaintiffs' claims are arbitrable because (1) the asserted claim is within the scope of the employment agreement; (2) ERISA is silent on whether claims under the Act can proceed in an arbitrable forum; and (3) the authority of this Circuit and the Supreme Court suggests ERISA does not preempt the Federal Arbitration Act.

In [\*Heartland Health & Wellness Fund, an Employee Welfare Benefit Plan, by Henry B. Taylor and Joseph M. Chorpensing, as Trustees, Plaintiff, v. Salem Twp. Hosp. Plan & Mutual Medical Plans, Inc., Defendants.\*, No. 3:14-CV-411, 2015 WL 5095424 \(S.D. Ohio Aug. 31, 2015\)](#), a suit by a Taft-Hartley employee benefit fund against the administrator of one of its participant's health plans, the court granted Defendants' motions for abstention pending resolution of a state court proceeding involving the same matter. The court found that because these are the same claims that are currently being litigated in Illinois state court, hearing Plaintiffs' case while the state proceeding is ongoing would be effectively the same as seeking a "removal determination in a forum other than the district court of the United States for the district and division within which the state court action is pending which is in contravention of the federal removal statute. The court explained that the defendant STH Plan cannot avoid ERISA preemption simply by attempting to characterize a coordination of benefits dispute as an eligibility issue. The state court is capable of determining whether or not ERISA has preempted the state law claims.

In [\*Trustees of Sheet Metal Workers Local Union No. 80 Ins. Trust Fund v. Duggan\*, No. CV 13-CV-10415, 2015 WL 4944125 \(E.D. Mich. Aug. 19, 2015\)](#), where Plaintiff alleged that Defendant violated ERISA by charging hidden administrative fees ("Disputed Fees"), the court granted Plaintiff's motion to file an amended complaint alleging that Defendant failed to properly disclose additional administrative fees beyond the Disputed Fees that are the subject of the amended complaint. The court noted that a claim that is similar to the one Plaintiff wishes to add here survived a motion to dismiss in a similar case against Defendant pending before another judge. Also, because discovery has not commenced and the court has yet to issue a scheduling order, the court found that Plaintiff did not wait an unreasonable amount of time to seek leave to amend.

In [\*Alquahwagi v. Shelby Enterprises, Inc.\*, No. 14-13691, 2015 WL 4944341 \(E.D. Mich. Aug. 19, 2015\)](#), a matter seeking life insurance benefits, the court denied Defendant's motion to strike Plaintiff's First Amended Complaint for failing to state that the court's review is limited to the

administrative record. Defendant in the alternative requested that the court specify that Plaintiff's only avenue for relief is through proceedings conducted in accordance with *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609 (6th Cir.1998). The court found it unnecessary to make such a specification since adherence to prior decisions of the Sixth Circuit is the rule, and prior decisions remain controlling authority unless an inconsistent decision of the United States Supreme Court requires modification of the decision or the Sixth Circuit sitting *en banc* overrules the prior decision.

In [\*Children's Hosp. Med. Ctr. of Akron v. Youngstown Associates in Radiology, Inc.\*, No. 14-3437, Fed.Appx. , 2015 WL 4899529 \(6th Cir. Aug. 17, 2015\)](#), the Sixth Circuit vacated and remanded the district court's decision on the merits of Plaintiff's allegedly assigned medical claim against Defendant because the court did not first consider the standing issue. Lower courts must first decide standing issues before they address questions on the merits.

**Second voluntary dismissal of pension benefit claim constituted an “adjudication on the merits” and Plaintiff did not exhaust administrative remedies.** In [\*Evans v. Laborers' Dist. Council & Contractors' Pension Fund of Ohio\*, No. 14-3301, Fed.Appx. , 2015 WL 451033 \(6th Cir. Feb. 3, 2015\)](#), Plaintiff had filed and voluntarily dismissed two court actions related to his alleged entitlement to pension benefits. When Plaintiff filed a third action, the Pension Fund filed a motion to dismiss, arguing that Plaintiff's voluntary dismissal of *Evans II* operated as “an adjudication on the merits” under Federal Rule of Civil Procedure 41(a)(1)(B) and that, although the Fund had not been sued in *Evans I*, the Fund was in privity with the Ohio Laborers' Fringe Benefit Programs (“OLFBP”), an entity which serves as the administrative office for the funds. The district court converted the motion to dismiss to a motion for summary judgment and denied the Fund's motion for summary judgment on the basis that the Fund had not shown that it was in privity with OLFBP. The 6<sup>th</sup> Circuit found that the previous two actions involved the same claim: Plaintiff's alleged entitlement to pension benefits. Therefore, under Federal Rule of Civil Procedure 41(a)(1)(B), the dismissal of *Evans II* operated as an “adjudication on the merits.” The court also found that the evidence overwhelmingly shows that the Pension Fund and OLFBP are essentially the same entity with respect to pension-benefit applications and their interests were co-extensive in such matters. Because they were in privity, the Fund was entitled to summary judgment. Lastly, the 6<sup>th</sup> Circuit found that the district court abused its discretion in excusing Plaintiff's failure to timely exhaust his administrative remedies on the grounds of futility. Plaintiff challenged the Plan's interpretation of its terms and never stated a factual basis for his failure to file timely appeals of the Plan's determinations. For these reasons, the court reversed the judgment and award of attorneys' fees in Plaintiff's favor and remanded for entry of judgment in favor of the Pension Fund.

In *Davidson v. Henkel Corp.*, No. 12-CV-14103, 2015 WL 74257 (E.D. Mich. Jan. 6, 2015), discussed above under ERISA Preemption, Defendants' moved to dismiss Plaintiff's ERISA claims for their failure to meet the pleading standards set forth in *Iqbal* and *Twombly*. The court found that because top-hat plans are subject to ERISA and are exempted from much of ERISA's regulatory scheme, Count II alleging breach of fiduciary duties under ERISA, 29 U.S.C. § 1104–1106, is subject to dismissal because top-hat plans are exempt from the fiduciary duty and prohibited transactions requirements. However, the court found that Plaintiff states a claim under ERISA in Count I, recovery of benefits due under ERISA, because Defendants may be liable under this theory. The Plan gave them discretionary control over participants' funds and their tax treatment and the Plan authorized and obligated Defendants to properly manage the tax withholding from Plaintiff's benefits, which they purportedly admitted to mishandling in an October 14, 2011 letter stating: "Yes, at the time your commenced receipt of this benefit, Henkel should have applied FICA tax to the present value of your nonqualified pension benefit." The court also found that Plaintiff's equitable estoppel claim under ERISA, Count III, may be a viable theory in ERISA cases. Accordingly, the court concluded that Plaintiff stated claims in Count I and III of his Complaint and these claims are not subject to dismissal under Rule 12(b)(6) or 12(b)(1).

#### G. Seventh Circuit

##### **Collateral estoppel and res judicata do not apply to employer's withdrawal liability.**

[Midwest Operating Engineers v. Cordova Dredge, No. 15 C 4446, 2015 WL 7731868 \(N.D. Ill. Dec. 1, 2015\)](#) (Judge Amy J. St. Eve). The employees of Cleveland Quarry voted to decertify Local 150 as their bargaining agent in an election conducted by the NLRB. In a separate suit against Cleveland Quarry by the Funds, the court found that as a matter of law the Funds are entitled to enforce Quarry's obligations to contribute to the Funds under the CBA. Quarry's appeal is pending in the Seventh Circuit. Cordova employees (also subject to the Quarry agreement) subsequently also voted to decertify Local 150 and Cordova ceased making contributions to the Funds. The court denied the Funds' motion for summary judgment as it applies to the preclusive effects of collateral estoppel and res judicata. The court found that the facts of the present case significantly differ from those presented before the *Cleveland Quarry* court and that Cordova—by way of the defendant Cleveland Quarry—did not have a full and fair opportunity to litigate the legal issues as presented here. However, the court granted the Funds' motion for summary judgment as it relates to Cordova's liability for contributions to the Funds under 29 U.S.C. § 1145.

**District court did not abuse its discretion in denying delinquent employer relief from default judgment under Fed.R.Civ.P. 60(b).** [Cent. Illinois Carpenters Health & Welfare Trust Fund v. Con-Tech Carpentry, LLC, No. 15-1269, F.3d , 2015 WL 7434500 \(7th Cir. Nov. 24, 2015\)](#) (WOOD, Chief Judge, and POSNER and EASTERBROOK, Circuit Judges). In this matter seeking delinquent contributions, the Seventh Circuit affirmed the district court's denial of Con-Tech's Fed.R.Civ.P. 60(b) motion after it failed to answer the Complaint or file a Rule 55(c) motion to set aside a default judgment. Here, suit was filed on September 25, 2014 and Con-Tech was served on October 14. Following expiration of the 21-day deadline to answer, Plaintiffs filed and served a motion asking the district court to find Con-Tech in default. Con-Tech did not respond to that motion nor attend the hearing. On January 13, 2015, the court entered a judgment in the funds' favor, awarding them about \$70,000 in past-due contributions, \$14,000 in interest, \$7,000 in liquidated damages, \$3,000 in audit costs, and \$4,000 in attorneys' fees. Two weeks earlier, counsel for Con-Tech filed an appearance and a motion for an extension of time to answer the complaint but it needed to file a Rule 55(c) motion to vacate the default. Plaintiffs informed Con-Tech of this requirement in a document filed on January 5 but instead of filing a Rule 55(c) motion, Con-Tech filed a motion for a stay in favor of arbitration. When the district court entered its judgment, the time to seek relief for "good cause" under Rule 55(c) expired and defendant was required to file a motion under Fed.R.Civ.P. 60(b). Con-Tech filed a Rule 60(b) motion on January 15 and informed the district judge that it had not ignored the suit but had instead started negotiating with Plaintiffs' lawyers. The district court rejected Con-Tech's motion, finding that it deliberately ignored the litigation. In affirming the district court, Judge Easterbrook explained that a defendant can both file an answer and try to negotiate a settlement; doing the latter does not eliminate the need to do the former. Further, Con-Tech could have filed an answer and asked the district court to stay the litigation while the parties negotiated. The court rejected Defendant's argument that if it had filed an answer or any other substantive paper, it would have waived its right to arbitrate under the Federal Arbitration Act (which it mistakenly invoked, although 29 U.S.C. § 1401(a)(1), part of the Multiemployer Pension Plan Amendment Act, is the governing statute). The court explained that nothing prevents a defendant from filing an answer that demands arbitration and offers other reasons why plaintiffs should not receive judicial relief.

In [Bedwell v. Aetna, Inc., No. 3:14-CV-00081-RLY, 2015 WL 4507211 \(S.D. Ind. July 23, 2015\)](#), the court dismissed Plaintiff's lawsuit seeking an order requiring the health plan to pay for medical expenses incurred by Plaintiff. Plaintiff named the claims administrator as defendant but the court found that the proper defendant in this case is the Plan itself. The court gave Plaintiff the opportunity to seek leave to file an amended complaint.

In [\*Sandefur v. Iron Workers St. Louis Dist. Council Pension Fund\*, No. 3:14-CV-00175-RLY, 2015 WL 4232490 \(S.D. Ind. July 13, 2015\)](#), Plaintiff alleged that Defendant violated ERISA and committed fraud when Iron Workers refused to provide her with retirement benefits. Iron Workers moved to dismiss the Complaint for failure to state a cause of action upon which relief can be granted pursuant to Federal Rule of Civil Procedure 12(b)(6). With respect to the ERISA claims, the court found that Defendant waived its Rule 8 challenge by not raising it until the reply brief. The court also found that the claim based on breach of fiduciary duty was not time barred under ERISA because even though Plaintiff became aware of the denial in 2006 and did not file suit until 2013, a participant's cause of action does not accrue until the plan issues a final denial. The court also found that there is no evidence that Plaintiff's claim is time barred under the pension plan because Defendant attached a version of the Plan that was not the governing contract between the parties. Similarly, any requirement to exhaust is only stated in a version of the Plan that the court found is not controlling so the court could not determine whether Plaintiff failed to exhaust administrative remedies.

In [\*Cocker v. Terminal R.R. Ass'n of St. Louis Pension Plan for Nonschedule Employees\*, No. 12-1239-DRH, 2015 WL 3623584 \(S.D. Ill. June 10, 2015\)](#) (**Not Reported in F.Supp.3d**), the court denied Defendant's motion to strike exhibits 4, 5 and 6 of Plaintiff's addendum which are correspondence and emails from cases pending in the Eastern District of Missouri, *Ingram and Smith v. Terminal Railroad Association of St. Louis Pension Plan for Nonschedule Employees*, Cause No. 4:13-cv-02500-RWS, and an affidavit by Plaintiff's counsel. Defendant contended that these exhibits are not part of the administrative record in this case, but the court considered them under the doctrine of judicial notice and Federal Rule of Evidence 201.

In [\*Concert Health Plan Ins. Co. v. Killian\*, No. 14 C 4697, 2015 WL 859562 \(N.D. Ill. Feb. 26, 2015\)](#), Concert Health Plan Insurance Company brought suit against James Killian alleging that he violated the Illinois insurance fraud statute. These parties have spent the last seven-plus years in this court and the Seventh Circuit litigating an ERISA suit that Killian brought against Concert for allegedly breaching its obligation to pay for medical expenses incurred by his wife. *Killian v. Concert Health Plan Ins. Co.*, No. 07 C 4755 (N.D. Ill. filed Aug. 22, 2007) (the "2007 case"). Killian moved to dismiss Concert's complaint under Rule 12(b)(6) based on failure to comply with the statute of limitations. The court denied the motion although it stayed the portion of Concert's insurance fraud claim that is a compulsory counterclaim in the 2007 case. The 2007 case remains pending, though the suit has been stayed as to the claims against Concert due to its state court liquidation proceedings.

In [\*Shawley v. Life Ins. Co. of N. Am.\*, No. 14-CV-671-JDP, 2015 WL 728505 \(W.D. Wis. Feb. 19, 2015\)](#), the court denied Plaintiff's motion to strike major portions of LINA's answer on the grounds that they contain identical "stock responses" to several allegations. Of the 156 paragraphs in Plaintiff's amended complaint, LINA answered over 100 of them with the following response, changing only the paragraph number:

Answering paragraph 12 of the Complaint, defendant affirmatively alleges plaintiff's claim for benefits will be determined solely and exclusively by reference to the administrative record pertaining to Plaintiff's claim for disability benefits. The administrative record speaks for itself. Defendant denies all allegations set forth in paragraph 12 to the extent inconsistent with the express content of the administrative record as a whole, and further denies the remaining averments set forth in paragraph 12.

Plaintiff argued that Rule 8(b)(1)(B) requires that a responding party specifically admit or deny the allegations against it. LINA argued that Plaintiff's 156-paragraph complaint is unnecessarily detailed and verbose, given the nature of his claim. The court found that Plaintiff's complaint also violates Rule 8 because it does not contain a "short and plain statement of the claim showing that the pleader is entitled to relief," nor are Plaintiff's allegations simple, concise, and direct. The court found that Plaintiff cannot meet his burden to show that the challenged allegations are so unrelated to Plaintiff's claim as to be devoid of merit, unworthy of consideration, and unduly prejudicial. The court found that forcing both parties to replead for both violating Rule 8 would simply delay this case and Rule 8 aims to achieve brevity, simplicity, and clarity in pleadings, not additional delays.

**The lack of sufficient evidentiary support for a motion is not a reason to enter summary judgment against the movant.** In [\*Hotel 71 Mezz Lender LLC v. Nat'l Ret. Fund\*, No. 14-2034, F.3d](#) , 2015 WL 499571 (7th Cir. Feb. 6, 2015), the National Retirement Fund ("NRF") and its trustees seek to hold Hotel 71 Mezz Lender LLC and Oaktree Capital Management, L.P. (collectively, the "Oaktree parties") responsible for multiemployer pension fund withdrawal liability pursuant to MPPAA section 4201. Oaktree, through Mezz Lender, provided financing for the acquisition of a hotel by Chicago H & S Hotel Property LLC ("H & S"). H & S defaulted on the loan, was taken into bankruptcy, and the hotel was liquidated. The Oaktree parties filed suit seeking a declaratory judgment that a reorganization plan released any claim of withdrawal liability and enjoined NRF from pursuing any claim of withdrawal liability against them. In a cross-motion for summary judgment against Mezz Lender, NRF affirmatively contended that Mezz Lender was in fact responsible for withdrawal liability because, *inter alia*, it was a trade or business under common control with H & S. Its summary judgment memorandum passed over in silence the legal criteria for identifying a trade or business on which such liability may be imposed and made no argument as to why Mezz Lender constituted such a trade or business. Mezz Lender itself did not seek summary judgment on this point. Whether Mezz Lender was

appropriately characterized as a “trade or business” requires the application of the *Groetzinger* test and Mezz Lender’s memorandum did not mention the *Groetzinger* test, let alone apply that test to the evidence. The district court, confronted with a minimal record which established only that Mezz Lender was a limited liability corporation which extended financing for the acquisition of a hotel by H & S and ultimately acquired complete ownership of H & S in a UCC foreclosure sale, concluded that NRF had not carried its burden on this issue and granted the Oaktree parties’ motion with respect to the issue of withdrawal liability. The court found that the district court had erred by *sua sponte* entering summary judgment in favor of the Oaktree parties on the question of withdrawal liability without first giving NRF notice that it was considering that course and the opportunity to respond. The lack of sufficient evidentiary support for the motion is not a reason to enter summary judgment against the movant, particularly where the court did not give the unsuccessful movant notice that it was entertaining the possibility of entering summary judgment against it or the opportunity to respond. Because the court was not convinced that the movant had no plausible arguments to make in opposition to an adverse grant of summary judgment, it vacated the judgment and returned the case to the district court for further proceedings.

#### H. Eighth Circuit

***Respondeat Superior* does not extend to who may be liable as a fiduciary under ERISA.** [Goodman v. Crittenden Hosp. Ass’n, Inc., No. 3:14-CV-229-DPM, 2015 WL 7016992 \(E.D. Ark. Nov. 12, 2015\)](#) (Judge D.P. Marshall Jr.). Plaintiff brought suit against Cigna and Methodist Le Bonheur Healthcare for breaching their fiduciary duties with respect to the administration of an underfunded health plan. The court denied Cigna’s motion to dismiss, finding that Plaintiff’s allegation that Cigna harmed the plan by not processing claims and therefore depriving the plan of Cigna’s substantial provider discount is good at the pleading stage. The court did dismiss the constructive fraud claim under Arkansas law against Cigna, but without prejudice. With respect to Methodist, however, the court granted its motion to dismiss because Methodist is not a fiduciary under ERISA. Specifically, the theory of liability against it – *respondeat superior* – doesn’t exist under ERISA. While *respondeat superior* is, carefully speaking, neither a remedy nor a cause of action; it’s a principle of liability—holding A responsible for B’s actions because the two are one in the law’s eyes. The court found that expansion of this doctrine to who may be liable for a fiduciary’s violations of duty would alter the balance Congress struck when it expanded the common law’s concept of a fiduciary. The court did note that the cases go both ways but neither the U.S. Supreme Court nor the Eighth Circuit has searched ERISA for *respondeat superior* liability.

In *Jones v. Aetna Life Ins. Co.*, No. 4:15CV338 JCH, 2015 WL 5486883 (E.D. Mo. Sept. 16, 2015), the court agreed with Defendants that Plaintiff’s Count II fiduciary breach claim must be

dismissed, as it consists of nothing more than a repackaged claim for benefits under 29 U.S.C. § 1132(a)(1)(13). The court found that Counts I and II assert the same alleged errors on Defendants' part, including failing to obtain adequate medical records, relying on the opinions of paid reviewing medical consultants rather than treating physicians, utilizing claims examiners with conflicts of interest, ignoring or not properly weighing social security disability records, heightening the requirement needed to prove disability, and failing to provide a full and fair review of Plaintiff's disability claim. Moreover, Plaintiff seeks the same relief in both her § 1132(a)(1)(B) claim and her § 1132(a)(3) claim, i.e., the benefits she allegedly was entitled to under the short term and long term disability benefits policy. The court found that Plaintiff's ability to seek this relief in her § 1132(a)(1)(13) claim forecloses her from also pursuing it in this § 1132(a)(3)(B) claim.

[Vickery v. ConAgra Foods, Inc., No. 4:15-CV-797 CAS, 2015 WL 5306204 \(E.D. Mo. Sept. 10, 2015\)](#). On ruling on a motion to dismiss, the court concluded that there are sufficient factual allegations that indicate ConAgra is a proper party defendant to Plaintiff's claim for denial of severance benefits. ConAgra argued that it should be dismissed because it is merely Plaintiff's former employer and not the Severance Plan or its plan administrator. The court did dismiss the Severance Plan from the breach of fiduciary duty claims because the Plan is not a proper defendant to those counts. The court also found that Plaintiff is not required to provide a more definite statement of his claim for benefits under ERISA and that dismissal of Plaintiff's claim for interim attorneys' fees is not required. The court did strike Plaintiff's request for a jury trial.

In [Jones v. Aetna Life Ins. Co., No. 4:15CV338 JCH, 2015 WL 4526027 \(E.D. Mo. July 27, 2015\)](#), Plaintiff sought disability benefits under 29 U.S.C. § 1132(a)(1)(B) (Count I); alleged a breach of fiduciary duty under ERISA (Count II); and alleged a claim for statutory penalties under 29 U.S.C. §§ 1022(a), 1024(b), and 1132(c), for failure timely to provide the Summary Plan Description and/or the administrative record. The court found that Plaintiffs' allegations are insufficient to meet the pleading requirements of Rule 8. For example, Plaintiff did not properly allege the specific roles and functions undertaken by each Defendant, nor did she delineate the sequence of events leading to the allegedly improper denial of benefits. The court granted Defendants' Motion to Dismiss, but granted Plaintiff leave to file an Amended Complaint in which she specifies the alleged duties and failures of each Defendant. The court rejected Defendant's argument that the breach of fiduciary duty claim was simply a repackaged claim for benefits. Plaintiff here makes a claim similar to that in *Silva v. Metropolitan Life Ins. Co.*, 762 F.3d 711 (8th Cir.2014), seeking equitable relief, in the form of restitution or a surcharge, under 29 U.S.C. § 1132(a)(3). The court granted Plaintiff leave to file an Amended Complaint, in which she asserts her claim for equitable relief under the correct provision of ERISA.

**Court denies dismissal of “duplicate” Section 502(a)(3) claim in denial-of-benefits matter.**

In [\*Bach v. Prudential Ins.\*, No. 1:14-CV-00025-JEG, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 454845 \(S.D. Iowa Feb. 4, 2015\)](#), Plaintiff brought suit against Prudential for the termination of his long-term disability claim. His Complaint alleges two counts: a Section 502(a)(1)(B) claim for the benefits and a Section 502(a)(3) claim for a breach of fiduciary duty. With respect to the latter, Plaintiff alleged that Defendant breached its fiduciary duty by failing to conduct a proper investigation, by failing to subject the findings of its investigation to a reasonable evaluation and by wrongfully denying Plaintiff’s claims without a reasonable basis for the denial. Plaintiff further alleged that this breach was in violation of Iowa Code § 507B.4 as well as 29 U.S.C. §§ 1104 and 1109. Both counts request relief under ERISA, including past-due and future benefits and attorneys’ fees, as well as compensatory and punitive damages. The court dismissed Plaintiff’s state-law breach of fiduciary duty claim as well as his request for compensatory and punitive damages, since they are beyond what ERISA authorizes. Although both counts seek nearly identical relief, the court noted that *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711 (8th Cir. 2014) directs the court not to dismiss either count at this stage since it is difficult to determine, solely from the face of the Complaint, the extent to which the two counts may ultimately differ. Before *Silva*, the Eighth Circuit routinely interpreted *Varity Corp.* as meaning where a plaintiff is provided adequate relief by the right to bring a claim for benefits under § 1132(a)(1)(B), the plaintiff does not have a cause of action to seek the same remedy under § 1132(a)(3)(B). However, *Silva* called these cases into question, at least at the motion to dismiss stage.

In *Boyd v. ConAgra Foods, Inc.*, No. 4:14-CV-01435-JAR, 2015 WL 170572 (E.D. Mo. Jan. 13, 2015), Defendant moved to dismiss Count II of Plaintiff’s First Amended Complaint. In Count I, Plaintiff alleges that ConAgra breached the fiduciary duty owed to Plaintiff by failing to pay his severance under the Plan. In Count II, Plaintiff alleges that ConAgra breached its fiduciary duties to Plaintiff by communicating inconsistent and ambiguous information to him. Plaintiff requests: (1) benefits owed to him under the terms of the Plan, (2) an equitable surcharge, consisting of either the benefits that would have been owed to Plaintiff under the terms of the Plan or the value of wages, health insurance, retirement contributions and any raises and bonuses Plaintiff would have received had the Plan been properly administered, (3) prejudgment interest, and (4) attorneys’ fees and costs. Defendant argued that the harm alleged and relief requested are unallowably duplicative of the harm alleged and relief requested in Plaintiff’s first claim for benefits, and further, that the compensatory relief Plaintiff seeks in Count II is not available under ERISA. The court agreed with Plaintiff that a surcharge, in the form of monetary compensation for a loss resulting from a trustee’s breach of duty, is available upon a showing that the plan participant was harmed as a result of the plan administrator’s breach of a fiduciary duty. At this stage of the litigation, the court allowed Plaintiff to move forward with simultaneous claims under § 502(a)(1)(B) and § 502(a)(3). A plaintiff is only barred from a

duplicate recovery under § 502(a)(1)(B) and § 502(a)(3), not pleading them as alternate theories of liability.

## I. Ninth Circuit

[Sanzone-Ortiz v. Aetna Health of California, Inc., No. 15-CV-03334-WHO, 2015 WL 9303993 \(N.D. Cal. Dec. 22, 2015\)](#) (Judge William H. Orrick). Court grants motion to compel arbitration of participant's ERISA claim against Aetna California challenging "benefits cap" for treatment of autism as violation of California's Mental Health Parity Act.

[Lasheen v. Embassy of The Arab Republic of Egypt, No. 13-17143, Fed.Appx. \\_\\_\\_, 2015 WL 9264053 \(9th Cir. Dec. 18, 2015\)](#) (KOZINSKI, BYBEE, and CHRISTEN, Circuit Judges). Default judgment against Defendants on Plaintiff's claim for denied medical benefits affirmed, where Defendants sporadically participated in the litigation and frequently failed to appear (including a mandatory status conference). The district court did not abuse its discretion in declining to grant the defendants a hearing on damages and awarding Plaintiff \$200,000 in lifetime benefits available under the Plan and attorneys' fees.

[In re Anthem, Inc. Data Breach Litigation, No. 15-CV-04739-LHK, 2015 WL 7443779 \(N.D. Cal. Nov. 24, 2015\)](#) (Judge Lucy H. Koh). Plaintiffs are citizens of New York who are Anthem health insurance customers and who claim that their PHI was compromised as a result of the Anthem data breach. The court found that Plaintiffs' breach of contract and unjust enrichment claims are completely preempted by ERISA § 502(a), that the court has subject matter jurisdiction over this action under 28 U.S.C. § 1331, and that removal was proper under 28 U.S.C. § 1441(a).

**Motions to dismiss denied where challenges are affirmative defenses that are not clear on the face of the complaint.** [Lifecare Mgmt. Servs., LLC v. Zenith Am. Sols., Inc., No. 3:15-CV-0307-RCJ-VPC, 2015 WL 7185459 \(D. Nev. Nov. 13, 2015\)](#) (Judge Robert C. Jones). This case involves a hospital's claim under ERISA that a trust fund and its third-party administrators improperly denied the hospital benefits under the trust fund's welfare benefit plan. Defendants filed two motions to dismiss, which the court denied. In Count I—Claim for Benefits, Defendants made three arguments for dismissal: (1) Zenith and BeneSys are not liable as third-party administrators; (2) Plaintiff's Complaint was untimely; and (3) Plaintiff failed to state a sufficient claim regarding benefits coverage. The court rejected all three arguments. Whether the TPAs are proper defendants is an affirmative defense and the court must wait to determine

this issue at the summary judgment stage unless the elements of the defense appear on the face of the Complaint, which they do not. The court also found that the Complaint does not clearly show Plaintiff's filing was untimely. The Plan's terms require a beneficiary to file a lawsuit within ninety days of completing the appeals process; however, the Complaint does not show whether the appeals process was ever completed. Plaintiff stated it filed a formal written appeal on May 13, 2013, and that on October 31, 2013 Zenith informed Plaintiff that "the Board of Trustees was upholding the processing decision," but Plaintiff alleged that it never received written notice of the denial of its appeal, including the specific reasons for denying it, as required by the Plan's summary. The court found that the Complaint does not show whether the appeals process was completed and, thus, when, or if, the limitations period began. Because the affirmative defense is not clear on the face of the Complaint, the court deferred this argument to the summary judgment stage. Lastly, the court found that Plaintiff sufficiently pled a claim for benefits. Regarding Count II—Failure to Supply Requested Plan Information, the court found that the timeliness analysis applies here as well. Regarding Defendant's standing challenge, the court also found that it is an affirmative defense and the defense is not clear on the face of the Complaint.

**Motion challenging ERISA plan's subrogation rights does not confer federal court with subject matter jurisdiction.** [Gay v. Guderjohn, No. CV-15-01545-PHX-DGC, 2015 WL 7075173 \(D. Ariz. Nov. 13, 2015\)](#). In a state court action, Plaintiff moved pursuant to Arizona Rule of Civil Procedure 19(a) to add a health plan governed by ERISA as an involuntary plaintiff in the state case, and the state court granted the motion. Plaintiff then filed a motion challenging the validity of the Plan's lien rights against any settlement Plaintiff might receive from Defendant, at which point the Plan filed a notice of removal, alleging that the motion's challenge to the subrogation rights of the ERISA plan raises a question of federal law. The court explained that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law. Here, only Plaintiff's motion challenges the Plan's subrogation rights but nothing in the complaint contains an ERISA-related claim. As such, the court found that it does not have subject matter jurisdiction. The court remanded the case back to state court.

**Court denies motion to dismiss putative class action alleging wrongful termination of medical benefits.** [Radevska v. Noble Americas Energy Sols., LLC, No. 15-CV-0271-GPC-RBB, 2015 WL 6869345 \(S.D. Cal. Nov. 9, 2015\)](#) (Judge Gonzalo P. Curiel). Plaintiffs brought a putative class action on behalf of themselves and others similarly situated, claiming that Defendants wrongfully terminated Plaintiffs' medical benefits in violation of ERISA. Defendants moved to dismiss, which the court denied. In so doing, the court declined to consider the Summary Plan Description and Administrative Services Only Agreement since Plaintiffs' claims do not necessarily rely on the contents of the SPD. On Plaintiffs' Section

502(a)(1)(B) claim, the court found that Plaintiffs sufficiently allege they were eligible to receive health benefits under the Plan. The court found that Defendant CHC-CA, a California corporation and wholly owned subsidiary of Cigna Corp responsible for administering claims and paying benefits provided by the Plan in accordance with its provisions, is a proper party. The court found that on Plaintiffs' ERISA Section 502(a)(3) claim that Plaintiffs stated facts sufficient to establish that Defendants were fiduciaries under ERISA with respect to eligibility determinations and equitable remedies are inappropriate against CIGNA. Here, Plaintiffs seek reformation, equitable estoppel, restitution, and surcharge.

In [\*Espy v. Independence Blue Cross\*, No. 13-56295, Fed.Appx. \\_\\_\\_, 2015 WL 4880474 \(9th Cir. Aug. 17, 2015\)](#), the Ninth Circuit vacated the district court's decision to dismiss the *pro se* plaintiff's action with prejudice based on her failure to file a memo in opposition to Defendant's motion to dismiss, treating that failure as consent to the granting of the motion, pursuant to Southern District of California Civil Local Rule 7.1(f)(3)(C). Most importantly, the court found that public policy of disposing the case on the merits strongly disfavored dismissal for failure to file a timely written opposition. The court found that it seems likely that her complaint could have survived at the motion to dismiss stage if the motion had been considered on the merits since the ERISA benefit and collateral estoppel claims appear to rest mainly on factual contentions. "Such factual arguments might be appropriate for summary judgment, but they are not often successful on a motion to dismiss, given that at the motion to dismiss stage a court should treat plausible factual allegations in the complaint as true."

[\*PARISA MOGHADDAM, Plaintiff, v. LIBERTY LIFE ASSURANCE COMPANY OF BOSTON, a New Hampshire corporation, Defendant.\*, No. SACV1400505DDPDFMX, 2015 WL 5470338 \(C.D. Cal. Sept. 17, 2015\)](#) The court denied Wells Fargo's motion to dismiss Plaintiff's first amended complaint which adds Wells Fargo as a defendant to Plaintiff's dispute against Liberty Life for the denial of disability benefits. Although the first amended complaint was not filed until after the one-year contractual limitations period, the court found that all three prongs of the relation back test inquiry are satisfied. The court also criticized Wells Fargo for not meeting and conferring prior to filing the motion to dismiss as required by the local rules.

Talbot v. Reliance Standard Life Ins. Co., No. CV-14-00231-PHX-DJH, 2015 WL 4134548 (D. Ariz. June 18, 2015). The Court dismissed Count IV with prejudice insofar as it alleged a breach of a fiduciary duty by RSLIC for failing to provide relevant Plan information and intentionally withholding such information. Further, the Court dismissed Count IV with prejudice insofar as it is seeking disgorgement for RSLIC's alleged breach of a fiduciary duty for arbitrarily and capriciously denying Plaintiff's benefits. At this juncture, the Court permitted Plaintiff to

proceed with the remainder of Count IV, keeping in mind that she is not entitled to relief thereunder where ERISA elsewhere provides an adequate remedy. Moreover, after further factual development, even if Plaintiff ultimately proves a breach of RSLIC, it may turn out that it is not appropriate to provide equitable relief beyond that provided for in § 1132(a)(1)(B) under the carefully integrated civil enforcement provisions that Congress enacted in ERISA.

In [\*Day v. AT & T Disability Income Plan\*, No. 11-17150, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 1567857 \(9th Cir. Apr. 9, 2015\)](#), the court determined that it has jurisdiction over the Plaintiff's appeal of a July 2008 attorneys' fees order. Defendant argued that Plaintiff's appeal was untimely because the notice of appeal was not filed within 30 days of a June 2010 judgment which resolved only a benefit offset issue. The district court issued an amended judgment in August 2011 which differed materially from the June 2010 judgment and addressed the merits of Plaintiff's underlying claim for short-term disability benefits. Plaintiff's notice of appeal was timely because it was within 30 days of the amended judgment.

In [\*Andrews v. U.S. Sec. Holdings Inc.\*, No. 2:14-CV-03207-ODW, 2015 WL 1238890 \(C.D. Cal. Mar. 17, 2015\)](#) (**Not Reported in F.Supp.3d**), the court declined Plaintiff's motion to remand to state court where at the time the Complaint was filed, Plaintiff asserted claims that were preempted by ERISA. Plaintiff's Complaint, among other things, seeks medical benefits under Defendants' employee welfare benefits plan. Defendant removed the case under federal question jurisdiction and Plaintiff did not seek remand for eleven months. Plaintiff conceded that the claims raising a federal question are meritless but the court found that a subsequent realization that those claims are meritless does not render the removal improper. Furthermore, a plaintiff may not compel remand by amending a complaint to eliminate the federal question upon which removal was based. The court also denied Plaintiff's alternative request for voluntary dismissal.

In [\*Barbarino v. Aetna Life Ins. Co.\*, No. 5:14-CV-03601-EJD, 2015 WL 1205316 \(N.D. Cal. Mar. 16, 2015\)](#) (**Not Reported in F.Supp.3d**), Plaintiff alleged claims under both Section 502(a)(1)(B) and 502(a)(3) in connection with the denial of her short and long-term disability claims. Defendants moved to dismiss the second claim, arguing that they cannot be brought concurrently. The court agreed with Plaintiff that her allegations under each claim are separate and distinct. Under her first claim, Plaintiff's allegations focus on the denial of her claim for benefits and requests payment of past benefits due to her. Under her second claim, Plaintiff's allegations focus on Defendants' alleged failure to provide an adequate process to evaluate claims, and consequently requests injunctive relief that includes enjoining Defendants from continuing with its alleged inadequate process and removing Aetna as administrator. Therefore,

to the extent that Defendants sole challenge to Plaintiff's second claim is that Plaintiff cannot pursue both claims concurrently, the court denied Defendants' Motion to Dismiss.

In [Elizabeth L. v. Aetna Life Ins. Co., No. CV 13-2554 SC, 2015 WL 799417 \(N.D. Cal. Feb. 23, 2015\)](#), Plaintiffs challenge Aetna's denials of coverage for residential mental health treatment under two health benefit plans governed by ERISA. Aetna denied coverage because it determined the residential mental health treatment facilities at issue did not satisfy the plans' requirement that covered facilities be staffed 24/7 with licensed mental health professionals. The dispute centers on whether the plans demand such 24/7 staffing in addition to the other requirements. The court twice granted motions to dismiss Plaintiffs' complaint with leave to amend. In the most recent dismissal, the court granted leave to amend on two narrow points: 1) that the 24/7 requirement is satisfied by the residential mental health treatment facilities; 2) a previously unpleaded claim for breach of fiduciary duty. With respect to the first point, the court granted leave to amend to "plead facts indicating that the 24/7 requirement was satisfied." The court explained that it was not asking Plaintiffs to provide facts showing that they satisfy the 24/7 requirement, but rather, to "plead sufficient facts" demonstrating they have satisfied the 24/7 requirement as the court has held it must be interpreted. Because the court found that Plaintiffs have not done so, it dismissed these claims with prejudice. With respect to the breach of fiduciary duty claim, Plaintiffs' theory is that in processing claims, Aetna improperly distinguishes between network and non-network facilities by requiring only non-network facilities satisfy the 24/7 requirement. Plaintiff argued that this is inconsistent with the plan language and results in Aetna being unjustly enriched Aetna at Plaintiffs' expense. The court determined that this theory depends on Plaintiffs' mistaken reading of the 24/7 requirement. As a result, Plaintiffs cannot state a claim for breach of fiduciary duty based on unjust enrichment because Aetna cannot be unjustly enriched by not paying claims it is not required to pay in the first place. However, the court found that there may be an actionable breach of fiduciary duty on some other theory, but it is not actionable as unjust enrichment. As such, the court granted Plaintiffs leave to amend on that theory.

**District Court has subject matter jurisdiction over removed action completely preempted by ERISA.** In [Filler v. Blue Cross of California, No. 13-55268, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 626770 \(9th Cir. Feb. 13, 2015\)](#), the Ninth Circuit Court of Appeals considered whether the district court had subject matter jurisdiction over this removed action. The court affirmed the district court's dismissal of Plaintiff's complaint, finding that the state law claims for negligent entrustment, conversion, and interference with contractual relations are completely preempted by ERISA and that the district court's jurisdiction was not defeated by Plaintiff's alleged lack of federal standing. As an assignee of his patients' ERISA benefits, Plaintiff had both Article III standing and statutory standing to sue, notwithstanding the anti-assignment clauses in the

patients' insurance contracts. Because this appeal challenged only the district court's subject matter jurisdiction, the court expressed no opinion on the merits of the dismissed or remanded claims.

In [\*Gonda v. Permanente Med. Grp., Inc.\*, No. 11-CV-01363-SC, 2015 WL 537770 \(N.D. Cal. Feb. 9, 2015\)](#), Plaintiff filed suit against his former employer and the employer's long-term disability plan insured and administered by Life Insurance Company of North America. The court granted Defendants' leave to amend their answer to add the affirmative defense that a Settlement Agreement releases Plaintiff's claims. Although the court found that the Defendants unduly delayed in raising the affirmative defense of the Settlement Agreement, there is no evidence of bad faith or futility. Most importantly, the court found that there will be no undue prejudice to Plaintiff.

In [\*Dairy Employees Union Local No. 17 v. Dairy\*, No. 5:14-CV-01295-RSWL-M, 2015 WL 505934 \(C.D. Cal. Feb. 6, 2015\)](#), a matter involving the collection of withdrawal liability, the court struck the following affirmative defenses in Defendant's Answer:

- First Affirmative Defense asserts that Plaintiffs lack standing to bring their claims. Because standing is an element of Plaintiff's prima facie case, it is properly addressed through denial or a motion to dismiss and cannot as a matter of law operate as an affirmative defense.
- Fifteenth Affirmative Defense asserts that Plaintiffs' claims are alleged against the wrong employer. This allegation challenges an element of Plaintiffs' prima facie case, as Plaintiffs bear the burden of establishing that Defendant had an obligation to contribute to Plaintiff Fund. Thus, this defense is not a proper affirmative defense and fails as a matter of law.
- Second, Third, Ninth, Tenth, Eleventh, and Thirteenth affirmative defenses are "committed to mandatory arbitration" by § 1401(a) of ERISA. Here, Plaintiffs allege that Defendant has not requested review or initiated arbitration with the Pension Fund pursuant to 29 U.S.C. §§ 1399(b)(2)(A), 1401. Defendant did not respond to Plaintiffs' § 1401(a) arguments and the court construed this as a concession by Defendant and struck these defenses for legal insufficiency.
- Fourth Affirmative Defense asserts "unclean hands," and for support, Defendant alleges only that this defense is "based upon their [Plaintiffs'] own fault or misconduct." This defense falls short of providing Plaintiffs with notice of the underlying factual bases of the defense and is stricken without prejudice.
- Twelfth Affirmative Defense alleges that Plaintiffs have failed to mitigate damages. This ground is legally insufficient under § 1401(a) of ERISA. Further, the allegation does not

give Plaintiffs “fair notice” of the “underlying factual bases” of this defense. This defense was stricken without prejudice.

- Allegations asserting Plaintiffs’ invalidity under the LMRA or Plaintiffs’ violations of the LMRA, are “impertinent” and “immaterial” to the issues in this matter and are stricken with prejudice.
- Fifth and Sixth affirmative defenses are “needlessly repetitive” and stricken with prejudice.

In *Frank v. Citigroup Inc.*, No. 14CV745 BTM NLS, 2015 WL 65498 (S.D. Cal. Jan. 5, 2015), a suit alleging entitlement to retirement plan benefits, the court granted Defendants’ motion to dismiss where it found Plaintiff’s complaint as completely lacking in factual support. The Complaint does not specifically identify the Plan in question, does not identify Plaintiff’s employer or provisions of the Plan which entitle her to benefits, and fails to set forth facts regarding the numerous alleged ERISA violations. The Court granted Plaintiff leave to file an amended complaint remedying the deficiencies.

**Section 502(a)(3) claims pled in the alternative to a Section 502(a)(1)(B) claim are permissible and disgorgement of profits remedy is available under Section 502(a)(3).** In *Bush v. Liberty Life Assurance Co. of Boston*, No. 14-CV-01507-YGR, \_\_F.Supp.3d\_\_, 2015 WL 54418 (N.D. Cal. Jan. 2, 2015), Plaintiff brought a putative class action against Defendants Liberty Life Assurance Company of Boston and Hyundai Motor America based on Liberty Life’s decision to decrease the long-term disability benefits it paid to Plaintiff by the amount he received from the Department of Veterans Affairs (“VA”). Plaintiff was employed by Hyundai and participated in its long-term disability plan that is insured and administered by Liberty Life. Hyundai is the named plan administrator. The court characterized Plaintiff’s six claims as the following: (1) disability benefits under section 502(a)(1)(B), against Liberty Life; (2) equitable relief pursuant to sections 102 and 502(a)(3), against both defendants; (3) equitable relief and disgorgement pursuant to section 502(a)(3), against Liberty Life; (4) violations of sections 104 and 402 and monetary penalties under sections 502(a)(1)(A) and 502(c), against both defendants; (5) violation of section 503, against both defendants; and (6) declaratory and injunctive relief pursuant to section 502(a)(3), against Liberty Life. Liberty Life filed a motion to dismiss claims 2 through 5, and Hyundai joined in part in Liberty Life’s motion. The court granted in part and denied in part Defendants’ motion.

The court found that even if Hyundai, as Plaintiff alleges, delegated certain of its responsibilities as plan administrator—such as drafting the SPD—to Liberty Life, those activities are insufficient to subject Liberty Life to liability as a *de facto* plan administrator in light of the high bar for such a finding in the Ninth Circuit. As such, the court dismissed Count II against

Liberty Life since the claim for equitable relief pursuant to section 502(a)(3) is premised on substantive violations of section 102 and related Department of Labor regulations that govern plan administrators. The court also dismissed Count IV against Liberty Life since the plan sponsor is the party responsible for providing an SPD pursuant to section 104 and drafting a written instrument compliant with section 402. However, the court declined to dismiss Count V against Liberty Life alleging violations of substantive requirements in section 503 regarding the notice and appeals process. The court noted that Liberty Life failed to put forward legal authority that establishes only plan administrators are responsible for complying with section 503.

Liberty Life (joined by Hyundai as to Count II) argued Counts II and III, seeking equitable relief pursuant to section 502(a)(3), must be dismissed as duplicative of Count I's section 502(a)(1)(B) claim. Defendants also argued that Count V should be dismissed for failure to state a claim and because it is impermissibly duplicative of Count I. With respect to Count II seeking equitable relief under sections 102 and 502(a)(3), Plaintiff only seeks relief under Count II if Count I fails. Specifically, only if the terms of the plan are interpreted to permit the VA benefits offset, then Plaintiff seeks reformation under Count II to redress alleged miscommunication of the terms of the Plan in the SPD. The court found that Plaintiff is entitled to pursue these alternative theories, seeking alternative relief, at this early stage in the litigation. With respect to Count III seeking disgorgement of profits earned by Liberty Life on allegedly wrongfully withheld benefits, and injunctive relief requiring Liberty Life to administer the plan without a VA benefits offset, the court found that interest on wrongfully withheld profits can be recovered under 502(a)(3). Moreover, the injunctive relief sought under Count III is specifically limited in the complaint such that, if available at all, it cannot be duplicative of relief available under Count I. Accordingly, the court found that Count III states a claim for relief that is not merely duplicative of the relief available under Count I.

Lastly, with respect to Count V alleging violation of ERISA section 503, Defendants argued that Count V should be dismissed because: (1) an alleged breach of Department of Labor regulations does not support a claim under section 502(c) or a claim under section 503; (2) a request for claim documents cannot be relied on to seek statutory penalties for violation of the claim regulations set forth in 29 C.F.R. § 2560.503-1(h)(2)(iii); and (3) to the extent Plaintiff seeks a remedy of remand under Count V, this claim is duplicative of Count I and also does not seek substantive relief. As to Defendants' first and second arguments, the court noted that Count V does not specifically seek section 502(c) penalties. The court noted that on the pleadings, Plaintiff is not required to identify specifically the forms of relief sought in connection with a cause of action. Also, Plaintiff is permitted to advance alternative theories at this early stage and Count V does so by alleging a specific violation of section 503. The court further noted that no double recovery will be permitted and declined to dismiss Count V at this time.

J. Tenth Circuit

**Federal district court has subject matter jurisdiction over ERISA claim for benefits under a federally-recognized Indian tribe's healthcare plan.** [Coppe v. Sac & Fox Casino Healthcare Plan, No. 2:14-CV-02598-GLR, 2015 WL 6806540 \(D. Kan. Nov. 5, 2015\)](#) (Not Reported in **F.Supp.3d**) (Magistrate Judge Gerald L. Rushfelt). In a lawsuit for benefits under the defendant healthcare plan filed in federal court pursuant to ERISA, Defendant's moved to dismiss based on lack of subject matter jurisdiction based on the argument that the Sac & Fox Nation has tribal sovereign immunity and can be sued only in its own tribal court. Plaintiff was a deli clerk and a security guard at the Casino, which the court found is unquestionably a commercial enterprise (rather than an essential government function). The court denied the motion, concluding that it has subject matter jurisdiction because of the unequivocal Congressional abrogation of sovereign immunity under 29 U.S.C. § 1003(b)(32) and the Plan's clear contractual waiver of sovereign immunity.

[LAURAL O'DOWD, for herself & all others similarly situated, Plaintiff, v. ANTHEM HEALTH PLANS, INC., doing business as Anthem Blue Cross & Blue Shield, ROCKY MOUNTAIN HOSPITAL AND MEDICAL SERVICE, INC., doing business as Anthem Blue Cross & Blue Shield, & WELLPOINT, INC., Defendants., No. 14-CV-02787-KLM, 2015 WL 5728814 \(D. Colo. Sept. 30, 2015\)](#). Plaintiff brought the following claims against Defendant Anthem: (1) a claim seeking a declaratory judgment that Defendant Anthem violated Colo. Rev. Stat. §§ 10-16-704, 10-16-104, and 10-16-107.7; (2) a claim seeking injunctive relief under ERISA, specifically 29 U.S.C. § 1132(a)(3); (3) a claim for payment of benefits and associated interest under ERISA, specifically 29 U.S.C. § 1132(a)(1)(B); and (4) a breach of fiduciary duty claim that mentions 29 U.S.C. §§ 1002 and 1104. *Id.* §§ 41-68. Anthem moved to dismiss. The court explained that while Plaintiff cannot obtain duplicative relief, she may pursue both her second and third claims. The court denied the motion to the extent it argues that claim one should be dismissed because Colo. Rev. Stat. § 10-16-104 is preempted by ERISA. But, the court granted the motion to the extent it seeks dismissal of the first claim to the extent it is premised on Colo. Rev. Stat. § 10-16-704.

In [Robison v. Reliance Standard Life Ins. Co., No. CIV-14-1262-D, 2015 WL 4647213 \(W.D. Okla. Aug. 4, 2015\)](#), Plaintiff filed an action in state court for short-term disability benefits (which Plaintiff contends is not paid pursuant to an ERISA plan) and long-term disability benefits (subject to ERISA). On the same day that Defendant removed the action to federal court, the state court granted default judgment against Defendant on both claims but reserved its ruling as to the amount of damages for the LTD claim. The court denied Plaintiff's motion to remand

the first cause of action and granted Defendant's motion to set aside the default judgment. The court explained that a federal court may reconsider a default judgment entered by the state court prior to the removal, if the removal notice has been filed within the time period specified in the removal statute. The court found that Defendant diligently attempted to obtain counsel and once counsel was retained, Plaintiff's counsel was promptly notified within two days of the date on which Defendant's answer was otherwise due. Second, the court found that Defendant identified potentially meritorious defenses to Plaintiff's claims, including ERISA preemption; failure to submit a satisfactory proof of disability; untimely submission of proof of loss; and failure to file suit within the contractual limitations period. Lastly, the court found that Plaintiff will not be prejudiced by the setting aside of the default judgment.

In [\*Berger v. SSM Health Care of Oklahoma, Inc.\*, No. CIV-14-872-D, 2015 WL 2455459 \(W.D. Okla. May 22, 2015\)](#), Defendant moved to strike the jury demand on Plaintiff's COBRA claim. The court found that an action under § 1132(a)(1)(A)—which encompasses a claim under § 1132(c) to enforce COBRA rights—does not require a jury trial. However, Plaintiff's Complaint asserts other claims for which a Seventh Amendment right to a jury trial exists. In such a situation, when a case involves both a jury trial and a bench trial, any essential factual issues which are central to both must be first tried to the jury, so that the litigants' Seventh Amendment jury trial rights are not foreclosed on common factual issues. The court is bound by the jury's determination of factual issues common to both the legal and equitable claims. The court found that while Defendant is correct that Plaintiff is not entitled to a jury trial on her COBRA claim, the court's determination of that claim must be consistent with a jury's findings common to other claims. The court concluded that its resolution of Plaintiff's COBRA claim must await a jury's findings.

In [\*Kosloff v. Smith\*, No. 13-1466-JTM, 2015 WL 567042 \(D. Kan. Feb. 11, 2015\)](#), a case brought by current fiduciaries of the Premier Hospice profit sharing 401(k) plan ("the Premier plan") against former fiduciaries of the same for alleged violations of ERISA, the court denied Plaintiffs' motion to amend the complaint. The court previously granted Defendants' motion to dismiss all ERISA claims arising before December 20, 2007, because of Plaintiffs' failure to sufficiently plead the fraud or concealment exception to the ERISA statute of repose. The proposed amended complaint alleges that the founder and former owner of Premier Hospice certified false Forms 5500 and transferred Premier plan funds to the SP Management profit sharing 401(k) plan, of which he was the sole trustee. Both allegations appear in the original complaint. The only substantive difference between the original complaint and the proposed amendment is that Plaintiffs now allege that the former owner was the sole participant in the Premier plan. Plaintiffs argued that such false certifications are active steps of concealment triggering the ERISA fraud or concealment exception. The court explained that it already

considered and rejected this argument in ruling on Defendants' first motion to dismiss. The court found that the proposed amendment otherwise sets forth materially identical allegations and would be subject to dismissal on the same grounds.

K. Eleventh Circuit

In [\*PEACOCK MEDICAL LAB, LLC, PBL MEDICAL, LLC, & LAKEDRIVE MEDICAL, LLC, Plaintiffs, v. UNITEDHEALTH GROUP, INC., UNITED HEALTH CARE SERVICES, INC., OPTUMINSIGHT, INC., and OPTUMHEALTH, INC., Defendants., No. 1481271CVHURLEYHOPKI, 2015 WL 5118122 \(S.D. Fla. Sept. 1, 2015\)\*](#), Plaintiffs, affiliates of a substance abuse treatment center, brought suit against Defendant for payment of unpaid claims based on the patients' assignment of benefits to the treatment center. The court ordered for a more definite statement and to show cause for why the patients are not "required" parties under Fed.R.Civ.P. 19 and should be joined to the lawsuit or order the treatment center to be joined as a required party.

In [\*Oswalt v. Sedgwick Claims Mgmt. Servs., Inc., No. 3:14-CV-956-WKW, 2015 WL 1565033 \(M.D. Ala. Apr. 8, 2015\)\*](#), the court dismissed without prejudice Plaintiff's claims against his former employer, BellSouth Telecommunications, LLC, and its disability claims insurer, Sedgwick Claims Management Services, Inc., alleging tort and statutory claims arising under state law. The court found that as a result of Plaintiff's Chapter 7 bankruptcy proceeding, Plaintiff lacks prudential standing to prosecute the present claims.

*Newton v. Hartford Life & Acc. Ins. Co., No. 7:14-CV-02210-RDP, 2015 WL 1498868 (N.D. Ala. Mar. 30, 2015)*. Defendant argued that Plaintiff's claim must be dismissed because a breach of fiduciary duty claim is not available where other avenues to obtain relief are available, such as Plaintiff's claims for benefits under Count One. The court agreed that claims for equitable relief under § 1132(a)(3) are available only when a plaintiff has no other claim for relief under ERISA, but in certain circumstances, some courts have allowed ERISA plaintiffs to plead dual claims where the claims have different factual predicates, even though the plaintiffs would ultimately be barred from recovering under both (a)(1)(B) and (a)(3) at summary judgment or trial. Plaintiff's primary claim, contained in Count One, seeks an award of plan benefits under § 1132(a)(1). The factual predicate of that claim is that Plaintiff is, in fact, physically disabled, and thus her benefits were wrongfully discontinued. Under Count Two, Plaintiff asserts a breach of fiduciary duty claim seeking to have her claim reopened and reconsidered as relief for the alleged breach of fiduciary duty. Although the requested relief in the two claims appears somewhat similar, the factual predicate for her claim under Count Two is Defendant's alleged failure to produce requested documents, and because the factual predicate underlying Count Two is distinct from

the factual predicate for Count One, Count Two may be pled and maintained alternatively, at least at this stage of the case. The court noted that at the end of the day, however, Plaintiff will not be able to recover under both theories.

In *Berkshire Life Ins. Co. of Am. v. Duggan*, No. 8:14-CV-246-T-23MAP, 2015 WL 224671 (M.D. Fla. Jan. 15, 2015), Plaintiff Berkshire alleged that Defendant's application for disability income insurance included false material statements and that the insurance plan is subject to ERISA. Plaintiff sued for (1) for a judgment declaring that the defendant is not a plan participant (Count I) and for rescission of the plan (Count II). Alternatively, Plaintiff sues under Florida law (1) for a judgment declaring that the plan is void or unenforceable (Count III) and (2) for rescission. Defendant moved to dismiss Counts I and II for failure to state a claim under ERISA because the plan is not an "employee welfare benefit plan," as defined in ERISA. Defendant also argued that even if the plan is an ERISA plan, ERISA is inapplicable because ERISA's "safe harbor" exemption applies. Lastly, Defendant argued that, if ERISA applies, Counts III and IV are preempted. The court denied Defendant's motion. The court found that Defendant failed to identify a deficiency of a necessary element of an ERISA plan. With respect to the "safe harbor" argument, the regulation explicitly obliges the employer who seeks its safe harbor to refrain from any functions other than permitting the insurer to publicize the program and collecting premiums. Here, the complaint alleges that Defendant's employer both "accept[s] delivery of any policy issued" to Defendant and is Defendant's contact "regarding any increases in coverage." These alleged "functions" exceed the "functions" permitted in Section 2510.3-1(j)(3). With respect to preemption, the court explained that the state law claims are alternative claims that are preempted only if ERISA applies, an issue that remains unresolved.

L. D.C. Circuit

XVI. ***Preemption***

A. First Circuit

In lawsuit seeking to recover from Defendant funds that Defendant contributed to a deferred compensation plan for Plaintiff's benefit, the court granted Plaintiff's Motion for Attachment and Attachment on Trustee Process in the amount of \$192,859 .89. The court noted a potential issue is whether attachment proceedings are proper given ERISA preemption principles. However, the Supreme Court, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 834 (1988), held that "state-law methods for collecting money judgments must, as a general matter,

remain undisturbed by ERISA; otherwise, there would be no way to enforce such a judgment won against an ERISA plan.” [Siefken v. Grp. Home Found. Inc., No. 1:15-CV-00209-GZS, 2015 WL 5178067 \(D. Me. Sept. 4, 2015\).](#)

**Whether ERISA preempts Massachusetts discrimination statute is not facially conclusive.**

In [Sirva Relocation, LLC v. Richie, No. 14-1934, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4395168 \(1st Cir. July 20, 2015\).](#), the First Circuit considered whether ERISA preempted an employee’s disability discrimination claim brought under a Massachusetts discrimination statute with the Massachusetts Commission Against Discrimination. The dispute concerned Aetna’s termination of long-term disability benefits after 24 months due to the disability policy’s mental condition limitation. The court noted that while most federal courts have found that the ADA conclusively permits an employer to offer disparate benefits based on the type of disability that may afflict an employee, it could not find facially conclusive the proposition that the ADA permits such a differential-benefit scheme and that, therefore, ERISA preempts the Massachusetts General Laws chapter 151B claim. The court found that there is room for principled disagreement about the viability of differential-benefits claims under the ADA and resolving the preemption question presented here calls for exactly the sort of extensive legal analysis that places the facially conclusive preemption exception out of reach. As such, the court’s abstention under *Younger v. Harris*, 401 U.S. 37 (1971) (doctrine of abstention requires federal courts, in the absence of extraordinary circumstances, to refrain from interfering with certain state proceedings) is appropriate.

In [Morjaria v. Harvard Vanguard Med. Associates, Inc., No. CIV.A. 14-10139-GAO, 2015 WL 1276827 \(D. Mass. Mar. 20, 2015\).](#) Plaintiff had enrolled her husband in her ERISA-governed life insurance plan, paid premiums for his coverage, but was informed by her employer after her husband’s death that the husband was enrolled in error and she was not entitled to any benefits. Plaintiff’s complaint alleged an ERISA breach of fiduciary duty claim against the employer and state law claims in the alternative. The court found that Plaintiff is incorrect in assuming ERISA would not govern these claims if her husband were found not to be eligible under the Plan because Plaintiff, and not her husband, is the participant in the Plan and putative beneficiary of the life insurance policy. Plaintiff, and not her husband, has standing to bring a claim. The court found that the state law claims are only potentially viable if Plaintiff is understood to assert them as the Plan participant. Because the court’s inquiry must be directed to the plan to evaluate them, those claims are preempted.

B. Second Circuit

**ERISA does not preempt constructive trust on life insurance policy proceeds.** [McCarthy v. Estate of McCarthy, No. 14-CV-6194 JMF, 2015 WL 7019768 \(S.D.N.Y. Nov. 10, 2015\)](#) (Judge Jesse M. Furman). In a matter alleging constructive fraud against Defendants, the court concluded that Plaintiffs are entitled to the proceeds of an Aetna insurance policy. The court found that it need not resolve whether one of the defendants was designated as the primary beneficiary on the Aetna Policy, because even assuming the defendant was so designated, equity commands that the court impose a constructive trust on the paid-out proceeds of that policy. The Decedent, upon his failure to maintain death benefits in the amount of \$4 million in accordance with the terms of the Marriage Settlement Agreement, had an obligation to name Plaintiffs as beneficiaries on later policies. Under New York law, that obligation is enforceable in equity despite the Decedent's failure to comply with the terms of the separation agreement and, when the Decedent died, Plaintiffs acquired not only a right at law to sue his estate for breach of contract, a right now worthless, but also an equitable right in the proceeds of the Aetna policy. The court found that ERISA does not preempt the imposition of a constructive trust on the proceeds of the policy. After proceeds have been distributed, parties' rights and equities may be determined without regard to ERISA because post-distribution suits do not interfere with any of those objectives.

In [Connecticut Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP, No. 3:14-CV-1859\(AVC\), 2015 WL 5122269 \(D. Conn. Aug. 31, 2015\)](#), an action for declaratory and injunctive relief and damages pursuant to ERISA and various state laws in which Cigna alleges that the surgical center defendants defrauded Cigna by using fee-forgiving billing practices, the court granted in part and denied in part Defendants' motion to dismiss. The court concluded that: 1) Cigna has constitutional and statutory standing; 2) Cigna's amended complaint provides fair notice under Fed.R.Civ.P. Rule 8; 3) Cigna seeks appropriate relief under ERISA § 502(a)(3); 4) Cigna failed to state a claim under Connecticut Unfair Trade Practices Act ("CUTPA"); 5) Cigna's state law claim of fraud is not preempted by ERISA; 6) Cigna's state law claim of tortious interference with contract is preempted by ERISA; and 7) Cigna's amended complaint sufficiently pleads fraud with particularity under Fed.R.Civ.P. Rule 9(b).

In [Kinzie v. Bank of New York Mellon Corp., No. 1:14-CV-1191 GLS/CFH, 2015 WL 3795793 \(N.D.N.Y. June 17, 2015\)](#), the court found Plaintiff's breach of contract claim, which seeks an order directing BNYM to issue him a lump-sum payment of the survivor benefits under the ESOP, to be preempted by ERISA.

In [\*McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna U.S. Healthcare\*, No. 15-CV-2007-KBF, 2015 WL 2183900 \(S.D.N.Y. May 11, 2015\)](#), Plaintiff, an out-of-network medical provider, brought a state-law claim of promissory estoppel against Aetna for reimbursement of a surgery Plaintiff performed on a patient who is a beneficiary of an Aetna-administered health care plan. Aetna removed the action and Plaintiff filed a motion to remand. The court found that Plaintiff's claim is properly one for coverage under an ERISA plan, denied the motion to remand, and ordered Plaintiff to file an amended complaint to assert ERISA causes of action.

**Wage Parity Law is not preempted by ERISA.** In [\*Concerned Home Care Providers, Inc. v. Cuomo\*, No. 13-3790-CV, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 1381380 \(2d Cir. Mar. 27, 2015\)](#), the court found that a provision of New York's home care worker wage parity law, which required licensed home care services agencies (LHCSA) receiving state Medicaid reimbursement to adopt a minimum rate of total compensation for home health aides (HHA) in New York City and surrounding counties, was not preempted by ERISA. The calculation of the minimum rate of compensation referenced the rate from the largest collective bargaining agreement covering home care aides in New York City, which included several ERISA plans, where employers were free to select the manner in which they paid the minimum rate of total compensation. The ERISA plans established by the largest collective bargaining agreement had no more than a remote bearing on the operation of the wage parity law.

In [\*Cummings v. Teachers Ins. & Annuity Ass'n of Am.-Coll. Ret. & Equities Fund\*, No. 1:12-CV-93, 2015 WL 1137760 \(D. Vt. Mar. 13, 2015\)](#) (**Not Reported in F.Supp.3d**), Defendants moved to dismiss Counts IV and V of Plaintiff's second amended complaint alleging common law breach of the fiduciary duties of care and loyalty in connection with Defendants handling of her TIAA-CREF retirement account. The court found that Counts IV and V allege claims under common law for breach of the fiduciary duties of care and loyalty based on the same factual allegations as her ERISA claims. Therefore, the court dismissed these claims, finding they are preempted by ERISA.

In [\*Pascazi v. Rivera\*, No. 13-CV-9029 NSR, 2015 WL 845839 \(S.D.N.Y. Feb. 26, 2015\)](#), Plaintiff sought to enjoin the enforcement of two administrative orders finding that his company violated New York's Prevailing Wage Law ("PWL"), arguing that the PWL is preempted by ERISA because it permits the Commissioner to pursue a company and its shareholders for failure to pay employees prevailing wages and supplements—which may in some circumstances include contributions to an ERISA plan. The court found that the NYDOL is pursuing a total package enforcement policy, as approved by the Second Circuit, and it does not violate the preemption provisions of ERISA.

C. Third Circuit

**Preliminary injunction of County’s apprenticeship requirements denied where Plaintiff did not meet burden of establishing likelihood of success on preemption issue.** [Associated Builders & Contractors, Inc. v. New Castle Cty., No. CV 15-682-SLR, F.Supp.3d , 2015 WL 7257916 \(D. Del. Nov. 17, 2015\)](#) (Judge Sue L. Robinson). Plaintiff Associated Builders and Contractors, Inc., Delaware Chapter (“ABC”), filed a complaint seeking to enjoin Defendant New Castle County (“NCC”) from enforcing the apprenticeship requirements of County Code § 2.05.303.D.3.a (“the Code”) to its “Route 9 Library Project.” The Code requires that when the probable cost of a NCC construction contract is expected to exceed \$100,000.00, construction contractors seeking to perform work on such publicly funded projects must meet certain requirements. ABC moved to enjoin the enforcement of certain apprenticeship requirements and associated regulations, arguing that they are preempted by ERISA. The court found that Plaintiff did not meet its burden to demonstrate its likelihood of success on the preemption issue, and specifically that (1) States have long regulated apprenticeship standards and training; (2) ERISA has nothing to say about the standards to be applied to apprenticeship training programs; and (3) what triggers ERISA’s potential application to such laws is not the existence of an apprenticeship training program, but the existence of a separate fund to support the training program and the related reporting, disclosure, and fiduciary responsibilities associated therewith. Here, the Code applies to ERISA and non-ERISA plans alike and has no directive related to the funding sources of any apprenticeship program. The court found that the irreparable harm factor favors defendants but that the balance of harm and public harm factors favor neither party.

In [Estate of Jennings v. Delta Air Lines, Inc., No. CIV.A. 15-962 JBS, 2015 WL 5089458 \(D.N.J. Aug. 27, 2015\)](#), Plaintiff asserted claims for breach of contract and negligence against Defendants for their roles in the allegedly wrongful denial of the Estate’s life insurance claim on Ms. Jennings’ husband’s unexpected death. The life insurance policy was provided by the husband’s employer as part of a group employee benefits plan. The court found that Plaintiffs’ challenge of Defendants’ conduct under the terms of an ERISA plan requires interpretation of the plan and is preempted by ERISA.

In [Associated Builders & Contractors, Inc. v. City of Jersey City, No. 2:14-CV-05445-SDW, 2015 WL 4640600 \(D.N.J. Aug. 3, 2015\)](#), Jersey City Ordinance 14.052 requires all contractors to enter into a “Project Labor Agreement” (“PLA”), which is defined as “a contract between a labor organization and a developer” that contains various requirements, including training for apprentices. Plaintiffs alleged that the PLA’s apprenticeship requirement is preempted by ERISA, which pertains to employee welfare benefit plans that include “apprenticeship or other

training programs.” The court found that ERISA preemption claims are subject to the same market participant exemption present in the NLRA preemption analysis. Since the court found that the PLA containing the apprenticeship requirement is protected from NLRA preemption due to the market participant exemption, it follows that ERISA does not pre-empt the apprenticeship requirement for the same reason. Therefore, the court dismissed this count of Plaintiffs’ Complaint.

In [Coggins v. Keystone Foods, LLC, No. CIV.A. 15-480, 2015 WL 3400938 \(E.D. Pa. May 27, 2015\)](#), Plaintiffs asserted that they do not seek any additional benefits from Keystone’s Healthcare Benefits Plan, but rather seek the additional out of pocket costs that they are allegedly entitled to have reimbursed under the Retirement Agreements. Plaintiffs’ theory is that the Healthcare Benefits Plan and Medical Reimbursement Plan provide benefits covered by ERISA, but the separate Retirement Agreements merely define Plaintiffs’ rights to continue receiving these benefits, rather than provide new benefits covered under ERISA. The court found that the Retirement Agreements are not “plans” that may be enforced under ERISA § 502(a)(1)(B), and therefore Plaintiffs’ claims are not completely preempted under *Davila*. The court granted Plaintiffs’ Motion to Remand.

In [Jones v. Citigroup Inc., No. CIV.A. 14-6547 ES, 2015 WL 3385938 \(D.N.J. May 26, 2015\)](#), the court found Plaintiff’s claims arising out of Defendants’ administration of the 401(k) Plan to be preempted by ERISA. The gravamen of Plaintiff’s Complaint is that Defendants improperly administered his Plan Loan, foreclosed on the Plan Loan in error and refused to reimburse him for alleged tax penalties associated with the Plan Loan’s foreclosure.

In [Jewish Lifeline Network, Inc. v. Oxford Health Plans \(NJ\), Inc., No. 15-CV-0254 SRC, 2015 WL 2371635 \(D.N.J. May 18, 2015\)](#), the court denied insurance company’s motion to dismiss state law claims by a health care service provider seeking to recover the cost of an ambulatory air-evacuation that it arranged. The court found that ERISA does not preempt Plaintiff’s claims since Plaintiff alleges that Defendant must pay for the costs of the emergency evacuation; not because the LMG Plan or ERISA require Defendant to do so, but because Defendant promised that it would. As such, it cannot be said that Plaintiff’s claims exist “only because of the terms of an ERISA-regulated employee benefit plan,” or that “no legal duty (state or federal) independent of ERISA” is present.

In [Trigg v. Merck Sharp & Dohme Corp., No. CIV.A. 14-6063, 2015 WL 1954212 \(E.D. Pa. May 1, 2015\)](#), Plaintiff brought claims under the ADEA and Pennsylvania Human Relations Act, alleging that the reason for his termination is a pretext for age-based discrimination. The court found that the amended complaint should not be dismissed for failure to exhaust administrative remedies under ERISA or due to ERISA preemption or that Plaintiff was not entitled to severance under the terms of the Separation Benefits Plan. The court did not read the amended complaint to include a claim for severance benefits under ERISA, but rather that the allegations relating to denial of severance supported his claim that younger team members were offered severance packages when terminated. It may well be that Plaintiff was not eligible for Merck's severance plan, but that fact goes to the employer's burden of production, under *McDonnell Douglas*, to articulate a legitimate non-discriminatory reason for its adverse employment action. However, should Plaintiff assert a claim for severance benefits under an ERISA plan, Defendant may raise any and all affirmative defenses to such a claim, including failure to exhaust.

In [Hayes v. Reliance Standard Life Ins. Co., No. 3:14-CV-0714, 2015 WL 1296005 \(M.D. Pa. Mar. 23, 2015\)](#), the court found Plaintiff's negligence and detrimental reliance claims against JRG Advisors LLC, an insurance broker, to not be preempted by ERISA. Plaintiff alleged that JRG was careless and negligent as follows: failing to properly investigate the insurability of Plaintiff; failing to confirm the correct policy under which Plaintiff could be insured; failing to properly perform the underwriting process for Plaintiff's application; failing to properly interpret Plaintiff's employment status; failing to question Plaintiff's employment status prior to accepting Plaintiff's application for insurance; failing to gather sufficient information regarding Plaintiff's employment status; and failing to perform an independent investigation of Plaintiff's employment status and his insurability.

In [Corrigan v. Local 6, Bakery, Confectionary & Tobacco Workers, No. CIV.A. 14-1073, 2015 WL 921600 \(E.D. Pa. Mar. 4, 2015\)](#), Plaintiff filed suit against Independence Blue Cross for breaching its contract and being negligent in failing to inform him of his right to continuing insurance coverage after the termination of his employment. The court granted Independence's motion for summary judgment, finding that ERISA preempted the state law claims. The court found that even if Plaintiff's claims were not preempted by ERISA, he presented no factual or legal support for his assertions that Independence had contractual and tort duties to notify Plaintiff of the discontinuation of his health care. The plan administrator was Hostess, which did in fact notify Plaintiff of the discontinuation of his insurance benefits.

In [Hershan v. Unum Grp. Corp., No. CIV. 2:14-6120 WJM, 2015 WL 502154 \(D.N.J. Feb. 5, 2015\)](#), the court found Plaintiff's breach of contract claim related to the denial of his disability

benefits as preempted by ERISA. Because the Complaint is governed exclusively by ERISA, the court struck from the Complaint Plaintiff's demand for extracontractual damages and trial by jury.

D. Fourth Circuit

[Prince v. Sears Holding Corp., No. 1:15-CV-6, 2015 WL 9307292 \(N.D.W. Va. Dec. 21, 2015\)](#) (Judge John Preston Bailey). State law claims against employer related to termination of spouse's life insurance coverage is completely preempted by ERISA.

**Claims alleging constructive fraud and negligence concerning an employee's eligibility to participate in an ERISA plan are preempted.** [Van Lier v. Unisys Corp., No. 1:15-CV-974, 2015 WL 6439394 \(E.D. Va. Oct. 22, 2015\)](#) (Judge T.S. Ellis, III). Plaintiff brought suit in state court alleging that her employer committed constructive fraud and negligence by representing to Plaintiff that she was not eligible for coverage under defendant's long term disability plan when, in fact, she was eligible. The court held that Section 514(a) of ERISA preempts Plaintiff's state law claims under the doctrine of conflict preemption because these claims implicate an ERISA plan and refer to an alleged misrepresentation made by an ERISA fiduciary to an employee eligible for the ERISA plan. The court also held that Plaintiff's state law claims are completely preempted by ERISA because could bring her claims under ERISA Section 502(a). The court rejected Plaintiff's argument that she does not have standing as a participant under ERISA. The court explained that because she was a participant at the time of the alleged misrepresentation, it does not matter that she is currently not able to participate in the LTD plan. The court dismissed the complaint without prejudice so that Plaintiff can amend her complaint to assert a claim under ERISA.

In [Smithson v. Smithson, No. CIV.A. 1:15-0583, 2015 WL 2359569 \(S.D.W. Va. May 15, 2015\)](#), Plaintiffs brought state law claims against Defendant seeking damages related to 401(k) account proceeds which were distributed to Defendant. Defendant removed the action asserting ERISA preemption but the court remanded the action to state court, finding that no federal jurisdiction exists where the proceeds from the 401(k) plan have been distributed and are no longer held by the plan administrator. As to the unpaid pension plan benefits, Plaintiffs are not claiming that they should not be distributed to Defendant but, rather, that she has no legal right to retain them. Even if provisions of ERISA will be invoked as a defense to Plaintiffs' claim, that fact alone does not establish Defendant's right to removal.

In [\*Nguyen v. Am. United Life Ins. Co.\*, No. 1:14CV687, 2015 WL 540565 \(M.D.N.C. Feb. 10, 2015\)](#), a dispute involving a conversion from a group policy to an individual life insurance plan within thirty-one days of termination of employment, the court found that the state law claims are preempted by ERISA.

E. Fifth Circuit

**Promissory estoppel claim preempted by ERISA.** [\*Kennedy Krieger Institute, Inc. v. Brundage Management Company, Inc., et al.\*, No. 5:15-CV-162-DAE, 2015 WL 7301185 \(W.D. Tex. Nov. 18, 2015\)](#) (Judge David Alan Ezra). The court found that Plaintiffs' promissory estoppel claim against Defendants for medical services provided to John Doe (participant's minor son) after the first seven days of care is preempted by ERISA. Specifically, whether Plaintiff's inpatient services "continued to be medically necessary" necessarily depends on whether they were medically necessary in the first place and requires reference to the Plan's definition of medically necessary. The court dismissed without prejudice Plaintiffs' promissory estoppel claim to the extent it seeks to recover for services provided beyond the first seven days of care.

In [\*Kelsey-Seybold Med. Grp. PA v. Great-W. Healthcare of Texas, Inc.\*, No. 14-20506, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 4720319 \(5th Cir. Aug. 10, 2015\)](#), the Fifth Circuit reversed and remanded the decision of the district court denying Plaintiff's motion to remand the case to state court, where Plaintiff filed suit against Defendant alleging that it had not paid the contractually required rate for medical services that it provided to members of Great West-affiliated healthcare plans. The Fifth Circuit found that although about 98% of Plaintiff's claims are claims for ERISA plan benefits, that fact is irrelevant since the question is not whether Plaintiff's claims relate to benefits under ERISA plans, but rather whether adjudication of those claims requires an interpretation of an ERISA plan. Defendant did not show that any of Plaintiff's claims concern "the right to payment under the terms of the benefit plan," as opposed to "the rate of payment as set out" in the parties' contractual agreement.

In [\*Patel v. Sea Nine Associates, Inc.\*, No. 3:15-CV-00754-M, 2015 WL 4617020 \(N.D. Tex. Aug. 3, 2015\)](#), the court found as not preempted Plaintiffs' suit against Defendants, claiming that they were induced into investing in employee benefit plans by fraudulent misrepresentations as to the tax-exempt status of those plans. Plaintiffs alleged that Defendants and their representatives presented Plaintiffs with information regarding a "419A Plan," a type of employee benefit program that purported to comply with Internal Revenue Code Section 419A(f)(6). Compliance meant that Plaintiffs would be exempt from limitations placed by the Internal Revenue Service on deductions taken from employer contributions to a welfare benefit

plan and Defendants allegedly represented that the 419A Plan was not a transaction that would result in the IRS requiring the filing of a Form 8886. Plaintiffs invested approximately \$1,280,000 in the plan marketed to them by Defendants, and took the income tax deductions they had been told by Defendants they were entitled to under the plan but the IRS imposed back taxes, substantial penalties and ever-accruing interest. The IRS also concluded that the plan was a prohibited individual investment account, because it presented all the classic symptoms of a 419A listed transaction and imposed penalties and interest associated with Plaintiffs' failure to file a Form 8886 when investing in a listed transaction. The court found that the duty Plaintiffs claim Comerica owed them, to "act in a manner conforming to the professional standards of care applicable to prudent insurance companies, trustees, investment advisors, or insurance advisors," relates to conduct that occurred before the marketed plan was entered into by Plaintiffs and not based on a relationship between traditional ERISA entities.

In [\*Kennedy Krieger Inst., Inc. v. Brundage Mgmt. Co.\*, No. 5:15-CV-162-DAE, 2015 WL 4528885 \(W.D. Tex. July 27, 2015\)](#), Plaintiffs filed suit in the District of Maryland against Brundage, the Brundage Plan, BMA, and Inetico for promissory estoppel, breach of contract, fraud (asserted only against Brundage), and violation of the Texas Insurance Code in connection with the denial of inpatient care for a developmentally disabled child who is covered by a self-funded health plan. The court found that the promissory estoppel claim is not preempted by ERISA based on the Fifth Circuit's decision in *Access Mediquip, L.L.C. v. UnitedHealthcare Insurance Co.* However, Plaintiffs' breach of contract claim is preempted. The court found that Plaintiffs' claim under the Texas Insurance Code fails to provide notice of the nature of their claim such that the court is unable to determine whether the claim is preempted by ERISA. The court dismissed without prejudice Plaintiffs' claim under the Texas Insurance Code. With respect to the Brundage Plan, the court found that there was no authority and certainly no "express statutory language," suggesting that actions against an ERISA plan are limited to those brought under ERISA. As such, the Brundage Plan is not entitled to judgment on the pleadings on this basis, and the dismissal of Plaintiffs' claims against the Brundage Plan for promissory estoppel and under the Texas Insurance Code is without prejudice.

In [\*Emigh v. W. Calcasieu Cameron Hosp.\*, No. 2:14-CV-02808, 2015 WL 4209230 \(W.D. La. July 10, 2015\)](#), the court determined Plaintiffs' claims are not completely preempted under ERISA and remanded the matter to state court. The court found that Plaintiffs' claims will not require the court to interpret an ERISA plan to determine whether Plaintiffs' were wrongfully denied coverage or whether the administration of a claim was improper since Plaintiffs' primary complaint involves WCCH's violations of the Balance-Billing Act. Further, the secondary argument that the employer-sponsors and third-party administrators are liable for WCCH's

actions does not convert this suit into an ERISA case because in seeking to impose solidary liability, Plaintiffs are not relying on ERISA or the particular terms of an ERISA plan.

In [\*JN'P Enterprises, LLC v. Companion Life Ins. Co.\*, No. CIV.A. H-14-3633, 2015 WL 2341791 \(S.D. Tex. May 13, 2015\)](#), the court found as not preempted an employer's claim for reimbursement after Defendants represented to the employer that its employee was entitled to weekly benefit payments of \$600 under an ERISA benefit plan for a period of two years and the employer made the payments. The employer could not bring its claim under Section 502(a)(1)(B) because it is not a plan participant or beneficiary. Defendants also failed to show that the employer is a fiduciary of the ERISA plan and has standing to pursue a claim for equitable relief under Section 502(a)(3). As such, the court remanded the claims to state court.

In [\*Aetna Life Ins. Co. v. Methodist Hospitals of Dallas\*, No. 3:14-CV-347-M, 2015 WL 918586 \(N.D. Tex. Mar. 4, 2015\)](#), the court determined, in the narrow circumstances presented in this case, that ERISA does not preempt the Texas Prompt Payment Act's mandatory payment deadlines, insofar as the deadlines apply to third-party administrators of self-funded health insurance plans. The court found that it has diversity jurisdiction to declare whether preemption is a valid federal defense to the Providers' claims under state law. Finding that there are no indispensable parties absent in this litigation, the Court denied the Providers' Motion to Dismiss under Rule 12(b)(7). Reaching the merits of the declaratory judgment action, the Court found that the Providers' claims under the TPPA are not preempted by ERISA, and granted the Providers' Cross-Motion for Summary Judgment.

In [\*Cardiovascular Specialty Care Ctr. of Baton Rouge, LLC v. United Healthcare of Louisiana, Inc.\*, No. CIV.A. 14-235-BAJ, 2015 WL 952121 \(M.D. La. Mar. 4, 2015\)](#), the court adopted the Magistrate Judge's Report & Recommendation denying Plaintiff's motion to remand this action, which alleges that United preauthorized it to treat the United Insureds for certain medical services, the United Insureds assigned their claims for reimbursement to Plaintiff, United informed Plaintiff that it would be reimbursed for those medical services, but United did not pay for these services, which totaled \$1,553,612.33. Plaintiff alleged various state law violations. United removed this action alleging that this court has federal question jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(a) of ERISA. United requested the court to exercise supplemental jurisdiction pursuant to 28 U.S.C. § 1367 over any state law claims that are not completely preempted. The court found that Plaintiff's breach of contract claim premised upon its assignment of rights pursuant to at least one ERISA plan is completely preempted. To the extent Plaintiff stated claims for negligent misrepresentation and detrimental reliance, and those

claims are premised on obligations independent of the insurance policies, then the court will exercise supplemental jurisdiction over those claims.

F. Sixth Circuit

**Breach of contract claim for lump sum benefit under pension plan is completely preempted by ERISA.** [Keever v. NCR Pension Plan, et al., No. 3:15-CV-196, 2015 WL 9255342 \(S.D. Ohio Dec. 17, 2015\)](#) (Judge Walter H. Rice). The court found that Plaintiffs' lawsuit seeking to recover the lump sum benefit that their mother elected to receive in lieu of monthly payments under the NCR Pension Plan, which is an ERISA-regulated employee benefit plan, is completely preempted by ERISA. The court further found that under the circumstances presented here, it cannot be said that the legal duty that was allegedly breached, i.e., NCR Pension Plan's duty to pay the lump sum benefit, is "independent of ERISA or the plan terms." Although Plaintiffs contended that they lack standing to bring an ERISA claim, the court found that they do have standing to pursue a claim for benefits since the mother was a beneficiary as defined by ERISA and her estate now stands in her shoes and is entitled to pursue a claim. Regardless, the court explained that even if Plaintiffs lacked statutory standing to pursue a claim for benefits that this would not necessarily deprive the federal court of subject matter jurisdiction.

**State law negligence claim against paper reviewing doctors properly removed due to complete preemption.** [Hackney v. AllMed Healthcare Management, Inc., No. 3:15-CV-00075-GFVT, 2015 WL 8682184 \(E.D. Ky. Dec. 11, 2015\)](#) (Judge Gregory F. Van Tatenhove). Plaintiff initially filed a Complaint in Shelby Circuit Court "relating to Defendant AllMed Healthcare Management Inc.'s actions in rendering an unlicensed medical opinion concerning Plaintiff." Specifically, Plaintiff filed for disability income benefits payable under a long-term insurance policy that is governed by ERISA. At the insurer's request, AllMed agreed to provide a written medical opinion concerning Plaintiff's physical condition. Robert J. Cooper, a contract employee of AllMed, and Skip Freeman, AllMed's medical director, participated in drafting and issuing the medical opinion ultimately sent to the disability insurer. Neither Cooper nor Freeman were licensed to practice medicine in Kentucky under KRS § 311.560.1. AllMed filed a notice of removal, asserting that the Complaint is completely preempted by ERISA. The court denied Plaintiff's motion to remand, finding that his claim against AllMed for negligence *per se* is really a "suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan." Further, the court found that Plaintiff does not allege the violation of any legal duty independent of ERISA or of the plan terms. Rather, the state law claim for negligence arises solely in the context of AllMed's review of Plaintiff's claim file, which, in turn, arises solely in the context of Lincoln National's review of his claim for disability benefits under ERISA. Plaintiff would not have a claim against AllMed but for his claim for disability benefits under ERISA.

**Claim for damages equaling value of ERISA pension plan benefits is not preempted by ERISA.** [Winter v. United Parcel Service, Inc. Delaware & United Parcel Service, Inc. Ohio, No. 14-10555, 2015 WL 8478460 \(E.D. Mich. Dec. 10, 2015\)](#) (Judge Arthur J. Tarnow). The court granted Plaintiff's motion for reconsideration on the court's previous finding that Plaintiff's fraudulent and innocent misrepresentation claims were preempted by ERISA. On reconsideration, the court found that Plaintiff's misrepresentation claims do not necessarily require evaluation of any ERISA plan or the parties' performance under it. Instead, Plaintiff's misrepresentation claims seem analogous to the breach of contract claim in *Marks v. Newcourt Credit Group, Inc.*, 342 F.3d 444 (6th Cir. 2003), which was held to refer to an ERISA plan only to ascertain damages. The court reconsidered its prior holding that Plaintiff's claim for damages equaling the benefits he would have received under the UPS/IBT Full-Time Pension Plan is preempted by ERISA and they are not preempted by ERISA to the extent he seeks to recover the value of benefits relinquished in reliance on Defendants' alleged misrepresentations, including (but not limited to) the value of lost benefits under the pension plan.

**Severance provision in employment agreement does not constitute an ERISA plan.**

[Williams v. CCPI, INC., No. 1:15-CV-269, 2015 WL 5935821 \(S.D. Ohio Oct. 13, 2015\)](#).

Plaintiff alleges that he is entitled to severance payments under the terms of an employment agreement between the parties. The court granted Plaintiff's motion to remand to state court, finding that the severance provision in the employment agreement does not constitute an ERISA plan and is thus not preempted. Although Defendant must exercise its judgment to determine whether Plaintiff was terminated without cause or resigned for "Good Reason", the court found that the discretion to determine a single employee's eligibility for severance payments of the type specified in the parties' agreement has not been held sufficient in and of itself to satisfy the first prong of the *Kolkowski* test (whether there is administrative discretion over the distribution of benefits). The agreement does not vest CCPI with any discretion to alter the level, amount, duration, or timing of benefits. The court found that the second factor to be considered – whether the agreement creates ongoing demand on the employer's assets – also weighs against a finding that the Employment Agreement is covered by ERISA.

In [LeBlanc v. SunTrust Bank, No. 3:15-CV-00630, 2015 WL 5038032 \(M.D. Tenn. Aug. 25, 2015\)](#), the court remanded Plaintiff's case to state court, where Plaintiff brought suit against her former employer and its benefits administrator, Sedgwick Claims Management Services, Inc., asserting various state-law claims based on the denial of short-term disability plan benefits under a plan exempted from ERISA because it is a "payroll practice." Defendants argued that although Plaintiff sued over denial of STD benefits, Plaintiff's state law claims actually seek recovery of

LTD benefits governed by an ERISA plan and are therefore preempted under ERISA. The court found that Plaintiff's claims are not based on the terms of an ERISA-regulated plan and she could not bring her claims under ERISA because she was unable to qualify for LTD benefits once her STD benefits were denied. Thus, Plaintiff did not ever apply for LTD benefits, she did not receive a denial of LTD benefits, there is not an administrative record to review, and she seeks damages from the individual Defendants, not from the LTD Plan's assets.

**ERISA § 515 preempts the contract defense of lack of consideration.** In [\*Orrand v. Scassa Asphalt, Inc.\*, No. 14-3954, F.3d , 2015 WL 4430447 \(6th Cir. July 21, 2015\)](#), the Sixth Circuit affirmed the district court's grant of summary judgment in favor of the Funds on their claim to collect delinquent fringe benefit contributions. The court held that 1) the employer's principal's verbal communication to a union official of its intent to terminate its relationship with the union did not relieve employer of its obligation to make contributions; 2) the union's letter notifying the employer that the CBA was set to expire did not relieve employer of its obligation to make contributions; and 3) ERISA preempted the employer's contract defense of lack of consideration. Defendant is required to pay \$141,356.18 in delinquent benefit contributions plus interest, statutory interest, and costs.

In [\*Bobak v. Blue Cross Blue Shield of Michigan\*, No. 14-14494, 2015 WL 3967925 \(E.D. Mich. June 30, 2015\)](#), Plaintiff's complaint alleged that Defendant induced him into an employment contract by misrepresenting aspects of an employee benefits plan and subsequently breaching an alleged agreement to provide Plaintiff with an additional five years of service under the employee benefits plan. The court found that based on these allegations, Plaintiff's claims of fraud in the inducement and breach of contract are preempted by ERISA and his claims were properly removed. But, the court found that it does not have jurisdiction because the claims are non-justiciable based on a straightforward application of the mootness doctrine. Plaintiff sought to be credited with five years of service but because Plaintiff had already vested in his benefits, the additional five years would not affect any other aspect of his retirement benefits, such that there is nothing left for Plaintiff to win.

In [\*Winter v. United Parcel Serv., Inc. Delaware\*, No. 14-10555, 2015 WL 2169808 \(E.D. Mich. May 8, 2015\)](#), Plaintiff brought claims against Defendants for fraudulent and innocent misrepresentation, alleging that agents of Defendants induced him to accept a supervisor position by misrepresenting the retirement benefits he would receive if he accepted the position. The court granted Defendants' motion to dismiss as to all counts, except the claims for rescission, on which it is denied without prejudice, because ERISA precluded Plaintiff from seeking any of its requested remedies except rescission from participant in the Supervisor Plan.

In [\*Saunders v. Ford Motor Co.\*, No. 3:14-CV-00594-JHM, 2015 WL 1980215 \(W.D. Ky. May 1, 2015\)](#), Plaintiff asserted a state law insurance bad faith claim, under KRS 304.12–230, arising from alleged improper processing of benefits under Ford’s self-funded ERISA employee benefit plan. The court found that this clearly “relates to” an employee benefit plan and therefore falls under ERISA’s express preemption clause, § 514(a), 29 U.S.C. § 1144(a). The court also concluded that because the proposed bad faith claim could not withstand a Rule 12(b)(6) motion to dismiss, Plaintiff’s proposed amendment is futile and his bad faith claim is dismissed.

In [\*Hechter v. Nationwide Fire Ins. Co.\*, No. 2:14-CV-2720, 2015 WL 1757542 \(S.D. Ohio Apr. 17, 2015\)](#), the court found that claims relating to OhioHealth’s alleged illegal billing practices, and DWA’s alleged cooperation with OhioHealth in furtherance of those billing practices are not completely preempted by ERISA. Plaintiff in this action brought claims against a third party hospital for breach of a preferred provider agreement and alleged that Defendants’ billing practices violated Ohio law. Plaintiff’s claims are concerned with the contractual relationship between her medical insurer and Defendants and do not seek to enforce rights under an employee benefit plan or to receive benefits. The court found no reason to exercise supplemental jurisdiction over the action and granted Plaintiff’s motion to remand.

In [\*Cole v. Am. Specialty Health Network, Inc.\*, No. 3:14-CV-02022, 2015 WL 1734926 \(M.D. Tenn. Apr. 16, 2015\)](#), a lawsuit by health service providers alleging that they signed a three-page Election to Participate before receiving a 82–page contract or “Provider Services Agreement” (“PSA”) containing terms to which they did not agree, the court dismissed the claims for breach of contract/unjust enrichment, wrongful trover/conversion, constructive trust, negligence, negligence per se, and accounting as being preempted by ERISA because these claims allege that Cigna improperly calculated and/or denied benefits pursuant to the applicable benefit plans and “relate to” such plans. The court also found that the claims for constructive trust and accounting are remedies, not causes of action, and would be dismissed on that basis as well. Additionally, the negligence and negligence per se claims would also be dismissed because in Tennessee contractual duties do not give rise to a negligence claim. The court did not dismiss or find preempted Plaintiffs’ claim for contract of adhesion but did dismiss the fraud claim for not being pled with sufficient particularity.

In [\*Terry v. Pepsi Bottling Grp. Inc. Long-Term Disability Plan\*, No. CIV. 15-7-ART, 2015 WL 1649126 \(E.D. Ky. Apr. 14, 2015\)](#), the court found as not preempted Plaintiff’s lawsuit seeking to enforce the terms of a settlement agreement where the PBG Plan agreed that it will not seek

nor be entitled to any recoupment/offset/reduction in regard to LTD benefits due to other benefits paid but later started to offset his LTD benefits by the amount he received in Social Security Disability benefits. The court held that Plaintiff alleges a breach of the settlement agreement—a purely state-law issue. As such, the court remanded the case to state court.

In [\*Prachun v. CBIZ Benefits & Ins. Servs., Inc.\*, No. 2:14-CV-2251, 2015 WL 457851 \(S.D. Ohio Feb. 3, 2015\)](#), the court denied to remand to state court an action filed by Plaintiffs seeking to recover the difference between benefits under the former employer’s health plan that the employee believed he was getting and the benefits actually provided. In this case, the employee alleged that he dropped his Medicare Part B coverage after being told by his employer that he did not need it, and that once he retired, he could reacquire it. After he retired, he was unable to reactivate his Medicare Part B coverage, and the insurance he was able to keep after his retirement did not pay for most of his medical expenses. The court concluded that this is a claim for benefits by a plan participant; it is cognizable under § 1132; and it is therefore completely preempted, even if phrased in terms of negligence.

*Davidson v. Henkel Corp.*, No. 12-CV-14103, 2015 WL 74257 (E.D. Mich. Jan. 6, 2015) involves a class action seeking to recover retirement plan benefits from a nonqualified deferred compensation plan which Plaintiff maintains were wrongfully reduced by Defendants failure to follow the Internal Revenue Code’s (“IRC”) special timing rule for the withholding of Federal Income Contributions Act (“FICA”) taxes on vested deferred compensation. Because Defendants failed to follow the special timing rule, Plaintiff lost the benefit of the IRC’s non-duplication rule resulting in devastating tax consequences. Instead of paying FICA taxes once on the entire amount of deferred compensation pursuant to the special timing and non-duplication rules, Plaintiff is now required to pay FICA taxes each year that he receives benefit payments from his deferred compensation plan. Defendants’ filed a motion to dismiss which the court denied in part and granted in part. The court found that Plaintiff’s state law claims are preempted by ERISA. Plaintiff argued that he cannot determine whether the Plan is an ERISA plan because Defendants have, in addition to the representations that the Plan is a “top-hat” plan, made representations that the Plan “is an excess benefit plan to provide for compensation above IRS limits pursuant to I.R.C. § 415, and as such would not be subject to ERISA.” Therefore, Plaintiff asserted that he is permitted to plead his state law claims in the alternative should it be determined that the plan is an excess benefit plan not governed by ERISA. The court found that the Complaint does not plausibly allege that the Plan is an excess benefit plan. An “excess benefit plan” is, by definition, one maintained “solely” for the purpose of providing benefits beyond the contribution limits imposed by 26 U.S.C. § 415. The Plan’s stated purpose is to benefit a select group of high level employees with supplemental retirement benefits. Plaintiff’s sole basis for maintaining that there is a question of fact as to whether the Plan is an excess benefit plan is based on an October 14, 2011 letter, wherein a Henkel representative indicated: “No, this benefit comes from the Henkel

Corporation Supplement Retirement Plan payment. This is the restoration plan which provides benefits similar to the qualified plan, but on compensation that exceed IRS limits for qualified plans.” The court found that without any indication in the Plan suggesting that it is an excess benefit plan for the purpose of avoiding § 415 limitations, the October 14, 2011 letter’s representations cannot alter the stated purpose of the Plan to benefit a select group of management or highly compensated individuals. Because the Complaint contains no plausible allegations supporting Plaintiff’s theory that the Plan may be an excess benefit plan, and because Plaintiff’s state law claims (breach of contract, misrepresentation, breach of fiduciary duty and negligence) do not arise out of any duty independent of ERISA, Plaintiff’s state law claims are preempted by ERISA.

G. Seventh Circuit

**Negligent misrepresentation claim preempted by ERISA.** [Arndt v. AON Hewitt Benefit Payment Services, LLC, et al., No. 15-C-750, 2015 WL 7313392 \(E.D. Wis. Nov. 19, 2015\)](#) (Judge William C. Griesbach). Plaintiff alleged that the Defendants had misrepresented the pension benefits he would receive upon his retirement and he relied on that misinformation, to his detriment, when he decided to retire from his job. Plaintiff further asserts that had he known what his actual benefit would have been, he would have kept working and he lost wages he would have earned had he kept working. The court dismissed Plaintiff’s claim with prejudice, finding that it satisfied the elements of conflict preemption.

**Separation payment and severance agreement terms as set forth in an email constitute an ERISA plan; claim for severance benefits under the Illinois Wage Payment Collection Act are preempted by ERISA.** [Cornell v. BP Am. Inc., No. 14 C 2123, 2015 WL 5766931 \(N.D. Ill. Sept. 30, 2015\)](#) (Judge Ronald A. Guzman). The court found that the BP Recovery Plan and the Value Share Plans are ERISA plans, notwithstanding that BP admitted that Form 5500s were not filed with the United States Department of Labor for those plans. “The filing of a proper form has no bearing ... on whether a plan is covered by ERISA,” and “courts have consistently rejected the argument that the failure to comply with formal requirements can prevent the establishment of an ERISA plan.” The BP Recovery Plan satisfies the requisite “ongoing administrative program” aspect of an ERISA-governed severance plan. The Rules of the BP Recovery Plan 2011 is a 16–page document setting forth when a Designated Corporate Officer may grant an Eligible Employee an Option to acquire such number of Shares as the Designated Corporate Officer may determine. The Rules lay out when Options may be granted, which may be at any time, subject to the application of Dealing Restrictions. They further discuss the Designated Corporate Officer’s power to adjust the number of Shares included in each Option, under certain circumstances, in any way which the Designated Corporate Officer considers appropriate, when and how Options may be exercised and relevant definitions of terms used in

the Rules, among other things. The court found that ERISA preempts the IWPCA claim with respect to the BP Recovery Plan and the Value Share Plan.

**ERISA does not preempt state law banning discretionary clauses from health and disability insurance policies; state ban does not conflict with ERISA’s civil enforcement scheme.** In [\*Fontaine v. Metro. Life Ins. Co.\*, No. 14-1984 \(7th Cir. Sept. 4, 2015\)](#), the Seventh Circuit rejected a federal preemption challenge to an Illinois insurance law, 50 Ill. Admin. Code § 2001.3, that prohibits provisions “purporting to reserve discretion” to insurers to interpret health and disability insurance policies,” affirming the decision of the district court in favor of Plaintiff. To be deemed a law that “regulates insurance” and thus to avoid preemption, a state law must satisfy two requirements: the state law must be specifically directed toward entities engaged in insurance and the state law must substantially affect the risk pooling arrangement between the insurer and the insured. The court found that Section 2001.3 meets both requirements. The law is grounded in policy concerns specific to the insurance industry regardless of whether it prohibits a plan sponsor from delegating discretionary authority to the insurer of an employee benefit plan. Prohibitions on discretionary clauses may have inevitable effects on entities outside the insurance industry but that does not change their character as insurance regulations. The court also rejected MetLife’s argument that the discretionary clause in this case is not actually in an insurance policy but in an ERISA plan document. MetLife’s argument, if accepted, would virtually read the saving clause out of ERISA. The court also found that Section 2001.3 does substantially affect the risk pooling arrangement between the insurer and the insured by altering the scope of permissible bargains between insurers and insureds and dictates the conditions under which risk is assumed in the insurance market. The court rejected MetLife’s argument that the law must determine whether a class of risks is covered, extend coverage to a class of previously excluded risks, and mandate new claim review procedures. Lastly, the court found that Section 2001.3 is not preempted by ERISA’s civil enforcement scheme. While a deferential standard for reviewing benefit denials is highly prized by benefit plans, it is not required by the text of the statute. This decision follows the Ninth and Sixth Circuit Courts of Appeal. See *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009); *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009). The court found that nothing in *Conkright v. Frommert*, 559 U.S. 506 (2010), issued after the Sixth and Ninth circuit decisions, impacts the courts analysis because it was not an ERISA preemption decision. *Conkright* does not overrule or limit *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) and the high threshold that must be met if a state law is to be preempted for conflicting with the purposes of a federal Act. As such, the court further held that Section 2001.3 is not impliedly preempted by ERISA’s civil enforcement scheme.

In [\*Jungles v. IBEW Local 134\*, No. 15 C 3329, 2015 WL 3855658 \(N.D. Ill. June 18, 2015\)](#) (**Not Reported in F.Supp.3d**), the court found that Plaintiff's state law claim is not preempted by ERISA, the court has no jurisdiction, and remand is proper. Plaintiff alleged that he was a participant in the electrical apprenticeship program run by EJATT. On September 8, 2008, the parties entered into a written apprenticeship probation agreement ("Probation Agreement") reinstating Plaintiff's participation in the electrical apprenticeship program. Plaintiff was eventually terminated due to a poor evaluation. He filed suit alleging that his termination from the program breached the terms of the Probation Agreement, resulting in economic damages of ongoing lost wages. Since Plaintiff's claim centers on the Probation Agreement and he does not seek access to the fringe benefit program, his claim is not preempted.

In [\*Univ. of Wisconsin Hosp. & Clinic Auth. v. Aetna Life Ins. Co.\*, No. 14-CV-882-BBC, 2015 WL 1065559 \(W.D. Wis. Mar. 11, 2015\)](#), the court found that Plaintiff's action, seeking to recover payment for procedure performed on a patient who is a participant in an ERISA-governed health plan, is preempted by ERISA. The court dismissed the complaint but gave Plaintiff an opportunity to amend its complaint to plead claims under ERISA.

In [\*Estate of Minko ex rel. Minko v. Heins\*, No. 14-CV-210-WMC, 2015 WL 856635 \(W.D. Wis. Feb. 27, 2015\)](#), Plaintiff Estate filed a state court action against Defendants, where the deceased was employed as a lawyer with Defendants, was promised a \$100,000 life insurance policy as a term of employment, but where Defendants had not procured a policy at the time of death. The complaint asserts the following causes of action: (1) breach of contract for "failure to obtain life insurance as promised and required as part of the compensation and consideration of David Minko's employment;" (2) breach of fiduciary duty based on Defendants' "failure to make effort and follow through to obtain the subject life insurance policy;" (3) unauthorized use and misappropriation of the name and good will of David Minko; and (4) injunctive relief enjoining the use of Minko's name, likeness or good will. The court found that these claims are not ERISA preempted because the Estate could not bring a claim under Section 502(a)(1) and the claims do not turn on interpretation of plan terms. The fact that the complaint references the amount of the promised policy—\$100,000—does not convert what are essentially state law contract and breach of fiduciary duty claims into one for benefits under the plan. As such, the court granted Plaintiff's motion to remand.

In [\*Schnepper v. Federated Mut. Ins. Co.\*, No. 3:14-CV-00154-RLY-WG, 2015 WL 506292 \(S.D. Ind. Feb. 6, 2015\)](#), the court found Plaintiffs' Complaint alleging Defendants breached their duty of good faith and fair dealing by denying treatment payments for Vectibix Chemotherapy and

breached its contract with Plaintiffs by failing to pay benefits for treatments as preempted by ERISA. The court denied Plaintiffs motion to remand.

#### H. Eighth Circuit

**Suit by hospitals against benefit plans is not preempted by ERISA and matter remanded to state court.** [The Nebraska Methodist Hospital, et al. vs. State Law Enforcement Bargaining Council Employee Health and Dental Benefit Plan, et al., No. 8:15CV216, 2015 WL 8328158 \(D. Neb. Dec. 7, 2015\)](#). In this case Plaintiffs are hospitals who sued the defendants contending that they entered into a contract with the defendants to pay agreed upon rates for particular goods and services rendered by the hospitals to the plans' participants. Defendants argued that the claims are completely pre-empted under ERISA, as the case concerns entitlement to benefits and interpretation of certain plan documents. The magistrate judge reviewed the motion and recommended that this case be remanded because the case concerns separate breach of contract and tort claims. The district judge agreed, finding that Plaintiffs' claims are clearly based on enforcement of their rights under separate contracts not requiring interpretation of any ERISA documents. Although Defendants' argument is without merit, the court did not believe it so far removed as to impose sanctions.

**Negligence claim against insurance broker is completely preempted by ERISA.** [Med. Admin. Servs., LLC v. Am. United Life Ins. Co., No. 4:15-CV-01289-JCH, 2015 WL 6557177 \(E.D. Mo. Oct. 29, 2015\)](#) (Judge Jean C. Hamilton). Plaintiff and his now deceased business partner sought to obtain a life insurance policy on the business partner with Plaintiff as beneficiary so that in the event of his death the business could continue operations. Plaintiff consulted with Shigemura, a Missouri insurance broker and AUL's agent, regarding the purchase of life insurance for this purpose. MAS, as the group policy holder, purchased a life insurance policy from AUL through Shigemura. When the business partner died, AUL informed Plaintiff that it received two beneficiary designations: one which designated Plaintiff as his primary beneficiary, and another that designated the Estate of Mr. Balter as his primary beneficiary. Plaintiff was unaware that the Estate Designation existed. AUL informed Plaintiff that unless he and the Estate reached an accommodation, AUL would file a federal interpleader. Plaintiffs filed a negligence action against AUL and the agent for preparing the Estate Designation when Shigemura knew that it was contrary to the business agreement and would cause MAS financial harm. The court found this claim completely pre-empted by ERISA since it could have been brought under ERISA Section 502.

**Counterclaim for accounting dismissed.** [Constr. Industry Laborers Pension Fund v. Explosive Contractors, Inc., No. 4:15-CV-00083-SRB, 2015 WL 6432776 \(W.D. Mo. Oct. 21, 2015\)](#)

(Judge Stephen R. Bough). In matter seeking delinquent withdrawal liability, the court dismissed Defendant's Counterclaim for an Accounting per Missouri law seeking an accounting of any allocation formulas and methodology used in calculating the alleged withdrawal liability, the alleged liquidated damages and alleged interest owed. The court found that the Counterclaim nowhere mentions any claimed right that 29 U.S.C. § 1451(a)(1) allows Defendant to pursue its counterclaim for accounting.

[ETTER WILKES PLAINTIFF v. NUCOR-YAMATO STEEL COMPANY DEFENDANT, No. 3:14-CV-00224-KGB, 2015 WL 5725771 \(E.D. Ark. Sept. 29, 2015\)](#). The court found that because Plaintiff brings her claims under Title VII and the ADA, which are federal laws, ERISA preemption does not apply.

In [Olmsted Med. Ctr. v. Carter, No. 14-CV-2916 PJS/BRT, 2015 WL 5039216 \(D. Minn. Aug. 26, 2015\)](#), Plaintiff Olmsted Medical Center filed suit against Defendant for payment of services it rendered on his injured knee. Defendant filed a third-party complaint against his employer, Mayo Clinic, alleging that Mayo is liable for the debt under the doctrine of promissory estoppel. Mayo removed the case, arguing that Defendant's claim is preempted by ERISA. On summary judgment, the court determined that Defendant's promissory-estoppel claim is far removed from a real promissory-estoppel claim, in which the plaintiff alleges that the defendant made a promise and then harmed him by failing to keep that promise. Here, an employee of Mayo Clinic Health Solutions was contacted with an inquiry about the scope of coverage under the plan. The employee responded to the inquiry by accurately describing that coverage. Defendant was not harmed because the employee made an error, but because Defendant allegedly breached his obligations under the plan by failing to return the Accident Letters and then failed to file a timely appeal. The court found that this claim is an ERISA claim for benefits, not a promissory-estoppel claim. The court found that the ERISA claim must be dismissed because Defendant did not exhaust his administrative remedies. The court dismissed the third-party claim against Mayo, and remanded Plaintiff's claim against Carter to state court.

In [Rouse v. U.S. Steel & Carnegie Pension Fund, No. 2:15CV9 HEA, 2015 WL 2453032 \(E.D. Mo. May 22, 2015\)](#), Plaintiff alleged three state law claims: breach of contract, unjust enrichment and fraud based on his allegations that he was promised health insurance coverage, complied with the requirements to receive continued coverage, was denied coverage and did not receive any notice prior to the cancellation of the coverage. The court found that these allegations fall squarely within ERISA preemption and Defendant has a right to remove Plaintiff's claims to federal court. The court also found that Plaintiff failed to allege a claim for benefits under the terms of the plan or that he seeks recovery under the provisions of Section

1132(a)(1). As such, the court dismissed the petition and gave Plaintiff 14 days to file an amended complaint.

## I. Ninth Circuit

**IIED claim arising from alleged tortious conduct in connection with disability claims handling is not completely preempted by ERISA.** [Daie v. The Reed Grp., Ltd., No. C 15-03813 WHA, 2015 WL 6954915 \(N.D. Cal. Nov. 10, 2015\)](#) (Judge William Alsup). Plaintiff filed a complaint in state court alleging intentional infliction of emotional distress (IIED). Specifically, Plaintiff alleged that he was wrongfully denied LTD benefits under the policy and that Defendants repeatedly engaged in extreme and outrageous conduct with the aim of forcing Plaintiff to drop his claim and return to work. Intel removed this action to federal court on the basis of federal-question jurisdiction — asserting that Plaintiff’s claim is preempted by ERISA and filing two current motions to dismiss and to transfer. The court found that Plaintiff’s IIED claim is not completely preempted by ERISA because it could not have been brought under Section 502(a)(1)(B) and Defendants’ alleged conduct implicates an independent legal duty. For purposes of removal, conflict preemption under Section 514(a) is a federal defense and does not convert a state claim into an action arising under federal law. Thus, the court did not analyze whether Plaintiff’s claim is conflict preempted. The court remanded the matter to state court and denied Defendants’ other motion as moot.

**Request for order to enforce a QDRO is not preempted by ERISA.** [NONNA VON SONN, Plaintiff, v. RAYMOND X. BACA, Defendant. NONNA VON SONN, Plaintiff, v. RAYTHEON BARGAINING RETIREMENT PLAN, Defendant., No. EDCV15000757TJHJCX, 2015 WL 6085693 \(C.D. Cal. Oct. 16, 2015\)](#) (Judge Terry J. Hatter, Jr.). The court found that removal was not proper of lawsuit seeking to enforce the terms of a 1998 judgment issuing a QDRO that required Plaintiff to be named “as the beneficiary of any [retirement/pension] benefits payable or available in the event of [Baca’s] death. The court found that Plaintiff’s Request for Order to enforce the terms of the Judgment is not an ERISA claim. The Judgment is a QDRO not preempted by ERISA because it specified: (i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order; (ii) the amount or percentage of the participant’s benefits to be paid by the plan to each such alternate payee, or the manner in which such order applies; and (iv) each plan to which such order applies. The court deferred to the jurisdiction of the Riverside County Superior Court to ensure that the terms of the 1998 QDRO are consistent with the terms of the Judgment, and to observe comity with respect to California’s traditional jurisdiction over matters of domestic relations and the superior competence of California state courts in settling family disputes.

**Complaint alleging wrongful termination and retaliation does not fall within scope of ERISA Section 510.** [Yoshimura v. Hawaii Carpenters Union Local 745, No. CV 15-00292 HG-RLP, 2015 WL 6126805 \(D. Haw. Oct. 15, 2015\)](#) (Judge Helen Gillmor). Plaintiff claims Defendants unlawfully demoted and terminated him in retaliation for his refusal to prepare and submit fraudulent time records to the United States Department of Labor. He alleged four state law causes of action. Defendant removed the action based on ERISA preemption and moved to dismiss Plaintiff's claims. The court denied the motion, finding that ERISA does not completely preempt Plaintiff's claims because they do not fall within the scope of ERISA Section 510, 29 U.S.C. § 1140. In addition, ERISA does not expressly preempt Plaintiff's claims because they do not encroach on ERISA-regulated relationships.

**Allegation of fraud related to the termination of insurance benefits is not preempted by ERISA.** [McGill v. Pacific Bell Telephone Company, No. CV1506323BROPLAX, 2015 WL 6039267 \(C.D. Cal. Oct. 15, 2015\)](#) (Judge Beverly Reid O'Connell). The *pro se* Plaintiff filed suit against Defendant alleging that it owes him \$5,000 for cancelling his insurance benefits without prior notice. Defendant removed the action and in seeking remand to state court, Plaintiff contended that his claim is not preempted by ERISA because he "alleges fraud in the method used to cancel the Plaintiff's insurance benefits by telling him in a recorded phone conversation not to sign with Aon Insurance," which is not a federal issue. The court found that Plaintiff's state law fraud claim does not fall within the scope of complete preemption under ERISA § 502(a), 29 U.S.C. § 1132(a). Moreover, the court found that Plaintiff could not have brought his claim under ERISA § 502(a)(1)(B) and he seeks to remedy violations of legal duties independent of ERISA. The court declined Plaintiff's request to impose sanctions on Defendant.

**ERISA does not regulate the relationship between third-party medical supply companies and ERISA plans.** [Nationwide DME, LLC v. Cigna Health & Life Ins. Co., No. CV-14-02026-PHX-SPL, F.Supp.3d , 2015 WL 5827985 \(D. Ariz. Sept. 30, 2015\)](#) (Judge Steven P. Logan). In suit by supplier of durable medical equipment against insurer of medical plans for payment of programmable computerized pumps for which the supplier sought preauthorization prior to providing the patients with the pumps, the court found that the supplier's state law claims are not preempted by ERISA. The court found that the existence of ERISA plans is not essential to the supplier's claims. Thus, the state-law claims survive the "reference to" preemption inquiry. The court also found that the claims survive the "connection with" inquiry because the state law claims will have no direct effect on the underlying ERISA plans.

[CATLIN SPECIALTY INSURANCE COMPANY, as Subrogee of GreatBanc Trust Co., Plaintiff, vs. FMV OPINIONS, INC., Defendant., No. CV 15-1062-R, 2015 WL 5601836 \(C.D. Cal. Sept. 22, 2015\).](#) The court granted Plaintiff's motion to remand where Plaintiff's Complaint asserts state-law claims for professional negligence, implied contractual indemnity, and equitable indemnity. The court found that while such claims may "relate to" the ERISA plan, they did not derive from it and cannot be said to create ERISA liability.

[In re Anthem, Inc., No. 15-CV-2874-LHK, 2015 WL 5286992 \(N.D. Cal. Sept. 9, 2015\).](#) Plaintiffs brought a putative class action for breach of contract against Defendants arising out of a cyberattack on the computer system of Defendants' parent company, Anthem, Inc. Defendants removed the case to federal court and Plaintiffs moved to remand the case back to state court. The court found Plaintiffs' breach of contract claims completely preempted by ERISA section 502(a)(1)(B). Plaintiffs seek to enforce certain rights under the terms of their ERISA plans through their breach of contract claims.

\*\*CORRECTION. On August 13, 2015, I reported that in [Rose v. HealthComp, Inc., No. 1:15-CV-00619-SAB, 2015 WL 4730173 \(E.D. Cal. Aug. 10, 2015\).](#) the court found Plaintiff's action asserting a state law privacy and unfair business practices causes of action are not preempted by ERISA and remanded the matter to state court. However, to clarify, the court held that there was no complete preemption so as to survive remand but the court did not reach the issue of conflict preemption.

In [Rose v. HealthComp, Inc., No. 1:15-CV-00619-SAB, 2015 WL 4730173 \(E.D. Cal. Aug. 10, 2015\).](#) the court found Plaintiff's action asserting a state law privacy and unfair business practices causes of action are not preempted by ERISA and remanded the matter to state court. The court rejected Defendant's allegations that Plaintiff's claims are related to the ERISA plan because she alleges that medical information was disclosed in the performance of Defendant's third party administrator duties under the self-insured health plan established by Harris Ranch.

In [Skillin v. Rady Children's Hosp., No. 14-CV-01057-BAS BLM, 2015 WL 4715018 \(S.D. Cal. Aug. 7, 2015\).](#) the court found not preempted by ERISA Plaintiff's representative action on behalf of himself and current or former employees of Rady alleging violations of California Labor Code sections 221 through 224 and 226. Here, Plaintiff alleges that Defendant withheld earned wages without proper authorization in violation of California law and failed to provide accurate itemized wage statements because of the improperly withheld wages, also in violation

of California law. The court rejected Defendant's argument that state laws that regulate deductions made from employee earnings are preempted by ERISA when the statutes are sought to be applied to deductions made to fund an ERISA plan. Rather, any duty or liability that Defendant has not to deduct an amount greater than the amount authorized does not exist only because of Defendant's administration of an ERISA-regulated plan. The alleged duties or liabilities arise independently from state law.

In [Marshburn v. Unum Life Ins. Co. of Am., No. 214CV00242CASPJWX, 2015 WL 4720397 \(C.D. Cal. Aug. 6, 2015\)](#), Unum argued that Plaintiff's state law claims relating to the denial of her disability benefits are preempted by ERISA based on its affirmative defense that Plaintiff was not eligible for the Conversion Policy that forms the basis of her state law claims. Specifically, Unum argued that Plaintiff was disabled at the time she could convert her coverage. The court applied *contra proferentum* to conclude that the LTD definition of disability applies to the court's analysis of whether Plaintiff was disabled at the time of conversion. Following a bench trial on Unum's affirmative defense, the court found that Plaintiff received her full salary through the end of her employment with Cedars-Sinai, therefore, she never suffered a "20% or more loss in [her] indexed monthly earnings," so as to meet the definition of "disabled" for purposes of long-term disability benefits. As such, her conversion policy was not improperly issued, and ERISA does not preempt her state law claims.

In [Perez v. Stratton, No. 14-CV-95-WMC, 2015 WL 4232442 \(W.D. Wis. July 13, 2015\)](#), the Secretary of Labor filed this civil suit under 29 U.S.C. §§ 1132(a)(2) and (5), alleging that defendants David Stratton and corporate defendant IDS Sales and Engineering, Inc. failed to remit employee salary deferral contributions to the IDS Sales & Engineering, Inc. Retirement Savings Plan. Stratton initially filed an answer but then filed an unopposed motion to withdraw that answer, which the court. Following Plaintiff's motion for default judgment, the court entered default judgment against Stratton in the amount of \$19,114.94, ordered Stratton to correct the prohibited transactions in which he engaged, and ordered a permanent injunction preventing Stratton from serving as an ERISA fiduciary.

In [Sender v. Franklin Res., Inc., No. 13-15502, Fed.Appx. \\_\\_\\_\\_\\_, 2015 WL 3727732 \(9th Cir. June 16, 2015\)](#), the court found that Plaintiff's claim under Cal. Corp.Code § 419(b) was not preempted by ERISA because the duty under that statute to replace a lost stock certificate is placed on the corporation issuing the shares. The claim does not require any interpretation of ERISA plan terms. The district court can exercise supplemental jurisdiction over this claim since it arises from the same "case or controversy" as Plaintiff's ERISA claim.

In [\*Calop Bus. Sys., Inc. v. City of Los Angeles\*, No. 13-56992, Fed.Appx. , 2015 WL 3463340 \(9th Cir. June 2, 2015\)](#), the court found that the City of Los Angeles's Living Wage Ordinance ("LWO"), which requires contractors who operate at the City's airports to pay their employees \$14.80 per hour, or \$10.30 per hour if the contractor provides health benefits, was not preempted by ERISA. The court determined that: 1) the LWO does not have a "reference to" employee benefits plans merely because it takes into account what health benefits employers offer in calculating the cash wage that must be paid; 2) the LWO's provision for collecting reports on employee compensation from employers does not create a "connection with" employee benefits plans because the provision imposes no obligations on plans themselves; and 3) the LWO does not give rise to a "connection with" benefits plans merely by creating economic incentives to offer certain kinds of benefits.

In [\*Grossman v. United Parcel Serv., Inc.\*, No. 13-CV-2824 PJH, 2015 WL 2438066 \(N.D. Cal. May 21, 2015\) \(Not Reported in F.Supp.3d\)](#), UPS argued that the following exchange, at Plaintiff's deposition, establishes that all of his claims arise out of UPS' intent to deny him retirement benefits and are thus preempted by ERISA:

Q: There are three different claims that you've brought. I just want to be clear that all of the claims that you brought are based on the fact pattern that unfolded in February and March of 2013, that you believe was UPS moving you into a position to force you to retire such that they would avoid having to pay you a higher pension. Is that accurate?

The court found that while Plaintiff's deposition response indicates that his claims are based solely on UPS' intent to deny him retirement benefits; his complaint also alleges discrimination on the basis of age and those claims are not preempted.

In [\*Edwards v. Lockheed Martin Corp.\*, No. 13-35591, Fed.Appx. , 2015 WL 3407241 \(9th Cir. May 28, 2015\)](#), the Ninth Circuit found that Plaintiff's state law claims related to the Lockheed Martin Corporation's Voluntary Executive Separation Program (VESP) are preempted by ERISA, rejecting Plaintiff's argument that VESP is not an employee benefit plan under ERISA, because ERISA is "not designed" to cover corporate programs that require a release of claims in exchange for payment, and because VESP eligibility determinations involve no discretion. The court found that under the plan Lockheed exercises significant discretion to determine an employee's eligibility for the program.

In [\*Int'l Franchise Ass'n, Inc. v. City of Seattle\*, No. C14-848 RAJ, 2015 WL 1221490 \(W.D. Wash. Mar. 17, 2015\)](#), Plaintiffs contended that certain health plan-related provisions of Seattle's Ordinance Number 124490 ("the Ordinance"), which establishes a \$15 minimum hourly wage, are preempted by ERISA. These provisions allow large employers (those with more than 500 employees), who offer their employees health plans classified as "silver" or "gold" under the federal Affordable Care Act, the opportunity to take advantage of an alternative, more favorable, wage schedule. The court determined that the Ordinance does not require any employer to provide any ERISA plan; it does not dictate the contents or any administrative requirements for such a plan; it does not have any direct impact on any ERISA plan; and it does not impose reporting, disclosure, funding, or vesting requirements on any ERISA plan. The court also determined that the Ordinance does not have any effect upon ERISA plans. It does not require any employer to provide benefits through ERISA plans nor does it dictate the contents of any such plan. The Ordinance merely allows large employers to take advantage of an alternative four-year phase-in schedule if they happen to provide certain benefits to their employees. Thus, ERISA plans are not required or "essential" to the laws' operation. Accordingly, the court found that the Ordinance does not have an impermissible "connection with" or "reference to" ERISA.

In [\*Provost v. ILWU-PMA Welfare Plan\*, No. SACV 14-01982-CJC, 2015 WL 470397 \(C.D. Cal. Feb. 4, 2015\)](#), the court found as not preempted an action filed by a doctor seeking payment for anesthesia services provided to a plan participant, where Plaintiff attested that he is asserting claims for negligent misrepresentation, breach of oral and implied-in-fact contracts, and estoppel that are all based on prior oral representations that the proposed surgery was authorized.

In *Cnty. Hosp. of the Monterey Peninsula v. Aetna Life Ins. Co.*, No. 5:14-CV-03903-PSG, 2015 WL 138197 (N.D. Cal. Jan. 9, 2015), Plaintiff Community Hospital of the Monterey Peninsula ("CHOMP") brought suit against Defendants Aetna Life Insurance Company, Valueoptions of California, Inc. and Valueoptions Inc., for declining to provide authorization for continued hospital care for a patient who was a member of an employer self-funded health plan administered by Defendants. The court found that ERISA does not preempt any of CHOMP's claims and remanded the case to Monterey Superior Court. In this case, CHOMP explicitly disavowed any claim based on the patient's right to benefits under its employer's ERISA plan. Instead, CHOMP bases its claim on state law payment standards for emergency and medically necessary services it provided after Defendants allegedly failed to take over the patient's care. The court found that Plaintiff could not have brought the instant claims under Section 502(a)(1)(B) because it is not seeking benefits under an ERISA plan. Additionally, CHOMP's claims depend on an interpretation of state law, and do not in any way involve the interpretation of any ERISA plans administered by Defendants. Then, in *Cnty. Hosp. of the Monterey Peninsula v. Blue Cross of California*, No. 14-CV-04552-LHK, 2015 WL 332746 (N.D. Cal. Jan. 26, 2015), the court found that the state law cause of action is not completely preempted

under *Davila*'s two-pronged test, since at a minimum, the second prong –where there is no other independent legal duty that is implicated by a defendant's actions –is not met. The court found that Plaintiff's claims do not rely on, and are independent of, any duty under an ERISA plan since the claims depend on interpretations of state law, and do not in any way require the interpretation of an ERISA plan administered by Defendants. Because the court has no basis to exercise subject matter jurisdiction over this action, it remanded the case to state court.

#### J. Tenth Circuit

In [\*Woolf v. Nucor Bldg. Sys. Utah, LLC\*, No. 1:14-CV-00177-CW, 2015 WL 1886853, at \\*2 \(D. Utah Apr. 24, 2015\)](#) (**Not Reported in F.Supp.3d**), the court remanded the case to state court, finding that Plaintiff's state law claims do not fall within ERISA's remedial scope and are not completely preempted. ERISA does not provide a cause of action to non-beneficiaries who claim they were defrauded out of pension benefits in violation of common law fraud principles. Since all of the funds from the 401(k) plan at issue have already been disbursed, any recovery could not be issued from an ERISA plan, making the relief sought ordinary damages for the alleged fraud Plaintiff suffered.

In [\*Coppe v. Sac & Fox Casino Healthcare Plan\*, No. 14-2598-RDR, 2015 WL 1137733 \(D. Kan. Mar. 13, 2015\)](#) (**Not Reported in F.Supp.3d**), Defendants filed a motion to dismiss or stay for failure to exhaust tribal remedies. They requested that the court rule as a matter of comity that before bringing a claim in this court, Plaintiff must bring an ERISA action for recovery of insurance benefits under the casino's nongovernmental plan in tribal court. The court assumed for purposes of this order that Plaintiff is not a member of the Sac & Fox Tribe and that the Plan is not a "governmental plan" as defined in ERISA. The court found that tribal courts do not have jurisdiction over ERISA actions and that the government's preemptive action under ERISA dictates that exhaustion in tribal court should not be required as a matter of comity. The court held that Congress preempted the tribe's adjudicatory authority over ERISA claims and, therefore, exhaustion of tribal remedies is not required.

In [\*Shafer v. Metro. Life Ins. Co.\*, No. 14-CV-00656-RM-KMT, 2015 WL 729376 \(D. Colo. Feb. 19, 2015\)](#), Plaintiff filed a motion for partial summary judgment regarding the proper standard of review contending that she is entitled to a de novo standard of review and a jury trial due to Section 10-3-1116(3) of the Colorado Revised Statutes, which states:

An insurance policy, insurance contract, or plan that is issued in this state shall provide that a person who claims health, life, or disability benefits, whose claim has been denied in whole or in part, and who has exhausted his or her administrative remedies shall be

entitled to have his or her claim reviewed de novo in any court with jurisdiction and to a trial by jury.

The court concluded that while the part of Colo.Rev.Stat. § 10–3–1116(3) (2008) providing for a *de novo* standard of review, standing alone, would not be preempted, the part of Colo.Rev.Stat. § 10–3–1116(3) providing for a jury trial conflicts with ERISA’s remedial structure by altering the judiciary’s role. Thus, the court concluded that ERISA preempts, in its entirety, Colo.Rev.Stat. § 10–3–1116(3).

K. Eleventh Circuit

**Lawsuit seeking damages related to misrepresentation about post-termination health insurance coverage not preempted by ERISA.** [Lamonica v. Brown Nursing Home, LLC, No. 3:15CV326-SRW, 2015 WL 9008449 \(M.D. Ala. Dec. 15, 2015\)](#) (Magistrate Judge Susan Russ Walker). Defendant removed Plaintiff’s lawsuit arising out of Defendant’s termination of her employment and subsequent representations about her health insurance on the basis of complete ERISA preemption. Plaintiff moved to remand and for attorneys’ fees, stating in her motion to remand that the gravamen of her complaint is not that she was wrongfully denied benefits under her employer-provided health insurance plan, but that defendant Brown lied to her about when her insurance coverage would be terminated. Plaintiff does not seek to recover plan benefits, but rather, compensation for damages she suffered as a result of Defendant’s alleged misrepresentations, including, but not limited to, medical expenses she incurred for treatment of the mental anguish and stress she experienced as a result of defendant Brown’s alleged misrepresentations. The court granted Plaintiff’s motion to remand, finding that Brown did not meet its burden of demonstrating that her claims could have been brought under ERISA § 502(a) or that Plaintiff’s claims do not implicate a duty independent of ERISA.

**Wrongful death claim against ERISA-governed health insurer is not preempted by ERISA.** [Ghee v. Regional Medical Center Board, et al., No. 1:15-CV-1430-VEH, 2015 WL 7755392 \(N.D. Ala. Dec. 2, 2015\)](#) (Judge Virginia Emerson Hopkins). The court granted Plaintiff’s motion to remand his wrongful death lawsuit against one of the defendants, US Able, an insurance company providing benefits under an ERISA-governed plan. The decedent’s doctor recommended a colectomy to remove impacted fecal material. US Able determined that non-surgical treatment was more appropriate than surgery and suggested that the decedent try to convince the hospital to perform the surgery on an emergency basis. Although the decedent returned to the hospital a few more times complaining of severe abdominal pain and rectal bleeding, the hospital discharged him until his final return where he died due to his improperly treated condition. The gist of the claim against US Able is that US Able interjected itself as a healthcare provider for decedent and then negligently provided a suboptimal standard of care

resulting in his death. Ghee has now brought this wrongful death action. The court concluded that this claim could not have been brought under ERISA's private enforcement mechanism, so it lacks subject-matter jurisdiction over the claim. Because the Alabama wrongful death statute does not allow recovery for the value of benefits denied, only punishment for causing a death, the court found that the suit could not be brought under ERISA.

**Suit for wrongful denial of chiropractic coverage brought by sub-assignee of plan participant is completely preempted by ERISA.** [Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Florida, Inc., No. 15-10459, Fed.Appx. , 2015 WL 7729474 \(11th Cir. Dec. 1, 2015\)](#) (Before MARCUS and JILL PRYOR, Circuit Judges and RESTANI, Judge). In this case a healthcare provider, South Miami Chiropractic, provided services to an insured under a Florida Blue health insurance plan. When South Miami Chiropractic sought payment from Florida Blue, the insurer failed to pay and South Miami Chiropractic then assigned its right to payment to Gables, which sought to collect from Florida Blue. The district court held that ERISA completely preempts Gables's claims and then dismissed the claims without prejudice for failure to exhaust administrative remedies. The Eleventh Circuit affirmed the district court's finding that the claims are completely preempted because they depend on whether Florida Blue has a duty to pay for services under an ERISA plan. Further, because Gables has standing to sue under the ERISA plan as a sub-assignee of the plan participant, it could have brought an ERISA claim for benefits.

**Claim involving continuation of life insurance benefits following retirement is preempted by ERISA.** [Woods v. American United Life Insurance Company, No. 1:15-CV-00859-JEO, 2015 WL 7075284 \(N.D. Ala. Nov. 13, 2015\)](#) (Magistrate Judge John E. Ott). In a dispute involving payment of life insurance benefits, the court granted Defendant's motion to dismiss Plaintiff's state-law claims and her demands for punitive and extra-contractual damages, and to strike her demand for a jury trial, finding that the claims are preempted by ERISA. Here, the insured retired from her employment with the Talladega County School System and elected to continue her existing coverage under the Alabama Education Association (AEA) group policy, an employee benefits plan governed by ERISA. The court found that her coverage remained under the scope of ERISA, notwithstanding that she was no longer employed by the County and was required to make her premium payments directly to the insurer. The court relied on other cases that hold that when an employee participates in an employee benefits plan and then keeps her coverage in force by paying the premiums herself after her employment ends, ERISA continues to govern the coverage.

In [Schoen v. Health Mgmt. Associates, Inc., No. 2:14-CV-411-FTM-29CM, 2015 WL 5021623 \(M.D. Fla. Aug. 25, 2015\)](#), the court found that Count I of Plaintiff's Complaint related to the

provisions of an Employment Agreement guaranteeing certain benefits separate and distinct from the benefits under a Supplemental Executive Retirement Plan (SERP) to be not preempted by ERISA.

## XVII. *Provider Claims*

### A. Second Circuit

**Assignee did not have right to seek equitable relief and lacks standing to seek an injunction.** [Montefiore Medical Center v. Local 272 Welfare Fund, et al., No. 14-CV-10229 \(RA\), 2015 WL 8073909 \(S.D.N.Y. Dec. 4, 2015\)](#) (Judge Ronnie Abrams). Plaintiff, as the assignee of the Fund's insurance beneficiaries, brought suit against the Fund for payment of urgent care claims under ERISA § 502(a)(1)(B) and § 502(a)(3). Defendants moved to dismiss under Federal Rule of Procedure 12(b)(1) Plaintiff's second cause of action for equitable relief on the grounds that Montefiore lacks standing to seek equitable relief, or, in the alternative, that equitable relief is not available because monetary damages would fully compensate Montefiore. The court adopted the magistrate judge's report recommending that the second cause of action be dismissed because the Fund beneficiaries did not assign Montefiore their rights to seek equitable relief, and, as a result, Montefiore lacks standing to seek an injunction.

**Prompt pay discount program does not violate state law but Aetna did not underpay any ERISA claim.** [Koenig v. Aetna Life Ins. Co., No. 4:13-CV-0359, 2015 WL 6554347 \(S.D. Tex. Oct. 29, 2015\)](#) (Judge Kenneth M. Hoyt). The court rejected Aetna's contention that NCMC's "prompt pay discount program" violates state law, particularly §§ 101.201, 102.003 of the Texas Occupations Code, on the basis that NCMC engaged in false, misleading or deceptive advertising. The court also found that § 324.101 of the Texas Health and Safety Code and § 552.003 of the Texas Insurance Code do not prohibit discounting a patient's bill for healthcare services. The court concluded that NCMC, at all times, acquired properly executed assignments, designating it as beneficiary as defined by ERISA. However, the court also concluded that the evidence fails to support a finding that Aetna underpaid NCMC on any ERISA claim.

**Arbitration provision contained in provider manual is enforceable.** [Grasso Enterprises, LLC v. CVS Health Corp., No. SA-15-CV-427-XR, 2015 WL 6550548 \(W.D. Tex. Oct. 28, 2015\)](#) (Judge Xavier Rodriguez). Plaintiff, owner of two compounding pharmacies, brought suit against CVS/Caremark for allegedly violating ERISA based on its procedures for processing

claims. Specifically, Plaintiff alleges that Defendant does not review claims, but instead uses a computerized automated system to process all claims and then reviews the claims after the 30-day period is over. The court determined that there is a valid agreement to arbitrate since both Grasso and CVS/Caremark are signatories to two Provider Agreements that incorporate the terms of the Provider Manual by reference. The Provider Manual contains an arbitration provision that is enforceable and not unconscionable. The court also determined that the dispute in question falls within the scope of the agreement. The court granted in part and denied in part Defendant's motion to dismiss and compel arbitration and dismissed as moot Plaintiff's motion for preliminary injunction.

**Dismissal of 502(a)(3) claim because relief available under 502(a)(1)(B) and dismissal of document penalty claim.** [Koenig v. Aetna Life Ins. Co., No. 4:13-CV-00359, 2015 WL 6473351 \(S.D. Tex. Oct. 27, 2015\)](#) (Judge Kenneth M. Hoyt). North Cypress brought suit against Aetna for substantial underpayment and/or nonpayment of certain healthcare claims from 2009 through 2014. The court found that new Supreme Court authority and Fifth Circuit authority did not modify the general rule that if relief is available under § 502(a)(1)(B), then equitable relief is not also available under § 502(a)(3). The court also found that Aetna is not the plan administrator subject to penalties under ERISA § 502(c). Although the Fifth Circuit has considered the *de facto* plan administrator theory, it has consistently refused to recognize such a theory where reliance would be deemed unreasonable in light of ambiguous plan documents.

In [Merrick v. UnitedHealth Grp. Inc., No. 14 CIV. 8071 ER, 2015 WL 5122545 \(S.D.N.Y. Aug. 31, 2015\)](#), four chiropractors brought a putative class action on behalf of themselves and others similarly situated, against United, asserting violations of ERISA. United moved to compel arbitration and dismiss only one of the chiropractor's claims. The court granted United's motion to compel arbitration and denied the motion to dismiss. In so doing, the court found that based on the facts as alleged, it is the Provider Agreements, not the healthcare plans, which require interpretation to determine whether United properly recouped payments or violated the ERISA's claim regulations. Accordingly, the claims arise under the Provider Agreements and may be subject to the agreements' arbitration provisions. The court stayed the action with respect to the one chiropractor's claims. Lastly, the court found that United's position in the instant action is not inconsistent with positions taken in previous litigation and United is not judicially estopped from asserting its current position.

In [Talarico v. Excellus Health Plan, Inc., No. 6:14-CV-1058 GTS/ATB, 2015 WL 2122176 \(N.D.N.Y. May 6, 2015\)](#), Plaintiffs asserted eleven claims, including five under ERISA, against Defendant arising from its reduction and then cessation of payment for services rendered by

Plaintiffs between approximately September of 2013 and December of 2014. Plaintiffs moved for a preliminary injunction (1) enjoining Defendant from improperly recouping payments that Defendant has made on past claims submitted by Plaintiffs, by failing to make payments on claims submitted for current charges for covered, medically necessary medical services provided to enrollees in Defendant's health care plans, (2) enjoining Defendant from telling enrollees in its health care plans that Plaintiffs have been paid for claims on which Defendant has recouped payment, and (3) compelling Defendant to provide Plaintiffs with a detailed accounting of all claims at issue in this action, including providing check numbers and dates on claims submitted by Plaintiffs on which Defendants purports to have made payment directly to its enrollees instead of to Plaintiffs. The court denied Plaintiffs' motion, finding that they have not demonstrated that irreparable harm would result if their motion is not granted. A few weeks before oral argument Plaintiffs became participating members of Defendant's recognized network of providers, in which status they became entitled to direct payment for their services (albeit at a discounted rate), but that they subsequently terminated that status. For the closure of a business to constitute irreparable harm, the plaintiffs must have had no choice but to close their business. Here, the court found that Plaintiffs' decision to close their business appeared to be more voluntary than compulsory.

In [\*Mbody Minimally Invasive Surgery, P.C. v. Empire Healthchoice HMO, Inc.\*, No. 13-CV-06551 TPG, 2015 WL 798082 \(S.D.N.Y. Feb. 25, 2015\)](#), Defendants moved for partial reconsideration of this court's order denying their motion to dismiss Plaintiffs' Section 502(a)(1)(B) claim, arguing that the court overlooked language in the health plans at issue in this case meriting dismissal of this claim. Plaintiffs are medical professionals offering bariatric surgery to help obese individuals lose weight. They sued the Defendant health insurance companies alleging they withheld or reduced payment for treatment provided to patients enrolled in Defendants' health insurance plans. Defendants argued that controlling authority in this circuit rejects the concept of a "*de facto*" plan administrator, or one that is not expressly named in the health plan documents. The court explained that it did not reach the question of whether Plaintiffs may maintain a § 502(a)(1)(B) claim against *de facto* plan administrators; rather, the court held that plaintiffs had plausibly alleged that Defendants are plan administrators themselves. To the extent Defendants wish to reargue that they are not plan administrators, the court noted that they will have ample opportunity to do so at later stages of the litigation where Plaintiffs' burden will be higher. The court denied Defendants' motion for reconsideration.

#### B. Third Circuit

**Complaint dismissed for failing to allege specific facts related to assignment and waiver of anti-assignment clause.** [\*Cohen v. Horizon Blue Cross Blue Shield of New Jersey\*, No. CV154525JLLJAD, 2015 WL 6082299 \(D.N.J. Oct. 15, 2015\)](#) (Judge Jose L. Linares). Plaintiff,

a board certified orthopedic surgeon, brought suit against Horizon for not paying for emergency spinal surgery he performed on Patient AM. The court granted Horizon's motion to dismiss the Complaint, finding that it fails to set forth the specific facts pertaining to the alleged assignment of Patient AM's rights to Plaintiffs and Horizon's alleged waiver of the anti-assignment clause in the ERISA plan. However, the court granted Plaintiffs leave to file an Amended Complaint to address these deficiencies. The deficiencies included failing to plead any underlying facts pertaining to the alleged assignment and failing to allege specific allegations of fact to support that Horizon waived the Plan's anti-assignment clause (even assuming that it could). The court declined to address the preemption arguments raised by Horizon.

**Provider has derivative standing to pursue document penalty claim but penalties are not warranted due to lack of bad faith.** [\*Ctr. for Orthopedics & Sports Med. v. Horizon, No. CV131963KSHCLW, 2015 WL 5770385 \(D.N.J. Sept. 30, 2015\)\*](#) (Judge Katharine S. Hayden). Plaintiff sought statutory penalties pursuant to § 502(c)(1)(B) for Horizon's alleged failure to provide Center with required information and compensatory damages and other equitable relief for Horizon's failure to maintain claims procedures that comply with 29 C.F.R. § 2560.503-1. The court found that the statutory penalties claim is not moot because Plaintiff withdrew its claim for benefits under § 502(a)(1)(B). A plaintiff may pursue a document penalty claim without also pursuing a claim for benefits. But, the claim for violating the claims procedures by not stating the time limit for initiating an appeal is moot because any deviation from ERISA's regulations would factor into the determination of whether Horizon's denial of reimbursement was arbitrary and capricious. The court found that plaintiff has derivative standing to pursue the statutory penalties claim but that penalties are not warranted because Horizon did not act in bad faith.

**Assignment of the right to payment is sufficient to confer standing to sue for payment under ERISA § 502(a)(1).** In [\*N. Jersey Brain & Spine Ctr. v. Aetna, Inc., No. 14-2101, F.3d\*](#), [2015 WL 5295125 \(3d Cir. Sept. 11, 2015\)](#), an action for unpaid insurance benefits, Plaintiff appealed an order dismissing its complaint for lack of standing under ERISA. The court held that as a matter of federal common law, explicit assignment of payment of insurance benefits to a healthcare provider, without direct reference to the right to file suit, is sufficient to give the provider standing to sue for those benefits under ERISA § 502(a), 29 U.S.C. § 1132(a). In coming to the same conclusion as its sister circuits, the court is guided by Congress's intent that ERISA "protect ... the interests of participants in employee benefit plans," 29 U.S.C. § 1001(b), and its conviction that the assignment of ERISA claims to providers serves the interests of patients by increasing their access to care. The Third Circuit reversed and remanded this action for further proceedings.

[Am. Chiropractic Ass'n v. Am. Specialty Health Inc., No. 14-1832, Fed.Appx. , 2015 WL 5313631 \(3d Cir. Sept. 11, 2015\).](#) The court held that the Assignment of Benefits gave the plaintiff doctor standing to sue his patients' insurers for reimbursement for services he provided and vacated the order dismissing his claims for reimbursement. While the Assignment made clear that the patient remained "financially responsible for all charges whether or not they are paid by insurance," this does not mean that the Assignment did not give the doctor the right to take steps to collect payment from the patient's insurer. The court did conclude that the American Chiropractic Association lacks associational standing to sue because it has not shown that any of its members possess standing to seek non-monetary relief and the district court correctly dismissed its ERISA and state law claims.

In [Bloom v. Independence Blue Cross, No. CIV.A. 14-2582, 2015 WL 4598016 \(E.D. Pa. July 31, 2015\).](#) involving a "simple payment dispute," the court concluded that Plaintiffs are not beneficiaries with direct standing to bring their claims under ERISA but have derivative standing after an assignment of benefits from Plaintiffs' patients as plan participants. The court found that the fact that Plaintiffs' patients were not forced to pay for the medical services they received does not invalidate an otherwise enforceable assignment of rights.

In [Neurosurgical Associates of NJ, P.C. v. QualCare Inc., No. CIV. 15-3236, 2015 WL 4569792 \(D.N.J. July 28, 2015\).](#) Plaintiff is a non-participating or out-of-network health care provider that performed cervical spinal fusion surgery on a patient who was a participant in an insurance plan maintained by Defendant. Plaintiff claims that the services rendered amounted to \$115,478.00 and were emergent in nature but Defendant reimbursed only \$4,074.01. Defendant moved to dismiss arguing that it is not an ERISA fiduciary and that Plaintiff did not adequately allege its entitlement to further reimbursement. Plaintiff alleged Defendant's fiduciary status based on the fact that it processed the patient's claim and handled the patient's appeals. While bare, the court found these allegations are sufficient to satisfy the Rule 12(b)(6) standard. And although the Complaint failed to identify any specific terms of the plan that would indicate further reimbursement is appropriate, on a motion to dismiss, the court may rely on documents integral to the complaint, which in this case would include the relevant plan documents. Included within Defendant's Reply papers were copies of plan documents providing some indication that greater reimbursement may have been warranted. Thus at this point, the court found that Defendant has not carried its burden of showing that no claim has been asserted by Plaintiff.

In [\*Advanced Orthopedics & Sports Med. v. Blue Cross Blue Shield of Massachusetts\*, No. CIV.A. 14-7280 FLW, 2015 WL 4430488 \(D.N.J. July 20, 2015\)](#), Plaintiff filed a five-count Complaint against Defendant seeking seeking money owed to Plaintiff for providing medical care to a patient insured under an employee health insurance plan administered by Defendant. Defendant moved to dismiss Plaintiff's Complaint in its entirety, on the basis that Plaintiff lacks standing to sue under ERISA. The Plan contains an unambiguous anti-assignment clause that the court found valid on its face. The court found that Plaintiff lacks standing and also that amendment of the Complaint would be futile, and so denied Plaintiff's Motion to Amend.

C. Fifth Circuit

[\*Cardiovascular Specialty Care Center of Baton Rouge, LLC v. United Healthcare of Louisiana, Inc.\*, No. 14-00235-BAJ-RLB, 2015 WL 7430034 \(M.D. La. Nov. 20, 2015\)](#) (Judge Brian A. Jackson). Plaintiff asserted that according to a Participating Provider Agreement between it and First Health Group Corporation Services, Defendant owes it money for medical services rendered to Defendant's insureds. Defendant moved to dismiss pursuant to Rule 12(b)(6). The court found that the Participating Provider Agreement and the Payor Agreement were not properly before the court so that Defendant's request that Plaintiff's five state law claims be dismissed based upon the language of these agreements is denied. The court also denied Defendant's request that Plaintiff's five state law claims be dismissed as completely and expressly preempted by ERISA. The court also found that Plaintiff's ERISA § 502(a)(1)(B) claim is properly pled but that its ERISA § 502(a)(3) is barred by Plaintiff's ERISA § 502(a)(1)(B) claim.

In [\*Trueview Surgery Ctr. One L.P. v. OneSubsea LLC Comprehensive Self-Insured Welfare Benefits Plan\*, No. 4:14-CV-2577, 2015 WL 4431408 \(S.D. Tex. July 17, 2015\)](#), Plaintiff filed suit against Defendant pursuant to a patient assignment seeking reimbursement for a septoplasty the patient underwent. The court rejected the Plan's argument that Plaintiff did not suffer an injury-in-fact because it never attempted to bill the patient for his share of the medical charges. The court relied on a recent Fifth Circuit decision that held that a medical service provider "has statutory standing under ERISA for the benefit claims at issue because of assignments from plan beneficiaries," even if the patient was "not billed for the amount allegedly due from the insurance plans." *N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182, 192–5 (5th Cir.2015). The court also found that the anti-assignment clause in the Policy does not prohibit assignments to medical service providers such as Plaintiff.

In [\*Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.\*, No. 13-20649, Fed.Appx. \\_\\_\\_\\_\\_, 2015 WL 3745291 \(5th Cir. June 16, 2015\)](#), the court held, among other things, that Plaintiff can

assert non-preempted state-law claims based on the rate at which these claims were partially paid. ERISA does not preempt state-law claims based on an allegedly improper rate of payment in violation of a provider agreement and because Plaintiff can amend its complaint to put at issue the rate at which BCBSTX paid the partially paid claims, amendment would not be futile. Thus, the district court erred when it denied leave to amend the state-law claims. On remand, Plaintiff should be permitted to amend its state-law claims to include its non-preempted rate-of-payment theory. The court held that the district court correctly dismissed Plaintiff's ERISA claim because it provided no factual support for its allegation that it is a participant or beneficiary as defined in ERISA. Plaintiff also did not plausibly allege that it was an assignee entitled to assert a claim under Section 502(a)(1)(B). Plaintiff raised the argument regarding assignments from its patient in its reply brief and thus waived its challenge to the district court's denial of leave to amend.

In [\*Grand Parkway Surgery Ctr., LLC v. Health Care Serv. Corp.\*, No. CIV.A. H-15-0297, 2015 WL 3756492 \(S.D. Tex. June 16, 2015\)](#), Plaintiff, an out-of-network medical provider that offers ambulatory surgical services to patients in both private and employer sponsored health benefit plans, filed suit against Health Care Service Corp. ("HCSC") for underpayment of 293 claims which totaled \$5,728,446.91. Plaintiff alleged a claim for benefits and breach of fiduciary duty claims under ERISA along with state law claims. On HCSC's motion to dismiss, the court denied its motion to dismiss the Section 502(a)(1)(B) claim since Plaintiff alleged the specific plan terms it believes confer the benefits it seeks even though it did not distinguish between claims based on ERISA plans and claims based on private plans. The court granted HCSC's motion to dismiss the breach of fiduciary duty claim because Plaintiff also asserted a claim to recover benefits under Section 502(a)(1)(B). The court dismissed Plaintiff's Section 503 claim because Plaintiff did not allege that HCSC is the Plan nor can the court infer that HCSC is the Plan. Lastly, the court dismissed Plaintiff's Section 502(c)(1) claim because Plaintiff did not allege that HCSC is the Plan Administrator rather than the separate Claims Administrator.

In [\*Cadiovascular Specialty Ctr. of Baton Rouge, LLC v. United Health Care of Louisiana, Inc.\*, No. CIV.A. 14-00235-BAJ, 2015 WL 1033763 \(M.D. La. Mar. 9, 2015\)](#), Plaintiff alleged that it provided certain medical services to United insureds and that United informed Plaintiff that it would be reimbursed for those medical services. The court found that Plaintiff's state law claims are preempted by ERISA and should be dismissed. The court granted Plaintiff leave to amend to add any claims under ERISA, noting that the Fifth Circuit has held that a district court's dismissal of a case involving only state claims preempted by ERISA without first allowing the plaintiff to amend his complaint to add ERISA claims constitutes an abuse of discretion.

D. Sixth Circuit

In [\*Brown v. Blue Cross Blue Shield of Tennessee, Inc.\*, No. 1:14-CV-00223, 2015 WL 3622338 \(E.D. Tenn. June 9, 2015\)](#), Plaintiff, a medical provider, brought suit under ERISA against BCBST for recouping alleged overpayments by offsetting them against new reimbursement claims from Plaintiff. The court granted Defendant's motion to dismiss for lack of subject matter jurisdiction because Plaintiff does not have standing under ERISA to pursue their claims. The court held that providers are not ERISA beneficiaries merely because they are entitled to receive payment; they do not have direct statutory standing. The court also followed the line of cases holding that forms providing for direct payment do not constitute an assignment of any patient's ERISA rights.

In [\*Alma Products I, Inc. v. Blue Cross & Blue Shield of Michigan\*, No. 14-CV-13066, 2015 WL 1498881 \(E.D. Mich. Mar. 31, 2015\)](#), Plaintiffs Alma Products I and Alma Products I Medical Insurance Plan ("Alma Products") claim that Defendant Blue Cross & Blue Shield of Michigan (BCBSM) inflated the amounts it reported hospitals charged for claims. BCBSM allegedly kept the difference between what it was actually paying to hospitals and the amounts it reported it was paying in violation of its third-party administrator (TPA) agreements and in breach of its fiduciary duty under ERISA. This case was stayed while BCBSM appealed the judgment entered against it in another case, *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan*, and the Sixth Circuit affirmed the judgment against BCBSM. BCBSM then moved to dismiss this case in its entirety, asserting that the statute of limitations had already expired on all of Alma Products' claims and Alma Products filed a motion for partial summary judgment. The court found that it would be premature to determine whether Alma Products' claims are barred by the statute of limitations, but granted BCBSM's motion to dismiss in part because ERISA preempts the state-law claims. Alma Products asserted that it is entitled to summary judgment on its claim for breach of fiduciary duty as to the disputed fees and on their claim for self-dealing as to those same fees based on the controlling decision in *Hi-Lex*. The court found that there is an issue of fact concerning whether Alma Products' claims are timely and denied their motion for partial summary judgment.

In [\*Kent Companies, Inc. v. Blue Cross & Blue Shield of Michigan\*, No. 14-CV-13070, 2015 WL 806922 \(E.D. Mich. Feb. 26, 2015\)](#), one of more than fifty similar cases brought against defendant Blue Cross and Blue Shield of Michigan ("BCBSM") for allegedly charging hidden administrative fees by, among other things, inflating hospital claims with hidden surcharges in violation of ERISA, the court denied without prejudice BCBSM's motion to dismiss based on untimeliness, finding that there are fact issues concerning whether Plaintiffs knew or should have

known of the hidden fees. The court noted that the Sixth Circuit has not addressed the issue of whether the pendency of a putative class action can toll the statute of limitations period in an ERISA breach of fiduciary case. At this early juncture it is not necessary for the court to address the issue of whether *Pipefitters Local 636 Ins. Fund v. BCBSM*, 722 F.3d 861 (6th Cir. 2013) tolled the statute of limitations period because it remains possible that the ERISA claims are timely under the limitations period set forth in § 1113(2). The court rejected Defendant's argument that amounts wired to its bank account were not "plan assets" as defined by ERISA. The court also denied Plaintiffs' motion for partial summary judgment but granted BCBSM's unopposed motion to dismiss the state law claims.

E. Seventh Circuit

**Service provider does not qualify as a beneficiary entitled to sue under ERISA Section 502(a)(1)(B).** [University of Wisconsin Hospitals and Clinics Authority v. Kay Kay Realty Corp. Flexible Benefit Plan, et al., No. 14-CV-882-BBC, 2015 WL 9028080 \(W.D. Wis. Dec. 15, 2015\)](#) (Judge Barbara B. Crabb). Plaintiff University of Wisconsin Hospitals and Clinics Authority is a public body created for the purpose of operating a number of healthcare facilities. It filed suit against Defendants Kay Kay Realty Corp. Flexible Benefit Plan, Aetna Life Insurance Company, Aetna Health and Life Insurance Company and Aetna Health Insurance Company for allegedly improperly denying it benefits under the terms of the Kay Kay Realty Corp. Flexible Benefit Plan. Plaintiff also asserted that the administrative procedures Defendants employed to decide its administrative claim did not comport with the procedural requirements set forth in 29 U.S.C. § 1133. The court denied Plaintiff's motion for summary judgment and granted Defendants' motion on the basis that Plaintiff failed to demonstrate the existence of any genuine issue of material fact with respect to whether it qualifies as a participant, a beneficiary or a fiduciary empowered to file suit under ERISA's civil enforcement provisions. The court found that Plaintiff did not produce any evidence that it actually received an assignment of the beneficiary's rights under the Plan. But, even if it had, the Plan prohibits participants from assigning their claims to third-parties, including participants' doctors and service providers. The court also rejected Plaintiff's argument that its status as a beneficiary is based on its network provider contract and on the terms of the Plan itself. The court explained that the Seventh Circuit recently held that a provider's right to direct payment under a plan does *not* make it a beneficiary entitled to sue under § 502. *See Pennsylvania Chiropractic Association v. Independence Hospital Indemnity Plan, Inc.*, 802 F.3d 926, 929 (7th Cir. 2015). The court did note that Plaintiff may have contract claims to enforce their negotiated network provider agreements with Aetna but the court lacks jurisdiction over these claims.

**Under current federal and Wisconsin state law, provider lacks standing to pursue its claims as a beneficiary under ERISA.** [Univ. of Wisconsin Hospitals & Clinics Auth. v. Aetna Health](#)

[& Life Ins. Co., No. 15-CV-240-WMC, 2015 WL 6736983 \(W.D. Wis. Nov. 3, 2015\)](#) (Judge William M. Conley). The court granted Defendants' motion to dismiss on the grounds that Plaintiff's claims fail as a matter of law because of an anti-assignment provision in the ERISA plan at issue. The plan specifies unambiguously that the benefit rights may not be assigned to another party with respect to a broad array of interests, including the right to bring legal action. The plan also expressly states that a direction to pay a provider, directly or otherwise, is not an assignment of any right and that a direction to pay does not extend to a provider any legal right to initiate court proceedings. The court explained that this outcome would appear unfortunate from a pure policy perspective since health care providers, particularly large hospitals like Plaintiff here, are far better equipped to hold insurance companies accountable for payment of covered medical treatment than the typical ERISA beneficiary, which would appear the most beneficial outcome in the long run (especially if repeated failures to pay begins to undermine the health providers willingness to afford care for fear of non-payment). The court advised that Plaintiff could perhaps name its patient as an involuntary plaintiff, or otherwise facilitate a lawsuit in its patient's name.

**Insurer has standing to bring recoupment claim against out-of-network health care provider and recoupment does not trigger ERISA's internal review requirements.**

[Connecticut Gen. Life Ins. Co. v. Sw. Surgery Ctr., LLC, No. 14 CV 08777, 2015 WL 6560536, at \(N.D. Ill. Oct. 29, 2015\)](#) (Judge John Robert Blakey). Cigna brought this suit against CMIS seeking a declaratory judgment that CMIS has engaged in fee-forgiving practices that have eliminated Cigna's obligation to pay or reimburse CMIS for services provided. It also sought recovery of alleged overpayments under ERISA and common law theories of unjust enrichment and restitution. On CMIS's motion to dismiss, the court found that Cigna met the requirements for Article III standing where it alleged that Cigna reimbursed CMIS nearly \$800,000 for procedures, which, under the plan terms, it did not have an obligation to pay since CMIS waived patient payment obligations, and that it has also devoted time and resources to an investigation of CMIS's billing procedures. The court also found that Cigna has statutory standing under ERISA because Cigna is a fiduciary that has discretionary authority over the payment of benefits. The court found that ERISA's internal review requirements do not apply to Cigna's recoupment claim.

In [Univ. of Wisconsin Hospitals & Clinics Auth. v. Aetna Health & Life Ins. Co., No. 15-CV-280-BBC, 2015 WL 5123712 \(W.D. Wis. Sept. 1, 2015\)](#), Plaintiff filed its lawsuit in state court asserting claims for breach of contract and other claims under state law, alleging that it was a third party beneficiary of a health insurance contract between one of its patients and Aetna. Defendants removed the case to this court under 28 U.S.C. §§ 1441 and 1446 on the ground that Plaintiff's claims are preempted by ERISA, which Plaintiff now concedes. Defendants sought

dismissal of the complaint with prejudice as a sanction for repeatedly filing state law claims that should have been brought under ERISA. Although the court declined to dismiss the case, I am directing plaintiff to show cause why it should not be required to reimburse defendants for their costs and fees related to removing the case and briefing their motion to dismiss.

In [\*Univ. of Wisconsin Hospitals & Clinics Auth. v. Aetna Health & Life Ins.\*, No. 15-CV-283-BBC, 2015 WL 5123734 \(W.D. Wis. Sept. 1, 2015\)](#), Plaintiff brought suit against Aetna as a third-party beneficiary to the insurance contract between one of its patients and Aetna. Upon removal, Plaintiff conceded that its claim is governed by ERISA because its patient is a participant in an ERISA benefits plan. Defendants sought dismissal of the complaint with prejudice on three grounds: (1) Plaintiff does not have the right to enforce the patient's rights under ERISA; (2) Plaintiff did not exhaust its administrative remedies; and (3) Plaintiff should be sanctioned for its repeated filings of state law claims that should have been filed as ERISA claims. Because the court agreed with defendant that Plaintiff failed to exhaust its administrative remedies, it granted Defendant's motion to dismiss without discussing the other arguments.

In [\*St. Alexius Med. Ctr. v. Roofers' Unions Welfare Trust\*, No. 14 C 8890, 2015 WL 5123602 \(N.D. Ill. Aug. 28, 2015\)](#), Plaintiff filed an amended complaint seeking to recover \$153,424.00 for unpaid hospital services and \$228,000.00 in statutory penalties due to Defendant's failure to timely provide Plaintiff with the Plan. Defendant moved to dismiss, which the court granted in part. The court applied the two-year contractual limitations period in the plan and found the Plaintiff's claim for benefits to be time-barred since it was filed almost five years after the expiration of the limitations period. As such, the court found that it need not reach Defendant's exhaustion argument. Applying a two-year statute of limitations to the August 2008 statutory penalty claim, the court also found this claim to be time-barred. But, the court declined to dismiss the January 2014 and March 2014 statutory penalty claims, rejecting Defendant's argument that the assignment of benefits does not confer standing to sue for statutory penalties.

#### F. Eighth Circuit

**Anti-assignment provisions do not prohibit patients from assigning their causes of action to medical provider.** [\*Riverview Health Institute v. Unitedhealth Group Inc., et al.\*, No. 15-CV-3064 \(PJS/BRT\), 2015 WL 9581807 \(D. Minn. Dec. 30, 2015\)](#) (Judge Patrick J. Schiltz). The court denied United's motion to dismiss Plaintiff's lawsuit claiming that United took "cross-plan offsets" in violation of the terms of various ERISA plans and ERISA. United relied on anti-assignment clauses found in 19 of the ERISA plans at issue, contending that Riverview lacks standing with respect to claims under those plans because the anti-assignment clauses barred the patients' assignments. The court found that United's argument is foreclosed by *Lutheran*

*Medical Center of Omaha, Nebraska v. Contractors, Laborers, Teamsters & Engineers Health & Welfare Plan*, 25 F.3d 616 (8th Cir. 1994), *abrogated on other grounds by Martin v. Arkansas Blue Cross & Blue Shield*, 299 F.3d 966 (8th Cir. 2002). The court concluded that *Lutheran Medical* constrains this court to hold that the anti-assignment provisions in the plans administered by United did not prohibit the patients from assigning their causes of action to Riverview.

In [\*Int'l Air Med. Servs. Inc., et al., Plaintiffs, v. Triple-S Salud Inc., Defendant. Additional Party Names: Francisco Ortiz-Maldonado\*, No. CV-15-00149-PHX-DGC, 2015 WL 5158832 \(D. Ariz. Sept. 3, 2015\)](#), Plaintiffs Francisco Ortiz-Maldonado and International Air Medical Services, Inc. (“IAMS”) brought suit under ERISA against Defendant for failure to pay for Maldonado’s air-ambulance service from a hospital in Florida to a hospital in Puerto Rico. Maldonado assigned to IAMS his rights under the Triple-S health insurance plan. Defendant moved to dismiss, arguing that (1) IAMS lacks standing to sue under ERISA; (2) Maldonado has died and is no longer a proper party; and (3) the District of Arizona is an improper venue and the case should be transferred to the District of Puerto Rico if the Court finds dismissal to be improper. The court granted the motion to dismiss, finding that (1) the health plan’s provision prohibiting the “transfer” of any of the rights and benefits under the contract is an anti-assignment clause so IAMS lacks standing to sue as either a participant, beneficiary, or fiduciary; (2) Maldonado’s death requires dismissal (without prejudice); and (3) although IAMS is an Arizona-based company, Triple S is a Puerto Rican entity over which the court does not have personal jurisdiction, so venue is not proper in Arizona.

#### G. Ninth Circuit

**Motion to transfer lawsuit for denied health benefits to the Eastern District of Virginia is denied.** [\*Ridenour v. Cigna Health and Life Insurance Company\*, No. 3:15-CV-03051-LB, 2015 WL 6674662 \(N.D. Cal. Nov. 2, 2015\)](#) (Magistrate Judge Laurel Beeler). In this matter involving the denial of speech and language therapy for Plaintiff’s child, the court denied Cigna’s motion to transfer venue to the Eastern District of Virginia. Plaintiff is a participant in the Orrick, Herrington & Sutcliffe LLP Welfare Benefit Plan. The firm’s principal place of business is in California but Plaintiff does not reside in the Northern District of California and, aside from working for a law firm that has its main office in San Francisco, has no connection to the district. Some operative facts occurred in California, but others occurred in Virginia. Plaintiff communicated with Orrick employees regarding the Plan, and the California Department of Insurance investigated the matter in California, but Plaintiff and his family live in Virginia and Plaintiff’s son was examined by doctors and receives therapy in Virginia. The court found that the matter could have been filed in the Eastern District of Virginia, the convenience of the parties is a neutral factor since Plaintiff’s and Cigna’s contacts with two forums are about

equal, the ease of access to evidence is also a neutral factor since the pertinent evidence will be in the claims file, and the local interest factor tilts toward the California forum.

In [\*Nutrishare, Inc. v. Connecticut Gen. Life Ins. Co.\*, No. 2:15-CV-00351-JAM-AC, 2015 WL 4225513 \(E.D. Cal. July 10, 2015\)](#), Nutrishare, a healthcare provider specializing in Total Parenteral Nutrition services and an out-of-network provider according to CIGNA's PPO plans, brought suit against CIGNA for payment for services it provided to its members. The court found the state law claims completely preempted by ERISA since each of the claims are based on the allegation that benefits are owed to Plaintiff based on its patients' healthcare plans provided by CIGNA. With respect to Plaintiff's § 502(a)(2) claim, the court dismissed this claim because Plaintiff failed to establish that the claim is for the benefit of the ERISA Plan rather than for the benefit of individual plan participants. However, because it is not clear that further amendment would be futile, the court granted the motion to dismiss this claim without prejudice.

In [\*Pain Mgmt. Specialists v. Blue Shield of California Life & Health Ins. Co.\*, No. CV 13-05417 DDP MRWX, 2015 WL 546025 \(C.D. Cal. Feb. 9, 2015\)](#), Defendants moved to dismiss Plaintiff's First Amended Complaint alleging causes of action for (1) wrongful denial of benefits under ERISA § 502(A)(1)(B) and (2) promissory estoppel. Plaintiffs' ERISA claim is predicated upon an assignment of rights under plans that all contain non-assignability clauses. The Ninth Circuit has explicitly held that such provisions are enforceable and ERISA welfare plan payments are not assignable in the face of an express non-assignment clause in the plan. The elements of a promissory estoppel claim are (1) a promise clear and unambiguous in its terms; (2) reliance by the party to whom the promise is made; (3) the reliance must be both reasonable and foreseeable; and (4) the party asserting the estoppel must be injured by his reliance. The court found that the FAC fails to sufficiently allege the first and third elements because Plaintiffs cannot plausibly allege that they, as non-preferred, out-of-network providers, were promised full for the services they rendered. Also, Plaintiffs cannot plausibly allege reasonable reliance on any promise of full payment where the plan specifically states that services provided by out-of-network providers may not be fully reimbursed. Even if Defendants made some oral representation contrary to that provision of the plan, Plaintiffs were on notice of Defendants' position regarding full payment as early as August 2008. The court granted Defendants' motion to dismiss with prejudice.

#### H. Tenth Circuit

In [\*NELSON VETANZE, doing business as OMNI CHIROPRACTIC, Plaintiff, v. NFL PLAYER INSURANCE PLAN, Defendant.\*, No. 11-CV-2734-RBJ, 2015 WL 5013614 \(D. Colo. Aug. 25, 2015\)](#), the court affirmed the denial of benefits to 21 Denver Broncos who received chiropractic

treatment from Plaintiff based on the Plan's exclusion of coverage for treatment of work-related injuries. Cigna, the third-party administrator, adopted a policy of not paying any chiropractic claims for services performed during each Club's Training Camp.

## I. Eleventh Circuit

**Medical provider fails to state a claim where health plan contains unambiguous anti-assignment clause.** [Griffin v. Focus Brands, Inc., No. 15-12137, Fed.Appx. , 2015 WL 9487801 \(11th Cir. Dec. 30, 2015\)](#) (Before MARTIN, JILL PRYOR and ANDERSON, Circuit Judges). The court concluded that Dr. Griffin failed to state a claim because she failed to allege facts sufficient to support a cause of action under § 502(a) of ERISA and affirmed the district court's dismissal of her complaint. Here, the court found that the ERISA health plan contained an unambiguous anti-assignment clause and Georgia statute O.C.G.A. § 33-2454(a) does not implicitly bar anti-assignment provisions. The court declined to apply equitable estoppel against Defendant where the claims administrator failed to notify Dr. Griffin of the anti-assignment provision after she asked whether the Plan contained such a term. The court made similar conclusions in parallel cases brought by Dr. Griffin: [Griffin v. S. Co. Servs., No. 15-12135, Fed.Appx. , 2015 WL 9487798 \(11th Cir. Dec. 30, 2015\)](#); [Griffin v. Health Sys. Mgmt., Inc., No. 15-12138, Fed.Appx. , 2015 WL 9466968 \(11th Cir. Dec. 29, 2015\)](#); [Griffin v. Gen. Mills, Inc., No. 15-12157, Fed.Appx. , 2015 WL 9466979 \(11th Cir. Dec. 29, 2015\)](#).

In [Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc., No. 14-81271-CV, 2015 WL 2198470 \(S.D. Fla. May 11, 2015\)](#), Plaintiffs sued Defendants for refusing to pay for urine tests it provided to 132 substance abuse patients. Plaintiffs claim that Defendant violated ERISA by denying, and failing to provide the criteria used in denying their claims, by failing to provide full and a fair review of their denied claims, by breaching their fiduciary duties, and by failing to provide requested plan documents. The court found that neither the Assignment of Benefits nor the Power of Attorney provide the Laboratories standing to bring their ERISA claims, which the court dismissed with prejudice.

*Tran Chiropractic Wellness Ctr., Inc. v. Aetna Inc.*, No. 8:14-CV-47-T-36EAJ, 2015 WL 144243, (M.D. Fla. Jan. 12, 2015) involves a claim by Plaintiff Tran Chiropractic Wellness Center, Inc., a provider of medically necessary and appropriate chiropractic and related services to patients covered under healthcare plans issued by Defendant Aetna, Inc. ("Aetna") or its affiliates ("Aetna Plans"), alleging that Aetna wrongfully denied claims submitted by Plaintiff. The court found that Plaintiffs satisfied Rule 8's pleading requirements where they alleged that they have assignments from all of the patients at issue in this suit. Rule 8 does not require Plaintiffs to attach those hundreds of assignments to their complaint. The court also found that

the pleadings sufficiently allege compliance with the exhaustion requirement under ERISA. Here, Plaintiffs allege that the exhaustion requirement was deemed fulfilled by operation of the law or, in the alternative, that the requirement is excused due to futility. The court found this allegation is sufficient to survive a motion to dismiss. Furthermore, the language of the plan at issue here suggests that the exhaustion of the available administrative review process may not be required before a lawsuit can be filed. Lastly, Defendants asked the court to dismiss Count V requesting injunctive relief pursuant to 29 U.S.C. § 1132(a)(3) based on the argument that a plaintiffs' breach of fiduciary claim based on the same factual allegations as its claim for unpaid benefits is duplicative. The court found that the claim is not duplicative because it does not rely on the same factual allegations or seek the same relief. Here, Plaintiffs sufficiently pleaded that Count V is based on Defendants' alleged retaliatory practices and repeated violations of procedural requirements—not the failure to pay benefits on any particular claim. Thus, Plaintiffs are permitted to proceed with Count V.

## XVIII. *Remedies*

### A. First Circuit

In [\*Cannon v. Aetna Life Ins. Co.\*, No. 14-CV-12546, 2015 WL 3766923 \(D. Mass. June 17, 2015\)](#), the court declined to dismiss Plaintiff's suit, finding that he could not have reasonably exhausted his administrative remedies with respect to his long-term disability claim since Aetna did not issue a formal written denial in compliance with the Regulations (or any written decision at all). However, the court stayed the case pending resolution of Plaintiff's other lawsuit involving his short-term disability claim since its disposition may affect his LTD case.

### B. Second Circuit

In [\*Levy v. Young Adult Inst., Inc.\*, No. 13-CV-2861 JPO, 2015 WL 170442 \(S.D.N.Y. Jan. 13, 2015\)](#), the court denied Plaintiffs motion for a preliminary injunction seeking to protect certain assets held in a trust under the terms of the Supplemental Pension Plan and Trust for Certain Management Employees of Young Adult Institute (the "SERP"), and also requesting expedited discovery. The court found that Plaintiffs did not demonstrate irreparable harm because Plaintiffs may reach beyond the SERP to satisfy any eventual judgment against Defendant. The court also found that Plaintiffs have not demonstrated an equitable interest in the Defendants' assets sufficient to freeze them prior to trial. The court had denied Plaintiffs' motion to amend their complaint to add equitable claims under ERISA § 502(a)(3), which sought a remedy at law or

duplicate claims filed under § 502(a)(1)(B). The court explained that Plaintiffs' existing equitable claim is insufficient to assert a lien or equitable interest over any of Defendants' funds. Further, Plaintiffs' proposed form of preliminary relief fails to identify a particular fund and targets Defendants' general assets. Plaintiffs are not entitled to enjoin the restoration of funds from Defendant's general assets to the Trust or to place a constructive trust over such funds.

### C. Third Circuit

The Third Circuit vacated the district court's dismissal of Plaintiff's claims based on her failure to exhaust administrative remedies. The district court erred by shifting the burden onto Plaintiff to establish that she had exhausted her administrative remedies instead of requiring Cigna to demonstrate that she had not. The district court also erred in dismissing the breach of fiduciary duty claim for failure to exhaust since exhaustion is not required for these claims. [Am. Chiropractic Ass'n v. Am. Specialty Health Inc., No. 14-1832, Fed.Appx. , 2015 WL 5313631 \(3d Cir. Sept. 11, 2015\).](#)

In [In re Aetna UCR Litig., No. CIV. 07-3541, 2015 WL 3970168 \(D.N.J. June 30, 2015\)](#), a matter challenging the use of the Ingenix data to establish UCR rates, the court dismissed the ERISA claims brought by the only provider plaintiff Mullins since the court found that, to the extent that ownership of any rights to payment were validly transferred by his patients, those rights belong to Eastern Monmouth Physical Therapy LLC, who is not a party to this action. As a threshold matter, the only provider plaintiff in this action, Mullins, has no basis to pursue his claims under ERISA. While plaintiffs maintain that other providers will be joined or rejoined to this action, the Court will not engage in a hypothetical analysis regarding the extent to which they will have standing to pursue ERISA claims later on. The court found that because the only provider plaintiff has no basis to pursue his ERISA claims, the association plaintiffs therefore cannot satisfy the first element under *Hunt v. Wash. State Apple Adver. Comm'n*, 432 U.S. 333, 343 (1977). The court also found the association plaintiffs fail to allege that the claims asserted will not require the participation of individual provider members—provider plaintiffs are permitted to sue under ERISA only upon proof of a valid assignment of benefits. Such a finding is necessary to prove that the provider plaintiffs have standing, and therefore also is necessary to show that the association plaintiffs have standing to sue in a representative capacity on the providers' behalf. Because the court found that the association plaintiffs fail to satisfy the *Hunt* test on both the first and third prongs, and they lack standing to pursue any claims in this action in a representative capacity.

In [Lees v. Munich Reinsurance Am., Inc., No. CIV.A. 14-2532 MAS, 2015 WL 1021299 \(D.N.J. Mar. 9, 2015\)](#), Plaintiff alleged that Defendant made misrepresentations to him regarding his

entitlement to certain pension credits and benefits. In ruling on Defendant's motion to dismiss Plaintiff's nine separate causes of action, the court found that Plaintiff's Section 502(a)(1)(B) claim is comprised largely of legal conclusions and conclusory statements. Because Plaintiff's Complaint does not contain sufficient factual matter, if accepted as true, would state a claim to relief that is plausible on its face under § 1132(a)(1)(B), dismissal of this count is warranted. The court declined to dismiss Plaintiff's breach of fiduciary duty claim based upon oral misrepresentations since Plaintiff alleged sufficient facts to support this claim and discovery into his employee file may reveal additional written materials to support his claim. With respect to Counts Four (promissory estoppel), Five (equitable fraud), Six (disgorgement), Seven (unjust enrichment/quantum meruit), and Nine (unclean hands/bad faith) of Plaintiff's Complaint, the court found that he seeks the same relief:

[R]eformation of the Munich pension plan to allow Plaintiff credit for the period of October 28, 1996 through August 15, 1999 when Plaintiff was on the payroll of SMS, disgorgement of the forsaken sign-on bonuses of Plaintiff, Rossmango and others similarly situate [sic] offered in 1999 plus interest and/or profit of same to be deposited with the Munich pension plan, liquidated damages together with interest, costs of suit, attorney's fees, and such other relief that this Court deems just, equitable and appropriate under the circumstances of this case.

The court found that Plaintiff is requesting compensatory damages merely framed as "equitable relief" which is not available under § 1132(a) (3). Additionally, Plaintiff may not seek the same relief under § 1132(a)(3) that he is seeking under § 1132(a)(2). As such, the court dismissed these counts with prejudice.

#### D. Fourth Circuit

In [\*Wright v. Hartford Life & Acc. Ins. Co.\*, No. 5:14-CV-00126-RLV, 2015 WL 4488656 \(W.D.N.C. July 23, 2015\)](#), Hartford stopped paying Plaintiff long-term disability benefits because she did not reimburse Hartford for an alleged overpayment. By the terms of 29 C.F.R. § 2560.503-1(m)(4) an adverse benefit determination is broader than a denial of benefits and includes a reduction in monthly benefit payments. Hartford was reducing Plaintiff's benefits by the amount of her Social Security Benefits and then reducing her benefits until she repaid the alleged overpayment. The court found that the plain language of § 2560.503-1(m)(4) encompasses Hartford's reduction of Plaintiff's benefits and the reduction constitutes an adverse benefit determination subject to the notification requirements of § 2560.503-1(g). Because Plaintiff did not receive written notice of an adverse benefit determination consistent with § 2560.503-1(g), the court found that she is deemed to have exhausted her remedies under § 2560.503-1(I).

In [Wright v. Hartford Life & Acc. Ins. Co., No. 5:14-CV-00126-RLV, 2015 WL 4488656 \(W.D.N.C. July 23, 2015\)](#), Plaintiff brought both a § 502(a)(1)(B) claim and a § 502(a)(3) against Defendant in connection with the handling of her long-term disability claim. Plaintiff sought equitable relief in the form of an injunction against Defendant from engaging in further violations of ERISA but the court found that this is equitable relief pursued with the ultimate aim of securing the remedies afforded by § 1132(a)(1)(B). The court found that Plaintiff's claim for equitable relief arises out of Hartford's handling of the LTD benefit claim and monetary relief under § 502(a)(1)(B) would adequately remedy Plaintiff's injury such that an additional claim under § 502(a)(3) is duplicative and unnecessary. The court granted Defendant's Motion to Dismiss Plaintiff's claim for equitable relief.

In [Rohrbaugh v. Cigna Health & Life Ins. Co., No. 1:15-CV-613 JCC/TCB, 2015 WL 3774528 \(E.D. Va. June 17, 2015\)](#), the court dismissed without prejudice Plaintiff's complaint seeking reimbursement for "out-of-network coverage of fees" in the amount of \$3,738.69 from a self-funded health plan, where there was no indication from the pleadings that Plaintiff has started the administrative process, much less exhausted it, or any showing of futility that would otherwise circumvent the exhaustion requirement.

#### E. Fifth Circuit

In [Shelby Cnty. Health Care Corp. v. Genesis Furniture Indus., Inc., No. 3:13-CV-00245-SA-SAA, 2015 WL 4477666 \(N.D. Miss. July 22, 2015\)](#), a suit filed by a provider of medical services, the court initially remanded the claim to Defendant to make a benefit determination. On remand, Defendant admitted that Plaintiff is entitled to \$15,000 under the terms of the Plan. With respect to Plaintiff's motion for prejudgment interest, the court explained that courts consulting Mississippi law have held a prejudgment rate of 8% compounding annually to be appropriate in ERISA cases. As Plaintiff lost the use of funds that Defendant now acknowledges have been due under the terms of the plan for over four years, the court found an award of prejudgment interest at the rate of 8%, compounding annually, to be appropriate.

In [De Santiago-Young v. HistoPath, Inc., No. 2:14-CV-179, 2015 WL 1880436 \(S.D. Tex. Apr. 23, 2015\)](#), a matter involving health coverage, the court dismissed Plaintiffs' claims for breach of fiduciary duty because they are not entitled to personal relief under § 1132(a)(2) and because, as a matter of law, they are not permitted to raise such claims under § 1132(a)(3) simultaneously with their claims for plan benefits under § 1132(a)(1).

F. Sixth Circuit

**A Plaintiff is not entitled to recover under both ERISA § 502(a)(1)(B) and § 502(a)(3) for an arbitrary and capricious denial of benefits.** In [\*Rochow v. Life Ins. Co. of N. Am.\*, No. 12-2074, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 925794 \(6th Cir. Mar. 5, 2015\)](#) (*en banc*), the 6<sup>th</sup> Circuit Court of Appeals issued its long-awaited *en banc* opinion, deciding whether Plaintiff is entitled to recover under both ERISA § 502(a)(1)(B) and § 502(a)(3) for LINA’s arbitrary and capricious denial of long-term disability benefits. The 6<sup>th</sup> Circuit vacated the district court’s disgorgement award and remanded the case to the district court to determine whether prejudgment interest is appropriate. 9 judges joined the majority, 3 judges joined in a concurring opinion, 6 judges joined the dissent, and 1 judge joined in part and dissented in part.

***The Majority:*** Rochow is made whole under § 502(a)(1)(B) through recovery of his disability benefits and attorney’s fees, and potential recovery of prejudgment interest. Allowing Rochow to recover disgorged profits under § 502(a)(3), in addition to his recovery under § 502(a)(1)(B), based on the claim that the wrongful denial of benefits also constituted a breach of fiduciary duty, would—absent a showing that the § 502(a)(1)(B) remedy is inadequate—result in an impermissible duplicative recovery, contrary to clear Supreme Court and Sixth Circuit precedent. Because Rochow was able to avail himself of an adequate remedy for LINA’s wrongful denial of benefits pursuant to § 502(a)(1)(B), he cannot obtain additional relief for that same injury under § 502(a)(3). However, Rochow’s request for prejudgment interest is a remedy that the district court could have granted, though not at an excessive rate.

***The Concurrence:*** The district court’s disgorgement order cannot stand for purely procedural reasons. When the district court granted Rochow’s motion for equitable accounting and ordered LINA to disgorge profits, it violated the mandate rule because the *Rochow I* panel did not remand the case to the district court. Any “post-remand” litigation was contrary to the 6<sup>th</sup> Circuit’s mandate.

***The Concurrence and Dissent:*** The majority and dissent part on whether Rochow’s fiduciary duty claim is merely a repackaging of his benefits-denial claim but this is a false dichotomy that imposes a requirement not found in ERISA. The governing inquiry under ERISA is whether other equitable relief is appropriate under the circumstances, and the extent to which the equitable disgorgement claim duplicates the benefits-denial claim is one factor to be considered in making that determination. *Varity Corp.* does not require a showing of a separate and distinct injury and the court should not preemptively disallow equitable remedies in particular circumstances where ERISA has not done so. Disgorgement as an equitable remedy in a denial-of-benefits case should be premised on a finding that the decision to deny benefits was not only arbitrary and capricious but also based on impermissible considerations that call for an equitable judicial response geared toward deterring similar decision making in the future.

***The Dissent:*** The majority's insistence that Rochow is not entitled to disgorgement of LINA's profit under § 1132(a)(3) rests on the faulty premise that Rochow suffered the single injury of LINA's arbitrary and capricious denial of benefits. LINA injured Rochow in two distinct ways: by arbitrarily and capriciously denying his disability benefits claim and by breaching its fiduciary duties to him. Equity has long recognized that a trustee or a fiduciary who gains a benefit by breaching his or her duty must return that benefit to the beneficiary. A proper interpretation of *Varity Corp.*, the cases following it, and the Supreme Court's decision in *CIGNA Corp. v. Amara*, demonstrate that a participant or beneficiary may recover under § 1132(a)(1)(B) for an arbitrary and capricious denial of plan benefits and may recover further equitable relief under § 1132(a)(3) to redress a breach of fiduciary duty. LINA's delay in payment of benefits to Rochow constituted both an arbitrary and capricious denial of plan benefits under § 1132(a)(1)(B) and a breach of LINA's fiduciary duties remediable under § 1132(a)(3). However, the dissent would return the case to the district court to recalculate the award to Rochow to correct several significant errors.

#### G. Seventh Circuit

**Summary Judgment against plan beneficiaries due to failure to exhaust administrative remedies affirmed.** In [\*Orr v. Assurant Employee Benefits\*, No. 14-2370, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 2372813 \(7th Cir. May 19, 2015\)](#), the court affirmed the district court's grant of summary judgment against the life insurance plan beneficiaries for failing to exhaust the Plan's required two levels of appeal based on the following events:

- On December 10, 2012, USIC notified Plaintiffs that it denied their claim for accidental death benefits on the ground that the insured's death resulted from his intoxication;
- On February 5, 2013, Plaintiffs sent USIC a letter titled "NOTICE OF INTENTION TO OPPOSE DENIAL OF POLICY PROCEEDS." The letter did not contest the denial, but requested documents and an extension of time to submit additional written materials;
- On February 13, 2013, USIC granted a 30-day extension and two days later sent the requested documents;
- On March 11, 2013, Plaintiffs sent USIC a letter titled "NOTICE OF FILING APPEAL (2<sup>nd</sup> level) OF DENIAL OF POLICY PROCEEDS" which argued at length that the denial was improper;
- On May 14, 2013, USIC sent Plaintiffs a letter setting forth the basis for the denial of the claim and instructed Plaintiffs to file a second level appeal;

- On July 15, 2013, Plaintiffs sent USIC a letter further challenging the denial of their claim and asserted that they already complied with the review procedure; Plaintiffs characterized the Feb. 5<sup>th</sup> letter at the first level appeal and the March 11<sup>th</sup> letter as the second level appeal. Plaintiffs' attorney closed the letter stating that he was in the process of investigating the facts of the case and expected to have more probative information available;
- On July 19, 2013, Plaintiffs filed suit.

In *Lyons v. Bd. of Regents of the Univ. of Wisconsin Sys.*, No. 14-CV-460, 2015 WL 59425 (E.D. Wis. Jan. 5, 2015), Plaintiff sought compensation from Defendants for medical bills he incurred for services provided by third parties. Plaintiff contended that when Defendants terminated his employment, they violated the Public Health Services Act (PHSA) as amended by the Consolidated Omnibus Reconciliation Act (COBRA) by failing to provide him notice of his right to continue coverage for up to 18 months. Noting that relief under COBRA is limited to “those categories of relief that were typically available in equity, such as injunctive remedies and equitable restitution,” the court found that Plaintiff seeks legal, rather than equitable relief. For restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant’s possession. Here, Plaintiff does not seek the return of any particular funds that Defendants received from him since there is no allegation that he ever paid anything to Defendants. Accordingly, the court granted Defendants’ motion for judgment on the pleadings.

#### H. Eighth Circuit

In [Nutt v. Kees, No. 3:10-CV-00307-KGB, 2015 WL 2194180 \(E.D. Ark. May 11, 2015\)](#), the court denied Plaintiffs motion to amend the judgment to provide equitable relief in the form of a surcharge and constructive trust. Plaintiffs argued that they should be awarded a surcharge making defendants liable for the “consequential damages of their actions, including but not limited to the financial hardship and impact on [p]laintiffs’ household as a result of carrying such large medical bills, the impact on [p]laintiffs’ credit history, and the financial stress and anxiety caused to [p]laintiffs in order to compensate fully for the consequence of the breach.” The court found that there was no precedent for awarding these types of damages. With respect to the requested constructive trust on funds anticipated to be paid to Defendant, the court found that the funds on which Plaintiffs seek a constructive trust do not in good conscience belong to them, but rather a purchase and sale agreement not directly connected to Plaintiffs in any way. As such, the court denied Plaintiffs’ motion for a constructive trust.

I. Ninth Circuit

**When the 180-day internal appeal deadline falls on a Saturday or Sunday, it is timely if mailed the following Monday.** In [\*LeGras v. AETNA Life Ins. Co.\*, No. 12-56541, F.3d](#), [2015 WL 3406182 \(9th Cir. May 28, 2015\)](#), the 180-day deadline for Plaintiff to file an internal appeal of the denial of his LTD claim fell on a Saturday. Plaintiff mailed his appeal the following Monday, but AETNA denied it as untimely, and the district court dismissed Plaintiff's lawsuit for failure to exhaust administrative remedies. The Ninth Circuit reversed and held that because the last day of the appeal period fell on a Saturday, neither that day nor Sunday count in the computation of the 180 days. Since Plaintiff mailed his notice of appeal on Monday, it was timely. The court explained that this method of counting time is widely recognized and furthers the goals and purposes of ERISA. As such, the court adopted it as part of ERISA's federal common law.

**ERISA does not provide remedies, such as contribution, for a breaching fiduciary against its co-fiduciaries under § 1132(a).** In [\*Brown v. California Law Enforcement Ass'n, Long-Term Disability Plan\*, No. 14-CV-03559-JCS, F.Supp.3d](#), [2015 WL 890564 \(N.D. Cal. Mar. 2, 2015\)](#), Plaintiff, who is medically retired from the Oakland Police Department, filed a putative class action against his long-term disability plan, the plan's sponsor, and the plan's administrator under ERISA for denied benefits and breach of fiduciary duty. Defendants are California Law Enforcement Association Group Long Term Disability Plan ("CLEA Plan"); California Law Enforcement Association ("CLEA"); and California Administration Insurance Services, Inc ("CAISI"). The CLEA Plan is offered by CLEA and administered by CAISI. Defendants filed a Third Party Complaint (TPC) against Brown's employee organization, the Oakland Police Officers' Association ("OPOA"), asserting a claim of equitable indemnity under 29 U.S.C. § 1132(a)(3). The TPC alleges that in the event that Defendants are held liable for breach of fiduciary duty, they should be indemnified by OPOA because Defendants tried to inform Brown of the risk of losing his benefits if he did not enroll in the CLEA Individual Plan after the termination of his CLEA Group Plan but OPOA misinformed Brown and prevented Defendants from giving the correct information.

The court found that Defendants' TPC, which alleges breach of fiduciary duty must be dismissed because of the lack of allegations that OPOA had any responsibility, authority, or control over the CLEA Plan's management, assets, or administration. Even if OPOA acted in a fiduciary role, Defendants have not stated a cognizable claim under § 1132(a)(3) because, as a general rule, ERISA does not provide remedies, such as contribution, for a breaching fiduciary against its co-fiduciaries under § 1132(a). Neither subsection (a)(2) or (a)(3) provides a remedy for injuries to a fiduciary because these subsections allow relief only for the plan and its beneficiaries. If Defendants failed to disclose the correct benefits information, they are

responsible for the resulting injury to the plan and beneficiaries under ERISA even if a third party co-fiduciary also harmed the beneficiaries.

In [Brooks v. Wapato Point Mgmt. Co. Health & Welfare Plan, No. 2:14-CV-00250-LRS, 2015 WL 711248 \(E.D. Wash. Feb. 18, 2015\)](#), the court determined that Plaintiffs do not have a remedy under § 1132(a)(1)(b) because they cannot be considered beneficiaries of a life insurance plan that did not exist at the time of the insured's death. The court also determined that Plaintiffs are not entitled to "equitable relief" under 29 U.S.C. § 1132(a)(3) in the form of a surcharge because there is no evidence that the employer defrauded the insured or engaged in other egregious conduct that might justify reinstatement of benefits through a § 1132(a)(3) equitable remedy. Further, the court found that it is unclear whether ERISA's fiduciary duty of notice extends past the employee to the designated beneficiaries of a life insurance plan. However, the court declined to decide whether Wapato Point had a duty to the employee's designated beneficiaries or whether it breached that duty since the alleged breach of duty cannot be enforced by the estate of the deceased employee (as had been found in a prior court proceeding), and there is no basis to conclude that the rights of the named beneficiaries exceed those of the deceased.

J. Tenth Circuit

K. Eleventh Circuit

In [Schoen v. Health Mgmt. Associates, Inc., No. 2:14-CV-411-FTM-29CM, 2015 WL 5021623 \(M.D. Fla. Aug. 25, 2015\)](#), the court denied Defendants' motion to dismiss Plaintiff's SERP claim for failing to exhaust administrative remedies. Although the SERP does require the filing of a claim and appeal, the court found that Plaintiff adequately pled exhaustion, or in the alternative, exhaustion would have been futile. Here, Plaintiff alleged that as a result of the acquisition of HMA by CHS on January 27, 2014, there was no known named plan administrator, and Plaintiff's demand was sent directly to HMA's counsel. HMA's response did not state that any future notice or communication under the SERP should be directed to any other address, nor did it identify any other individual to make such demand upon. Subsequently, HMA made a partial payment that did not satisfy Plaintiff's demand. Plaintiff also alleged that any further demand or administrative procedure would be futile because: (a) HMA failed to provide written notice within ninety (90) days in compliance with the terms of the SERP; and (b) HMA did not detail the manner in which the cash benefit was calculated, precluding Plaintiff from any meaningful review on appeal.

## XIX. *Retaliation/Discrimination Claims*

### A. First Circuit

**Denial of severance benefits affirmed but interference claim remanded for consideration under appropriate summary judgment standard.** In [Niebauer v. Crane & Co., No. 14-2059, F.3d](#), 2015 WL 1787931 (1st Cir. Apr. 21, 2015), Plaintiff–Appellant Robert alleged that the administrator of his former employer’s executive severance plan denied him severance benefits after erroneously determining that he had retired voluntarily from his position. He also alleged that his former employer improperly interfered with his rights under the plan, in violation of 29 U.S.C. § 1140. After ordering additional discovery to fill in gaps in the administrative record, the district court granted the Defendants’ motion for summary judgment on both counts. The court held that arbitrary-and-capricious review applied, rejecting Plaintiff’s argument that the compensation committee’s interpretation of emails it considered, wherein Plaintiff discussed his retirement from Crane, is not subject to *de novo* review since simple fact-gathering cannot displace the deference owed to a plan administrator. The court also rejected Plaintiff’s argument that the committee’s decision was procedurally flawed by relying on an incomplete factual record and failing to comply with ERISA’s notice requirements. Because it found that the committee’s decision was supported by substantial evidence, the court affirmed the decision. With respect to the § 1140 claim, the district court’s analysis relied on the “substantial evidence” standard applicable to assessing denial-of-benefits claims under ERISA. In interference cases, the ultimate inquiry is whether the employment action was taken with the specific intent of interfering with the employee’s ERISA benefits. The typical summary judgment standard—under which evidence is reviewed in the light most favorable to the nonmoving party—applies in assessing interference claims. Therefore, the court remanded this claim to the district court for consideration under the appropriate standard of review.

### B. Second Circuit

In [Krause v. Eihab Human Servs., Inc., No. 10 CV 898 RJD SMG, 2015 WL 4645210 \(E.D.N.Y. Aug. 4, 2015\)](#), the court granted Defendants summary judgment on Plaintiffs’ ERISA § 510 claim because it found that Plaintiffs provided no evidence that Defendants terminated them for the purpose of interfering with their health or dental insurance coverage, and even if the Plaintiffs did lose health or dental insurance coverage as a result of their termination, there is no cause of action for this “mere consequence” of Plaintiffs’ termination.

**Physicians are not beneficiaries under ERISA and therefore lack standing to bring suit seeking to enjoin insurer from removing them from its coverage network.** In [Rojas v. Cigna](#)

[Health & Life Ins. Co., No. 14-3455, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4256306 \(2d Cir. July 15, 2015\)](#), when the plaintiff physicians (“Rojas”) and Cigna could not resolve a dispute concerning alleged fraud and abuse of blood allergy tests ordered for the physicians’ patients, Cigna notified the physicians that they would terminate them as a healthcare provider in its network. Rojas filed suit seeking, among other things, an injunction prohibiting all retaliatory acts against Rojas including the termination of the provider agreements. Rojas contended that Cigna had violated the anti-retaliation provision of ERISA, 29 U.S.C. § 1140, which makes it unlawful for any person to discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan. The district court denied Rojas’s motion for a preliminary injunction, finding that Rojas lacked standing to bring an ERISA action since the physicians are not participants, beneficiaries, or fiduciaries of an ERISA plan. The district court reasoned that healthcare providers don’t become beneficiaries solely by virtue of receiving reimbursement from a plan administrator, even if they have taken assignments of the reimbursement rights of plan participants. The Second Circuit affirmed, concluding that healthcare providers are not “beneficiaries” of an ERISA welfare plan by virtue of their in-network status or their entitlement to payment. The court noted that its interpretation is consistent with every circuit that has considered this question (6<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup>). The patients assigned to their doctors the right to collect payment, not the right to assert anti-retaliation protections.

C. Third Circuit

[Conneaney v. Main Line Hospitals, Inc., et al., No. 15-02730, 2015 WL 9302912 \(E.D. Pa. Dec. 22, 2015\)](#) (Judge Gerald J. Pappert). At motion to dismiss stage, whether Plaintiff can prove that all seven Defendants acted with the specific intent to deny her ERISA protected benefits is not the issue at this juncture. Plaintiff sufficiently alleged that Defendants terminated her with the intent to deny her ERISA protected benefits to which she was entitled.

**Tender-back and ratification do not apply to releases that purport to waive ERISA claim and Section 510 claim is equitably tolled.** [Tabor v. Allstate Insurance Company, et al., No. CV 15-2602, 2015 WL 7756188 \(E.D. Pa. Dec. 1, 2015\)](#) (Judge S.J. Buckwalter). Plaintiffs who had signed a release agreement with Defendant brought suit challenging the validity of the release and bringing various claims, including an interference/retaliation claim under ERISA § 510 and anti-cutback claims. The court found that Plaintiffs’ ratification of the release agreement has no impact on Plaintiffs’ federal law claims under the ADEA or ERISA given that tender-back and ratification cannot apply to releases that purport to waive such claims. The court found that equitable tolling applies to a portion of the elapsed time for Plaintiffs’ claims under ERISA § 510. Specifically, the filing of the *Romero* complaint, under which Plaintiffs were eligible class members, tolled the statute of limitations such that the claim is timely filed.

*Horneff v. PSEG Nuclear, LLC*, No. CIV. 13-975 RBK/KMW, 2015 WL 263128 (D.N.J. Jan. 21, 2015) arose out of Plaintiff's termination from employment some eight months prior to the partial vesting of his pension benefits. Plaintiff alleged he was fired from his job in retaliation for Plaintiff's participation in an internal investigation and because Defendants wanted to save money and a younger workforce. Defendant contended that there was an actual and legitimate reason to terminate Plaintiff—his failure to report allegations of sexual harassment in the workplace, which he had a duty to report. In evaluating Plaintiff's claim under ERISA Section 510, the court found that the circumstantial evidence is far too vague to support a finding that Defendants terminated Plaintiff's employment in order to interfere with Plaintiff's his ERISA-protected benefits. The only evidence cited by Plaintiff in support of his position demonstrates that he was terminated eight months before his Pension Plan benefits would have partially vested, and some nineteen months before they would have fully vested. The court found that this temporal proximity is not itself unusually suggestive, and Plaintiff failed to provide any other evidence tending to show Defendants' specific intent. Additionally, there is no evidence of how much money Defendants stood to save by terminating Plaintiff before his benefits either partially or fully vested and Plaintiff did not show that those who made the decision to terminate his employment knew that he was in the Pension Plan. The Court found that Plaintiff failed to state a prima facie case under Section 510, but even if he had, he entirely failed to overcome Defendants' asserted legitimate, non-discriminatory reason for his termination.

#### D. Fifth Circuit

In [\*Seal v. Maverick Claims, LLC\*, No. CIV.A. 14-245, 2015 WL 4509629 \(E.D. La. July 24, 2015\)](#), in Defendants' motion for summary judgment, they argued that Plaintiff's wrongful termination claim was preempted under ERISA. In his response, Plaintiff contended that the claim is not preempted because ERISA prohibits discharge of an employee in retaliation for exercising his rights under the statute. In their reply, Defendants averred that any 29 U.S.C. § 1140 claim fails because (1) it is untimely, (2) Plaintiff was terminated for being ineffective in his position, not in retaliation for exercising his rights under the plan, and (3) the manager who terminated Plaintiff did not know of Plaintiff's requests for documents when he decided to terminate Plaintiff; therefore, Plaintiff cannot show discriminatory intent. The court agreed with Defendants and found that Louisiana's one-year prescriptive period for wrongful termination is applicable to this claim and it is untimely. The court rejected Plaintiff's argument that Defendants' statute of limitations defense has been waived under the Federal Rules of Civil Procedure due to the fact that Defendants failed to raise it as an affirmative defense in their Answer.

In *Licon v. Nat'l Oilwell Varco, L.P.*, No. 4:13-CV-3599, 2015 WL 338867 (S.D. Tex. Jan. 26, 2015), the court granted summary judgment to Defendant on Plaintiff's ERISA § 510 retaliation claim because Plaintiff cannot establish that Defendant discriminated against him with the specific intent to interfere with his ERISA rights. Here, Plaintiff appears to allege that he was retaliated against by Defendant after he complained to upper management about another employee who modified Plaintiff's medical insurance plan without his authorization, causing calculations in his pension contributions to deviate from previous amounts and otherwise forcing him to forgo making 401(k) contributions. Plaintiff suggests that after informing Defendant of his intentions to file a lawsuit in order to stop such mismanagement, he was retaliated against under the guise of an unauthorized drug screen and alcohol breath test. The court agreed with Defendant that the record does not contain any evidence of its intention to interfere with the plaintiff's ERISA rights or to retaliate against him to prevent him from attaining any benefits to which he would have become entitled to under an employee benefit plan. The situation regarding the modification of Plaintiff's medical insurance benefits was eventually resolved, further dispelling any possible inference of intent. Even if Plaintiff could establish a prima facie case under § 510, his claim still fails because he cannot demonstrate that Defendant's articulated, legitimate, non-retaliatory reason for his discharge was merely a pretext for retaliation under ERISA. Based on Plaintiff's own admissions, he used marijuana six days prior to submitting to drug testing at Defendant's request. Accordingly, Plaintiff failed to raise a fact issue on his ERISA retaliation claim and Defendant is entitled to judgment as a matter of law.

E. Sixth Circuit

In [\*Pennington v. Engineered Packaging Servs. Co.\*, No. 1:13-CV-826, 2015 WL 2383474 \(S.D. Ohio May 19, 2015\)](#), the court granted Defendant summary judgment on Plaintiff's ERISA § 510 claim, finding that the proximity between his termination and his surgery two years prior does not support an ERISA interference claim. Plaintiff conceded that while he was employed, he received all benefits that he was entitled to, including medical leave with full pay and continuation of health insurance. The employer's stray comments about the rising costs of insurance are too general to raise a reasonable, plausible inference that the employer fired Plaintiff with intent to interfere with his medical benefits.

In [\*Hogan v. Jacobson\*, No. 3:12-CV-820-DJH, 2015 WL 1931845 \(W.D. Ky. Apr. 28, 2015\)](#), the court dismissed Plaintiff's interference claim against two LINA employees who reviewed her medical records in connection with her long-term disability claim. The court found that aside from the fact that Hogan was not employed by Defendants, she does not allege any action by either of them that is prohibited under ERISA section 1140. Plaintiff alleged that Defendants provided opinions concerning her diagnosis and treatment, including her physical and mental restrictions and limitations. One defendant concluded that there was a lack of clinical evidence to

support Plaintiff's reported symptoms. Plaintiff alleged that Defendants sought to render a diagnosis and treatment conclusion that would prevent her from becoming eligible to receive her long-term disability benefits for their own financial gain, both in terms of favorable performance reviews and in compensation. Nothing in Plaintiff's amended complaint could be read to suggest that she was discharged, fined, suspended, expelled, disciplined, or discriminated against.

In *Bellegia v. Givaudan Flavors Corp.*, No. 1:13-CV-654, 2015 WL 421985 (S.D. Ohio Feb. 2, 2015), Plaintiff alleged that Defendant terminated his employment because he had used short-term disability benefits and FMLA leave. Interrogatory responses listed all of the customer care representatives who worked at the Cincinnati location during Plaintiff's tenure, those who took FMLA or disability leave at any time, and those who have been terminated or left the company. Of the total of 69 employees, 18 took some period of FMLA or disability leave during that period; of those 18, 9 have left the company: one retired, two resigned for other jobs, one employee's position was eliminated, four resigned for personal or private reasons; Plaintiff was terminated based on performance; and one was terminated two years before Plaintiff for violating company policy. The court found that this pattern for the customer care representatives does not reflect an atmosphere of hostility or retaliation against employees who exercised their right to FMLA leave or short-term disability. The court concluded that Plaintiff has not established a genuine factual dispute that the reasons cited by Defendant for his termination are a pretext for unlawful retaliation, or interference with his FMLA rights and his ERISA-protected disability benefits.

#### F. Seventh Circuit

**Plaintiff provided an ERISA framework supported by factual allegations that make it plausible Defendant's actions were "at least" motivated by intent to frustrate Plaintiff's attainment of benefits.** [Deka v. Countryside Ass'n for People With Disabilities, Inc., No. 15-CV-2611, 2015 WL 5996337 \(N.D. Ill. Oct. 14, 2015\)](#) (Judge Amy J. St. Eve). The court denied dismissal of ERISA § 510 interference claim where Plaintiff alleged that: she participated in Countryside's long-term disability coverage and group health insurance plans during her five year tenure with the company; she was qualified for her position, identifying a number of occasions on which Countryside recognized and commended her for her contributions to the organization; Countryside learned about Plaintiff's multiple sclerosis no later than February 27, 2012 when she submitted her FMLA leave application; on February 28, 2012, Countryside discontinued her health insurance; and, on March 30, 2012, terminated her employment "with the specific intent" of preventing her from using employment-related health insurance benefits. Plaintiff also identified a number of comments Countryside's directors made to her regarding the costliness of covering serious illnesses and their disapproval of FMLA leave.

In [Rowlands v. United Parcel Serv., Inc., No. 1:13-CV-59 RLM, 2015 WL 728296 \(N.D. Ind. Feb. 19, 2015\)](#), Plaintiff brought suit against her former employer, United Parcel Service, under Title VII, the ADA, the ADEA, and ERISA after her employment was terminated. She alleged that UPS discriminated and/or retaliated against her and denied her benefits to which she would have been entitled in the future based on her sex, age, and/or disability (an unspecified knee injury), and that similarly situated male employee were treated more favorably with respect to the enforcement of the company's policies and procedures and disciplinary issues. UPS moved to dismiss the ADA and ERISA claims under Fed.R.Civ.P. 12(b) (6). The court dismissed the ERISA claim, finding that Plaintiff's amended complaint does not contain factual allegations that would support a plausible claim under a retaliation or interference violation. Plaintiff does not allege that UPS terminated her employment based on a previous exercise of an ERISA right, nor provide any factual basis for believing that UPS's stated reason for discharging her was actually a pretext to avoid paying the cost of benefits that Plaintiff might have been entitled to at some undisclosed point in the future. "At bottom, her allegations are simply that she would have gotten some benefits if she hadn't been fired, so UPS must have fired her to keep her from getting those benefits."

G. [Eighth Circuit](#)

H. [Ninth Circuit](#)

**Plaintiff established prima facie case of ERISA interference to defeat summary judgment.** [Hannan v. Business Journal Publications, Inc., et al., No. 3:14-CV-00831-SB, 2015 WL 7720496 \(D. Or. Nov. 30, 2015\)](#) (Judge Michael H. Simon). The district court adopted Magistrate Judge Beckerman's findings and recommendation denying Defendants' motion for summary judgment with respect to Hannan's ERISA interference claim. Defendants argued that Hannan failed to establish a prima facie case of ERISA interference and failed to raise genuine issues of material fact regarding whether Defendants' stated reasons for terminating Hannan's employment were pretextual. Hannan responded that she established a prima facie case of ERISA interference because she raised genuine issues regarding whether: (1) she was qualified for her position; and (2) the circumstances of her discharge give rise to an inference of discrimination. Her evidence includes the fact that although Defendants claim they eliminated Hannan's position, Defendants hired someone else to perform her previous duties. She also presented evidence that Defendants were concerned about the cost of retiree health insurance and that Defendants terminated Hannan eighteen months before she would otherwise have qualified for retiree health insurance benefits.

[Johnson v. Wyndham Vacation Ownership, Inc., No. C15-0766RSL, 2015 WL 7431421 \(W.D. Wash. Nov. 20, 2015\)](#) (Judge Robert S. Lasnik). After learning that Plaintiff would need 2-3 months of physical therapy, Defendant changed Plaintiff's employment status to part-time such that he became ineligible for medical benefits. The court found that whether Defendant acted for the purpose of avoiding the payment of anticipated benefits or whether it was simply applying established corporate policy when it recharacterized plaintiff to part-time status and terminated his healthcare benefits cannot be determined in the context of this motion for summary judgment. Thus, the court denied Plaintiff's motion.

In [Cole v. Permanente Med. Grp., Inc., No. 13-15952, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 3982534 \(9th Cir. July 1, 2015\)](#), the Ninth Circuit affirmed the district court's grant of summary judgment in favor of Defendant on Plaintiff's Section 510 claim. The court found that Plaintiff was terminated because she knowingly violated Permanente's confidentiality policy by accessing her then-husband's medical records 12 times and another person's records more than once. Plaintiff did not present any evidence that showed Defendant's articulated motive for terminating her was pretext for a discriminatory motive or that the person who made the decision to terminate her employment was aware that the termination would reduce Plaintiff's pension benefits or disqualify Plaintiff from any benefits.

In [Orfano v. NV Energy, Inc., No. 2:12-CV-00970-GMN-PA, 2015 WL 430425 \(D. Nev. Feb. 3, 2015\)](#), the court granted summary judgment to Defendant on Plaintiff's Section 510 claim, where Plaintiff alleged that Defendant terminated his employment to avoid the expense of contributions to his 401(k) and pension plans. Plaintiff claimed that four other high level employees were terminated around the same time as Plaintiff in a cost-cutting measure to make Defendant more attractive to potential suitors for acquisition. The court found that Plaintiff's assertions and supporting evidence fail to demonstrate that Defendant acted with a specific intent to interfere with his ERISA rights. The court found that Plaintiff's argument is further weakened by Defendant's assertion with supporting factual evidence that it hired individuals to replace each of the four other former employees and all the replacements were eligible for the same benefits, and all participated in the Company's 401(k) and pension plans. The court concluded that Plaintiff failed to establish a prima facie case of discrimination, but even proceeding with the remaining analysis under the *McDonnell Douglas* framework, Defendant articulated a legitimate non-discriminatory reason for terminating Plaintiff's employment. Specifically, Defendant terminated Plaintiff upon violations of company policy after an independent investigation substantiated a female employee's complaint about differential treatment by Plaintiff based upon her gender.

I. Eleventh Circuit

**District court erred by finding that employee was not qualified for his position in determining that employee did not establish a prima facie case of ERISA interference.**

[Liebman v. Metro. Life Ins. Co., No. 14-13197, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 9259224 \(11th Cir. Dec. 18, 2015\)](#) (Before ED CARNES, Chief Judge, MARTIN, Circuit Judge, and THAPAR,\* District Judge). The Eleventh Circuit vacated and remanded the district court's grant of summary judgment in favor of MetLife on Liebman's ERISA interference claim under 29 U.S.C. § 1140. To establish a prima facie ERISA case, an employee must show that he: (1) was entitled to ERISA protection; (2) was qualified for his position; and (3) was discharged under circumstances that give rise to an inference of discrimination. The district court held that Liebman was not qualified for his position at MetLife but the Eleventh Circuit disagreed. It held that the replacement employee was substantially younger than Liebman, and nine years in virtually same position, and nearly three decades with employer, was long enough to support inference that Liebman was qualified for his job. The district court did not address whether Liebman was discharged under circumstances that give rise to an inference of discrimination. The court noted that Liebman attested that his supervisor made several comments suggesting he was jealous of Liebman's pension plan. Although MetLife contended his declaration contradicted his deposition testimony and had moved to strike a witness's sworn affidavit, the district court did not rule on these issues. The Eleventh Circuit remanded the matter to district court to determine the admissibility of the declarations before determining whether Liebman can establish a prima facie case under ERISA.

XX. *Retiree Medical*

A. Supreme Court

*M & G Polymers USA, LLC v. Tackett*, No. 13-1010, \_\_\_S.Ct.\_\_\_, 2015 WL 303218 (U.S. Jan. 26, 2015) involved a class action brought by retirees, their spouses and dependents, against M&G Polymers USA, LLC ("M&G"), asserting claims under the Labor Management Relations Act (LMRA) and the Employee Retirement Income Security Act (ERISA) arising from M&G's alleged violation of collective-bargaining agreements (CBA) granting the retirees lifetime contribution-free health care benefits. The retirees' claimed that a promise in the agreement that they will receive a full Company contribution towards the cost of health care benefits created a vested right to such benefits that continued beyond the expiration of the agreement. The relevant language in the master collective-bargaining agreement read: "Effective January 1, 1998, and for the duration of this Agreement thereafter, the Employer will provide the following...." The 6<sup>th</sup>

Circuit Court of Appeals applied the *Yard–Man* inferences to conclude that, in the absence of extrinsic evidence to the contrary, the provisions of the contract indicated an intent to vest retirees with lifetime benefits. The U.S. Supreme Court held that no inferences from the context of labor negotiations were to be applied in determining whether CBAs created a vested right to lifetime contribution-free health care benefits, abrogating *International Union, United Auto., Aerospace, and Agr. Implement Workers of America (UAW) v. Yard-Man, Inc.*, 716 F.2d 1476, *Policy v. Powell Pressed Steel Co.*, 770 F.2d 609, *Noe v. PolyOne Corp.*, 520 F.3d 548, *Cole v. ArvinMeritor, Inc.*, 549 F.3d 1064, and *Armistead v. Vernitron Corp.*, 944 F.2d 1287. The Court vacated and remanded the district court’s entry of a permanent injunction requiring M&G to restore retirees’ benefits. Justice Thomas delivered the opinion for a unanimous Court. Justice Ginsburg filed a concurring opinion, in which Justices Breyer, Sotomayor, and Kagan, joined.

In *Yard–Man*, the 6th Circuit found a provision governing retiree insurance benefits ambiguous as to the duration of those benefits and purported to apply ordinary contract law to resolve the ambiguity. First, the court inferred from the existence of termination provisions for other benefits that the absence of a termination provision specifically addressing retiree benefits expressed an intent to vest those benefits for life. The court applied the rule that contracts should be interpreted to avoid illusory promises, reasoning that, absent vesting, the promise would be illusory for the subset of retirees who would not become eligible for those benefits before the contract expired. Finally, the court relied on “the context” of labor negotiations to resolve the ambiguity, inferring that the parties would have intended such benefits to vest for life because they are not mandatory subjects of collective bargaining; are typically understood as a form of delayed compensation, and are keyed to the acquisition of retirement status. The 6<sup>th</sup> Circuit concluded that these contextual clues outweighed any contrary implications derived from a routine duration clause.

The Court found that the inferences applied in *Yard–Man* and its progeny do not represent ordinary principles of contract law, rather, they rely on the court’s suppositions about the intentions of parties negotiating retiree benefits. Refusal to apply general durational clauses to provisions governing retiree benefits distorts an agreement’s text and conflicts with the principle that a written agreement is presumed to encompass the whole agreement of the parties. The Court also found that the 6<sup>th</sup> Circuit misapplied the illusory promises doctrine by applying it to provisions that it deemed only “partly illusory” for not benefitting all retirees. The use of this doctrine is inappropriate in the context of collective-bargaining agreements, which often include provisions inapplicable to some category of employees. Finally, the Court found that the 6<sup>th</sup> Circuit also failed to consider other traditional contract principles, including the rule that courts should not construe ambiguous writings to create lifetime promises and the rule that contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement. The Court believed that *Yard–Man* and its progeny affected the outcome in this case and ordered that the 6<sup>th</sup> Circuit should be the first to review the agreements under ordinary principles of contract law.

The concurring opinion instructed the 6<sup>th</sup> Circuit on remand to examine the entire agreement to determine whether the parties intended retiree health-care benefits to vest. Because the retirees have a vested, lifetime right to a monthly pension, a provision stating that retirees “will receive” health-care benefits if they are “receiving a monthly pension” is relevant to this examination. The concurrence also found relevant a “survivor benefits” clause instructing that if a retiree dies, her surviving spouse will “continue to receive [the retiree’s health-care] benefits ... until death or remarriage.” If, after considering all relevant contractual language in light of industry practices, the Court of Appeals concludes that the contract is ambiguous, it may turn to extrinsic evidence.

B. First Circuit

In *Teamsters Local Union No. 340 v. Eaton*, No. 2:13-CV-264-JDL, 2015 WL 413864 (D. Me. Jan. 30, 2015), the court considered whether Defendants’ interests in their health and welfare benefits as established by the 2001 plan were vested and thus could not be reduced or eliminated by the Local’s new executive board in 2013. The court found that Defendants’ interests were not vested and granted Plaintiff’s motion for judgment.

C. Second Circuit

**Retirement plan’s definition of “normal retirement age” as five years of service violates ERISA.** In [Laurent v. PricewaterhouseCoopers LLP](#), No. 14-1179, F.3d, 2015 WL 4477191 (2d Cir. July 23, 2015), Plaintiffs, former employees of PricewaterhouseCoopers LLP (“PwC”), sued the company and its retirement plan, alleging that they were denied “whipsaw payments” because the plan defines “normal retirement age” as five years of service (which coincides with the time at which employees vest in the plan). Whipsaw payments guarantee that plan participants who take distributions in the form of a lump sum when they terminate employment will receive the actuarial equivalent of the value of their accounts at retirement. In 2006, Congress passed the Pension Protection Act, which provided that plans did not fail to satisfy ERISA solely because they did not provide actuarial equivalence for participants who terminated employment before normal retirement age and took a lump-sum payment, and thus eliminated mandatory whipsaw payments. The distributions at issue in this case predate the passage of the Pension Protection Act so the Act does not apply to this case. The district court denied Defendants’ motion to dismiss and held that the plan violated ERISA because (1) five years of service is not an “age” under ERISA, (2) the plan violated ERISA’s anti-backloading rules, and (3) the plan’s documents violated ERISA’s notice requirements. The Second Circuit held that the plan’s definition of “normal retirement age” as five years of service violates ERISA not because five years of service is not an “age,” but because it bears no plausible relation to “normal retirement,” and is therefore inconsistent with the plain meaning of the statute. ERISA defines “normal retirement age” as the earlier of “the time a plan participant attains normal

retirement age under the plan” or the statutory default of age 65 or the fifth anniversary of plan participation. The court reasoned that the repetition of the phrase, “normal retirement age,” in § 3(24)(A) suggests that “the time” that a plan establishes as its normal retirement age must have some reasonable relationship to the age at which participants would normally retire. Giving the terms “normal” and “retirement” their ordinary meaning, “normal retirement” does not suggest anytime the employer wishes, or whenever an employee leaves a company after a few years on the job. The Second Circuit affirmed the district court without reaching the alternative reasons for denying the motion.

#### D. Sixth Circuit

**Supreme Court decision in *Tackett* does not change previous determination that surviving spouses of Caterpillar retirees are entitled to lifetime health benefits.** [Kerns v. Caterpillar Inc., No. 3: 06-CV-1113, F.Supp.3d , 2015 WL 7283142 \(M.D. Tenn. Nov. 17, 2015\)](#) (Judge Aleta Trauger). The court in this matter previously decided that Caterpillar breached its contractual obligation to provide lifetime health benefits to surviving spouses of Caterpillar retirees at no cost. Following a series of motions and determinations, both parties filed motions for reconsideration which the court denied. Caterpillar moved the court to reconsider its prior rulings on the basis that, in *M & G Polymers USA, LLC v. Tackett*, 135 S.Ct. 926, 190 L.Ed.2d 809 (2015), the Supreme Court abrogated *Int’l Union, United Auto., Aerospace, & Agr. Implement Workers of Am. (UAW) v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir.1983), upon which this court relied in its previous rulings. The court reiterated its previous conclusion that the various provisions of the contracts at issue in this case, when read together, demonstrate unambiguously the parties’ intention for the surviving spouses to have lifetime “no cost” health benefits. Even if there is ambiguity as to the parties’ intentions, the extrinsic evidence before the court overwhelmingly supports the court’s conclusion. The court found nothing in the Supreme Court’s *Tackett* decision changes its previous rulings in this matter. On Plaintiff’s motion to reconsider, the court found no basis for reconsideration of its conclusion that, pursuant to *Reese v. CNH Am. LLC*, 574 F.3d 315 (6th Cir. 2009) (standing for the proposition that, even if the retiree has a vested right to lifetime health benefits from his employer, unless there is some exceptional language that dictates that benefits can “never vary,” that retiree is entitled to lifetime benefits subject to reasonable changes), Caterpillar’s imposition of additional deductibles, co-insurance, and increased out-of-pocket costs were “reasonable” charges and, as such, permissible under ERISA and the LMRA.

**Upon reconsideration, retirees are entitled to vested retiree health insurance benefits.** [Reese, et al. v. CNH Industrial N.V. & CNH Industrial America, LLC, No. CV 04-70592, F.Supp.3d , 2015 WL 6865964 \(E.D. Mich. Nov. 9, 2015\)](#) (Judge Patrick J. Duggan). In a matter involving retiree health insurance benefits, the court granted Plaintiff’s motion for

reconsideration, vacated the court's September 28, 2015 Judgment, denied Defendants' motion for summary judgment, granted Plaintiffs' motion for summary judgment, and denied as moot Plaintiffs' motion to strike. On reconsideration, the court found that CNH incorrectly asserted that the only conclusion to be reached once the *Yard-Man* inferences are removed is that the parties intended Plaintiffs' retiree health insurance benefits to terminate with the 1998 Central Agreement. The court explained that the Supreme Court's opinion in *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926 (2015) did not create new rules for construing collective bargaining agreements. Instead, *Tackett* simply reaffirmed that collective bargaining agreements are interpreted "according to ordinary principles of contract law...." CNH failed to apply those ordinary principles of contract law to the relevant agreements in its motion for summary judgment, a mistake the court repeated in reaching its September 28, 2015 decision. Applying the ordinary principles of contract law, the court concluded that Plaintiffs are entitled to vested retiree health insurance benefits.

**Post-*Tackett* motion for reconsideration results in reversal of previous finding in favor of class of retirees.** [Zino v. Whirlpool Corp., No. 5:11CV01676, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 6559579 \(N.D. Ohio Oct. 30, 2015\)](#) (Judge Benita Y. Pearson). Defendants moved for reconsideration based on the Supreme Court's decision in *Polymers USA, LLC v. Tackett*, 524 U.S., 135 S.Ct. 926, 190 L.Ed.2d 809 (2015). The court granted in part and denied in part Defendants' motion. Upon reconsideration, the court abandoned employment of the *Yard-Man* presumption, related contract interpretation principles, and progeny, including any carried forward effect. Relying on ordinary principles of contract law to ascertain the meaning of the CBAs at issue, the court maintained its ruling as to three of four subclasses (although for two of those classes the court applied different reasons). With respect to the subclass of retirees who retired after April 18, 1983, but before January 1, 1993, the court found that they were not promised company-paid health benefits under any of the applicable welfare plans.

E. D.C. Circuit

**Claim for equitable relief dismissed where court determined that there was no cognizable harm from any failure to comply with ERISA's disclosure requirements.** In [Perry v. Int'l Bhd. of Teamsters, No. 14-CV-484 \(TSC\), \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 4329769 \(D.D.C. July 15, 2015\)](#), Plaintiff filed suit against his former employer challenging the denial of certain retirement benefits under ERISA and for payment of unused vacation time under state law. Plaintiff's claim for pension and retirement health benefits was denied because his time of service was short by six days. He was directed to secure employment for six days to "bridge his time," a practice which Plaintiff alleged his employer "consistently" permitted. However, he was later informed that his retiree health benefits application was denied. The denial letter indicated that Plaintiff could appeal to the Administrative Committee but did not contain the requisite ERISA

documents or detail Plaintiff's rights as required under 29 C.F.R. § 2560.503-1(h)(2)(ii). It did, however, refer to the Teamster Benefit Trust's Guide to Your Benefits, specifically to excerpts setting forth the length of service requirements for lifetime retirement coverage. Plaintiff sent a letter on August 1, 2012 to John Slatery (Director of Benefit Trust Administration) confirming an April 9 telephone call and specifically "confirming that he was informed by [sic] Mr. Slatery was going to forward his appeal to the Administrative Committee." Approximately one year later, Plaintiff's counsel requested "any and all documentation and policies and determinations related to the award of bridge time to union members to enable them to qualify for retiree benefits" from the IBT and explicitly indicated that Plaintiff was not filing an appeal. In response, the IBT sent copies of the April 6 and August 1 letters but did not send any documents required by the ERISA regulations.

Count I of the Second Amended Complaint sought equitable relief based on IBT's breach of its obligations under ERISA to disclose certain plan documents and procedures, which interfered with Plaintiff's ability to seek review of the denial of his benefits. It also sought reformation of the plan to make Plaintiff eligible for benefits if he served for at least as much time as any individual who received retirement benefits, regardless of whether that individual should have received them. The court found that the employer is not the plan administrator and is not obligated to provide plan documents or provide Plaintiff with the requisite information about seeking review of the benefits determination. Even if the court were to accept Plaintiff's argument that because IBT communicated with Plaintiff about the denial of his benefits, IBT held itself out as a fiduciary with respect to the benefits determination and was therefore obliged to provide the determination information, Plaintiff has shown no harm arising from the failure to make the requisite disclosures. With respect to the reformation claim, the court found that reformation is "used to prevent fraud," and is reserved "for those situations in which the moving party demonstrates that reformation is necessary to either correct a mistake or prevent fraud." Here, Plaintiff did not base his departure date on any representation that he would receive benefits despite his ineligibility. Further, Plaintiff did not identify any mistake, mutual or otherwise, in the drafting or application of the eligibility rules. Any ongoing practice by the IBT/TBT of bending or ignoring the eligibility rules could not amount to an amendment of those rules since amendment may be accomplished only in accordance with the plan's amendment procedures. Reformation or estoppel are not proper to accomplish what the law specifically prohibits. The court dismissed Count I since Plaintiff "failed to point to cognizable harm he suffered from the purported failure to comply with ERISA's disclosure requirements" and Count II for no independent basis for the court to exercise jurisdiction over that claim.

## **XXI. Severance Benefit Plans**

A. Second Circuit

[Anderson v. Xerox Corp.](#), No. 14-2849-CV, [Fed.Appx.](#) [2015 WL 5023929](#) (2d Cir. Aug. 26, 2015), a matter involving a claim against a retirement plan, the Second Circuit affirmed the district court's judgment in favor of Defendants on the ground that when Plaintiff was terminated from employment by Xerox in 2002, he executed an agreement relinquishing "any and all claims of any kind, known or unknown"—including ERISA claims-arising out of "facts which [had] occurred prior to the date of [the] Release." Plaintiff received a severance payment totaling approximately \$47,000 for his release of claims. Relying on *Frommert v. Conkright*, 535 F.3d 111, 120–23 (2d Cir.2008), *rev'd and remanded on other grounds*, 559 U.S. 506 (2010), the court found such release enforceable.

**Severance policy constitutes an ERISA "plan, fund, or program" under § 1002(1).** In [Okun v. Montefiore Med. Ctr.](#), No. 13-3928-CV, [F.3d](#) [2015 WL 4385294](#) (2d Cir. July 17, 2015), the Second Circuit vacated and remanded district court's dismissal of Plaintiff's claim for severance benefits because of its erroneous conclusion that the severance policy at issue was not an employee welfare benefit plan under ERISA. In this matter Plaintiff alleged that his for-cause termination was a pretext for his employer to interfere with his right to severance payments under the Policy and ERISA. The parties dispute whether the Policy is adequately alleged to constitute the kind of undertaking to pay severance benefits that can be described as a "plan, fund, or program," as that phrase is used in the definition of "employee welfare benefit plan." In determining whether an ERISA plan exists, the court considers three non-exclusive factors: (1) whether the employer's undertaking or obligation requires managerial discretion in its administration; (2) whether a reasonable employee would perceive an ongoing commitment by the employer to provide employee benefits; and (3) whether the employer was required to analyze the circumstances of each employee's termination separately in light of certain criteria. The court concluded that, on the facts alleged in the complaint, the Policy falls within the meaning of the phrase "any plan, fund, or program" because it represents a multi-decade commitment to provide severance benefits to a broad class of employees under a wide variety of circumstances and requires an individualized review whenever certain covered employees are terminated. The employer assumed the responsibility to pay benefits on a regular basis, and thus faces periodic demands on its assets that require long-term coordination and control.

In [Andrews v. Realogy Corp. Severance Pay Plan for Officers](#), No. 13-CV-8210 RA, [2015 WL 736117](#) (S.D.N.Y. Feb. 20, 2015), Plaintiff claimed he was entitled to severance benefits under the Defendant Plan because his employment transfer to a business that purchased his employer

constituted an “involuntary termination.” The Plan provides that an employee is eligible for severance pay if, in relevant part:

(a) you are involuntarily terminated for ...

elimination or discontinuation of your job or position, if you are not offered a comparable position with an Employer, a third party or an outsourcing company. Comparability shall be determined in the sole and absolute discretion of the Plan Administrator, and such analysis may include without limitation the following as compared with your current position: (1) the location of the position offered; (2) the total compensation of the position offered including base pay, variable pay and other benefits; and (3) the primary duties and responsibilities of the position offered....

Plaintiff primarily argued that he was due severance payments because he was not offered a “comparable position.” Specifically, Plaintiff contended that the new employer offered lesser in the way of severance benefits and bonuses and that taking into consideration “total compensation” in its discretionary determination of comparability, the Plan Administrator should find that the employment offer was not comparable to his employment. In finding that Plaintiff was offered comparable employment, the Plan Administrator found that the new position was in the “same location” as the previous position; that Plaintiff had “the same duties and responsibilities he had prior to the sale”; that the “base pay was also the same”; and that “most of the benefits provided by the new company were comparable to the benefits Plaintiff had prior to the sale. The court found that the Plan Administrator considered all of the data available at the time of the offer, including comparable bonus eligibility through 2010 and comparable severance eligibility through mid-2011. The court further found that the Plan Administrator was under no obligation to assume that the terms of Plaintiff’s future employment over some indeterminate “longer period” would be worse than his employment at the old employer and therefore find the employment not to be comparable. Under the arbitrary and capricious standard of review, the court could not say that that decision was without reason, unsupported by substantial evidence or erroneous as a matter of law.

In *Gilman v. Marsh & McLennan Companies, Inc.*, No. 10-CV-8158 JPO, 2015 WL 321827 (S.D.N.Y. Jan. 26, 2015), Plaintiffs were terminated following the New York Attorney General’s (“NYAG”) investigation of Marsh’s contingent commission practices on the suspicion that they violated antitrust laws, securities laws, and other New York business. The NYAG ultimately filed a civil complaint against Marsh, which was eventually dismissed. Shortly after the filing of the complaint, Marsh suspended Plaintiffs with pay. They were fired after refusing to participate in interviews with Marsh’s attorneys and NYAG. Shortly after being fired, Plaintiffs were criminally indicted in New York Supreme Court and were acquitted of all charges except one. That conviction was subsequently vacated. The parties vigorously disputed whether Marsh fired

Plaintiffs “for cause” or fired them merely to appease the NYAG. The court found that even if Marsh did fire them solely for the purpose of appeasing the NYAG, they would not be entitled to severance pay under the Severance Plan because they do not meet the requirements of subsection (i): they were not terminated as part of a downsizing, restructuring, or the closing of a facility; they were not determined to lack the skills to do their jobs; and their positions were not eliminated.

B. Third Circuit

In [\*Schweikert v. Baxter Healthcare Corp.\*, No. CIV.A. 12-5876 FLW, 2015 WL 4578443 \(D.N.J. July 29, 2015\)](#), Plaintiff brought several claims against his former employer, including a claim for benefits under the company’s ERISA-governed Severance Plan. On abuse of discretion review, the court found that an abundance of evidence exists to justify the Administrative Committee’s decision denying Plaintiff severance pay on the basis of his termination for accepting employment with Ikaria, an unrelated company. First, the court found that the Severance Plan permits a denial of severance pay even if an employee does not breach a specific provision of the Employment Agreement or the Code of Conduct. Second, the Code of Conduct identifies “Time Conflicts of Interest” as conflicts that “may happen when you are engaged in a second job or business of your own that may conflict with your responsibilities with Baxter,” and directs employees to “disclose any apparent or actual conflicts to management. When Baxter approves an apparent or actual conflict, the approval decision must be documented.” The court found that Defendant had ample reason to conclude that Plaintiff’s dual, full-time employment with Baxter and Ikaria posed at least an apparent time conflict of interest for Baxter and Plaintiff did not disclose his employment with Ikaria to any Baxter management officials.

In [\*Becknell v. Severance Pay Plan of Johnson & Johnson & U.S. Affiliated Companies\*, No. CIV.A. 13-4622 FLW, 2015 WL 3823325 \(D.N.J. June 19, 2015\)](#), Plaintiff applied for severance benefits three years after he left work due to disability and began receiving long-term disability benefits. The Plan denied the claim, finding that his termination from employment did not result from one of the severance events enumerated in Article 4.1a of the Plan. This provision provided benefits to regular full-time or part-time employees who are terminated due to position elimination; an inability to meet the requirements of his or her position (as determined by management); reduction in force; or for such other reasons as the Pension Committee may, in its sole discretion, deem appropriate.” The Plan also determined that Plaintiff’s loss of LTD eligibility in 2009 could not constitute a Severance Event resulting in eligibility for plan benefits because Plaintiff’s employment had already ended. The court found that Defendants’ interpretation of the Severance Plan, which excludes employees who have received long-term disability payments from also receiving severance benefits, is reasonable and not arbitrary and capricious. The court denied the motion for class certification as moot.

In [Becknell v. Severance Pay Plan of Johnson & Johnson & U.S. Affiliated Companies, No. CIV.A. 13-4622 FLW, 2015 WL 3823325 \(D.N.J. June 19, 2015\)](#), although Defendant did not issue a timely decision on Plaintiff's appeal of the denial of severance plan benefits, the court declined to apply *de novo* review and the rationale of *Gritzer v. CBS, Inc.*, 275 F.3d 291 (3d Cir. 2002) to Plaintiff's claim because in *Gritzer* there was no evidence in the record that the defendant committee made any determination, but here, Defendants' Claims Administrator made an initial determination providing the reasons for denying Plaintiff's severance request, and it ultimately did decide Plaintiff's appeal (albeit late). Because the record included both the decisions of the Committee and the Claims Administrator and their construction of the Severance Plan, the court found that it should defer to the analysis conducted by the administrator.

In [Felker v. USW Local 10-901, No. CIV.A. 13-7101, 2015 WL 1867910 \(E.D. Pa. Apr. 23, 2015\)](#), the Severance Plan established pursuant to an agreement between Sunoco and Plaintiffs' Union, gave the Plan Administrator *or his delegate* discretionary authority for administering the terms and provisions of the Plan. Sunoco, Inc. was named as the Plan Administrator and through a Board resolution it designated its CEO to make decisions regarding the Plan. The CEO then executed an Officer's Certificate appointing Vincent Brigandi as Plan Administrator. Plaintiffs challenged this delegation but the court found that no authority supports their position that the language in the Plan is insufficient to allow Sunoco to delegate its discretionary authority to administer the Plan. Further, ERISA does not require language of express delegation. If Congress intended that express procedures for delegation be mandatory, it would not have used the word "may" in the pertinent provision of ERISA, 29 U.S.C. § 1105(c)(1)(B). Because the court found that Sunoco's delegation of discretionary authority to administer the Plan to Brigandi was proper, his decision to deny severance benefits is subject to the arbitrary and capricious standard of review.

#### C. Fourth Circuit

In [Blanch v. Chubb & Sons, Inc., No. CIV. CCB-12-1965, F.Supp.3d , 2015 WL 5090477 \(D. Md. Aug. 28, 2015\)](#), a lawsuit involving a host of allegedly unpaid benefits following Plaintiff's termination from employment, the court granted Plaintiff's motion to reconsider its previous decision. The court considered two ERISA issues. The first relates to Plaintiff's claim for the denial of severance benefits. The Committee deciding Plaintiff's claim denied it because he was discharged for cause, including "fraud against the Company," as well as "violation of the Company's internal policies." This was based on evidence indicating that Plaintiff had accepted meals from contractors from whom he approved (and in one case solicited) inflated estimates of claims. The court rejected Plaintiff's argument that the Committee's initial denial of benefits was

impermissibly conclusory, insofar as it stated that he had been terminated for cause without reviewing the evidence underlying that determination. The court found that it was sufficient that the Committee initially explained that Blanch had been denied benefits because he had been terminated for cause, rather than some other ground of decision. The Committee did not need to extensively outline the facts supporting the termination. The court granted summary judgment in favor of Defendant on this claim. The second ERISA claim involves a statutory penalty claim under 29 U.S.C. § 1132(c)(1) for Defendant's alleged failure to provide Plaintiff with access to the severance plan documents for more than two years. The court found that Plaintiff's demand letter did not include a request for plan documents and that Defendant did respond to his request, which was not made until 30 days prior to the production of documents.

D. Fifth Circuit

[\*Napoli v. Johnson & Johnson, Inc.\*, No. 14-31000, Fed.Appx. \\_\\_\\_, 2015 WL 5203002 \(5th Cir. Sept. 8, 2015\).](#) The Fifth Circuit reversed and remanded the district court's grant of summary judgment to Defendant, finding that the plan administrator's denial of post-termination severance benefits was not supported by substantial evidence. The record did not contain any personnel records or contemporaneous employment documents showing that Plaintiff actually was fired for a "Group I violation" or for making improper expenditures. "We are aware of no case, and Johnson & Johnson does not provide one, holding that a single, cursory, post-termination letter—one that fails to detail the alleged violation or cite to contemporaneous accounts of the violation—constitutes substantial evidence."

E. Seventh Circuit

F. Ninth Circuit

In *Gale v. EIX Severance Plan for Nonrepresented Employees*, No. SACV 14-00044-JLS, 2015 WL 93441 (C.D. Cal. Jan. 7, 2015), the court granted summary judgment in favor of Defendants in this action where Plaintiff challenged his denial of severance benefits under the EIX Severance Plan for Nonrepresented Employees (the "Plan"). Southern California Edison, the Plan's sponsor, operates the San Onofre Nuclear Generating Station ("SONGS"), where Plaintiff previously worked. The SONGS 2012 Employee Requested Severance Program ("SERSP") provided severance benefits to eligible employees who were accepted for participation. To be eligible for benefits under the Plan through the SERSP, an individual had to be a SONGS employee at the time the SERSP was announced on September 24, 2012. In addition, an employee had to have been terminated from employment while the Plan was in effect. Employees also had to apply to participate in the SERSP within the application period of September 27, 2012 to October 12, 2012. Another requirement for eligibility was that an

employee had to be designated as “Surplus,” that is, selected for termination by his Participating Employer as part of, *inter alia*, a reduction in force. Before the application period, Plaintiff requested a retirement benefit commencement date of October 1, 2012 and September 30, 2012 as his last day of work, but later changed his last day of his employment from September 30, 2012 to September 4, 2012. Defendants denied Plaintiff participation in the SERSP because: (1) he was not a full-time employee and was not designated as Surplus; and (2) he did not meet the definition of Surplus as defined in the Plan.

With respect to the standard of review the court noted that where members of a plan administrator are employees of a large corporation, the conflict of interest is minor if the effect of the disputed claim on the company’s operating results is immaterial. Here, SCE had operating revenue of \$12.56 billion in 2013 and Plaintiff’s claim would cost the company roughly \$130,000. Thus, Plaintiff’s claim for severance benefits could not have seriously impacted SCE’s bottom line. Because of this, the court employed only a low-level of additional skepticism in applying the abuse of discretion standard.

The court found that Defendants’ denial of benefits was not an abuse of discretion. Plaintiff alleged that the Committee did not adequately investigate his claim because it delegated the responsibility for making initial claim determinations to HR Operations, which also assisted the Committee in processing Plaintiff’s appeal. The court found that the Committee engaged in a meaningful dialogue with Plaintiff, adequately and independently investigated his allegations, and found them to be without merit. In sum, the court found that the evidence points to the single conclusion that Plaintiff was simply not eligible to participate in the SERSP for a number of reasons.

G. Eleventh Circuit

XXII. *State Bans on Discretionary Clauses*

A. Fifth Circuit

In [\*Ravannack v. United Healthcare Ins. Co.\*, No. CIV.A. 14-2542, 2015 WL 2354186 \(E.D. La. May 15, 2015\)](#), the court denied Defendant’s summary judgment motion on the standard of review. The plan at issue contained a “Discretionary Clause Amendment,” which deleted almost every reference to Defendant’s discretion. The court found that Texas state law prohibits the inclusion of discretionary clauses in insurance policies. The court noted that nearly half of all states either ban or restrict the use of discretionary clauses in insurance policies and every federal decision that the court could locate has enforced state law bans on discretionary clauses against ERISA plans. In light of this, the court determined that the “Discretionary Clause Amendment” was intended to bring the plan in line with Texas state law banning discretionary clauses. The

court stated its inclination to hold that, pursuant to Texas law, the plan does not grant “discretionary authority to determine eligibility for benefits or to construe the terms of the plan,” but because Plaintiff made no motion on the standard of review and the grounds identified by the court were not fully briefed by the parties, the court gave Defendant an opportunity to file a brief.

## B. Sixth Circuit

In [\*Breland v. Liberty Life Assur. Co. of Boston\*, No. 14-CV-10508, 2015 WL 1132948 \(E.D. Mich. Mar. 12, 2015\)](#), the court found that Liberty Life’s action in sending the policy to Plaintiff’s counsel did not meet the definition of delivering the insurance policy to a person in the State of Michigan and, thus, Michigan’s anti-discretionary clause regulation does not void the policy’s discretionary clause. The court determined that the appropriate standard of review is “arbitrary and capricious.”

In [\*Hess v. Metro. Life Ins. Co.\*, No. 13-CV-10696, 2015 WL 669409 \(E.D. Mich. Feb. 17, 2015\)](#), the Summary Plan Description attached to the Certificate of Insurance contains a provision granting discretionary authority to the Plan Administrator and other Plan fiduciaries. Plaintiff argued that Mich. Admin. Code R. 500.2202, entitled “Insurance Policy Forms—Discretionary Clauses” and in effect as of July 1, 2007, prohibits the enforcement of discretionary clauses in any part of an ERISA plan. The rule states in relevant part that on or after July 1, 2007, “an insurer shall not issue, advertise, or deliver to any person in this state a policy, contract, rider, indorsement, certificate, or similar contract document that contains a discretionary clause.” *Id.* at (2)(b). The rule further states that on or after July 1, 2007, “a discretionary clause issued or delivered to any person in this state in a policy, contract, rider, indorsement, certificate, or similar contract document is void and of no effect.” *Id.* at (2)(c). The court explained that an ERISA Plan or SPD is not among the documents subject to approval by the Commissioner of Michigan’s Office of Financial and Insurance Services (“Commissioner”). Here, the Commissioner objected to a discretionary clause in the long-term disability insurance policy form, # G.24303, which read, “MetLife in its discretion has authority to interpret the terms, conditions, and provisions of the entire contract. This includes the Group Policy, Certificate and any Amendments.” The court found that Plaintiff does not contend, nor is there any evidence showing, that # G.24303 was an ERISA SPD. The court further found that the Commissioner did not reach the discretionary clause in the SPD. Accordingly, the court applied the arbitrary and capricious standard to this case, based on the reservation of discretionary authority reserved to Defendant in the SPD.

C. Eighth Circuit

D. Ninth Circuit

**Grant of discretion in SPD and ASA is not enforceable as a plan term and is invalidated by Washington State law; on *de novo* review, Plaintiff is entitled to disability benefits.** In [Mirick v. Prudential Ins. Co. of Am., No. C14-1801RSL, F.Supp.3d , 2015 WL 1914453 \(W.D. Wash. Apr. 27, 2015\)](#), a matter involving a denial of disability benefits, the court found that a grant of discretion contained in the Summary Plan Description (SPD) and Administrative Services Agreement (ASA) is not enforceable since these documents are not part of the plan. The short-term disability (STD) plan states only that Prudential has the authority to make benefits determinations, which is not enough to change the standard of review from *de novo*. Additionally, even if the SPD and ASA are plan documents, Washington State law invalidates the attempt to grant deference to Prudential's claim decision.

With respect to the merits of the STD claim, the court found that Prudential's denial of benefits was in error. Plaintiff reported cognitive difficulties that significantly interfered with her ability to perform at the high level required by her job as a biostatistician. Her diagnosis of lupus and objective findings (including a SPECT scan and cognitive testing) support her subjective reports. She and her doctors believed that time off from work was necessary to reduce her symptoms and provide an opportunity to investigate treatment options. The only contrary evidence was Prudential's reviewing doctor's insistence that if plaintiff does not have lupus, she must be able to perform her job and a vocational consultant's opinion that Plaintiff's employer would likely allow her to take breaks during the workday. The court found that Plaintiff adequately established that she could not perform the high-level analyses and research that were normally required for her job. Lastly, the court found that the ability to work part-time does not preclude benefits where the definition of "Disability" is defined as the loss of 20% or more of earnings due to the sickness or injury that rendered the employee unable to perform the material and substantial duties of the job.

[Jahn-Derian v. Metro. Life Ins. Co., No. CV 13-7221 FMO SHX, 2015 WL 900717 \(C.D. Cal. Mar. 3, 2015\)](#) (Not Reported in F.Supp.3d), the court found that the *de novo* standard of review applies to Plaintiff's ERISA claim because of California Insurance Code § 10110.6, even though the Kaiser LTD Plan documents grant discretionary authority to the plan administrator and fiduciaries.

E. Tenth Circuit

XXIII. *Statute of Limitations*

A. First Circuit

In [\*Morjaria v. Harvard Vanguard Med. Associates, Inc.\*, No. CIV.A. 14-10139-GAO, 2015 WL 1276827 \(D. Mass. Mar. 20, 2015\)](#), the court found that Plaintiff's ERISA claim for breach of fiduciary duty was timely, where Plaintiff filed a complaint that she did not serve, but served an amended complaint within the 120-day deadline for service, and the statute of limitations ran in the interim. The court found that the amended complaint was valid despite that the initial complaint was never served and that it relates back to the date of the original filing. Thus, the amended complaint is not barred by the statute of limitations.

B. Second Circuit

In [\*Ramnaraine v. Merrill Lynch & Co, Inc.\*, No. 14-3562-CV, Fed.Appx. , 2015 WL 5010304 \(2d Cir. Aug. 25, 2015\)](#), the Second Circuit affirmed the district court's dismissal of Plaintiff's breach of fiduciary duty claim, which alleged that Defendants failed to comply with his instructions to sell all shares of Merrill Lynch stock held in his three ERISA plans, because Plaintiff had actual knowledge of the purported breach in September 2007 but did not file his complaint until June 2011.

In [\*Jevelekides v. Lincoln Nat. Corp.\*, No. 3:14-CV-1517 LEK/DEP, 2015 WL 3849312 \(N.D.N.Y. June 22, 2015\)](#), Plaintiff's long-term disability claim began in February 2007 and written proof of claim was due by November 2007. In October 2008, Lincoln informed Plaintiff that she had been overpaid LTD benefits because she and her dependent had been awarded monthly SSDI benefits beginning in March 2008. Plaintiffs filed suit in July 2014 challenging the SSDI offset. The court found that the suit was barred by the LTD policy's contractual limitations provision which states that "[n]o legal action to recover any benefits may be brought until sixty days after the required written proof of claim has been given. No legal action may be brought more than three years after the date written proof of claim is required." The court found that the limitations period required Plaintiffs to file suit by November 5, 2010 and her lawsuit is time-barred.

In *Chepilko v. Cigna Grp. Ins.*, No. 12-3229-CV, \_\_\_Fed.Appx.\_\_\_\_, 2015 WL 264635 (2d Cir. Jan. 22, 2015), a matter involving a *pro se* litigant who disputes a denial of long-term disability benefits, the 2<sup>nd</sup> Circuit Court of Appeals affirmed the district court’s decision finding that Plaintiff’s claim action was time barred. The court found that the Cigna insurance policy states plainly and unambiguously that “[n]o action ... will be brought to recover on the policy .... unless brought within 3 years ... after the time within which proof of loss is required by the policy.” Plaintiff’s “Proof of Loss Date” was June 4, 2002, but he did not file his complaint until over five years later.

In *Boles v. Eastman Kodak Co.*, No. 14-CV-6243-FPG, 2015 WL 213248 (W.D.N.Y. Jan. 14, 2015), the court dismissed Plaintiff’s complaint seeking payment of deferred vested benefits owed in 1998 because it is untimely under both the Plan’s 90-day limitations period and the otherwise applicable 6-year statute of limitations.

### C. Third Circuit

**Breach of fiduciary duty claim based upon alleged misclassification as independent contractor barred by the statute of limitations.** [Williams v. Webb Law Firm, P.C., No. 14-3747, Fed.Appx. \\_\\_\\_\\_\\_, 2015 WL 6522564 \(3d Cir. Oct. 29, 2015\)](#) (VANASKIE, SLOVITER, and RENDELL, Circuit Judges). Plaintiff brought a breach of fiduciary duty claim against Defendant based on the allegation that it misclassified him as an independent contractor, instead of as an employee. The Third Circuit affirmed the district’s grant of summary judgment in favor of Defendant due its finding that Plaintiff’s claim is barred by the applicable statutes of limitations in 29 U.S.C. § 1113. The district court did not err by finding that Plaintiff’s lawsuit failed under both: (1) the date of the last action which formed a part of Defendant’s alleged breach of fiduciary duty occurred on January 1, 2006 (and, therefore, the six-year statute of limitations in 29 U.S.C. § 1113(1) bars the claim), and (2) Plaintiff knew about the material elements of Defendant’s alleged breach and knew that these actions constituted a breach of a fiduciary duty, at the latest, in May 2007 (and therefore the three-year statute of limitations in § 1113(2) bars his claim).

[Teamsters Local Union No. 469 v. Teamsters Joint Council No. 73 Pension Fund, No. CIV.A. 14-7466 MCA, 2015 WL 5603656 \(D.N.J. Sept. 22, 2015\)](#). The court found that Plaintiffs’ breach of fiduciary duty claim against the Trustees for terminating the Fund’s accrual of future benefits is barred by ERISA’s three year statute of limitations. Here, Plaintiffs had actual knowledge of the events which they claim constituted a breach—termination of the benefits because of mismanagement—and knew that those events supported a claim of breach of fiduciary duty as early as 2009. The court also found that Plaintiffs knew about the benefit

suspension when the Fund Trustees notified all active participants, including the Individual Plaintiffs, on September 14, 2009.

**Failure to inform claimant of plan’s time limitation to file a civil action renders it unenforceable.** In [\*Mirza v. Ins. Adm’r of Am., Inc.\*, No. 13-3535, F.3d , 2015 WL 5024159 \(3d Cir. Aug. 26, 2015\)](#), the Third Circuit held that the regulations implementing ERISA, which specifically requires that a benefit denial letter set forth a “description of the plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action,” (29 C.F.R. § 2560.503–1(g)(1)(iv)), means that plan administrators must inform claimants of plan-imposed deadlines for judicial review. In this case the disability plan contained a one-year limitations period for filing a civil action but the denial letter advising Plaintiff of his right to judicial review did not mention this time limit. Plaintiff filed suit almost 19 months after he received the denial letter and the district court granted summary judgment in favor of Defendants on the issue of whether the disability claim for benefits was time-barred in light of the plan’s one-year limitations period. The Third Circuit vacated and remanded the decision of the district court, holding that the appropriate remedy for Defendants’ regulatory violation is to set aside the plan’s time limit and apply the limitations period from the most analogous state-law cause of action—here, New Jersey’s six-year deadline for breach of contract claims. Doing so renders Plaintiff’s civil action timely. The court found, contrary to the district court, that the issue of equitable tolling is not relevant to Plaintiff’s claim. This decision is in accord with the decisions of the First and Sixth Circuit Courts of Appeals. *See Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675, 680 (1st Cir. 2011) and *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503, 505 (6th Cir. 2014). Two other Circuits that considered a plan’s limitation period did not specifically speak to the meaning of the ERISA regulation at issue here. *See Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009); *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 496 F. App’x 129 (2d Cir. 2012) (unpublished). The court also rejected Defendants’ “substantial compliance” argument.

In [\*Nutrishare, Inc. v. Connecticut Gen. Life Ins. Co.\*, No. 2:15-CV-00351-JAM-AC, 2015 WL 4225513 \(E.D. Cal. July 10, 2015\)](#), Nutrishare, a healthcare provider specializing in Total Parenteral Nutrition services and an out-of-network provider according to CIGNA’s PPO plans, brought suit against CIGNA for payment for services it provided to its members. The court found the state law claims completely preempted by ERISA since each of the claims are based on the allegation that benefits are owed to Plaintiff based on its patients’ healthcare plans provided by CIGNA. With respect to Plaintiff’s § 502(a)(2) claim, the court dismissed this claim because Plaintiff failed to establish that the claim is for the benefit of the ERISA Plan rather than for the benefit of individual plan participants. However, because it is not clear that further amendment would be futile, the court granted the motion to dismiss this claim without prejudice.

In [\*Darko v. Variable Annuity Life Ins. Co.\*, No. CV 14-1109-SLR, 2015 WL 3614638 \(D. Del. June 10, 2015\)](#) (Not Reported in F.Supp.3d), the court found that the statute of limitations on Plaintiff's claim started to accrue in the months following his request for a cash distribution since he claimed he never received the distribution. Under 10 Del. C. § 8111, Plaintiff is afforded one year from 1998 to bring a cause of action but did not file his lawsuit until 2014, thus, Plaintiff's claim is time barred.

D. Fourth Circuit

**Contractual limitations period commenced when the insurer closed the disability claim for failure to provide sufficient proof of ongoing disability.** [\*Schulte v. Boston Mutual Life Insurance Company\*, No. JKB-14-419, 2015 WL 7273148 \(D. Md. Nov. 18, 2015\)](#) (Judge James K. Bredar). The court found that Plaintiff did not carry her burden of establishing eligibility for long-term disability benefits, but regardless, her claim is time-barred by the Plan's contractual limitations period. The LTD Policy provides that a claimant "cannot start any legal action...more than 3 years after the time proof of claim is required." The court found that the limitations period would have commenced no later than April 19, 2010, when Defendant closed Plaintiff's claim for failure to provide sufficient proof of ongoing disability. As such, Plaintiff should have filed her Complaint on or before April 19, 2013; instead, she filed it on February 11, 2014, almost a year out of time. Here, Defendant's did not raise the limitations defense in its Answer as required by Rule 8(c) of the Federal Rules of Civil Procedure. However, the court explained that there is ample authority in this Circuit for the proposition that absent unfair surprise or prejudice to the plaintiff, a defendant's affirmative defense is not waived when it is first raised in a pre-trial dispositive motion. The court found that Plaintiff has made no showing that she was prejudiced by the inclusion of the affirmative defense in Defendant's Motion.

In [\*Caldwell v. Standard Ins. Co.\*, No. 2:14-CV-25242, 2015 WL 4727378 \(S.D.W. Va. Aug. 10, 2015\)](#), Standard moved to dismiss Plaintiff's complaint seeking long-term disability benefits, arguing that the action was filed outside the three-year contractual limitation period set forth in the policy and is therefore time-barred. Plaintiff argued that her complaint was timely filed, or, in the alternative, that the policy's limitation period is rendered unenforceable by W. Va.Code § 33-6-14. Upon analyzing the U.S. Supreme Court decision in *Heimeshoff*, the court determined that § 33-6-14 is a "controlling statute to the contrary" of the plan's limitation period. The court concluded that the legal cause of action accrued, at the earliest, on September 23, 2013, the date of Standard's letter announcing the denial of her first internal appeal. Further, the Virginia Code voids any contractual provision that limits the period in which a plaintiff can bring suit to less than two years from the date the cause of action accrues. Thus, in this case, any contractual

limitation that prohibits the filing of a civil action before September 23, 2015 is unenforceable. By every calculation, the limitation period contained in the policy expires well before that date and is unenforceable. The court denied Defendant's motion and held that Plaintiff's complaint is not time-barred.

**Defined contribution plan's separate account feature is an "accrued benefit" that may not be decreased by plan amendment; transferor court's choice-of-law rules apply when a case has been transferred pursuant to 28 U.S.C. § 1404(a).** In [\*Pender v. Bank of Am. Corp., No. 14-1011, F.3d\*](#), 2015 WL 3541927 (4th Cir. June 8, 2015), the Bank amended its 401(k) Plan to give eligible participants a one-time opportunity to transfer their account balances to its defined-benefit plan ("the Pension Plan"). The 401(k) Plan participants' accounts reflected the actual gains and losses of their investment options. The Pension Plan participants' accounts reflected the hypothetical gains and losses of their investment options. The Pension Plan participants' selected investment options had no bearing on how Pension Plan assets were actually invested. Instead, the Bank invested Pension Plan assets in investments of its choosing and retained the spread between the participants' hypothetical investments and the Bank's actual investments. An IRS audit resulted in a determination that the transfers violated the law. Plaintiffs, who held such separate accounts and agreed to the transfers, brought suit seeking disgorgement of profits as to any gains the employer retained from the transaction. The district court dismissed their case, holding that they lacked statutory and Article III standing.

The 4<sup>th</sup> Circuit disagreed and held that Plaintiffs have both statutory and Article III standing and that the claim is not time-barred. The court found that a defined contribution plan's separate account feature constitutes an "accrued benefit" that "may not be decreased by amendment of the plan" under Section 204(g)(1). For the violation of Section 204(g)(1), an accounting for profits is an equitable remedy available under Section 502(a)(3). As such, Plaintiffs have statutory standing. For Article III standing purposes, Plaintiffs incurred an injury in fact, i.e., an invasion of a legally protected interest, because they suffered an individual loss, measured as the spread between the profit the Bank earned by investing the retained assets and the amount it paid to them.

The court found that the applicable statute of limitations is the most analogous statute of limitations for imposing a constructive trust. In Illinois it is five years and in North Carolina it is ten years. The 4<sup>th</sup> Circuit joined the majority of the other circuits and held that the transferor court's choice-of-law rules apply when a case has been transferred pursuant to 28 U.S.C. § 1404(a). Since this case was transferred to North Carolina, the Seventh Circuit's choice-of-law rules apply here. Because of North Carolina's "significant connection" to the dispute, the Pension Plan's choice-of-law provision applying North Carolina law when federal law does not apply, and the federal policies underlying ERISA, the court found that North Carolina's 10-year limitations period applies. Accordingly, Plaintiffs' claims are not time-barred because they filed

suit four years before the statute of limitations would have run. The court reversed and remanded the district court's grant of summary judgment in favor of the Bank.

In [Winburn v. Progress Energy Carolinas, Inc., No. 4:11-CV-03527-RBH, 2015 WL 505551 \(D.S.C. Feb. 6, 2015\)](#), the court found that the plaintiff had actual knowledge of the essential facts constituting the breach of fiduciary duty in July of 2008 when she was mailed a CD containing the relevant AD&D policy exclusions; that the express three-year statute of limitations in Section 1113 should not be equitably tolled and the defendants were not equitably estopped to assert the three-year statute of limitations; and the lawsuit was not timely filed. The court granted Progress's motion for summary judgment on the breach of fiduciary duty claim on statute of limitations grounds.

#### E. Fifth Circuit

In [Thomas v. Prudential Ins. Co. of Am., No. CIV.A. 14-00747-BAJ, 2015 WL 2406036 \(M.D. La. May 19, 2015\)](#), the court found that Plaintiff's lawsuit for long-term disability benefits was contractually time-barred where the terms of the Plan require that legal action commence within three years from the time that proof of claim is required and her lawsuit was filed twenty months past the contractually required deadline. Proof of claim is required within 90 days after the end of the 180-day elimination period for that claim. Plaintiff's disability commenced "on or about" June 26, 2009 so the elimination period would have ended on December 23, 2009. Proof of claim would have been required 90 days thereafter, by March 23, 2010. Commencement of legal action would have had to occur within three years from the time the proof of claim was required, or by March 23, 2013. Plaintiff did not file her lawsuit until December 1, 2014. The court declined to consider the Summary Plan Description which states that any defenses based on timeliness is tolled during the time that a second administrative appeal is pending. The court explained that the SPD does not constitute part of the Plan.

In [Bartlett v. Comerica Inc., No. 3:14-CV-3809-B, 2015 WL 2359511 \(N.D. Tex. May 18, 2015\)](#), the court found that the 4-year statute of limitations did not begin to accrue when Defendant began allegedly underpaying Plaintiff's retirement benefit. Applying the clear repudiation rule, the court concluded that based on the language of an April 2010 letter, and the context in which it was received, Plaintiff could not have been expected to know that his benefit had been miscalculated when he received the letter. Plaintiff did not request information about, or apply to receive, his benefits when he received Defendant's communication about his benefits. Instead, Defendant sent this letter to Plaintiff after it realized it had made a mistake in not beginning payments to Plaintiff under the BEP plan within 60 days of Plaintiff's resignation from Comerica. The court found this fact significant because having not requested information

about his benefits, Plaintiff had less reason to closely scrutinize the letter. Further, nowhere did the letter state that Plaintiff's benefit was being reduced from the \$1,203.44 a month that Plaintiff had previously been told he would receive. Accordingly, the court could not definitively conclude from the facts alleged in Plaintiff's complaint and incorporated documents that Plaintiff's claim for benefits accrued more than four years before he filed suit in October of 2014.

F. Sixth Circuit

**Claim for COLA benefits based on alleged unlawful plan amendment is time-barred.**

[Johnson v. AXA Equitable Long Term Disability Plan, No. 13-13067, 2015 WL 7075910 \(E.D. Mich. Nov. 13, 2015\)](#) (Judge Arthur J. Tarnow). Plaintiff brought a claim to recover withheld COLA benefits under 29 U.S.C. § 1132(a)(1)(B), arguing that an amendment that purported to eliminate his entitlement to COLAs was procedurally deficient and therefore invalid. The court found the claim time-barred since, in connection with Plaintiff's bankruptcy proceedings in 1995, Defendants sent Plaintiff's attorney an unamended copy of the disability plan which would have alerted Plaintiff to the alleged deficiencies in the COLA-eliminating amendment soon after receiving the letter. Plaintiff did not file this lawsuit until well after the six-year statute of limitations expired. The court found that there was no fraudulent concealment to toll the statute of limitations.

**“Cutback” claims in amended complaint were time-barred and did not relate back to “whipsaw” claim asserted in original class complaint.** [Durand v. Hanover Ins. Grp., Inc., No. 14-5648, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 6760548 \(6th Cir. Nov. 6, 2015\)](#) (KEITH and CLAY, Circuit Judges; MARBLEY, District Judge). The Sixth Circuit affirmed the judgment of the district court dismissing claims from this class action suit. Specifically, the district court found that Plaintiffs' “cutback” claims were time-barred and did not relate back to the “whipsaw” claim asserted in the original class complaint. In March 2007, lead Plaintiff Durand filed a class action complaint challenging the projection rate used by the Plan to calculate the lump-sum payment Durand elected to receive after ending her employment at the Company in 2003. The district court dismissed the complaint on November 9, 2007 due to failure to exhaust, but that decision was overturned by the Sixth Circuit, which held that exhaustion should be excused as futile where an employee challenges the legality of a plan's methodology for calculating benefits. Relevant to this appeal is Defendants' seventh defense that putative class members who received lump-sum distributions after December 31, 2003 were barred due to an amendment to the Plan that took effect after that date (the “2004 Amendment”). Plaintiffs sought to amend the complaint with two additional named plaintiffs to assert on behalf of putative subclasses that the 2004 Amendment was an illegal reduction in benefits. The Sixth Circuit found that the cutback claims added by amendment in 2009 do not satisfy the standards of Rule 15(c)(1)(B). The

original complaint challenged only the methodology of Defendants' whipsaw calculation for those Plan participants who have elected or will elect to receive a lump-sum and exit the Plan. In contrast, the cutback claims challenge the legality of the 2004 Amendment, which changed the rate governing the allocation of interest credits to members' nominal account balances during their continued participation in the Plan. Because the two claims challenge different plan policies as illegal under distinct provisions of ERISA, they do not relate back. The court also rejected Plaintiffs' argument that their breach of fiduciary duty claims related to their cutback claims and are viable even if the cutback claims themselves are time-barred. The court found that the alleged nondisclosures cannot support a breach of fiduciary duty claim related to the lapse of Plaintiffs' cutback claims concerning the 2004 Amendment.

In [\*Shapiro v. Fid. Investments Institutional Operations Co., Inc.\*, No. CV 14-143-DLB-CJS, 2015 WL 5076984 \(E.D. Ky. Aug. 27, 2015\)](#), Plaintiff alleged in November 2006 he sent Fidelity a letter requesting reimbursement of his 401(k) funds and after eight years with no response, he sent another letter requesting confirmation that his account had been refunded. Fidelity responded within two weeks informing Plaintiff that his 401(k) plan had been terminated effective November 6, 2006 but did not indicate whether his 401(k) had been reimbursed. Plaintiff filed his lawsuit a few months following receipt of Fidelity's letter. The court rejected Plaintiff's argument that the concealment exception to the statute of limitations applies here where Fidelity simply did not act. Fidelity's motives in not informing Plaintiff that it failed to reimburse his account are irrelevant. Because Plaintiff did not allege that Fidelity took action designed to cover up the 2006 disbursement, Plaintiff cannot avail himself of the concealment exception. The court further held that Fidelity's failure to reimburse Plaintiff's account did not amount to a continuing violation, and/or a separate breach of fiduciary duty because Plaintiff failed to allege the necessary elements of a continuing violation; to wit, that Fidelity committed a wrongful act after 2006. The court denied Plaintiff's motion for leave to file a § 502(a)(1)(B) claim because he failed to identify any specific right or benefit he would seek to enforce, but also that the claim is time-barred applying the most analogous state law statute of limitations (here, five years under KRS § 413.120(2)).

**Existence of ERISA plan is a nonjurisdictional issue; claim for benefits not time-barred where administrator did not disclose plan's time limits for filing suit.** In [\*Russell v. Catholic Healthcare Partners Employee Long Term Disability Plan\*, No. 13-4084, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 3540997 \(6th Cir. June 8, 2015\)](#), the Sixth Circuit issued an amended opinion in this matter involving a denial of long-term disability benefits for a claimant who worked as a registered nurse for about thirty years when she applied for disability benefits in 2007. Unum granted Plaintiff twenty-four months of LTD benefits starting in 2007, and then terminated her benefits in 2009. After exhausting administrative remedies, Plaintiff filed her lawsuit in 2011;

approximately 8 months after Unum issued a final denial on her claim. The district court found that Plaintiff's claim was time-barred and, that even if her claim had been timely, her claim failed on its merits because the administrative decision was not arbitrary and capricious. Plaintiff also disputed whether the United States Courts have jurisdiction over this case because the plan may be a church plan and not an ERISA plan.

Following its decision in *Daft v. Advest, Inc.*, 658 F.3d 583 (6th Cir. 2011), the court found that the existence of an ERISA plan is a nonjurisdictional element of a plaintiffs' ERISA claim. In other words, the court considered the existence of an ERISA plan to be a substantive element of the claim rather than jurisdictional in this case. The court also found the interests of fairness compelled a nonjurisdictional conclusion here. Plaintiff initially invoked federal jurisdiction in 2011 and did not raise the issue of jurisdiction until after Defendants prevailed in trial court. With respect to the timeliness issue, the court held that the action was timely pursuant to the intervening precedent in *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014). The court found that Defendant did not include notice of the time limit for Plaintiff to seek judicial review in its adverse benefit determination letters so the Plan's time limit for filing suit cannot foreclose judicial review of the merits of Plaintiff's claim. However, with respect to the merits of Plaintiff's claim, the court held that Defendants' termination of her LTD benefits was not arbitrary and capricious. The court relied on its conclusion that both of Plaintiff's treating physicians found her to be capable of sedentary/seated work immediately before Defendant terminated benefits.

In [\*Jammal v. Am. Family Ins. Grp.\*, No. 1:13 CV 437, 2015 WL 1810304 \(N.D. Ohio Apr. 21, 2015\)](#), a putative class action alleging a misclassification of agents as "independent contractors" and seeking ERISA plan benefits for these alleged "employees," the court found that no clear and unequivocal repudiation of benefits can occur until after the Plaintiffs were entitled to the payment of benefits and failed to receive them. The court found that neither party provided sufficient information upon which the court could determine when the payment of each type of ERISA benefits should allegedly have occurred, and thereby determine the date of the denial of benefits or administrative failure that triggers the running of the statute of limitations for each separate claim. The court rejected "equitable tolling" of the statute of limitations, finding that there is no need for equitable tolling beyond the date Plaintiffs were allegedly treated as employees and denied benefits. All that can be certainly stated based on the information provided by the parties is that all applicable statute of limitations on all counts (except for the breach of fiduciary duty claim) would have run within six years after the termination date of each individual agent. By termination, each employee would unquestionably have been aware of the conditions and controls that were in place during their working relationship with Defendants and all claims for benefits would have accrued. As all named Plaintiffs separated from Defendants within six years of filing suit, the court found that at this time they all survive summary judgment on the statute of limitations in connection with all but one of the counts. The court found that the

statute of limitations on the breach of fiduciary duty claim is three years from the time each agent was terminated, which barred one of the named plaintiffs from pursuing this claim.

In *Wernimont v. Prudential Ins. Co. of Am.*, No. 1:13-CV-937, 2015 WL 328603 (W.D. Mich. Jan. 26, 2015), the court denied Defendant's motion seeking to dismiss Plaintiff's long-term disability claim on the basis that it is time-barred by the contractual limitations period. The "Legal Action" provision states that no action shall be brought "more than three years after the end of the time within which proof of loss is required." However, the court found that "the time within which proof of loss is required" is, at best, ambiguous, as applied to the facts in this case. "Proof of Loss" indicates that two time limits must "both" be met, to wit: the time limit governing the "initial proof of loss" and the time governing "proof for each later month of continuing loss." Here, where Plaintiff's loss is "continuing" and where Plaintiff has purportedly not yet reached the "last month" of his loss, the provision is unclear as to when the time limit ends. The "Proof of Loss" provision requires that "both" the initial proof of loss and continuing proof of loss be furnished to trigger the "end of the time within which proof of loss is required" referenced in the "Legal Action" provision. The court found Plaintiff's interpretation of the contractual provisions, which would require proof of loss initially and subsequently for continuing losses, to be a fair reading. Because the court held that Defendant has not demonstrated that Plaintiff's action was filed outside the limitations period provided for by the policy, it found it unnecessary to determine whether the interests of justice require equitable tolling of the limitations period.

G. Seventh Circuit

H. Eighth Circuit

**Long-term disability claim is not time-barred based on the application of a state law limitations period and language of LTD plan's contractual limitations period.** [Mulholland v. Mastercard Worldwide, No. 15-1211, Fed.Appx. , 2015 WL 6161462 \(8th Cir. Oct. 21, 2015\)](#) (WOLLMAN, BYE, and GRUENDER, Circuit Judges). The court reversed and remanded the district court's determination that Plaintiff's long-term disability claim was time-barred based on *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S.Ct. 604 (2013). The LTD plan provided that legal action of any kind could not be brought more than three years after proof of disability was required to be filed "unless the law in the state where [the plan participant] live[s] allows a longer period of time." The court found that the provision in *Heimeshoff* did not contain the additional language allowing a participant to file suit beyond three years if the law of the state provided for a longer period, and thus concluded that the instant suit was not time-barred. In Missouri, the applicable limitations period for ERISA actions is the ten-year limitations period

in Mo.Rev.Stat. § 516.110(1). In *Harris v. The Epoch Group, L.C.*, 357 F.3d 822, 824–26 (8th Cir.2004), this court previously held that where the ERISA-governed benefit plan contained a contractual limitations period nearly identical to the one here, the decision in *Johnson v. State Mut. Life Assurance Co. of Am.*, 942 F.2d 1260, 1261–62, 1266 (8th Cir. 1991) (en banc) (because ERISA contains no statute of limitations for actions to recover benefits under an employee benefit plan, looking to state law for most analogous statute of limitations) is binding.

**Plan’s two-year contractual limitations period trumps analogous state law’s statute of limitation.** In [Munro-Kienstra v. Carpenters’ Health & Welfare Trust Fund of St. Louis, No. 14-1655, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3756712 \(8th Cir. June 17, 2015\)](#), the Eighth Circuit determined that Plaintiff’s lawsuit for the denial of health care benefits by the Carpenters’ Health and Welfare Trust Fund of St. Louis’ Employee Welfare Benefit Plan was time-barred based on the Plan’s provision stating that any ERISA action for denial of benefits must be brought within two years of the date of denial. Plaintiff learned that she had been denied coverage in July 2009 and filed this action in January 2012. The court rejected Plaintiff’s argument that the Plan’s contractual two-year statute of limitations was invalid because the Plan’s rules of construction stated that its terms should be read to comply with Missouri law. The court previously concluded that the ten-year period under Mo.Rev.Stat. § 516.110(1) is the most analogous statute of limitations under Missouri law for a claim for ERISA benefits. The court found that there is no conflict between the Plan’s contractual limitations period and Missouri law so recourse to the Plan’s rules of construction is unnecessary. The court also rejected the *Heimeshoff* argument that Mo.Rev.Stat. § 431.030, which prohibits parties from shortening the limitations period for enforcing a contract, is a controlling statute that prevents the Plan’s contractual limitations provision from taking effect. The court, following the Seventh Circuit, concluded that applying the Missouri statute here would negate an ERISA plan provision, negatively impact the administration of ERISA plans, and create inconsistencies with other ERISA provisions, such that its application would violate ERISA’s comprehensive preemption provision.

#### I. Ninth Circuit

**Date of initial claim denial does not trigger Plan’s 2-year contractual limitations period.** [Watkins v. Citigroup Retirement Systems, No. 15-CV-731 DMS \(NLS\), 2015 WL 9581838 \(S.D. Cal. Dec. 30, 2015\)](#) (Judge Dana M. Sabraw). In this case Defendant relied on the Plan’s two-year contractual limitations period to argue that Plaintiff’s lawsuit is time barred because it was filed nearly three years after he received the initial denial of his claim on April 11, 2012. The court found that although Plaintiff did have actual knowledge of the initial denial of his claim no later than April 11, 2012, the record also reveals the denial was debated for over 19 months—from April 11, 2012 to December 18, 2013. The court rejected Defendant’s invitation to interpret the contractual limitations period to be triggered when the claim was initially denied

because the Plan provides that: “The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary.” The court found that this language applies to a claim or an appeal, or both, and clearly indicates that resolution (not awareness) of the claim is the triggering event. On December 18, 2013, Plaintiff was expressly advised that his claim was denied and that he could pursue his claim through a “formal” claims and appeals procedure. The court found that Plaintiff’s lawsuit is timely because it was filed within two years of this date.

In [Reynolds v. Merrill Lynch Basic Long Term Disability Plan, No. CIV. 15-00109 JMS, 2015 WL 3822319 \(D. Haw. June 19, 2015\)](#) (Not Reported in F.Supp.3d), the court found that Plaintiff’s document penalty claim under 29 U.S.C. § 1132(c) accrued thirty days after Plaintiff made his written request for Plan documents and Defendants failed to provide the requested information. The parties agreed that the most analogous statute of limitation under Hawaii law is Hawaii Revised Statutes (“HRS”) § 657–1, which provides a six-year statute of limitation for “personal actions of any nature whatsoever not specifically covered by the laws of the State. Plaintiff first requested the documents in writing in January 2004 but did not file his Complaint until ten years later. The court granted Defendant’s motion to dismiss on the basis that Plaintiff’s claim is time-barred, rejecting Plaintiff’s argument that the claim accrues only when there is an express and unequivocal denial of benefits or that the continuing violation doctrine applies to his claim.

In [Goodes v. Pac. Gas & Elec. Co., No. 13-16027, \\_\\_\\_ Fed.Appx. \\_\\_\\_, 2015 WL 1189961 \(9th Cir. Mar. 17, 2015\)](#), the court found Plaintiffs’ claim for long-term disability benefits and for breach of fiduciary duty based on the miscalculation of those benefits to be time-barred since they had “reason to know” about the final benefit determination as early as February of 1993 and, at the very latest, as of December of 1998. Specifically, on February 8, 1993, PG & E’s benefits representative, sent Plaintiff a letter which stated the final benefit amount that he would receive under the plan and informed him of when his benefits payments would end. Another PG & E representative sent Plaintiff’s union representative another letter on December 17, 1998, detailing Plaintiff’s benefit amount and duration. Plaintiffs had until December 17, 2002 to file a timely claim based on lost benefits, and until December 17, 2001 to file a timely complaint based on a breach of fiduciary duty. However, they did not bring the present action until April 4, 2012, which was about a decade too late.

In *Trustees of the Plumbers & Pipefitters Nat. Pension Fund & Int’l Training Fund v. All Seasons Interior & Exterior Maint., Inc.*, No. 2:14-CV-00436-GMN-GW, 2015 WL 430708 (D. Nev. Feb. 3, 2015), Plaintiffs, who are express trusts created to represent certain organized labor

unions, brought suit against Defendant All Seasons for failing to make employee benefit contributions to the trusts as required by a collective bargaining agreement entered into by All Seasons and a union represented by Plaintiffs. All Seasons failed to make the agreed upon contributions for a period between May 20, 2009 and January 20, 2010 relating to projects for which it was operating as a subcontractor for Defendant Gamma. Plaintiffs filed their Complaint on March 21, 2014. Defendants Gamma and Fidelity and Deposit Company of Maryland (“FDCM”) filed a Motion for Summary Judgment, on the basis that the statutes of limitations for Plaintiffs’ claims against them had both already run by the time Plaintiffs filed their Complaint. Under Nevada law, Plaintiffs’ claim for out-of-state general contractor liability against Gamma is limited to three years after the date contributions or premiums should have been made or paid by the subcontractor. Likewise, Plaintiffs’ claim on FDCM’s contractor license bond is limited to 2 years after the commission of the act on which the action is based. Plaintiffs did not dispute that their Complaint was filed after the running of the applicable statutes of limitations for their claims against Gamma and FDCM but asserted that their motion should be denied because of the doctrine of equitable tolling. The court declined to address the issue of equitable tolling because—despite Plaintiffs’ acquiescence on this point—it found that Gamma and FDCM have failed to present sufficient evidence showing that there is not a genuine issue of material fact concerning whether the statutes of limitations have run on Plaintiffs’ claims. The court explained that under federal law, a plaintiff’s claim accrues and the statute of limitations begins to run, when the plaintiff knows or has reason to know of the injury that is the basis of the action. The court found that it is very likely that Plaintiffs knew or should have had reason to know of the deficiencies at the time All Seasons filed bankruptcy on May 25, 2012, which precipitated Plaintiffs decision to conduct the audit. Therefore, if the bankruptcy filing date begins the running of the limitations periods, then Plaintiff had until May 25, 2014 and May 25, 2015 to file its claims against FDCM and Gamma, respectively, and the Complaint would be timely for both claims. But, it is also possible that Plaintiffs knew or should have known of All Seasons’ deficient payments prior to the bankruptcy filing. The court found that it cannot make that determination as a matter of law and denied the motion.

#### J. Tenth Circuit

**Language in SPDs did not contractually vest retirees with lifetime health or life insurance benefits and “fraud or concealment” provision is exception to six-year statute of repose.** In [Fulghum v. Embarq Corp., No. 13-3230, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 1905798 \(10th Cir. Apr. 27, 2015\)](#), the Tenth Circuit affirmed in part the grant of summary judgment in favor of Defendants-Appellees on Plaintiffs-Appellants’ claims that Defendants violated ERISA and the ADEA when they altered or eliminated health and life insurance benefits for retirees. With respect to the ERISA claims, the court considered language in SPDs that it categorized into four groups.

- Group One: The court concluded that Defendants did not contractually agree to provide Plaintiffs with lifetime health or life insurance benefits based on language in Summary

Plan Descriptions where they contained at least one Reservation of Rights (“ROR”) clause to which Defendants expressly and unambiguously reserved the right to change or discontinue any or all benefits or to amend or terminate the plan. The Tenth Circuit joined its other sister circuits in concluding that plan language that arguably promises lifetime benefits can be reconciled with an ROR clause if the promise is interpreted as a qualified one, subject to the employer’s reserved right to amend or terminate those benefits.

- Group Two: These SPDs did not contain an ROR clause, but the court found that language that specifically states that a participant is “entitled to have an individual life insurance policy issued to” her if the group life insurance “ceases because the Group Policy is terminated or amended so as to terminate the life insurance,” coupled with the provision stating that insurance terminates when the policy terminates, demonstrates Defendants had the power to terminate a retiree’s group life insurance benefit and did not promise lifetime life insurance benefits under those plans.
- Group Three: These SPDs contain provisions stating benefits “will continue after retirement” and that retirees “will be insured.” This language does not clearly and expressly promise lifetime benefits because it does not state that benefits will continue, unaltered, until the retiree’s death.
- Group Four: These SPDs do not promise lifetime benefits to retirees simply because they contain duration limits for some plan participants but not for retirees. Further, all the SPDs contain ROR clauses permitting Defendants to amend the plans for reasons of business necessity and Plaintiffs presented no appellate argument that the amendments were not motivated by business reasons.

The court further concluded that because no reasonable person in the position of a plan participant would have understood any of the language identified by Plaintiffs as a promise of lifetime health or life insurance benefits, there is no ambiguity that must be resolved in Plaintiffs’ favor and the district court did not abuse its discretion by refusing to consider extrinsic evidence. Lastly, the court reversed the district court’s dismissal of Plaintiffs’ breach of fiduciary duty claims to the extent those claims are premised on a fraud theory. The court concluded that the exception to the general six-year statute applies when the alleged breach of fiduciary duty involves a claim the defendant made “a false representation of a matter of fact, whether by words or conduct, by false or misleading allegations or by concealment of that which should have been disclosed, which deceives and is intended to deceive another so that he shall act upon it to his legal injury” or when the defendant conceals the alleged breach of fiduciary duty. On remand, Defendants may present argument that Plaintiffs did not bring suit within “six years after the date of discovery” of the alleged breach.

**The “fraud or concealment” provision is an exception to the statute of repose and not a separate statute of limitations.** In [\*Fulghum v. Embarq Corp.\*, No. 13-3230, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 759169 \(10th Cir. Feb. 24, 2015\)](#), Plaintiffs brought this suit after Defendants altered or eliminated health and life insurance benefits for retirees, asserting that Defendants (1) violated ERISA by breaching their contractual obligation to provide vested health and life insurance benefits; (2) breached their fiduciary duty by, *inter alia*, misrepresenting the terms of multiple welfare benefit plans; and (3) violated the ADEA and applicable state laws by reducing or eliminating health and life insurance benefits. The district court granted Defendants’ summary judgment on the breach of fiduciary duty claims, the ADEA claims, the state-law age discrimination claims, and some of the contractual vesting claims. The 10<sup>th</sup> Circuit Court of Appeals concluded that Defendants did not contractually agree to provide Plaintiffs with lifetime health or life insurance benefits and thus affirmed in part the grant of summary judgment as to the contractual vesting claims. The court reversed the grant of summary judgment against those class members whose contractual vesting claims arise, in whole or in part, from summary plan descriptions other than those identified in Defendants’ motion. But, the court affirmed the grant of summary judgment in favor of Defendants on the ADEA claims. The court also reversed the district court’s dismissal of Plaintiffs’ breach of fiduciary duty claims brought pursuant to 29 U.S.C. § 1132(a)(3) and the dismissal of Plaintiffs’ remaining breach of fiduciary duty claims to the extent those claims are premised on a fraud theory.

With respect to the breach of fiduciary duty claim, in the Third Amended Complaint, seventeen named plaintiffs raised claims alleging Defendants breached their fiduciary duties by withholding benefits due them, misrepresenting and concealing material benefits information, and misleading them into believing their health and life insurance benefits could not be amended or terminated. The breach of fiduciary duty claims were purportedly brought pursuant to both 29 U.S.C. § 1132(a)(3) and 29 U.S.C. § 1104(a)(1). Defendants moved for summary judgment on the basis that the § 1104(a)(1) claims were untimely under § 1113. The district court granted the motion on the timeliness basis as to fifteen of the seventeen plaintiffs. In its discussion of the breach of fiduciary duty claims, the district court analyzed the Plaintiffs’ claims as brought pursuant to § 1132(a)(3) and then dismissed all of Plaintiffs’ breach of fiduciary duty claims as untimely. The court found that because the six-year statute of repose set out in 29 U.S.C. § 1113 is not applicable to Plaintiffs’ § 1132(a)(3) claims, the district court erred to the extent it dismissed the § 1132(a)(3) claims as untimely. As such, the court’s analysis of Plaintiffs’ breach of fiduciary duty claims is confined to the claims arising pursuant to 29 U.S.C. § 1104(a)(1).

The court concluded that the exception to the general six-year statute applies when a plaintiff alleges the defendant breached a fiduciary duty by making a false representation of a matter of fact, whether by words or conduct, by false or misleading allegations or by concealment of that which should have been disclosed, which deceives and is intended to deceive another so that he shall act upon it to his legal injury or when the defendant conceals his breach of fiduciary duty by withholding information of which he knows and which he is duty

bound to reveal. Thus, Plaintiffs' claims are timely only if the alleged breach of fiduciary duty is based on a fraud theory. The court found that the district court erred when it dismissed Plaintiffs' breach of fiduciary duty claims based on Rule 9(b) to the extent Plaintiffs' breach of fiduciary duty claims are premised on a fraud theory. The court instructed on remand that Defendants, if they so choose, may present argument regarding the timeliness of Plaintiffs' breach of fiduciary claims, including that Plaintiffs did not bring suit within "six years after the date of discovery" of the alleged breach.

#### K. Eleventh Circuit

In [Smiley v. Hartford Life & Acc. Ins. Co., No. 15-10056, Fed.Appx. , 2015 WL 4385673 \(11th Cir. July 17, 2015\)](#), the Eleventh Circuit affirmed the district court's decision finding that Hartford, a third-party claims administrator, was not the plan administrator and therefore not subject to statutory penalties under § 1132(c)(1). The court also rejected the *de facto* administrator argument and found that since the record demonstrates that the employer retained the authority to make final decisions on appeal from the claims administrator, Hartford was not the plan administrator, either in name or in fact, and was not liable for failing to furnish Plaintiff with certain Plan documents. The court also found that the district court did not abuse its discretion in refusing to impose statutory penalties on the plan administrator. The court found that there was no evidence that the plan administrator refused or failed to provide Plaintiff with the relevant documents, which were already in her possession.

### XXIV. *Statutory Damages & Notice Violations*

#### A. First Circuit

In [De Leon-Serrano v. Nw. Selecta, Inc., No. CIV. 13-1474 DRD, 2015 WL 1968598 \(D.P.R. May 1, 2015\)](#), the court rejected the employer's argument that the notice requirements in 29 U.S.C. § 1166, which use the term "shall," are permissive rather than mandatory. To adopt employer's argument would allow an employer or a plan administrator to properly decide not to inform its employees or qualified beneficiaries of their rights to continuing coverage, which does not comport with the purposes of ERISA. The court determined that Defendant failed to adequately notify Plaintiffs of their right to continuing health coverage, which is subject to penalties of 29 U.S.C. §§ 1132(a)(1)(A) and 1132(c)(1). Under these provisions, the Court has the discretion to award Plaintiff any amount from \$0 to \$110 per violation. The court ordered a status conference to discuss (a) whether a jury is required to determine any factual aspect of this case<sup>3</sup>, (b) whether Plaintiffs' claim for reimbursement of medical expenses is preempted by the

statutory penalties of ERISA, and (c) whether there is any need to continue discovery in the instant case.

#### B. Second Circuit

In [Williams v. AAA S. New England, No. 13 CV 855 VB, 2015 WL 864891 \(S.D.N.Y. Mar. 2, 2015\)](#), Plaintiff, *pro se*, alleged that her former employer's third-party administrator of its health benefit plan, BCI, failed to provide her with timely notice of her right to COBRA continuation coverage in violation of ERISA § 606(a)(4)(A). The court determined that because the Plan designates the employer as its administrator, BCI cannot be held liable for failure to give proper notice and dismissed the claim against BCI. Plaintiff also brought two claims under ERISA § 502 against the employer alleging that it: (i) breached its fiduciary duty owed to her under ERISA § 404(a) in violation of ERISA § 502(a)(3); and (ii) denied her COBRA continuation coverage in violation of ERISA § 502(a)(1)(B). Specifically, Plaintiff alleged that AAA told her "her name was not in the system" and she was not "eligible for benefits in the three months following her termination." The court found that, even assuming the employer was acting in a fiduciary capacity and made material misrepresentations, the complaint does not allege plaintiff relied on those misrepresentations to her detriment since she admits later receiving a COBRA election form from BCI. Because Plaintiff did not plead any alternative bases of harm resulting from the employer's alleged misrepresentations, the complaint fails to state a claim for breach of fiduciary duty under ERISA § 502(a)(3). With respect to the ERISA § 502(a)(1)(B) claim, the court found that Plaintiff is entitled to COBRA continuation coverage under the Plan but she failed to allege she paid the required initial premium. As such, she has not plausibly alleged COBRA continuation coverage was due to her under the terms of the plan and fails to state a claim under ERISA § 502(a) (1)(B).

#### C. Third Circuit

In [Daus v. Gardiner, No. CV 11-67, 2015 WL 1969140 \(D.V.I. May 1, 2015\)](#), Plaintiff alleged that she never received a "COBRA letter" after she was fired, and claims that by failing to provide her with such, "Defendants have violated the COBRA law." Plaintiff did not allege that Defendants' Group Health Plan was covered by ERISA, that Defendants either were the administrator of the Group Health Plan or that they did not notify the administrator of the Group Health Plan of Plaintiff's termination, or that Defendants had more than 20 employees. With respect to this last requirement the court disagreed that it is an affirmative defense that Plaintiff is not required to anticipate in its pleadings. Accordingly, the court dismissed Plaintiff's COBRA claim without prejudice and granted Plaintiff leave to file an amended complaint on this claim.

D. Fourth Circuit

[\*Boyd v. Sysco Corp.\*, No. 4:13-CV-00599-RBH, 2015 WL 5178151 \(D.S.C. Sept. 3, 2015\)](#). The court granted Defendants' Motion for Summary Judgment on Plaintiff's ERISA penalty claim. The court found that failure to produce the "claims file" does not support imposition of a penalty. The court explained that the claims file is not covered by the ERISA disclosure statute. The regulations implementing 29 U.S.C. Section 1029(c) are found at 29 C.F.R. Section 2520.101-1 et seq. However, the regulation cited by Plaintiffs is 29 C.F.R. Section 2560.503, which implements 29 U.S.C. Sections 1133 and 1135, and relates to claims procedures. Although claims administrators must provide those appealing adverse claims determinations with claims information, the failure to do so does not fall under the ERISA penalty statute. The court also found that Plaintiff's counsel sent the request for information to the address for appeals of an unfavorable claim decision, but not to the designated plan administrator.

In *Green v. Baltimore City Bd. of Sch. Comm'rs*, No. CIV.A. WMN-14-3132, 2015 WL 302812 (D. Md. Jan. 22, 2015), the court granted Plaintiffs' Motion for Summary Judgment on their claims for violating their right to COBRA notice under 29 U.S.C. § 1166 and breach of fiduciary duty under 29 U.S.C. § 1104. The court found that Plaintiffs suffered a qualifying event on the dates of their suspension, triggering Defendant's obligations under COBRA, and that all invoices and bills issued by Defendant to Plaintiffs after the qualifying event are null and void. At the time of their suspension notice, Plaintiffs were neither made aware that their insurance coverage would be continued automatically nor were they informed that such continuation would mean that they would be obligated to pay both the employer and employee shares of the insurance premiums. The court found that Plaintiffs' knowledge of these facts regarding coverage are so essential that making an informed decision regarding coverage without those facts would be difficult if not impossible. The invitation in the suspension letter to "contact the Office of Benefits Management to discuss the options available" fails to inform Plaintiffs that the terms and conditions of coverage were to change and did not satisfy Defendant's notification obligations under COBRA.

E. Fifth Circuit

**Service of document requests on Plan Administrator's attorney is sufficient for document penalty claim.** [\*Ctr. for Restorative Breast Surgery, L.L.C. v. Humana Health Benefit Plan of Louisiana, Inc.\*, No. CIV.A. 10-4346, 2015 WL 5822656 \(E.D. La. Oct. 6, 2015\)](#) (Judge Eldon E. Fallon). The court denied dismissal of Plaintiffs' ERISA 502(c) claims against Humana, where its attorney indicated that he would accept personal service of document requests. The court found that if the attorney indicated that he would accept personal service of document requests

on behalf of Humana, Humana was effectively served for purposes of ERISA section 502(c) based on principles of agency law. Further, the attorney did not inform Plaintiffs that he was not an appropriate representative of Humana's document requests until three years after Plaintiffs filed their first document request with the attorney. The court found it disingenuous, at best, for Humana to assert that a response by counsel years after the Plaintiffs' first request for documents could possibly be considered timely.

In [\*Seal v. Maverick Claims, LLC\*, No. CIV.A. 14-245, 2015 WL 4509629 \(E.D. La. July 24, 2015\)](#), the court rejected Defendant's argument that document penalties pursuant to § 1132(c) should only be assessed from the date Plaintiff became eligible to enroll in Defendant's 401(k) Plan to the date of Plaintiff's termination. The court explained that there was no case law to support a finding that the penalty ceases to accrue upon termination. The administrator failed to produce plan documents to Plaintiff on four occasions and did not produce them when the request was made by Plaintiff's attorney. The court found that there was no justifiable reason for the repeated lack of response, and based on these facts, penalties are appropriate here. The court was not convinced that Plaintiff's claim is mooted by Defendants' offer of judgment in the amount of \$15,620. Nevertheless, the court did not find that summary judgment is appropriate on the matter of penalties due to the fact that the record does not clearly establish the appropriate date on which Defendants produced the required materials.

#### F. Sixth Circuit

[\*Harris-Frye v. United of Omaha Life Ins. Co.\*, No. 1:14-CV-72, 2015 WL 5562196 \(E.D. Tenn. Sept. 21, 2015\)](#) The court overruled Defendant Board of Trustees' objections to the Magistrate Judge's calculation of statutory penalties under 29 U.S.C. § 1132(c) for failure to provide Plaintiff a copy of the Policy in the amount of \$12,760.00, calculated at \$110.00 per day for the 116 days between January 5, 2013 and May 1, 2013. The court also assessed an additional penalty of \$61,380.00 for Defendant's failure to furnish a copy of the Plan Document, calculated at \$110.00 per day for the 558 days between May 31, 2013 and December 10, 2014.

#### G. Seventh Circuit

In [\*Anderson v. Celadon Trucking Servs., Inc.\*, No. 1:13-CV-01610-TWP, 2015 WL 3827726 \(S.D. Ind. June 19, 2015\)](#), a matter involving an insured plan providing long term disability benefits, Plaintiff alleged that Defendant, her former employer, is liable under § 1132 for failure to comply with a request for information, specifically verification of her employment and/or coverage status. The court found that there is nothing in § 1132 that places such an obligation on the owner of a plan, only the administrator. Plaintiff did not dispute the fact that Celadon was the owner of the Plan and Prudential was the administrator. The court held that because there is no

dispute that Celadon is not the Plan administrator, it cannot be held liable under § 1132 for its alleged failure to provide information to either Plaintiff or Prudential, and Celadon is therefore entitled to summary judgment and dismissal of Plaintiff's claims.

H. Eighth Circuit

I. Ninth Circuit

**Penalties cannot be assessed against third-party claims administrator.** [Koch v. Infosys, Ltd., No. C14-1649RSL, 2015 WL 8328067 \(W.D. Wash. Dec. 9, 2015\)](#). Koch alleged that he is entitled to ERISA penalties because Aetna failed to respond to requests for information. The court explained that ERISA penalties may only be assessed against the plan administrator, as designated in the plan documents. 29 U.S.C. §§ 1002(16)(A), 1132(c)(1). In this case, the plan documents specify that the plan administrator is Infosys. As such, the court held that penalties may not be assessed against Aetna as a third-party claims administrator and granted Aetna's motion for summary judgment on this claim. The court relied on *Sgro v. Danone Waters of N. Am., Inc.*, 532 F.3d 940, 944-45 (9th Cir. 2008) and *Moran v. Aetna Life Ins. Co.*, 872 F.2d 296, 301 (9th Cir. 1989).

In *Lybecker v. Union Pac. Corp.*, No. CV-13-0231-LRS, 2015 WL 144413 (E.D. Wash. Jan. 12, 2015), Plaintiff's amended complaint included one claim against Union Pacific under ERISA § 502(c)(1)(B) for its alleged failure to produce plan documents in a dispute concerning life and accidental death benefits, where those benefits were ultimately paid by the plan's insurer, Prudential. The court found that Plaintiff has no statutory standing to bring this action for a penalty claim against UPC because she has no "colorable claim" of entitlement to a plan benefit. Plaintiff relied on her claim against Prudential as the source of her "participant" status asserting that she had a "colorable claim" to life insurance plan benefits because she was entitled to "the greater of the profits Prudential earned on her money or interest on that money." The court found that this prayer for relief standing alone is not sufficient to satisfy the definition of "participant" or "beneficiary" under the colorable claim test because such claim must be for a benefit (and not solely interest or penalty) under the plan. Before June 18, 2013, Plaintiff had received every benefit due to her under the subject plan, with what Plaintiff calls "fair rate" for interest on the money Prudential earned on that benefit paid fully but not timely. The court noted that the Ninth Circuit has never held that payment of interest is a "benefit" for purposes of statutory standing analysis under Section 1132(a)(1) and the court found no case law to support the view that interest is considered a "benefit" in the ERISA context. When this action commenced, Plaintiff did not have any claim to any further payments from Prudential. Because Plaintiff lacks standing, the court found that Union Pacific is entitled to judgment as a matter of law and dismissed

Plaintiff's claim. Lastly, the court agreed with Defendant's position that § 1132(c) is inapplicable because Plaintiff failed to comply with the statute's requirement that requests for information be made *in writing* and directed to the *plan administrator*. Union Pacific did not receive the requests in writing and Prudential (not Union Pacific), was the plan administrator of the subject plan involved.

J. Eleventh Circuit

In [\*House v. Aetna Life Ins. Co., Bank of Am. Corp.\*, No. 8:15-CV-560-T-24 TGW, 2015 WL 2250976 \(M.D. Fla. May 13, 2015\)](#), Plaintiff asserted a claim against Aetna, pursuant to 29 U.S.C. § 1132(c)(1), for failure to produce his claim file and Plan documents. In ruling on Aetna's motion to dismiss, the court determined that Plaintiff did not sufficiently plead that Aetna was a *de facto* plan administrator. To be the *de facto* plan administrator, the entity must control the administration of the plan and control the dissemination of information. Plaintiff must allege that because Aetna undertook the responsibility to disseminate ERISA information and to control the administration of the Plan (due to Bank of America being an inactive plan administrator), Aetna is alleged to be a *de facto* plan administrator. The court rejected Aetna's argument that Plaintiff cannot, as a matter of law, state a claim against it under § 1132(c). The court granted Plaintiff leave to amend the complaint in order to sufficiently allege that Aetna was a *de facto* plan administrator. However, the court found that Plaintiff cannot assert a claim under § 1132(c) relating to his request for his claim file.

K. D.C. Circuit

XXV. *Stock Bonus Plans*

A. Eleventh Circuit

XXVI. *Subrogation/Reimbursement Claims*

A. First Circuit

**Post-petition reduction of disability benefits to recoup overpayment does not violate Bankruptcy Code.** [\*In re DeLotto\*, No. BR 15-10648, 2015 WL 6876775 \(Bankr. D.R.I. Nov. 9, 2015\)](#) (Bankruptcy Judge Diane Finkle). Plaintiff filed various motions challenging Liberty Life's reduction of his disability insurance benefits by an amount it overpaid as a result of an award of Social Security benefits. Plaintiff contended that the recoupment constituted "setoff" in

violation of Bankruptcy Code §§ 362(a)(6) and (7). The court found that Liberty Life's post-petition reduction of Plaintiff's long-term disability benefits to recover its pre-petition overpayment in accordance with the Policy terms constitutes permissible recoupment that is an exception to the automatic stay. The court explained that no matter how unfortunate the consequences might be, its exercise of such rights does not offend notions of equity or fairness. The court denied all of Plaintiff's motions.

In [\*Sugalski v. The Paul Revere Life Ins. Co.\*, No. CIV.A. 14-40015-TSH, 2015 WL 1443117 \(D. Mass. Mar. 30, 2015\)](#), Plaintiff took the position that the money which she received from a jury verdict and settlement of her personal injury claim did not include any amount for lost income and therefore, Paul Revere was not entitled to recoup any amount for so-called "Loss of Time" under the Plan. Paul Revere argued that it interpreted the relevant plan provisions narrowly to include only loss of time awards, settlements involving liability insurance, or court actions related to the injury which resulted in the claimant's disability. Here, Plaintiff did not apportion the settlement from her personal injury litigation to preclude portions of the settlement from being subject to the benefit offset. The court found that Paul Revere's interpretation of the Plan was not arbitrary and capricious.

B. Third Circuit

C. Fourth Circuit

[\*Ret. Comm. of DAK Americas LLC v. Smith\*, No. 7:14-CV-36-FL, 2015 WL 5714579 \(E.D.N.C. Sept. 29, 2015\)](#). Plaintiffs filed suit to recover alleged overpayments of pension benefits made to Defendants, seeking equitable restitution of the overpayments. One set of defendants paid back the money and then sought its return. The other set of defendants did not. With respect to the latter, the court granted Plaintiff's claim for equitable restitution, finding that the alleged overpayments are specifically identifiable funds within the possession and control of defendants and constitute property belonging in good conscience to the Plan, based upon the correct interpretation of the Plan which did not authorize the overpayment. The court dismissed Defendants' counterclaims premised upon the conduct of Plaintiff, including equitable estoppel, constructive fraud, breach of fiduciary duty/surcharge.

In [\*CSC Employee Benefits Fiduciary Comm. v. Avera\*, No. 5:15-CV-4-BO, 2015 WL 4041333 \(E.D.N.C. July 1, 2015\)](#), the fiduciary of a health and welfare plan brought suit against a plan

participant and her personal injury attorneys seeking reimbursement from sums recovered from a third party for medical benefits paid for the treatment of injuries caused by the third party. The court granted the Attorneys' motion to dismiss the ERISA claims against them, finding that neither the law firm nor the attorney were signatories to the Plan, otherwise agreed to disburse funds in accordance with the Plan, or wrongfully enabled the beneficiary to avoid Plaintiff's claim.

In [\*Barnhill Contracting Co. v. Oxendine\*, No. 7:14-CV-211-FL, 2015 WL 2227848 \(E.D.N.C. May 12, 2015\)](#), the court permitted Plaintiff (plan sponsor, administrator, and fiduciary of a health plan) to bring a claim under §502 a(3) against Defendants (plan participant and her attorneys) to enforce the reimbursement, subrogation, and recovery rights under the Plan. The court found that although the Fourth Circuit has not addressed the standard for equitable relief in a suit directly against a third party, such as an attorney holding settlement funds, other circuit courts of appeals recently have uniformly allowed equitable relief against third parties in circumstances analogous to the present case. The court determined that Plaintiff may seek a declaration as to its reimbursement and recovery rights under the Plan for specifically identifiable funds—the settlement proceeds up to the amount of \$69,117.31 in medical benefits paid—in the possession and control of the defendant attorneys, where Plaintiff alleged that Defendants had notice of the plan's subrogation rights. The court did not dismiss Plaintiff's conversion claim but it did dismiss Plaintiff's claims for internal or negligent interference with contract.

**Insurer cannot impose rescission or equitable lien on most of overpaid disability benefits.**

In [\*Fine v. Sun Life Assur. Co. of Canada\*, No. 1:14CV551 LMB/TCB, F.Supp.3d , 2015 WL 1534513 \(E.D. Va. Apr. 6, 2015\)](#), a matter involving a claim for LTD benefits, Sun Life counterclaimed against Plaintiff to recover benefits paid to him after January 1, 2012, the date by which it contends he became ineligible for benefits because his disability earnings exceeded 80% of his indexed total monthly earnings. The court found that Sun Life did not abuse its discretion in terminating Plaintiff's benefits but that equitable considerations now prevent Sun Life from recouping most of the amount previously paid in error. The court was not convinced that Sun Life is entitled to rescission of each of its monthly payments to Plaintiff after January 1, 2012. The court explained that rescinding payments and holding the beneficiary liable for the entire rescinded amount, without regard to what became of the payments after they were received, would have the effect of imposing personal liability on the defendant. Further, no provision of the Policy permits rescission to recover overpayments. The court also rejected Sun Life's argument that it is entitled to restitution through an equitable lien on the present value of one of Plaintiff's bank accounts and on a portion of the proceeds from the eventual sale of Plaintiff and his spouse's apartment. The court found that Sun Life failed to meet its burden of tracing the

spent overpayments to a product in Plaintiff's possession, except for \$9,943.61, which was the balance of the bank account (where Plaintiff deposited benefit payments) as of the date Sun Life stopped payment of benefits.

D. Fifth Circuit

In [\*Cont'l Ins. Co. v. Dawson\*, No. 3:13-CV-4150-M, 2015 WL 1443122 \(N.D. Tex. Mar. 31, 2015\)](#), Continental filed suit against Dawson alleging claims under ERISA as a derivative fiduciary of the Plan, seeking to enforce Aetna's subrogation and reimbursement rights under the Plan by bringing a claim under § 502 of ERISA, declaratory relief that Continental had an equitable lien on Dawson's recovery from a personal injury settlement, and a permanent injunction prohibiting Dawson from retaining any recovery from the settlement without reimbursing Continental for the amounts assigned to it by Aetna. The court held that Continental's ERISA claim and breach of contract claim are barred as a matter of law.

In [\*Rhea v. Alan Ritchey, Inc.\*, No. 4:13-CV-00506, 2015 WL 1456210 \(E.D. Tex. Mar. 30, 2015\)](#) (Not Reported in F.Supp.3d), the court found that a document titled "Summary Plan Description" was the "plan document" that contained an enforceable reimbursement provision. The court distinguished *Amara* since in this case there is only an SPD and no alternative document. "Plaintiff cannot both obtain the benefit of a plan as a covered person and not also comply with her obligations under it as a covered person. Such would be a windfall that is not contemplated or warranted under ERISA."

E. Sixth Circuit

**Summary Plan Description may be a controlling plan document.** In [\*Bd. of Trustees v. Moore\*, No. 14-4048, F.3d , 2015 WL 5010985 \(6th Cir. Aug. 25, 2015\)](#), the Board of Trustees of the National Elevator Industry Health Benefits Plan sued Moore and the law firm Goodson & Company, Ltd. (collectively, "Moore"), seeking reimbursement for \$34,204.10 in medical expenses that the Plan paid on Moore's behalf, following Moore's \$500,000 settlement of a negligence action filed against a third party responsible for his injuries. Moore counterclaimed that the Trust Agreement did not provide for reimbursement and that the Board had violated its fiduciary duty by misrepresenting the terms of the Plan. The Sixth Circuit affirmed the district court's decision concluding that the summary plan description containing the subrogation provision set out the binding terms of the Plan and that the plain language of the provision required reimbursement. The Sixth Circuit also concluded that the district court's denial of Moore's discovery demand that the Board produce "all documents and all information on every subrogation claim the Board has ever asserted against a plan participant" did not constitute an abuse of discretion.

In coming to its decision, the Sixth Circuit considered three issues: (1) whether the SPD is a controlling plan document, making the subrogation provision enforceable; (2) whether the settlement funds were wholly “excess and separate” from the medical costs the Board seeks to recover and therefore exempt from subrogation; and (3) whether subrogation applies in the absence of a judicial finding or admission of liability by the third party. As to the first issue, the court found that the summary plan description is the controlling document there is no other plan document that establishes Moore’s right to receive medical benefits and the Plan’s subrogation rights. Nothing in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011) prevents a document from functioning both as the ERISA plan and as an SPD, if the terms of the plan so provide. As to the second issue, the court disagreed with Moore that the subrogation’s provision means that the settlement amounts are “excess and separate” from the expenses paid by the Plan and are not recoverable in subrogation. The court found that the word “excess” creates a mathematical limitation on the plan’s subrogation rights, not a categorical one. As to the third issue, the court found that the terms of the subrogation provision does not require a judicial determination of liability.

In [\*CAESARS ENTERTAINMENT OPERATING COMPANY, INC., as fiduciary & on behalf of, HARRAHS OPERATING COMPANY, INC. WELFARE BENEFIT PLAN PLAINTIFF v. MICHAEL JOHNSON, & BRIAN CLARE, individually, as administrator & fiduciary of his client trust “IOLTA” account, & as owner-operator of BRAIN E. CLARE - ATTORNEY AT LAW DEFENDANTS\*, No. 3:13-CV-00620-CRS, 2015 WL 5020695 \(W.D. Ky. Aug. 21, 2015\)](#), the court held that Plaintiff did hold an “equitable lien by agreement” in the amount of \$136,479.57 on the settlement the attorney deposited in his IOLTA, but that an individual holding an “equitable lien by agreement” on certain property does not have legal title to that property. Caesars’ equitable interest did not encroach upon Defendants’ legal title at the time the attorney disbursed the settlement, thus Caesars cannot establish that it had legal title to the allegedly converted property and cannot prevail on its conversion claim. The court also dismissed Plaintiff’s breach of fiduciary duty claim against the attorney since whether by virtue of common law, the “nature” of the IOLTA, the Kentucky Rules of Professional Conduct, or the Kentucky Uniform Trust code, the attorney was not encumbered with fiduciary duties.

In [\*Admin. Comm. of Dillard’s, Inc. Grp. Health, Dental, & Vision Plan v. Sarrough\*, No. 1:14-CV-01165, 2015 WL 3466568 \(N.D. Ohio June 1, 2015\)](#), the Plan sought a constructive trust and equitable lien over a wrongful death settlement awarded to Defendants. The Plan paid \$260,370.63 of the decedent’s medical expenses. Defendants won \$300,000 in wrongful death settlements associated with the death and the Plan made a claim to these settlement proceeds to recoup the medical costs it incurred. The Probate Court ordered that the entire \$300,000 settlement should be allocated to a wrongful death claim; 40% of the settlement was for

attorneys' fees, with the remainder split equally between the decedent's four children. None went to the Plan despite its intervention. The court found that the elements of res judicata are met here since the Probate Court issued a valid, final decision on the merits regarding the allocation of settlement funds; the parties in this case are the same as those in the probate proceedings; and the claims in this action were litigated in Probate Court. The ERISA plan only entitles Dillard's to "recoveries and funds paid by a Third Party to a Covered Person relative to the injury or sickness..." The Probate Court reviewed the facts and concluded that the settlement was a recovery paid to the decedent's children, not to the decedent herself. As such, the plain terms of the plan place such a recovery outside of Dillard's reach.

In [McClure v. United Parcel Serv. Flexible Benefits Plan, No. 1:14-CV-845, 2015 WL 803094, at \(W.D. Mich. Feb. 25, 2015\)](#), Plaintiff brought suit seeking the court to: 1) declare the rights of the parties under the United Parcel Service Flexible Benefits Plan (the Plan) and his State Farm automobile insurance policy and determine that State Farm is required to reimburse the Plan for all accident-related medical expenses incurred by the Plan; 2) require the Plan to intervene in a pending state-court action against drivers of vehicles who caused his injuries in order to exercise its subrogation rights and protect its interests; 3) enjoin the Plan from seeking reimbursement from any recovery that Plaintiff might obtain against the other drivers in the state-court action; and (4) order State Farm to reimburse Plaintiff to the extent the Plan is deemed to be entitled to reimbursement from Plaintiff's potential recoveries against the other drivers in the state-court action. State Farm filed a motion to dismiss pursuant to Rule 12(b)(1) for lack of ripeness. The court denied State Farm's motion, finding that Plaintiff's claims are ripe for adjudication. First, there is more than a mere possibility that Plaintiff will obtain a third-party recovery from which the Plan will seek reimbursement since the Plan has already demanded reimbursement from any recovery in the state-court litigation. The uncertainty of whether State Farm's coverage is primary presents a substantial controversy of sufficient immediacy between parties having adverse interests, especially where the parties in the state-court litigation have stipulated to adjourn trial in that case pending a decision by this court. Second, the factual record is sufficiently developed to allow this court to render a fair adjudication on the merits of the claims. Finally, a ruling from this court will likely aid the state court in resolving Plaintiff's claim against State Farm and may guide the parties in formulating their state-court litigation strategies.

In *Metro. Life Ins. Co. v. Bentley*, No. 14-CV-14939, 2015 WL 163581 (E.D. Mich. Jan. 13, 2015), the court denied Plaintiff Metropolitan Life Insurance Company's motion for a temporary restraining order ("TRO") but scheduled a hearing to consider its request for a preliminary injunction, in this matter where MetLife alleges that it erroneously overpaid monies to Defendant as beneficiary of a decedent's life insurance benefits. Four factors govern whether the court will issue a TRO (the same four factors governing whether to issue a preliminary injunction): (1)

whether the plaintiff has demonstrated a substantial likelihood of success on the merits; (2) whether there is a threat of irreparable harm to the plaintiff; (3) whether issuance of the injunction would harm others; and (4) whether the public interest is served by granting injunctive relief. Plaintiff, in its motion for a TRO, did not engage in any analysis of the four factors governing the propriety of granting temporary injunctive relief. Further, even if assuming, without deciding, that § 502(a)(3) of ERISA entitles a plan fiduciary to immediate equitable relief, Plaintiff did not provide the requisite proofs to demonstrate that § 502(a)(3) applies to this specific situation. Plaintiff did not identify anything in its initial filings demonstrating that a “term of the plan” requires enforcement to remedy the overpayment.

F. Seventh Circuit

**Suit seeking to enjoin attorney from prosecuting state court action for payment of attorneys’ fees based on common fund doctrine is prohibited by the Anti-Injunction Act.** [International Union of Operating Engineers Local 399 Health and Welfare Fund v. Walsh, Knippen, Pollock & Cetina, Chartered, No. 15 C 7143, 2015 WL 7077334 \(N.D. Ill. Nov. 13, 2015\)](#) (Judge Robert W. Gettleman). Defendant Walsh represented an ERISA plan participant in an action against a third-party that caused an accident and her injuries. Walsh obtained the settlement in that lawsuit plus an additional settlement in an underinsured motorist claim, totaling \$248,035.40. Walsh then paid the Fund \$176,881.10 in full reimbursement of the amounts owed by the participant under the plan and reimbursement agreement but then sued the Fund in state court under the common fund doctrine, seeking \$58,960.37 (one-third of \$176,881.10) in attorney’s fees for its legal services in creating the settlement fund from which the Fund’s claim for reimbursement was satisfied. After attempting unsuccessfully to remove the matter to federal court on the basis of complete preemption, the Fund filed suit seeking an order enjoining Walsh from prosecuting the state court action which would invalidate or reduce an alleged equitable lien created by the plan terms. The court found that the Fund failed to explain how the terms of a repayment agreement signed by the participant can justify an injunction against Walsh, which is not a party to the plan or that agreement. The Supreme Court’s decision in *U.S. Airways v. McCutchen*, 133 S. Ct. 1537 (2013) holds only that parties to a plan agreement can be held to the specific terms of that agreement without regard to equitable defenses, even in a suit for equitable lien brought under § 502(a)(3). The court found that *McCutchen* has no impact *Trustees of the Carpenters’ Health and Welfare Trust Fund of St. Louis v. Darr*, 694 F.3d 803, 807 (7th Cir. 2012), which held that a suit brought under § 502(a)(3) against a non-party to a plan seeking to enjoin that non-party from proceeding against a fund in state court is prohibited by the Anti-Injunction Act. Because *Darr* remains good law, the court granted Walsh’s motion to dismiss.

In [\*Pactiv Corp. v. Sanchez\*, No. 13-CV-8182, 2015 WL 4508667 \(N.D. Ill. July 23, 2015\)](#), Pactiv's Health and Welfare Benefit Plan excludes coverage for medical care where benefits are available under Workers' Compensation laws and obligates Defendant to refund the Plan the amounts that it paid where another party is responsible for medical expenses. Defendant did not dispute Pactiv's interpretation of the Plan, rather, he argued that waiver, issue preclusion, and claim preclusion bar the claim. The court found that Pactiv seeks equitable relief available under ERISA § 502(a)(3). In requesting a set-off, Pactiv also is seeking reimbursement from a particular fund—the State Court Judgment that has been entered against it. The court rejected Defendant's argument that Pactiv waived its right to set-off or to reimbursement by failing to assert a Section 8(j) credit in the Workers' Compensation proceeding. With respect to issue preclusion, the court found that the issue litigated in state court is distinct from the central liability question here, which is whether Defendant must reimburse Pactiv for benefit payments under the terms of the Plan. With respect to claim preclusion, the court found that Plaintiff could not have asserted its ERISA rights under the Plan in the Workers' Compensation proceeding as federal courts have exclusive jurisdiction over § 502(a)(3) claims. The court declined to offset Plaintiff's relief against any attorneys' fees or costs Defendant incurred.

#### G. Eighth Circuit

In [\*Pharmacia Corp. Supplemental Pension Plan, ex rel. Pfizer Inc. v. Weldon\*, No. 4:14CV1498 CDP, 2015 WL 5021889 \(E.D. Mo. Aug. 24, 2015\)](#), Plaintiff brought suit against Defendant seeking reimbursement for more than \$1.3 million in pension distributions that they mistakenly paid to her. When Defendant retired she elected to receive her pension benefits in set monthly payments over a period of three years, but the payments continued beyond three years. Defendant and her financial advisor brought the payments to the attention of the Plan's third-party administrator, who assured Defendant that the payments were correct. The Plan ultimately stopped making the mistaken payments in 2009 and brought suit almost five years later asserting a variety of claims under ERISA and state law. Defendant filed a motion to dismiss, asserting that Plaintiffs' ERISA claims fail because they seek legal, not equitable, relief, and that the state-law claims are preempted by ERISA. Defendant also filed a motion for summary judgment, asserting that Plaintiffs failed to file their lawsuit within the applicable statutes of limitation and that the affirmative defense of laches should apply to bar their claims. The court concluded that the Plan's ERISA claims for restitution and unjust enrichment survive to the extent they seek to recover specifically identifiable funds (or the traceable proceeds of such funds) in Defendant's possession and control. The court dismissed the claim seeking enforcement of the terms of the Plan because Defendants' did not identify any plan provision requiring repayment of any benefit overpayments. The court dismissed the count for "recoupment/money had and received," various state-law claims, and unjust enrichment as a federal common law claim because they seek relief not allowed by ERISA or they assert state-law claims that are preempted by ERISA. The court denied Defendant's summary judgment motion because genuine disputes of material fact remain

as to when the cause of action accrued, and whether Plaintiffs' delay in bringing their claims was unreasonable.

**Suit for reimbursement against secondary insurer for medical claims paid on behalf of common insureds constitutes legal relief not available under ERISA.** In [\*Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Student Assur. Servs., Inc.\*, No. 14-2376, F.3d , 2015 WL 4716916 \(8th Cir. Aug. 10, 2015\)](#), a dispute between two insurance companies regarding the primary responsibility to cover medical expenses incurred by their common insureds, the Eighth Circuit affirmed the district's dismissal of the suit to enforce the terms of the Central States Plan because the complaint seeks legal, rather than equitable relief. After the insured students sustained athletic injuries, Central States paid the students' medical expenses and sought reimbursement from Student Assurance in the amount of \$137,204.88 in benefits. Student Assurance refused to pay and Central States sued for declaratory relief, restitution, and the imposition of an equitable lien and constructive trust to secure reimbursement for the benefits. Following the analysis of *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) and its sister circuits, the court concluded that Central States' claims for restitution and for an equitable lien or a constructive trust are legal rather than equitable claims, because the fund seeks compensation out of the general assets of the non-ERISA insurers, and does not assert the right to particular property in the possession of the insurers.

#### H. Ninth Circuit

**Subrogation/reimbursement provision contained only in SPD, incorporated by the master plan document which is otherwise silent on subrogation, is not enforceable because it is in conflict with the master plan document.** [\*Apollo Educ. Grp. Inc. v. Henry\*, No. CV-15-00143-PHX-DJH, F.Supp.3d , 2015 WL 9257027 \(D. Ariz. Dec. 17, 2015\)](#) (Judge Diane J. Humetewa). This matter involves a subrogation action brought by a health plan against a participant for reimbursement of medical expenses following a settlement with a third party. Plaintiffs brought suit against Defendant seeking equitable relief in the form of enforcement of their reimbursement rights under the Plan, injunctive and declaratory relief, and an order for damages in the amount of \$47,930.87 for Defendant's alleged breach of the agreement to reimburse Plaintiffs. Defendants moved to dismiss on the basis that the written instrument on the Plan does not contain any subrogation/reimbursement provision, which is only contained in the Summary Plan Description ("SPD"). Here, the Plan incorporated the SPD. Defendants also moved to dismiss on the basis that the Plan and the SPD are in conflict and that in this event the terms of the Plan control. With respect to the first argument, the court was skeptical of Defendant's claim that under no circumstances may an SPD be incorporated into a written instrument. However, the court found that it need not decide that issue because it found that Defendant is entitled to relief based on the second argument that the written instrument and the

SPD are in conflict with regard to the issue of reimbursement. The language of the SPD itself states that the written instrument “will control in the event of any conflict between the provisions of the Plan and this SPD.” The court found that if the SPD and the Master Plan Document have become one in the same through incorporation, there would be no need for a conflict provision like the one in the SPD. Thus, by including the conflict provision in their SPD, the court found that Plaintiffs implicitly recognize that the SPD retains its separateness from, and is less authoritative than, the master plan document. Because there is no reimbursement provision in the master plan document, the court held that Defendant is not required to reimburse Plaintiffs for the medical expenses paid on his child’s behalf and dismissed the action.

**Counterclaim of breach of fiduciary duty based on pursuing subrogation rights dismissed in the absence of factual allegations that fiduciary failed to apply credit to benefit plan members or defray administrative costs.** [JDA Software Inc., et al., Plaintiffs, v. Sergio Berumen, et al., Defendants., No. CV-14-01565-PHX-DLR, 2015 WL 8003210 \(D. Ariz. Dec. 7, 2015\)](#) (Judge Douglas L. Rayes). The court granted the Counter-defendants’ motion to dismiss an amended counterclaim alleging that they breached a fiduciary duty owed to defendants\counter-plaintiffs as Plan members by pursuing subrogation/reimbursement rights (1) while intending to misuse subrogation monies and (2) without mitigating damages. The court previously found the fact that JDA is credited with the third party recovery, alone, does not plausibly suggest wrongdoing. The court found that there were no factual allegations suggesting that JDA failed to apply this credit to benefit the Plan members or defray administrative costs, such that the counter-plaintiffs have not alleged a plausible breach of fiduciary duty based on misuse of subrogation monies. The court also found that counter-plaintiffs stop-loss allegations may be asserted as an affirmative defense to the amount of recovery to which counter-defendants might be entitled.

**Health plan’s subrogation provision does not apply to wrongful death action brought by a plan participant’s children and mother.** *MedCath Inc. Employee Health Care Plan v. Stratton*, No. CV-14-08099-PCT-NVW, \_\_F.Supp.3d\_\_, 2015 WL 225414 (D. Ariz. Jan. 16, 2015) is an action by a health plan seeking to enforce a subrogation provision against the estate of a plan participant who had brought a negligence action related to medical care she received under the plan. The plan participant passed away and her surviving son intervened as plaintiff and filed an amended complaint for himself and on behalf of his minor siblings and grandmother. The amended complaint asserted an Arizona Wrongful Death Act claim seeking monetary judgment on behalf of each of the statutory beneficiaries as compensation for grief and sorrow and for the loss of the decedent’s love, affection, companionship, tutelage, and guidance. It does not seek to recover any damages incurred by the plan participant. Plaintiff sought to intervene and filed this action to adjudicate its ERISA subrogation claim. The court found that the First Amended

Complaint fails to state any ERISA claim upon which relief can be granted. ERISA permits Plaintiff to seek equitable relief to enforce the terms of the Plan, but the written plan documents authorize Plaintiff to recover payments for health care expenses incurred by the plan participant only from proceeds paid in compensation for the participant's injuries. The court found that they do not entitle Plaintiff to recover from proceeds received in the wrongful death action for the losses suffered by the participant's children. The Estate of Tracie Stratton was not a party to the wrongful death action and did not continue her professional negligence action after her death. Plaintiff does not allege that the Estate has received any proceeds that would be subject to Plaintiff's subrogation and reimbursement rights. As such, Plaintiff's subrogation and reimbursement rights do not apply in the circumstances of this action and the question of whether an ERISA plan preempts the Arizona Wrongful Death Act does not arise.

I. Tenth Circuit

J. Eleventh Circuit

In [Pate v. Winn-Dixie Stores, Inc., No. CV213-166, 2015 WL 1097394 \(S.D. Ga. Mar. 11, 2015\)](#), the court invoked its power under FRCP 16 and its "inherent power" to order a non-party health Plan representative to attend a settlement conference in a personal injury matter, in which the Plan had asserted a subrogation lien. The parties had reached a "tentative settlement" which depended on the Plan compromising its lien. The Plan refused to compromise so Plaintiff, joined by Defendant, filed a motion seeking its attendance at a further settlement conference. The court found that an order directed at the Plan is necessary for the court to perform its function of facilitating productive settlement discussions under Rule 16.

XXVII. *Venue*

A. Second Circuit

**Court enforces *pro se* litigant's choice of his home forum to litigate denial of pension benefits.** [McQuennie v. Carpenters Local Union 429, No. 3:15-CV-00432, 2015 WL 6872444 \(D. Conn. Nov. 9, 2015\)](#) (Judge Victor A. Bolden). In action brought by *pro se* plaintiff for pension benefits, the court denied Defendants' motion to dismiss the case for improper venue and to transfer this action to the Central District of California. The court construed Plaintiff's pleading to allege that his claim for pension benefits continues to be denied to this date. Because Plaintiff resides in Connecticut, he most recently was to receive benefits, if any, in Connecticut, and thus the alleged breach, if any, took place in Connecticut and venue is proper in this district.

The court found that while the convenience of witnesses and locus of operative facts weigh heavily in favor of transferring this action, more compelling the considerations that (i) Plaintiff has chosen to sue in his home forum, which “choice is generally entitled to great deference” and “should rarely be disturbed,” (ii) Plaintiff’s choice of forum receives even greater deference in the ERISA context; and (iii) Defendants have much greater means to litigate in this district than Plaintiff, who is *pro se*, has to litigate in California.

B. Third Circuit

**Forum selection clause is enforceable in breach of fiduciary duty action.** [Harley v. The Bank of New York Mellon, No. 1:15-CV-1384, 2015 WL 6956564, at \\*1 \(M.D. Pa. Nov. 10, 2015\)](#) (Judge Sylvia H. Rambo). In this ERISA breach of fiduciary duty action, Defendant moved to transfer venue to the Southern District of New York pursuant to a forum selection clause contained in a master trust agreement governing Defendant’s direction of assets in a pension plan. The court found that the forum selection clause is valid and applies to the current dispute. Accordingly, the court granted Defendant’s motion to transfer venue.

In [Plotnick v. Computer Sciences Corp. Deferred Comp. Plan For Key Executives, No. 14-CV-303 KM, 2015 WL 4716116 \(D.N.J. Aug. 7, 2015\)](#), Plaintiff filed a putative class action lawsuit alleging that CSC violated ERISA by retroactively applying an amendment to the benefits plan in which he participates. Defendants moved to transfer venue to the Eastern District of Virginia, which the court granted. Plaintiff maintains residences in Jacksonville, Alabama, and Atlantic City, New Jersey. Defendant is headquartered in Falls Church, Virginia. The court found that Defendant had made the requisite showing under 28 U.S.C. § 1404(a) in support of the transfer. First, this action could have been brought in the Eastern District of Virginia since the benefits plan that is the subject of this litigation was administered from CSC’s headquarters in Falls Church, Virginia, which lies in that district. Second, the private factors weigh in favor of transfer since Plaintiff moved his permanent residence to Alabama in August 2009 and his diminished presence in New Jersey weighs in favor of transfer. Finally, the public factors announced in *Jumara* do not cut against transfer since there are practical considerations which could make the litigation easier and more expeditious, or less expensive if the matter is transferred to the Eastern District of Virginia. The court found the remaining factors to be neutral.

In [Carpenters Combined Funds, Inc., ex rel. Klein v. Kelly Sys., Inc., No. CIV.A. 14-1681, 2015 WL 3457872 \(W.D. Pa. May 29, 2015\)](#), the court transferred this matter, an action seeking to enforce the collective bargaining obligations of non-parties, to the United States District Court for the Middle District of Pennsylvania. Defendants declared that all of the potential evidence in this case is located at their Harrisburg offices and any potential testimony concerning those

records and/or their business practices would necessarily come from employees located in that region. Further, any evidence from contracting jobs for third parties performed by those entities would also be related to construction sites in the Middle and Eastern Districts of Pennsylvania because that is where those companies do business. The court found that the *Jumara* factors determinative of whether to grant a motion to transfer venue under Section 1404(a) supported a transfer of venue. The court declined to enforce a forum selection provision in Trust documents that Plaintiff failed to demonstrate were incorporated into the CBAs.

In *Erwood v. Life Ins. Co. of N. Am.*, No. CIV.A. 14-1284, 2015 WL 143892 (W.D. Pa. Jan. 12, 2015), the court denied Defendants' motion to transfer venue to the Northern District of Georgia, in this matter where Plaintiff seeks to recover life insurance benefits under a benefit plan established by WellStar Health System on behalf of its employees, including her deceased husband. The Plan is funded by a group life insurance policy purchased by WellStar from Defendant Life Insurance Company of North America ("LINA"). LINA both insures the Plan and handles all claims administration on behalf of the Plan. Plaintiff filed this action in the United States District Court for the Western District of Pennsylvania pursuant to ERISA's broad venue provisions. Plaintiff resides in Georgia and WellStar is a Georgia corporation, with no offices or employees in Pennsylvania. Georgia is the location where LINA entered into an Agreement with WellStar to insure benefits and review claims brought by WellStar employees and their beneficiaries. However, LINA reviewed Plaintiff's claim for benefits "out of a location in Pennsylvania." Plaintiff argued that venue is proper in Pennsylvania, where LINA is headquartered, and in Pittsburgh, the location of the United States District Court for the Western District of Pennsylvania, where the claim was administered and denied. The court found that in weighing private considerations, it is clear that key documents and witnesses to the dispute are located in both venues, rendering party and witness convenience, expense and travel factors less pivotal. With regard to public factors, ERISA claims typically are resolved on motions for summary judgment. Thus, court convenience and docket are not weighty factors in favor of transfer. Similarly, while WellStar may not have assets in Pennsylvania, Plaintiff may enforce a judgment entered against it in this district in Georgia pursuant to either 28 U.S.C.A. § 1963 or the "Uniform Enforcement of Foreign Judgments Law," Ga.Code Ann. § 9-12-130, which permits enforcement in Georgia of any "judgment, decree, or order of a court of the United States." Accordingly, enforceability of the judgment is not a factor weighing in favor of transfer. The court noted that the only consideration tipping in favor of transfer appears to be Defendants' preference to litigate this action in Georgia but they have not met their burden to establish that transfer is warranted such that Plaintiff's choice of venue should be disturbed.

C. Fourth Circuit

In [\*Trustees of Nat. Asbestos Pension Fund v. KC Firestop & Insulation Co., LLC\*, No. CIV. PJM 14-3873, 2015 WL 2085486 \(D. Md. May 4, 2015\)](#), the court denied Defendant's motion to dismiss or transfer venue. The court found that ERISA's special venue provision trumps the general venue provisions of 28 U.S.C. § 1391(b). Venue is proper in Maryland because the Pension Fund at issue in this delinquent contributions action is administered in Maryland. Regarding possible transfer, the court explained that Trustees of ERISA funds are given the privilege to sue employers who fail to contribute to the fund in the district where the plan is administered without regard to the location of the employers. Even though Defendant may have fewer resources than the Pension Fund, the policy rationale supporting ERISA's special venue provision requires more than Defendant has argued here to justify transferring this case away from the Pension Fund's preferred forum.

D. Sixth Circuit

**Motion to transfer venue granted where sole connection to forum is Plaintiff's counsel's law office.** [\*Hopkins v. Life Insurance Company of North America\*, No. 315CV00375GNSCHL, 2015 WL 9244489 \(W.D. Ky. Dec. 17, 2015\)](#) (Judge Greg N. Stivers). Plaintiff brought suit against LINA for denial of long-term disability benefits in the Western District of Kentucky. She resides in North Carolina, LINA is a Pennsylvania company with its principal place of business in Philadelphia, LifePoint Hospitals, Inc. (the employer who sponsored the LTD Plan) is headquartered in Tennessee, and Hopkins' treating physicians are all in Virginia. LINA filed a motion seeking to transfer this matter to the Middle District of North Carolina, the district in which Hopkins resides. The court found that consideration of the pertinent factors here leads to the common-sense conclusion that Kentucky is not the proper place for this action, where the sole connection here is Plaintiff's counsel's law practice. The court granted LINA's request and transferred the matter.

**Court transfers matter based on forum-selection clause contained in pension plan.** [\*Keever v. NCR Pension Plan, et al.\*, No. 3:15-CV-196, 2015 WL 9255342 \(S.D. Ohio Dec. 17, 2015\)](#) (Judge Walter H. Rice). Defendants sought to enforce Paragraph 8.9 of the NCR Pension Plan, which states: Effective on and after February 11, 2011, any claim or action filed in court or any other tribunal in connection with the Plan by or on behalf of a Participant or beneficiary shall only be brought or filed in the United States District Court for the Northern District of Georgia. Plaintiffs challenged that this forum-selection clause is unenforceable because it was not a "bargained for" provision, and is contrary to public policy. The court followed the majority opinion in *Smith v. Aegon Companies Pension Plan*, 769 F.3d 922 (6th Cir. 2014), petition for

cert, filed, 83 U.S.L.W. 3768 (U.S. Mar. 13, 2015) (No. 14-1168, 14A682), and determined that the forum-selection clause is enforceable. Rather than dismiss the action, the court transferred it to Northern District of Georgia.

[Whitehouse v. Life Insurance Company of North America, No. 3:15-CV-00639-TBR, 2015 WL 7587361 \(W.D. Ky. Nov. 25, 2015\)](#) (Judge Thomas B. Russell). Plaintiff filed suit in Kentucky but she resides in Illinois, LINA administered her claim in Texas, and the breach (if any) happened in Illinois. The court denied the motion to transfer venue filed under Federal Rule of Civil Procedure 12(b)(3), but pursuant to 28 U.S.C. § 1404(a), the court directed the clerk to transfer the action to the United States District Court for the Central District of Illinois, Peoria Division.

[Harry Dull, et al., Plaintiffs, v. Energizer Pers. Care, LLC, et al., Defendants. Additional Party Names: Donald Kearns, Sr., Donald Steely, Irene Dunne, Jeffrey Taylor, Joyce Dull, Magdalene Wheeler, Richard Fields, Thomas Lawson, No. 3:14-CV-195, 2015 WL 5308871 \(S.D. Ohio Sept. 11, 2015\)](#). In this putative class action challenging the termination of life insurance benefits under ERISA and the LMRA, the court dismissed without prejudice the ERISA claim for improper venue in the Southern District of Ohio. None of the plans at issue are administered in Ohio. None of the alleged breaches occurred in Ohio, where under ERISA, a breach “takes place” where the plaintiff receives his or her benefits and Plaintiffs do not live in Ohio. Lastly, Defendant neither “resides” nor “may be found” in Ohio, where for ERISA venue purposes, a defendant may be found in any district in which its minimum contacts would support the exercise of personal jurisdiction within the limitations of the Due Process Clause of the Fourteenth Amendment.

In [Hilbert v. Lincoln Nat. Life Ins. Co., No. 3:14-CV-565-JGH, 2015 WL 1034058 \(W.D. Ky. Mar. 9, 2015\)](#), the court granted Lincoln’s motion to transfer this case to a more convenient forum – the Middle District of Pennsylvania – where the action might have been brought under 28 U.S.C. § 1404(a). Here, this Court is 600 miles away from Plaintiff’s home, which is located within the Middle District of Pennsylvania. One of the divisional courthouses in that district is only four miles away from her home. Plaintiff’s former employer established and administered her benefits plan and it is also located in the Middle District of Pennsylvania. All of Plaintiff’s medical information and all of her treating physicians are located in the Middle District of Pennsylvania. Defendant’s principal place of business is in the Eastern District of Pennsylvania. The only connection to this court is that Plaintiff’s counsel resides and practices law within the Western District of Kentucky.

E. Seventh Circuit

[Nagle v. The Hartford Life & Accident Ins. Co., No. 15-CV-6073, 2015 WL 9268420 \(N.D. Ill. Dec. 21, 2015\)](#) (Judge Thomas M. Durkin). Sale of operative policy from an office in Chicago is sufficient to establish specific jurisdiction over Plaintiff's ERISA claims and proper venue.

In [David Frye Tr. v. Indiana Concrete Sawing & Drilling, Inc., No. 1:15-CV-00137-JMS, 2015 WL 4041540 \(S.D. Ind. July 1, 2015\)](#), a matter seeking unpaid contributions to a pension fund, Defendant sought to change venue to the Northern District of Indiana, which the court denied. The parties agreed that this action could have been brought in either the Northern or Southern District of Indiana. The court determined that overriding Plaintiff's chosen forum would not promote the interests of justice and the convenience of the parties and witnesses.

*Aeschliman v. Dealer Mktg. Servs., Inc.*, No. 14-CV-1448, 2015 WL 231949 (C.D. Ill. Jan. 16, 2015) involves state law claims of breach of contract, violation of the Illinois Wage Payment and Collection Act, and violation of ERISA. Defendants removed the entire civil action from the Circuit Court of Tazewell County, Illinois to this court pursuant to 28 U.S.C. § 1441 on the basis of federal question jurisdiction. Defendants sought to dismiss the action for lack of venue or alternatively, to change venue to the Southern District of Iowa, Davenport Division. Plaintiff's ERISA claim is that DMS failed to notify its plan administrator that Plaintiff was terminated, thus depriving him of COBRA benefits under ERISA. The court explained that much like the breach of contract claim, where the decision to withhold the COBRA benefits from Plaintiff is the location of the material events for this claim. The parties did not present the court with any information to definitively conclude where that decision was made, nor was there any evidence of where DMS' plan administrator, alleged to be the individual responsible for administering DMS' ERISA plan obligations, works or resides. The court presumed that the plan administrator is one of the DMS employees that is located or works in Davenport, Iowa. As such, the court concluded the ERISA claim weighs in favor of transferring the matter to Iowa, but other more significant relevant factors weigh in favor of keeping this action in Peoria, Illinois. The court denied Defendants' motion.

F. Ninth Circuit

[ORANGE COUNTY IBEW-NECA LABOR MANAGEMENT COOPERATION COMMITTEE, et al., Plaintiffs, v. PRO TECH ENGINEERING CORPORATION, Defendant. Additional Party Names: Douglas Chappell, Elec. Indus. Admin. Maint. Fund, Nat'l Elec. Benefit Fund, NECA-](#)

[IBEW Family Med. Care Plan, Orange Cnty. Elec. Joint Apprenticeship & Training Trust Fund, Orange Cnty. IBEW-NECA Elec. Workers Defined Contribution Plan, No. 14-CV-04225-LHK, 2015 WL 5591113 \(N.D. Cal. Sept. 23, 2015\).](#) In a matter seeking fringe benefit contributions to several trust funds, the court denied Defendant's motion to transfer venue from the Northern District of California to the Southern District of California. Because three of the plans involved in this case are administered in Santa Clara County and because some of the operative facts in the lawsuit occurred in the Northern District of California, the court concluded that the lawsuit is sufficiently related to the Northern District of California to afford substantial deference to Plaintiffs' choice of forum under ERISA's liberal venue rules and the balance of convenience is not strongly in favor of Defendant.

In [Schuett v. FedEx Corporation Retirement Appeals Comm., No. 15-CV-0189-PJH, 2015 WL 4484153 \(N.D. Cal. July 22, 2015\)](#), where Plaintiff filed a lawsuit for a claim for benefits and for breach of fiduciary duty related to a denial of spousal death benefits for her same-sex spouse, Defendants filed a motion pursuant to 28 U.S.C. § 1404(a) to transfer the action to the Western District of Tennessee for convenience of the parties and witnesses. Plaintiff resides in the Northern District of California. Defendant FedEx is headquartered in Memphis, Tennessee and is the named Plan Administrator for the defendant benefit plan. FedEx delegated the plan administration to the FedEx Retirement Service Center in Deerfield, Illinois, and the appeals package was assembled by Aon Claims Management in Lincolnshire, Illinois. Defendant RAC is an internal committee consisting of FedEx employees who work in Memphis and the relevant committee members reside in Tennessee or Northern Mississippi. The records pertaining to Plaintiff's claim for benefits are maintained in Illinois, with copies in Memphis, Tennessee. Judge Phyllis Hamilton denied Defendants' motion, finding that: (1) Plaintiff's choice of forum weighs strongly against transfer, especially where Plaintiff has chosen to file suit in her home forum and has significant ties to this forum; (2) with regard to the convenience of parties and witnesses, Defendants did not show that it will be more inconvenient for any of their witnesses to travel to California than it would be for Plaintiff and her witness to travel to Tennessee; (3) with regard to ease of access to evidence, defendants did not identify any other relevant documents apart from those that would be part of the administrative record; (4) with regard to the familiarity of each forum with the applicable law, this factor does not favor either side because all federal courts have equal familiarity with the governing law; (5) with regard to the local interest in the controversy, Plaintiff is a long-time resident of this judicial district, was married here to the Plan participant, and California has an interest in ensuring that its citizens receive any benefits to which they are entitled; and (6) with regard to the relative congestion and time to trial in each forum, there is not a strong disparity between the two jurisdictions (383 cases per judge in N.D. Cal. and 326 per judge in W.D. Tenn).

In [\*FCE Benefit Administrators, Inc. v. Training, Rehab. & Dev. Inst., Inc.\*, No. 15-CV-01160-JST, 2015 WL 2173744 \(N.D. Cal. May 7, 2015\)](#) (Not Reported in F.Supp.3d), a suit by a third party administrator that provides services for fringe benefit health plans against its former client, the court enforced a mandatory forum selection clause in the TPA Agreement requiring that suit be filed in San Mateo County. However, the court retained jurisdiction over the ERISA claims alleged in the cross-complaint.

In [\*Del Aguila v. Genentech-Roche Transitional Benefit Plan\*, No. C 14-4265 MMC, 2015 WL 2089636 \(N.D. Cal. May 4, 2015\)](#) (Not Reported in F.Supp.3d), the court granted Defendants' motion for partial dismissal of Plaintiff's amended complaint for *forum non conveniens*. Plaintiff filed suit against Genentech, alleging entitlement to benefits, including stock-settled appreciation rights ("S-SARs"), all of which are governed by the Genentech-Roche Pharma Transitional Benefits Plan (the "Transitional Benefits Plan"). The Roche S-SAR Plan ("S-SAR Plan") contains a forum selection clause requiring that any disputes arising under or in connection with this Plan shall be resolved by the Courts of Basel, Switzerland. The court found that the Transitional Benefits Plan itself clearly designates the S-SAR Plan as the controlling document for disposition of S-SARs and that the forum selection clause applies to a portion of Plaintiff's case.

#### G. Tenth Circuit

In *Danny P. v. Catholic Health Initiatives*, No. 1:14-CV-00022-DN, 2015 WL 164183 (D. Utah Jan. 13, 2015), the court granted Defendants motion to transfer venue from Utah to Washington under 28 U.S.C. § 1404(a). Plaintiffs brought suit under ERISA to recover expenses incurred by them for the treatment of one of the plaintiffs at the Island View Residential Treatment Center located in Utah. Plaintiffs are residents of Kitsap County, Washington. The health plan was provided to Plaintiffs through employment that took place in Washington. The court found that although the proper laying of venue is not a factor under § 1404(a), it adds weight to the analysis of transferring "in the interest of justice" where the validity of venue in Utah is doubtful. The court also found that the Western District of Washington bears a greater, and therefore a more just connection to the case than Utah. Lastly, the court noted that although choice of counsel is not addressed in 28 U.S.C. § 1404(a), and the Tenth Circuit has yet to rule on this issue, the Seventh Circuit has held that convenience of counsel is not a relevant factor in determining whether change of venue is proper under § 1404(a). The court found the Seventh Circuit's reasoning persuasive and does not consider the convenience of counsel to be a relevant factor.

H. Eleventh Circuit

In *Turner v. Sedgwick Claims Mgmt. Servs., Inc.*, No. 7:14-CV-1244-LSC, 2015 WL 225495 (N.D. Ala. Jan. 16, 2015), the court, after a lengthy analysis, enforced the following venue provision in Ascension's long-term disability plan:

**10.20 Forum Selection Clause.**

Except as the law of the United States may otherwise require, any action by a Plan Participant or Beneficiary relating to or arising under the Plan shall be brought and resolved only in the U.S. District Court for the Eastern District of Missouri and in any courts in which appeals from such court are heard, and such court shall have personal jurisdiction over any Participant or Beneficiary named in such action.

The court held that pursuant to the mandatory forum-selection clause in the Plan documents, Plaintiff could file her ERISA action only in the United States District Court for the Eastern District of Missouri and a motion for a transfer to that district under the federal *forum non conveniens* statute, 28 U.S.C. § 1404(a) is the correct procedural vehicle by which to enforce a forum-selection clause pointing to a different federal court.

I. D.C. Circuit

XXVIII. ***Withdrawal Liability & Unpaid Benefit Contributions***

A. First Circuit

**Employer effectively submitted notice of termination from collective bargaining relationship, ending union's right to conduct an audit of its records.** In [\*New England Carpenters Cent. Collection Agency v. Labonte Drywall Co.\*, No. 14-1739, F.3d , 2015 WL 4597552 \(1st Cir. July 31, 2015\)](#), the Trustees for a group of union-related benefits funds and their collection agency brought suit against Defendant under ERISA and LMRA, seeking enforcement of an agreement that required Defendant to allow audit of its records. Defendant agreed to abide by the terms and obligations of the collective bargaining agreement ("CBA") through incorporation by reference in a statewide agreement, which it terminated effective April 3, 2007. Plaintiffs sought to audit Defendant through August 31, 2009. The district court granted judgment for Defendant after a bench trial and Plaintiffs appealed. The First Circuit held that: (1) the terms of a statewide agreement to abide by the terms of a CBA that simply required "notice of termination" in writing did not require Defendant to use any particular language in its notice

of termination; (2) Defendant's letter expressed unequivocal intent to withdraw from collective bargaining relationship so as to be a legally effective termination; (3) actual notice was sufficient to terminate the collective bargaining relationship under the terms of the statewide agreement; (4) union, as the other party to the statewide agreement to abide by the terms of the CBA, received actual notice of the letter providing unequivocal intent to withdraw from collective bargaining relationship; (5) the employer had authority to terminate the statewide agreement to abide by the terms of the CBA before the collective bargaining agreement's expiration date; and (6) the union did not have right to conduct audit of employer's records.

**Denial of motion to dismiss unpaid pension contributions claim based on “alter ego” theory.** In [Raso v. Pegasus & Sons Masonry Co., No. CIV.A. 15-10730-ADB, F.Supp.3d 2015 WL 3833737 \(D. Mass. June 22, 2015\)](#), a matter seeking unpaid pension contributions, Pegasus & Sons Masonry Co., Inc. and Pegasus, LLC filed a motion to dismiss one count of Plaintiff's complaint which alleged that even though Pegasus, LLC is not a signatory to the collective bargaining agreements, it operates as the alter ego of Pegasus Masonry, and is thus liable for the previous judgment against Pegasus Masonry, as well as Pegasus Masonry's unpaid contributions accruing after January 2011. Plaintiff alleged that they are both owned and managed by the same individual, operated out of the same building, and that the two companies conduct the same type of contracting business. The court found that these alleged facts indicate common ownership and shared location between Pegasus Masonry and Pegasus, LLC, and similarity of the two companies in terms of management, business purpose, and operation. Because a plaintiff need not allege all possible factors relevant to the alter ego analysis in order to withstand a motion to dismiss and drawing all reasonable inferences in favor of Plaintiff, the court found that the allegations plausibly suggest potential inequities which may further support a finding of alter ego liability.

B. Second Circuit

**Sole owner of company found liable for unpaid contributions.** [Sheet Metal Workers' Nat. Pension Fund v. Vardaris Tech Inc., No. 13-CV-5286 ARR, 2015 WL 6449420 \(E.D.N.Y. Oct. 23, 2015\)](#) (Judge Allyne R. Ross). The court granted Plaintiffs' summary judgment motion against corporate defendant, Vardaris Tech Inc., and its sole owner, Elias Rizos, in his individual capacity for failing to make contractually required contributions to five multi-employer benefit funds. The court found that the unpaid contributions became plan assets when they became due. Defendant Rizos exercised a level of control over those assets sufficient to make him a fiduciary under ERISA.

**Default judgment granted against Defendants for unpaid required contributions to benefit funds.** [Trustees of Sheet Metal Workers' Int'l Ass'n Local Union No. 28 Ben. Funds v. Maximum Metal Mfrs., Inc., No. 14-CV-2890 JLC, 2015 WL 5771853 \(S.D.N.Y. Oct. 2, 2015\)](#) (Judge James L. Cott). The court found Defendants Maximum, Maynard, and Smith jointly and severally liable for their violations of Sections 515, 404(a), and 406(a) of ERISA and awarded (1) \$122,574.05 in unpaid fringe benefit contributions; (2) \$41,661.40 in interest; (3) \$3,260.00 in attorneys' fees and (4) \$480.00 in court costs for a total of \$167,975.45.

[Gesualdi v. Tri-State Soil Solutions, LLC, No. 13-CV-5429 JS AKT, 2015 WL 5604150 \(E.D.N.Y. Sept. 23, 2015\)](#). The court granted default judgment in favor of Plaintiffs and against Defendant, awarding the following damages: \$123,533.13 in unpaid contributions; \$83,650.13 in interest on the unpaid contributions and interest accruing at \$60.911 per diem from September 20, 2014 through the date of judgment; \$68,203.26 in liquidated damages and additional liquidated damages at \$60.911 per diem from September 20, 2014 through the date of judgment; \$33,731.75 in attorneys' fees; and \$27,195.18 in costs and expenses.

[Trustees of Leather Goods, Plastics, Handbags & Novelty Workers Union Local 1 Joint Ret. Fund v. Key Handling Sys. Inc., No. 14-CV-2675 JS ARL, 2015 WL 5604178 \(E.D.N.Y. Sept. 23, 2015\)](#). The court granted default judgment in favor of Plaintiffs and awarded damages against Key Handling as follows: \$107,107.00 in damages based on Key Handling's withdrawal liability; \$8,945.88 in interest through November 21, 2014, plus additional interest at a daily rate of \$17.61 per day from that date through the date judgment is entered; \$21,421.40 in liquidated damages; \$6,228.75 in attorneys' fees; and costs in the amount of \$600.00. The court dismissed the complaint against the unidentified XYZ defendants.

[Trustees of Bldg. Trades Educ. Ben. Fund v. Fervent Elec. Corp., No. 14-CV-5511JS ARL, 2015 WL 5604220 \(E.D.N.Y. Sept. 23, 2015\)](#). The court granted Plaintiffs' motion for a default judgment to the limited extent that Plaintiffs are awarded \$458, but denied Plaintiffs' request for damages with leave to renew.

[Sullivan v. M.A.C. Design Corp., No. 14-CV-1846 NGG VVP, 2015 WL 5518456 \(E.D.N.Y. Sept. 17, 2015\)](#). The court awarded unpaid contributions in the amount of \$7,458.54 jointly and severally against both MAC and Syed; Interest on the unpaid contributions in the amount of \$3,431.04 through April 15, 2015, plus \$2.03 per day thereafter to the date of judgment jointly and severally against both MAC and Syed; Liquidated damages on the unpaid contributions in

the amount of \$3,431.04 through April 15, 2015, plus \$2.03 per day thereafter to the date of judgment jointly and severally against both MAC and Syed; Unpaid dues and assessment in the amount of \$671.88 jointly and severally against both MAC and Syed; Interest on the unpaid dues and assessment in the amount of \$275.42 through April 15, 2015, plus \$2.03 per day thereafter to the date of judgment jointly and severally against both MAC and Syed; Audit costs in the amount of \$2,240.00 jointly and severally against both MAC and Syed; Attorneys' fees and costs in the amount of \$10,916.00 jointly and severally against both MAC and Syed.

[\*Empire State Carpenters Welfare, Annuity, & Apprenticeship Training Funds ex rel. Morin v. Conway Const. of Ithaca, Inc.\*, No. 07-CV-2259 DRH SIL, 2015 WL 5355155 \(E.D.N.Y. Sept. 14, 2015\).](#) Overruling Defendant's objections, the court adopted Judge Locke's Report and Recommendation that Plaintiffs be awarded "a total of \$202,958.75 in damages, consisting of: (i) \$90,884.85 in unpaid contributions; (ii) \$24,918.34 in interest; (iii) 24, 918.34 in liquidated damages; (iv) \$3,711.46 in audit expenses; and (v) \$58,525.76 in attorneys' fees and costs.

In [\*Trustees of the New York City Dist. Council of Carpenters Pension Fund v. Onyx Glass & Metal Corp.\*, No. 14 CIV. 7333 PAE, 2015 WL 5144120 \(S.D.N.Y. Sept. 1, 2015\).](#) the court granted Plaintiffs' motion to confirm an arbitration award against Defendants for delinquent contributions. The court also granted the requested fees and costs but with a slight reduction for the rate requested for an attorney one year removed from law school.

In [\*Bd. of Trustees of the Heat & Frost Insulators Local No. 33 Pension Fund v. D & N Insulation Co.\*, No. 3:11-CV-01998 \(JAM\), 2015 WL 5121458 \(D. Conn. Aug. 31, 2015\).](#) three construction companies in West Haven, Connecticut closed their business operations and did not pay "withdrawal liability" to the union's pension fund for vested but unfunded pension benefits. The individual who led these companies started a new company—defendant E.R.P. Group, Inc. ("ERP")—that used nonunion employees to perform much of the same work that had been done by the now-shuttered businesses. The court granted summary judgment to Plaintiff, finding that the three closed companies are subject to withdrawal liability and that ERP is indeed the alter ego of the earlier companies and is therefore responsible for the withdrawal liability owed by the earlier companies.

In [\*Bricklayers Ins. & Welfare Fund v. LaSala\*, No. 12-CV-2314 JG RLM, 2015 WL 5022585 \(E.D.N.Y. Aug. 24, 2015\).](#) Plaintiffs alleged that principals of two subcontracting firms breached their fiduciary duty under ERISA by failing to remit employee union dues. After a bench trial in connection with Plaintiffs' third claim for relief against the "LaSala Defendants" for allegedly

breaching fiduciary duties involving an amended payment agreement, the court found that though Mark and Ken Jr. are shareholders and officers of Town and New Town, there was no evidence that they had any trustee relationship with the employee-benefit funds, or any discretionary authority or control respecting the management of these various plans. Unpaid contributions are not assets of the plan. Therefore, the court concluded that they are not fiduciaries under 29 U.S.C. § 1002(21)(A). With respect to Ken Sr., his promise to pay was contingent upon an event that never happened, and the court found that he did not violate any fiduciary duty, to the extent he had one, by failing to pay \$1.5 million out of his personal assets to satisfy Town and New Town's debts to the Funds. Even if the promise were unconditional, Ken Sr. would still not be personally liable under ERISA for a breach of fiduciary duty since the owed amounts were not plan assets.

In [\*Sheet Metal Workers' Nat. Pension Fund v. Maximum Metal Manufacturers Inc.\*, No. 13 CIV. 7741 PAE, 2015 WL 4935116 \(S.D.N.Y. Aug. 18, 2015\)](#), the court granted the Benefits Funds' motion for summary judgment against all defendants for the period from August 1, 2009 through July 31, 2013, but denied summary judgment as to the portion of the Benefits Funds' claims relating to contributions for the period between March 2009 and July 2009, because those claims are subject to a binding arbitration clause in the 2005 CBA. The court also awarded the Benefits Funds attorneys' fees in the amount of \$24,217.88, and costs in the amount of \$940.68.

In [\*Trustees of the Sheet Metal Workers' Nat. Pension Fund v. Steel & Duct Fabrication, Inc.\*, No. 14 CIV. 5503 KAM SMG, 2015 WL 4925170 \(E.D.N.Y. Aug. 18, 2015\)](#), the court granted Plaintiffs' discovery demand that Defendants make available for an audit their books and records in order to determine the amount of contributions owed to Plaintiffs, on behalf of their participants, for the period January 1, 2008 through April 30, 2014, pursuant to 29 U.S.C. §§ 1132(g), 1145.

In [\*Trustees of the Operative Plasterers' & Cement Masons' Int'l Ass'n Local 262 Welfare Fund v. Emerald Drywall Finishing Corp.\*, No. 14-CV-4631 JGK JLC, 2015 WL 4621534 \(S.D.N.Y. July 31, 2015\)](#), the court awarded Plaintiffs (1) \$44,347.29 in unpaid fringe benefit contributions; (2) \$804.31 in interest; (3) \$8,869.46 in liquidated damages; (4) \$4,273.73 in unpaid union dues; (5) \$2,100.00 in attorney's fees; (6) \$540.00 in court costs; and (7) \$3,500.00 in accountant fees for a total of \$64,434.79.

In [\*Demopoulos v. Anchor Tank Lines, LLC\*, No. 14 CIV. 7107 LGS, 2015 WL 4529315 \(S.D.N.Y. July 27, 2015\)](#), the latest in what is now an eight-year saga of lawsuits, the court dismissed Plaintiff's complaint seeking damages from Defendants Anchor Tank Lines LLC, Tank Acquisition Company LLC, Leonard Baldari, Robert Baldari and Michael David Hiller in connection with payments that were required but not made to International Brotherhood of Teamsters Local 553's benefit funds.

In [\*Trustees of the Local 7 Tile Indus. Welfare Fund v. Titan Interiors, LLC\*, No. 12-CV-135 JG SMG, 2015 WL 4509061 \(E.D.N.Y. July 24, 2015\)](#), the court granted the Trustees summary judgment in the amount of \$258,871.58, consisting of a principal deficiency of \$67,304.36, interest of \$91,828.61, liquidated damages of \$91,828.61, and audit costs of \$7,910, plus additional interest and attorney's fees and costs.

In [\*Mason Tenders Dist. Council of Greater New York v. Fortune Interiors Dismantling Corp.\*, No. 12 CIV. 4253 PAC, 2015 WL 4503630 \(S.D.N.Y. July 23, 2015\)](#), Plaintiffs moved for summary judgment on the grounds that Silver and Fortune are either alter egos or single employers as a matter of law, and accordingly Silver is liable for Fortune's debt. Defendants opposed and cross-moved for summary judgment that Silver is not liable for Fortune's delinquent payments. The court found that genuine issues of material fact remain, and it cannot be said as a matter of law that any differences between the companies are mere technical changes made to avoid Fortune's contractual and statutory obligations to the Plaintiffs.

In [\*Trustees of New York City Dist. Council of Carpenters Pension Fund, Welfare Fund, Annuity Fund, & Apprenticeship, Journeyman Retraining, Educ. & Indus. Fund v. Jalt Concrete Corp.\*, No. 15-CV-3812 PKC, 2015 WL 4503531 \(S.D.N.Y. July 23, 2015\)](#), the court granted the petition to confirm the Arbitration Award, awarding the Funds \$457,460.80 in unpaid contributions, \$86,270.93 in interest on unpaid contributions, \$91,492.16 in liquidated damages, \$2,364.40 to the petitioners' Promotional Fund, \$400 in court costs, \$1,500 in attorneys' fees, \$500 in arbitrator fees, and interest in the amount of 5.25% per annum on the total sum of the Award, accruing from the date of the Award. The court also awarded the Funds \$3,067.50 in attorneys' fees and costs.

In [\*Trustees of New York City Dist. Council of Carpenters Pension Fund, Welfare Fund, Annuity Fund, Apprenticeship, Journeyman Retraining, Educ. & Indus. Fund, Charity Fund v. Dedicated Indus. LLC\*, No. 14-CV-7610 RA, 2015 WL 4503695 \(S.D.N.Y. July 23, 2015\)](#), the court

granted the petition to confirm the arbitral Award and directed the Clerk of Court to enter judgment in favor of Petitioners and against Respondent in the amount of \$66,893.61, plus interest at the rate of 5.25% from June 17, 2014, through the date of judgment, together with attorney's fees and costs in the amount of \$656.98.

In [\*Demopoulos v. Anchor Tank Lines, LLC\*, No. 14 CIV. 7107 LGS, 2015 WL 4430699 \(S.D.N.Y. July 20, 2015\)](#), the court dismissed Plaintiffs' Amended Complaint seeking damages from Defendants Anchor Tank Lines LLC, Tank Acquisition Company LLC, Leonard Baldari, Robert Baldari and Michael David Hiller in connection with payments that were required but not made to International Brotherhood of Teamsters Local 553's benefit funds.

In [\*Food Employers Labor Relations Ass'n v. Great Atl. & Pac. Tea Co.\*, No. 14-3349-BK, Fed.Appx. , 2015 WL 4038579 \(2d Cir. July 2, 2015\)](#), the Second Circuit affirmed the bankruptcy court's denial of Plaintiff's motion for allowance of an administrative expense claim arising out of Defendant's withdrawal from participation in the FELRA pension plan.

**Company is not a “trade or business” for the purposes of the MPPAA where its mission was primarily personal and any profit it derived was incidental.** In [\*UFCW Local One Pension Fund v. Enivel Properties, LLC\*, No. 14-2487, F.3d , 2015 WL 3971221 \(2d Cir. July 1, 2015\)](#), the Second Circuit affirmed the district court's determination that Defendant was not a “trade or business” and that withdrawal liability did not attach. For an entity to be a “trade or business,” it must operate (1) for the primary purpose of income or profit, and (2) with continuity and regularity. The district court concluded that Enivel failed both prongs of the “trade or business” definition, because while the secondary purpose of Enivel was for income or profit, the primary purpose of Enivel was personal. A condo owned by Enivel was originally purchased as a residence for owners' daughter and only after she moved away did Enivel lease the unit to offset the investment's carrying costs. Similarly, other properties the company owned were personal investments and leased only to offset their carrying costs. The Second Circuit rejected the Fund's argument that status as a separate juridical entity prohibited any conclusion that Enivel's purpose is something other than the generation of income or profit. Even though Enivel had a “profit motive,” its efforts more accurately reflect the nature of its investments. In the alternative, the district court concluded that any income or profit activities engaged in by Enivel were not continuous and regular, but were interrupted and/or sporadic. The Second Circuit agreed and found that the time expended by the owners and any other individuals doing work for Enivel was negligible.

In [\*Sullivan v. United Const. Field, Inc.\*, No. 12-CV-682 ENV VVP, 2015 WL 4040417 \(E.D.N.Y. June 30, 2015\)](#), Plaintiffs' filed an objection to the Magistrate Judge's Report and Recommendation that defendant Mian not be held individually liable as a fiduciary for unpaid contributions. The district court found that Mian is also individually liable as a fiduciary for unpaid employer contributions to the funds under ERISA. According to the well-pleaded allegations in the complaint, which are accepted as true, Mian is an officer of United and a party and signatory to the 2008 CBA with the union; he had control over report submissions and payment of contributions to the funds; he wrote checks on United's behalf and managed the disposition of United's assets; and was responsible for diverting the assets at issue away from the benefit funds and, instead, made payments to other entities and individuals.

In [\*Trustees for the Mason Tenders Dist. Council Welfare Fund, Pension Fund, Annuity Fund, Training Program Fund v. YES Restoration\*, No. 14 CIV. 8536 KPF, 2015 WL 3822764 \(S.D.N.Y. June 19, 2015\)](#), the court granted Petitioner's motion for summary judgment on its petition to confirm the arbitration award. Respondent did not oppose the petition or otherwise appear in this action.

In [\*Trustees of New York City Dist. Council of Carpenters Pension Fund, Welfare Fund, Annuity Fund v. Vintage Tile & Flooring, Inc.\*, No. 14-CV-06450 KBF, 2015 WL 3797273 \(S.D.N.Y. June 18, 2015\)](#), the court granted default judgment to the Fund, finding that the facts alleged in the complaint support Defendants' liability under ERISA § 515 and Vintage 2's liability for Vintage 1's obligations under a previous judgment. The court declined to award the Funds \$252,300 in damages based on the sanctions imposed in the prior action.

In [\*Sheet Metal Workers' Nat. Pension Fund v. Coverex Corporate Risk Solutions\*, No. 09-CV-0121 SJF ARL, 2015 WL 3444896 \(E.D.N.Y. May 28, 2015\)](#), the court awarded Plaintiffs (1) unpaid contributions for the period from July 1, 2008 through August 31, 2008 in the total amount of \$35,160.71; (2) interest thereon in the total amount of \$22,966.89; (3) liquidated damages for the period from July 1, 2008 through August 31, 2008 in the total amount of \$7,032.05; (4) attorney's fees in the total amount of \$41,130.00; and (5) costs in the total amount of \$1920.79, for a total award of \$108,210.44.

[\*Buffalo Laborers Welfare Fund v. H&M Plumbing & Mech. Contracting Inc.\*, No. 14-CV-960S, 2015 WL 1735198 \(W.D.N.Y. Apr. 16, 2015\)](#) (granting default judgment and awarding Fund Plaintiffs \$195,398.70 in delinquent fringe benefit contributions, \$51,767.27 in interest,

\$51,767.27 in liquidated damages, and \$5,525.57 in attorneys' fees and costs; awarding Union \$9,326.94 in dues checkoffs, \$1,055.10 in NYLPAC contributions, and \$2,110.20 in Construction Industry Fund contributions, as well as \$2,978.63 in interest).

[United Ass'n. of Plumbers & Steamfitters Local No. 22 v. H&M Plumbing & Mech. Contracting Inc., No. 14-CV-070S, 2015 WL 1735117 \(W.D.N.Y. Apr. 16, 2015\)](#) (finding that the collective relief requested in the motion for a default judgment does not comport with the relief requested in connection with each of the three causes of action alleged in the Third Amended Complaint and denying motion for default judgment).

[Gesualdi v. Reliance Trucking of CG Inc., No. 14-CV-4112 ADS SIL, 2015 WL 1611313 \(E.D.N.Y. Apr. 10, 2015\)](#) (granting default judgment).

[Trustees of Empire State Carpenters Annuity, Apprenticeship, Labor-Mgmt. Cooperation, Pension & Welfare Funds v. Gregory, No. 14-CV-2900 ADS SIL, 2015 WL 1611307 \(E.D.N.Y. Apr. 10, 2015\)](#) (confirming Arbitration Award in the total amount of \$1,174,026.22, together with reasonable attorneys' fees and costs of \$1,365, but denying Plaintiffs' application for injunctive relief).

[Trustees of the New York City Dist. Council of Carpenters Pension Fund, Welfare Fund, Annuity Fund, & Apprenticeship, Journeyman Retraining, Educ. & Indus. Fund v. Innovative Furniture Installations, Inc., No. 14-CV-2508 ER, 2015 WL 1600077 \(S.D.N.Y. Apr. 9, 2015\)](#) (granting Plaintiffs' motion for summary judgment confirming arbitration award in favor of Plaintiffs in the amount of \$1,061,016.94, with interest to accrue at the rate of 5.25%, and also attorneys' fees and costs in the amount of \$7,231).

**Award of liquidated damages against individual defendant does not constitute “appropriate equitable relief,” and award of prejudgment interest and attorneys' fees against individual defendant must be justified.** In [Bricklayers & Allied Craftworkers Local 2, Albany, N.Y. Pension Fund v. Moulton Masonry & Const., LLC, No. 14-295, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 795290 \(2d Cir. Feb. 26, 2015\)](#), the 2<sup>nd</sup> Circuit affirmed the district court's default judgment against Defendants for \$662,135.21, which accounts for \$451,300.52 in withheld fringe benefit contributions and deductions, \$104,628.81 in prejudgment interest, \$99,203.93 in liquidated damages, and \$7,001.95 in attorneys' fees and costs. But, the 2<sup>nd</sup> Circuit found that the district court erred by entering a default judgment against Duane Moulton in his individual capacity

which included liquidated damages as well as prejudgment interest and attorneys' fees. The individual defendant was liable as an ERISA fiduciary under Section 409 of ERISA. Although under 29 U.S.C. § 1132, the corporate defendant is liable for unpaid contributions, interest, liquidated damages provided under the plan, attorneys' fees and costs, and any other legal or equitable relief the court deems appropriate, the same is not true for the individual defendant. As a fiduciary, the individual defendant can only be required under ERISA to make good to the plan any losses to the plan resulting from his breach, and such other equitable or remedial relief as the court may deem appropriate. The fiduciary's liability here would include the \$451,300.52 in withheld fringe benefit contributions and deductions, but it does not also include liquidated damages, prejudgment interest, and attorneys' fees. Liquidated damages do not serve to make good to the plan any losses and do not constitute "appropriate equitable relief" as recognized by the common law of trusts. Prejudgment interest can constitute appropriate equitable or remedial relief under 29 U.S.C. § 1109(a), but in order for the district court to grant such relief against a fiduciary in his individual capacity, it is required to articulate the reasons justifying such an award and the interest rate chosen. Because the district court failed to engage in this analysis, the court had no choice but to vacate and remand. Similarly, while the district court may award attorneys' fees, absent any specific analysis from the district court explaining why attorneys' fees are justified against the individual defendant in this case, a meaningful review is forestalled. On remand, the district court is directed to analyze whether attorneys' fees are justified in this case.

*In Upstate New York Engineers Health Fund v. FMC Demolition, Inc.*, No. 5:13-CV-1307 BKS/DEP, 2015 WL 401113 (N.D.N.Y. Jan. 28, 2015), a matter involving failure to remit fringe benefit contributions and deductions where the Defendant did not answer the complaint, the court granted Plaintiffs final judgment pursuant to Rule 54(b) on their first, third and fourth causes of action. The court awarded Plaintiff judgment against Defendants for the sum of \$13,064.97, which includes \$6,278.91 in unpaid contributions and deductions,<sup>4</sup> \$1728.65 in interest, \$2,024.89 in liquidated damages and \$3,032.52 in attorneys' fees and costs, plus interest thereon at the rate provided for by 28 U.S.C. § 1961(a). The court further awarded interest for the period from April 4, 2014 to date at the rates specified in its Memorandum–Decision and Order. The court also ordered Defendants to produce their books and records for Plaintiffs' review and audit covering April 1, 2012 to date, to pay the cost and expense of the audit, to pay all auditing fees and to pay all attorneys' and paralegal fees and costs incurred in obtaining that audit.

*In Upstate New York Engineers Health Fund ex rel. Harrigan v. Ransom*, No. 5:13-CV-01434 MAD, 2015 WL 145441 (N.D.N.Y. Jan. 12, 2015), the court granted Plaintiffs' motion for entry of default judgment against Defendants for the sum of \$128,674.54 including \$66,500.76 in unpaid contributions and deductions, \$27,454.77 in interest for the period from November 15,

2011 through May 20, 2014, \$27,069.92 in liquidated damages, and \$7,649.09 in attorneys' fees and costs; prejudgment interest and liquidated damages for the period from May 21, 2014 through January 12, 2015 at the rates provided for by 29 U.S.C. 1132(g)(2) and the Trusts and Collections Policy; and interest thereon at the rate provided for by 28 U.S.C. § 1961(a). The court further ordered that Defendants are required to produce their books and records for the period from May 2011 to date for Plaintiffs' review and audit, and to pay the cost and expense of such audit, including all attorneys' and paralegal fees and costs incurred in obtaining the audit.

In *Trustees of the United Health & Welfare Fund v. N. Kofsky & Son, Inc.*, No. 08 CIV. 11219 KNF, 2015 WL 59173 (S.D.N.Y. Jan. 5, 2015), Trustees of the United Health and Welfare Fund brought suit against Defendants N. Kofsky & Son, Inc. (“NKS”), Kofsky & Son, Inc. a/k/a Kofsky & Son Plumbing (“KSI”), Richard Kofsky and Stephen Kofsky, seeking monetary contributions that Defendants allegedly failed to pay to the Fund as required by, *inter alia*, a collective bargaining agreement between NKS and the International Longshoremen’s Association, Local 976. The Fund alleged that Defendants NKS and KSI are jointly and severally liable to the Fund for unpaid contributions because, at all relevant times, they had an alter ego or single employer relationship. The Fund also alleged that Richard Kofsky and Stephen Kofsky are individually liable to the Fund for the unpaid contributions because they conspired to defraud it of the required benefit contributions by transferring assets from NKS to KSI, which, since KSI is not a signatory to the CBA, enabled them to conceal NKS’s financial activity. After a bench trial, Defendants filed a motion for judgment on partial findings under Fed.R.Civ.P. 52(c). The court found that Plaintiffs did not meet their burden of proving, by a preponderance of the evidence, that they are entitled to the relief they seek. Accordingly, the court granted Defendants’ motion and dismissed the action.

### C. Third Circuit

**Arbitrator’s interpretation of provisions in a project labor agreement does not violate a well-defined policy.** [D.A. Nolt, Inc. v. Local Union No. 30, et al., No. 12-5810, 2015 WL 6378601 \(E.D. Pa. Oct. 22, 2015\)](#) (Judge Anita B. Brody). The court granted Defendant’s motion for summary judgment and granted in part and denied in part Plaintiff’s motion for summary judgment. The court upheld the arbitrator’s interpretation of the Employee Benefit Funds provision and award, but modified the arbitrator’s award to reflect the proper total number of hours worked by Plaintiff’s non-union employees, 12,873.75. Although the court explained that this “pay twice” result may seem counter-intuitive, Plaintiff has not shown that the arbitrator’s decision is illegal or unconscionable.

**Joint employer theory of liability does not extend to nonsignatory employers.** [Carpenters Combined Funds Inc. v. Kelly Sys., Inc., No. 1:15-CV-1091, 2015 WL 6083598 \(M.D. Pa. Oct.](#)

[15, 2015](#)) (Judge Christopher C. Connor). In matter seeking fringe benefit contributions, the court declined to extend the joint employer theory of liability to hold nonsignatory employers liable under Section 515 of ERISA for obligations springing from a collective bargaining agreement signed by another employer. Therefore, even assuming Carpenters is able to prove Defendants were joint employers with the signatory Novinger's, the court found that Plaintiffs still fail to state a claim based on a joint employer theory of liability upon which relief can be granted and dismissed the claim with prejudice.

**Motion to dismiss denied where complaint adequately pleads claim for withdrawal liability based on alter ego theory, successor liability, and common control.** [New Jersey Bldg. Laborers' Statewide Pension Fund & Trustees Thereof v. CID Constr. Servs., LLC, No. 15CV3412SRCCLW, 2015 WL 5965627 \(D.N.J. Oct. 14, 2015\)](#) (Judge Stanley R. Chesler). In matter seeking withdrawal liability, the court denied both CID's motion to dismiss and CID's motion for summary judgment. With respect to summary judgment, the court found that the Pension Fund has had no opportunity to conduct discovery on the actual relationship between the alleged alter ego company and the judgment debtor, and thus material issues of fact pertaining to the relationship between the companies remain in dispute. With respect to the motion to dismiss, the court found that the Pension Fund adequately pled an alter ego theory of liability: CID and U.S.E.U.S. collaborate on labor and employee relationships, and that the companies use the same equipment and machinery; and the companies have common ownership, common business operations, and a common corporate structure, as well as operating from the same location and operations. The court also found that the Complaint pleads sufficient facts to make plausible that CID would be responsible for U.S.E.U.S.'s withdrawal liability on a theory of successor liability: the Pension Fund asserts that the entities are related through family ownership and employment, and that the companies share equipment, premises, and a place of business; and CID exists to avoid U.S.E.U.S.'s withdrawal liability. Lastly, the court found that there are sufficient facts alleged in the Complaint that the Pension Fund has stated a common control claim upon which relief could be granted by the Court: the Pension Fund alleges that CID exists to avoid U.S.E.U.S.'s withdrawal liability, and that the businesses shared common ownership, common business operations, and a common corporate structure; the same individual or individuals own, manage, and oversee the operations of CID and U.S.E.U.S.; and CID and USEUS perform the same or similar services, in construction, and that they use and share the same equipment and machinery. CID and U.S.E.U.S. both engage in the business of construction.

**Default judgment granted in favor of funds of unpaid benefit contributions.** [IBEW Local 102Welfare, Pension, Annuity & Joint Apprenticeship Training Funds v. BCG Solar, LLC, No. 13-CV-4473 \(KM\), 2015 WL 5996320 \(D.N.J. Oct. 13, 2015\)](#) (Judge Kevin McNulty). The court entered default judgment against BCG but not against BAM, and awarded IBEW

\$95,356.85, comprising (i) \$64,043.29 in outstanding fees; (ii) liquidated damages of \$23,808.66; and (iii) \$7,504.90 in attorneys' fees and costs. Postjudgment interest will accrue at the appropriate rate pursuant to 28 U.S.C. § 1961.

[\*Greater Pennsylvania Carpenter's Pension Fund v. Novinger's, Inc.\*, No. CIV.A. 14-956, 2015 WL 5691093 \(W.D. Pa. Sept. 28, 2015\)](#). The court found that Defendants are liable for liquidated damages, attorney fees and costs borne by Plaintiff but denied Plaintiff's motion insofar as it seeks interim withdrawal payments.

[\*Trustees of the Local 888 Health Fund v. Kissler & Co.\*, No. CIV. 14-8097 WJM, 2015 WL 5666203 \(D.N.J. Sept. 25, 2015\)](#). In matter seeking delinquent contributions under a CBA, the court granted in part and denied in part Defendant's motion to dismiss. The court denied Defendant's motion to dismiss Plaintiff's claim for \$46,319.84 under the CBA, but granted the motion to dismiss Plaintiff's claim for \$98,970.50 under the MOU.

[\*Einhorn v. Highway Safety Sys., Inc.\*, No. CIV. 13-2021 RBK, 2015 WL 5567303 \(D.N.J. Sept. 22, 2015\)](#). The court granted Plaintiff's motion for default judgment against Defendant Highway Safety Systems, Inc. in the amount of \$576,808.79.

**Withdrawal liability is based on single highest contribution rate but the surcharge is not part of that rate.** In [\*Bd. of Trustees of IBT Local 863 Pension Fund v. C & S Wholesale Grocers, Inc.\*, No. 14-1956, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5438539 \(3d Cir. Sept. 16, 2015\)](#), the Third Circuit affirmed the district court's partial grant and denial of the parties' cross-motions for summary judgment in this matter seeking unfunded vested benefits following Defendant's withdrawal from the IBT Local 863 Pension Fund. The district court ruled that the annual withdrawal liability payment should be based on the single highest contribution rate (rather than averaging the rates in the CBAs), but should not include a surcharge pursuant to 29 U.S.C. § 1085(e)(7)(A). The Third Circuit held that the phrase "highest contribution" rate means the single highest contribution rate established under any of three collective bargaining agreements. The court also held that the annual withdrawal liability payment did not need to include a 10 percent surcharge.

[\*Elbeco Inc. v. Nat'l Ret. Fund\*, No. 5:15-CV-00318-JFL, 2015 WL 5168473 \(E.D. Pa. Sept. 2, 2015\)](#). Plaintiff sought a declaration that the amount of its withdrawal liability is \$913,970,

which is the figure cited in the April 2014 withdrawal liability estimate. Plaintiff also initiated arbitration with the American Arbitration Association regarding the withdrawal liability assessment. Defendant filed a Motion to Dismiss, which the court granted because although it has jurisdiction over the present dispute, Plaintiff failed to state a claim upon which relief can be granted. Equitable Estoppel is not a cause of action but a judicial doctrine that bars assertion of a claim or defense.

In [\*Kelly v. Gas Fields Specialists, Inc.\*, No. 1:14-CV-4, 2015 WL 4926576 \(M.D. Pa. Aug. 18, 2015\)](#), the court granted the Fund's motion for summary judgment on the issue of liability, finding that Defendant cannot avoid its obligation to contribute to the Funds on behalf of all of its employees, and the Funds are entitled to judgment as a matter of law pursuant to Section 515 of ERISA.

In [\*Int'l Bhd. of Elec. Workers Local Union No. 98 Health & Welfare Fund v. LMI Elec. Inc.\*, No. CIV.A. 15-380, 2015 WL 4389628 \(E.D. Pa. July 17, 2015\)](#), Plaintiffs alleged LMI failed to submit the full amount of contributions and deductions owed to the collective Funds. The Funds also alleged that two fiduciaries breached their fiduciary duties under ERISA and are personally liable for the outstanding contributions and deductions. The court denied Defendants' motion to dismiss both claims. The court found that LMI merely contests the truth of Plaintiffs' well-pled facts and fails to meet its burden under Fed.R.Civ.P. 12(b)(6) of showing that Plaintiffs' complaint fails to state a claim upon which relief can be granted. The court also found that the Funds made a prima facie showing that both individual defendants are ERISA fiduciaries by virtue of their discretionary control over plan assets.

In [\*Carpenters Health & Welfare Fund of Philadelphia & Vicinity v. Mgmt. Res. Sys., Inc.\*, No. CIV.A. 14-07097, 2015 WL 2395152 \(E.D. Pa. May 19, 2015\)](#), the court granted Defendants' motion to dismiss, finding that Defendants are not bound by the 2012-2015 CBA, and rejecting Plaintiffs' contention that the 1997 Assent Letter binds Defendants to all successive collective bargaining agreements negotiated between IFCA and the Union.

[\*Trustees of the New Jersey B.A.C. Health Fund v. Org Contracting\*, No. CIV.A. 13-5854 MAS, 2015 WL 1730171 \(D.N.J. Apr. 14, 2015\)](#) (granting default judgment to Plaintiff for Defendant's failure to make contributions to Plaintiff pursuant to the CBA).

In *Int'l Union of Painters & Allied Trades Dist. Council 711 Health & Welfare, & Vacation Fund, & Finishing Trades Inst. v. Petric & Associates, Inc.*, No. CIV.A. 13-1947 SDW, 2015 WL 273653 (D.N.J. Jan. 22, 2015), an action pursuant to Section 502 of ERISA and Section 301 of LMRA, Plaintiffs filed a six-count Third Amended Complaint against Petric, Conti, and Travelers Casualty and Surety Company, which issued a contract bond and served as surety to the bond on behalf of Conti. Plaintiffs allege that Petric failed to remit fringe benefit contributions in violation of 29 U.S.C. § 1145. Plaintiffs contend that as Principal to the Construction Contract, and pursuant to the Contract Bond, Conti is jointly and severally liable to pay the delinquent fringe benefit contributions. Plaintiffs claim that Conti breached a verbal agreement with the Union, of which Plaintiffs were third-party beneficiaries. The Complaint further alleges that Travelers, as surety on the Contract Bond, is jointly and severally liable for payment of the delinquent contributions. As part of Petric's Answer to Plaintiff's Complaint, Petric filed a ten-count cross-complaint alleging nine breach-of-contract claims against Conti relating to the Subcontract Agreement between Petric and Conti, and alleging one claim for recovery under the Contract Bond against Travelers. In turn, Conti filed a two-count cross-complaint against Petric asserting breach of contract and a claim for indemnity, also pursuant to the Subcontract between Petric and Conti. Plaintiffs filed a motion to strike or dismiss Defendants' crossclaims on the grounds that 1) these claims do not arise from the same transactions underlying Plaintiffs' suit; 2) the unrelated claims are complex and only serve to complicate the adjudication of Plaintiffs' relatively discrete ERISA claims. The court granted Plaintiffs' motion, finding that: (1) the proofs that would be required to support Petric's contentions at trial differ in nature and volume from the proofs that would be required to litigate Plaintiffs' claims so that the crossclaims do not meet the "logical relationship" test; (2) Petric's crossclaims would drastically complicate the adjudication of Plaintiff's comparatively straightforward ERISA claim and could potentially confuse the factfinder at trial; (3) Conti's alleged breach of an ancillary contract does not provide a legally cognizable defense to an action brought under ERISA to collect delinquent trust fund contributions; and (4) public policy favors simplified trust fund collection litigation and Petric's tangentially related crossclaims contravene this statutory goal.

In *Int'l Union of Painters & Allied Trades Dist. Council 711 Health & Welfare & Vacation Funds & Finishing Trades Inst. v. Cobra Const.*, No. 13-CV-07495, 2015 WL 71487 (D.N.J. Jan. 5, 2015), Plaintiffs International Union of Painters and Allied Trades District Council 711 Health & Welfare and Vacation Funds and Finishing Trades Institute, and Vincent M. Lane, Trustee moved for default judgment against Defendant Cobra Construction pursuant to Federal Rule of Civil Procedure 55(b)(2). The court previously denied the motion without prejudice for failure to submit the CBAs covering the full period for which Plaintiffs seek damages, or sufficient evidence demonstrating that Defendant agreed to abide by the terms of the CBAs. Plaintiffs subsequently submitted a supplemental affidavit in support of their motion for default

judgment, which the court considered to grant Plaintiffs' motion. The court ordered that judgment shall be entered in favor of Plaintiffs and against Defendant in the amount of \$4,582.88, representing \$2,993.56 in unpaid benefit contributions, \$1,120.00 in attorneys' fees, and \$469.32 in costs.

D. Fourth Circuit

[\*Boland v. Cacper Constr. Corp\*, No. 14-CV-01943 \(CRC\), F.Supp.3d , 2015 WL 5465769 \(D.D.C. Sept. 17, 2015\)](#). Trustees of two union pension funds moved to alter or amend the court's default judgment denying personal liability against an individual defendant. The trustees argued that Kulig was liable based on the uncontested allegation that he continued to carry on the business of Cacper Construction, beyond that necessary to wind up its affairs, after the company was dissolved. The court agreed that Kulig did in fact operate Cacper Construction in a manner beyond that necessary to wind up its affairs post-dissolution and that he is personally liable for the delinquent contributions. The court amended its judgment of July 16, 2015 so as to include a default judgment against Kulig in the full amount of \$31,367.22.

In [\*Bd. of Trustees v. All Around Spiral, Inc.\*, No. 1:14-CV-782 JCC/IDD, 2015 WL 5040168 \(E.D. Va. Aug. 26, 2015\)](#), the court denied Plaintiffs' motion for summary judgment in part because there are genuine issues of material fact as to the CBA that binds Defendant, for what period of time Defendant was bound, and as to the accuracy of the claimed contributions.

In [\*Trustees of Plumbers & Pipefitters Nat. Pension Fund v. Stevens Mech. Contractors Inc.\*, No. 1:14-CV-1769, 2015 WL 4911768 \(E.D. Va. Aug. 17, 2015\)](#), an action seeking unpaid contributions, interest on unpaid contributions, liquidated damages, injunctive relief, and attorneys' fees and costs, the court granted Pipefitters National Pension Fund's Motion for Default Judgment against Defendant in the amount of \$11,201.28; and in favor of the International Training Fund against Defendant in the amount of \$261.67. The court also awarded Plaintiffs \$2,378.79 in attorneys' fees and costs.

In [\*Bd. of Trustees v. Midatlantic Site Servs., LLC\*, No. 1:14CV1281, 2015 WL 4634417 \(E.D. Va. Aug. 3, 2015\)](#), the court ordered a default judgment be entered against Defendant Midatlantic Site Services, LLC in favor of Plaintiffs in the total amount of \$6,790.01, which includes attorneys' fees in the amount of \$5,794.95 and \$628.00 in costs. The court also ordered Defendants to submit to an audit of its wage, payroll, personnel records and project records for all periods for which the Defendant is obligated to contribute to the Plaintiffs. The court enjoined

Defendant to submit complete and accurate remittance reports containing information such as: (1) all employees for whom contributions are due; (2) the hours worked by employees; (3) the hours for which employees were paid; (4) the gross earnings of employees; and (5) the contributions due to the Plaintiffs.

In [\*Bd. of Trustees, Nat. Stabilization Agreement of the Sheet Metal Indus. Trust Fund v. 5 Starr Serv. & Constr., LLC\*, No. 1:15CV403 LMB/MSN, 2015 WL 4139226 \(E.D. Va. July 8, 2015\)](#), the grant court granted default judgment in the total amount of \$40,338,60, consisting of \$23,654.29 in delinquent payments; \$1,202.45 in accrued interest; \$4,730.89 in liquidated damages; \$2,379.43 in late fees; \$1,470.00 in audit fees; and \$6,901.54 in attorney's and costs to be recovered by plaintiffs.

In [\*Bd. of Trustees, Sheet Metal Workers' Nat. Pension Fund v. Caddo Sheet Metal, LLC\*, No. 1:14-CV-858, 2015 WL 4032037 \(E.D. Va. June 30, 2015\)](#), the court determined that Defendant's obligation to pay the exit contribution did not survive the expiration of the CBA.

**Summary judgment in favor of Fund in suit for withdrawal liability affirmed.** In [\*Trustees of the Plumbers & Pipefitters Nat. Pension Fund v. Plumbing Servs., Inc.\*, No. 13-2403, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 3940851 \(4th Cir. June 29, 2015\)](#), a matter involving withdrawal liability, the Fourth Circuit affirmed the district court's decision in favor of the Fund, finding that: (1) the district court had personal and subject matter jurisdiction, (2) venue was proper in Virginia, and (3) PSI bound itself to make contributions to the Fund. The court had personal jurisdiction over Defendants because any action brought under ERISA may be brought in the district where the plan is administered and ERISA provides for nationwide service of process. Where a defendant has been validly served pursuant to a federal statute's nationwide service of process provision, a district court has personal jurisdiction over the defendant so long as jurisdiction comports with the Fifth Amendment. Defendants did not demonstrate extreme inconvenience or unfairness. Defendants also made no argument as to why the interest of justice favors hearing the case in Alabama, where there would be no, or little, need for witnesses. The court has subject matter jurisdiction because federal district courts have jurisdiction to hear actions compelling an employer to pay withdrawal liability. Lastly, the court found that given the existence of a valid contract requiring PSI to contribute to the Fund, PSI is an employer under ERISA. Because PSI failed to timely demand arbitration, all the Fund had to prove to win summary judgment was that it gave PSI proper notice of the assessed withdrawal liability, which it did.

In [\*Trustees of the Plumbers & Pipefitters Nat. Pension Fund v. Monarch Plumbing & Heating Co.\*, No. 1:14-CV-1767 AJT/MSN, 2015 WL 2454273 \(E.D. Va. May 22, 2015\)](#), the court ordered default judgment against Defendant Monarch Plumbing & Heating Co. in favor of Plaintiff Trustees of the Plumbers and Pipefitters National Pension Fund, in the total amount of \$15,632.33 in delinquent contributions, plus interest continuing to accrue at twelve percent per annum from April 17, 2015, until full payment is made.

[\*Bd. of Trustees v. DMJ Indus. Contractor, Inc.\*, No. 1:14-CV-1189, 2015 WL 1809246 \(E.D. Va. Apr. 20, 2015\)](#) (granting Plaintiffs' motion for default judgment and awarding damages in the total amount of \$6,930.94, but denying Plaintiffs injunctive relief).

E. Fifth Circuit

In this dispute involving employer contributions to a 401(k) plan, the court found that Oxbow has failed to overcome the presumption of arbitrability, and that the Union's grievance is subject to arbitration under the 2013 CBA. [\*United Steelworkers & Its Local 275 v. Oxbow Calcining, LLC\*, No. 14-273-SDD-SCR, \\_\\_\\_ F.Supp.3d \\_\\_\\_, 2015 WL 5440612 \(M.D. La. Sept. 14, 2015\)](#).

F. Sixth Circuit

**Summary judgment granted in favor on behalf of Plaintiffs seeking contributions and related damages on behalf of employee benefit plans. [\*WILSON , v. BUCHANAN EXCAVATING, et al.\*, No. 2:14-CV-1397, 2015 WL 6155876 \(S.D. Ohio Oct. 20, 2015\)](#)** (Magistrate Judge Norah M. Cann King). In a Report and Recommendation, the court granted Plaintiff's motion for summary judgment on their unpaid contributions claim, and awarded Plaintiff \$23,901.89 in unpaid contributions from January 1, 2011 through February 1, 2013 and \$3,330.01 in unpaid contributions from February 2013 through April 2013 (for a combined total of \$27,231.90) pursuant to 29 U.S.C. § 1132(g)(2)(A); \$15,702.22 in interest, calculated to August 15, 2015, plus \$13.44 per day thereafter, so long as the judgment remains unpaid pursuant to 29 U.S.C. § 1132(g)(2)(B); \$15,702.22 in liquidated damages, calculated to August 15, 2015, plus \$13.44 per day thereafter, so long as the judgment remains unpaid pursuant to 29 U.S.C. § 1132(g)(2)(C); Court costs in the amount of \$400.00 pursuant to 29 U.S.C. § 1132(g)(2)(D); Reasonable attorney's fees pursuant to 29 U.S.C. § 1132(g)(2)(D); and Injunctive relief pursuant to 29 U.S.C. § 1132(g)(2)(E), including a mandatory injunction directing defendants to comply with its contribution and audit obligations under the various agreements as set forth in more detail in the Complaint.

[BOARDS OF TRUSTEES OF OHIO LABORERS' FRINGE BENEFIT PROGRAMS, Plaintiffs, v. SOLID ROCK CONSTRUCTION SOLUTIONS, LLC, Defendant., No. 2:15-CV-2399, 2015 WL 5719582 \(S.D. Ohio Sept. 30, 2015\).](#) The court found that Plaintiffs are entitled to judgment in the amount of \$26,618.22 in unpaid fringe benefit contributions, liquidated damages, and prejudgment interest, and an award of attorney's fees in the amount of \$3,315.00.

[CAROL A. WILSON, ADMINISTRATOR, et al., Plaintiffs, v. BRIDGE OVERLAY SYSTEMS, INC., Defendant. Additional Party Names: Ohio Operating Engineers Apprenticeship Fund, Ohio Operating Engineers Pension Fund, Ohio Operating Engineers Safety & Educ. Fund, No. 2:14-CV-00156, F.Supp.3d , 2015 WL 5381513 \(S.D. Ohio Sept. 15, 2015\).](#) The court granted Plaintiffs' motion for summary judgment and denied Defendant's cross-motion for summary judgment, finding Defendant's five defenses all fail as a matter of law. The court granted Plaintiffs the relief they seek according to the audited period of April 1, 2006 to April 1, 2014: (1) Delinquent fringe benefit contributions for the period April 1, 2006 to April 1, 2014 in the amount of \$102,895.91 under 29 U.S.C. § 1132(g)(2)(A); (2) Interest in the amount of \$85,985.03 calculated to January 15, 2015, plus \$50.75 per day thereafter as long as the judgment remains unpaid under 29 U.S.C. § 1132(g)(2)(B); (3) Statutory interest in the amount of \$85,985.03 calculated to January 15, 2015, plus \$50.75 per day thereafter as long as the judgment remains unpaid under 29 U.S.C. § 1132(g)(2)(C); (4) Attorneys' fees under 29 U.S.C. § 1132(g)(2)(D), to be determined after the entry of judgment; and (5) Court costs in the amount of \$400.00, under 29 U.S.C. § 1132(g)(2)(D).

In [BOARDS OF TRUSTEES OF OHIO LABORERS' FRINGE BENEFIT PROGRAMS, Plaintiffs, v. CAVER BROTHERS DEVELOPMENT, INC., Defendant., No. 2:15-CV-2461, 2015 WL 5047521 \(S.D. Ohio Aug. 27, 2015\),](#) the court granted default judgment to Plaintiffs and awarded \$7,154.73 in unpaid fringe benefit contributions, liquidated damages, and prejudgment interest, and an award of attorney's fees in the amount of \$1,912.50.

In [Wilson v. Bill Hawk, Inc., No. 2:15-CV-1039, 2015 WL 3755973 \(S.D. Ohio June 16, 2015\),](#) the court recommended that default judgment be granted to Plaintiffs on their claim that although Defendant paid the delinquent contributions in full, it still owes late charges for interest which accrued before it paid the delinquent contributions. The court recommended that judgment be entered against Defendant in the amount of \$9,881.69 in accumulated interest and \$2,090.00 for attorneys' fees and costs.

[Michigan Laborers' Pension Fund v. Rite Way Fence, Inc., No. 13-CV-13727, 2015 WL 1885542 \(E.D. Mich. Apr. 24, 2015\)](#) (in matter seeking to recover fringe benefits allegedly owed under certain collective bargaining agreements, granting Plaintiffs' motion in part by awarding judgment against Rite Way and Marx, jointly and severally, in the amount of \$131,126.22).

**Affirmative defenses of laches and equitable estoppel are unavailable in ERISA § 515 collection action.** In [Operating Engineers Local 324 Health Care Plan v. G & W Const. Co., No. 12-1786, F.3d , 2015 WL 1758652 \(6th Cir. Apr. 20, 2015\)](#), a lawsuit to recover delinquent fringe-benefit payments under a contract between Defendant and the Union, the Sixth Circuit considered whether § 515 of ERISA bars equitable defenses of laches, estoppel, and waiver. The Funds had moved to strike the affirmative defenses, which the district court denied, but certified the case for interlocutory appeal. The court held that laches cannot bar an action to collect unpaid monetary contributions owed to the Funds when the suit is brought under ERISA § 515 within the applicable statute of limitations. Because laches within the term of the statute of limitations is no defense at law to claims for monetary damages, the laches defense is insufficient as a matter of law under Rule 12(f). With respect to equitable estoppel against the Funds based on the Union's alleged conduct of not seeking fringe benefits for nonunion members, the court held that the defense is barred by ERISA § 515 because equitable estoppel based on union conduct is not among the few defenses that may be raised to a collection action. Lastly, the court found that the Funds have not offered any "developed argumentation" on the waiver defense so the court declined to address whether it is appropriate to bar the affirmative defense of waiver in this ERISA § 515 collection action.

In [United Food & Commercial Workers Union-Employer Pension Fund v. Rubber Associates, Inc., No. 5:14-CV-183, 2015 WL 778781 \(N.D. Ohio Feb. 24, 2015\)](#), the court granted Plaintiff's Motion to Dismiss pursuant to Fed.R.Civ.P. 12(b)(6), Defendant's counterclaim seeking equitable relief from an arbitrator's opinion finding Rubber Associates liable to Plaintiff United Food and Commercial Workers Union–Employer Pension Fund for withdrawal liability in the amount of \$1,713,169.00.2. The court explained that the Sixth Circuit has not recognized a claim under the federal common law of ERISA for equitable relief in the case of union-mandated withdrawals, and this court found no basis for doing so. Congress did not include union-mandated withdrawal among the exceptions for certain specific withdrawal situations, and ERISA's purpose will not be advanced by creating such an exception in this case.

In *Operating Engineers Local 324 Health Care Plan v. Diversicon Excavating LLC*, No. 12-11492, 2015 WL 225506 (E.D. Mich. Jan. 16, 2015), the court considered whether unpaid plan fringe benefits constitute plan assets sufficient to make employers plan fiduciaries. Noting that

this is an unsettled issue in the Sixth Circuit, the court recognized that the vast majority of persuasive authority indicates that employer contributions become an asset of the plan only when the contribution has been made. Consequently, the Court held that Defendant Farrell did not exercise authority over plan assets when he did not pay fringe benefits and, therefore, did not breach his fiduciary duty when he did not pay them.

#### G. Seventh Circuit

[\*Cent. States, Se. & Sw. Areas Pension Fund v. Bulk Transp., Corp.\*, No. 13 C 9112, 2015 WL 5722822 \(N.D. Ill. Sept. 28, 2015\)](#). The parties dispute whether the Pension Fund may require Bulk Transport to comply with the American Arbitration Association's ("AAA") current rules governing the initiation of withdrawal-liability arbitration. The court concluded that the Pension Fund may not require Bulk Transport to comply with the AAA's current rules and directed the parties to comply with the Pension Benefit Guaranty Corporation's ("PBGC") default rules.

[\*Cent. States, Se. & Sw. Areas Pension Fund v. Duluth Paper & Specialties Co.\*, No. 15-CV-00796, 2015 WL 5559748 \(N.D. Ill. Sept. 18, 2015\)](#). The court denied motion to dismiss where the Pension Fund alleged that Duluth effected a complete withdrawal from the Pension Fund and thus incurred withdrawal liability. It also alleged that it sent a notice and demand of payment to Duluth, and that while Duluth paid the Pension Fund some of the liability, \$393,431.75 of the principal balance still remains outstanding. The court found that the Pension Funds' allegations adequately state a cause of action against Duluth for withdrawal liability.

[\*Cent. Laborers' Pension Fund v. AEH Constr., Inc.\*, No. 14-3052, 2015 WL 5450350 \(C.D. Ill. Sept. 15, 2015\)](#). The court amended its previous order of default judgment and ordered judgment entered *nunc pro tunc* in favor of Plaintiffs and against Defendant AEH Construction, Inc. in the total amount of \$25,391.66 (consisting of audit liabilities, delinquent contributions, report form shortages, liquidated damages, and audit costs in the amount of \$22,001.16; reasonable attorney's fees in the amount of \$2,953.50; and costs in the amount of \$437).

In [\*Trustees of Teamsters Union No. 142 Pension Fund v. Underground Inc.\*, No. 2:14-CV-449-PRC, 2015 WL 5098483 \(N.D. Ind. Aug. 31, 2015\)](#), the court granted Plaintiffs' summary judgment in their favor in the amount of \$10,667.08 for unpaid contributions, interest, and attorneys' fees.

In [Cent. States v. Gary Rinker Trucking, Inc., No. 14 CV 7218, 2015 WL 4880909 \(N.D. Ill. Aug. 14, 2015\)](#), the court granted summary judgment in favor of the Plaintiff Pension Fund on its claim for withdrawal liability. The court awarded the Pension Fund the unpaid contributions, interest thereon, fees, costs, and the greater of an amount equal to the interwar or liquidated damages in the amount of twenty percent of the unpaid amounts.

In [Mike Avila Tr. v. Bronger Masonry, Inc., No. 1:14-CV-00913-JMS, 2015 WL 4758754 \(S.D. Ind. Aug. 12, 2015\)](#), Plaintiffs asked the Court to order Masonry to pay the benefits they claim the Funds are due from the date of the requested preliminary injunction forward. The court found that even though Plaintiffs are likely to succeed on the merits, they have not shown that a money judgment in their favor after resolving their claims on the merits would be seriously deficient as a remedy for the harm suffered. The court denied the motion, explaining that the Seventh Circuit has emphasized that a preliminary injunction is an exercise of a very far-reaching power, never to be indulged in except in a case clearly demanding it.

**Notice of contingent withdrawal liability satisfies the successor liability notice requirement.** In [Tsareff v. ManWeb Servs., Inc., No. 14-1618, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4508637 \(7th Cir. July 27, 2015\)](#), a multiemployer pension fund trustee brought suit against an employer and its successor to collect on withdrawal liability allegedly owed by the employer. The district court granted in part the trustee's motion for summary judgment and granted the successor's motion for judgment as a matter of law. The Seventh Circuit held that the successor had sufficient pre-acquisition notice of the predecessor's contingent withdrawal liability. Specifically, ManWeb had sufficient pre-acquisition notice of Tiernan & Hoover's contingent withdrawal liability. Second, the court held that the district court erred as a matter of law in concluding that the plan had to establish that successor had notice that the predecessor failed to arbitrate. Notice is not required by the successor liability notice requirement nor supported by the policies underlying the imposition of successor liability in the context of the MPPAA. Lastly, the court held that the district court abused its discretion in finding no successor liability. Any dispute over withdrawal liability *shall* be arbitrated so the district court's substantive review of the underlying withdrawal liability constitutes an error of law. The court reversed and remanded the case to the district court to consider the successor liability continuity requirement.

In [Wisconsin Elec. Employees Health & Welfare Plan v. KMS Elec., LLC, No. 14-CV-521, 2015 WL 4487072 \(E.D. Wis. July 23, 2015\)](#), the Funds filed a motion for summary judgment on its claim that Defendant failed to make contributions to employee retirement accounts. Grandow, in his capacity as "owner" of KMS signed the Letter of Assent. The court denied the motion, finding that the Funds did not show that Grandow had actual or apparent authority to act on

behalf of KMS to consent to the CBA when he signed the Letter of Assent or that KMS's conduct establishes its acceptance of the CBA.

In [\*Cent. Illinois Carpenters Health & Welfare Trust Fund v. Rice Equip. Co.\*, No. 14-3390, 2015 WL 4378192 \(C.D. Ill. July 16, 2015\)](#), the court set aside the order of default against Defendant and denied Plaintiff's motion for summary judgment. The court found that Defendant showed good cause for setting aside the default, acted quickly in response to the entry of default, and asserted a potentially meritorious defense.

In [\*Cent. States, Se. & SOUTHWEST areas Pension Fund v. Northville Racing Corp.\*, No. 14 C 7184, 2015 WL 3818650 \(N.D. Ill. June 18, 2015\)](#) (**Not Reported in F.Supp.3d**), an action seeking withdrawal liability, the court denied Defendants' motion to dismiss as to Karoub Family Investments, finding that it could plausibly infer from Plaintiff's brief allegations that Karoub Family Investments, a limited liability company under the common control of the Karoub Controlled Group, is a trade or business. However, the court granted Defendants Alice Karoub and Karoub Trust, finding that Plaintiff did not allege that they received income or profit from the properties and engaged in any conduct additional to leasing the property, let alone continuous or regular activity, from which the court could infer that Alice Karoub and Karoub Trust are a trade or business.

[\*RKN Concrete Constr., Inc. v. Laborers' Pension Fund\*, No. 13 C 9153, 2015 WL 1888513 \(N.D. Ill. Apr. 24, 2015\)](#) (finding that RKN Concrete Construction, Inc. is liable to the Funds for interim withdrawal liability payments; however, Ryan Specialized Service, Inc. is not liable under the successor, single employer, or alter ego theories the Funds assert).

[\*Bd. of Trustees of the Auto. Mechanics' Local No. 701 Union & Indus. Pension Fund v. Joyce\*, No. 14 C 9890, 2015 WL 1888005 \(N.D. Ill. Apr. 24, 2015\)](#) (denying Defendants' motion to dismiss Board's claims that Defendants evaded and avoided ERISA withdrawal liability under 29 U.S.C. § 1392(c) and committed fraud in fact and in law under the Illinois Uniform Fraudulent Transfer Act ("IUFTA")).

In [\*Cent. States, Se. & Sw. Areas Pension Fund v. Vanguard Servs., Inc.\*, No. 09 CV 4721, 2015 WL 791497 \(N.D. Ill. Feb. 24, 2015\)](#), Vanguard was previously ordered to pay \$4,769,353.60 to the Pension Fund in unfunded pension withdrawal liability. Vanguard filed a post-judgment

motion to enforce an indemnification agreement between Vanguard and Wise, pursuant to which Vanguard asserts that Wise is liable for \$300,404.69 of its withdrawal liability. The court rejected each of Wise's arguments disclaiming liability. First, the court found that Vanguard seeks to enforce the indemnification clause of the September '94 Schedule under contract law so Wise's "employer" status under the MPAA is irrelevant. Second, Vanguard was assessed withdrawal liability on August 11, 2009. The Pension Fund's cause of action against Vanguard, and its cause of action under the indemnification clause against Wise, accrued in 2009. Thus, because the Pension Fund filed this action in 2009, its claim is timely. Third, the court found that Wise's conduct is unambiguously consistent with an agreement to be bound by the terms of the September '94 Schedule, which is operative. Lastly, there is no dispute that Vanguard incurred a liability and it is irrelevant under the plain language of the contract whether Wise "caused" Vanguard to incur the liability. The court granted the Pension Fund's motion to enforce the indemnification agreement between Vanguard and Wise and ordered Wise to pay an amount to be determined after further briefing.

In *Operative Plasterers & Cement Masons Local 599 Pension Fund v. Valda Plastering Co.*, No. 14-CV-1-WMC, 2015 WL 273216 (W.D. Wis. Jan. 21, 2015), Defendant withdrew from the plan, failed to pay its withdrawal liability as assessed by the pension fund, and failed to make timely payments as required to avoid additional penalties in the form of liquidated damages. Defendant initially answered the complaint but then withdrew its answer and did not contest Plaintiffs' motion for default judgment. The court awarded a total of \$272,366.40 in damages, together with interest at the rate allowed by law. The award includes a principal withdrawal liability of \$224,858.00, plus liquidated damages of \$44,971.60 (20% of the principal).

#### H. Eighth Circuit

**Disputed issues of material fact as to whether a company is a successor for purposes of withdrawal liability.** [Greater Kansas City Laborers Pension Fund v. Al Muehlberger Concrete Co., LLC](#), No. 4:14-CV-229-SRB, 2015 WL 6457295 (W.D. Mo. Oct. 26, 2015) (Judge Stephen R. Bough). The Pension Fund moved for summary judgment seeking a ruling that LLC is a successor to INC, and thus liable for INC's withdrawal liability. The court found that there was conflicting evidence as to whether LLC is INC's "successor," including whether the entities shared the same owner, shared a significant number of employees, and shared the same type of work. The parties also disagree upon a number of the other nine factors the court will evaluate at trial to determine whether successor liability is proper. As such, the court denied summary judgment.

**Trustees of benefit plans entitled to creditor's bill against company who defaulted on payments for benefit contributions as set forth in a settlement agreement between the parties.** [Trustees for the Ibew, Local 1 Health & Welfare Fund v. Greenpower Servs., LLC, No. 4:14-CV-00455-JCH, 2015 WL 6163512 \(E.D. Mo. Oct. 20, 2015\)](#) (Judge Jean C. Hamilton). Following a settlement and consent judgment in favor of Plaintiffs against Greenpower Services in the total amount of \$43,057.93, and Greenpower's failure to make an installment payment, causing the entire balance to become due, the court granted Plaintiffs' Motion for a Creditor's Bill in Equity and to Pierce the Corporate Veil. The court found that Plaintiffs have established the necessary prerequisites to the issuance of a creditor's bill, including that they established that Greenpowerstl is the alter ego of Greenpower Services.

[Raines v. Integrity Acoustic Solutions, Inc., No. CIV. 14-2900 PAM/JJK, 2015 WL 5638047 \(D. Minn. Sept. 24, 2015\)](#). The court found that Integrity Acoustics did not maintain records sufficient to establish whether employees performed work covered by the CBA, and therefore Defendants have not carried their burden and Plaintiffs are entitled to summary judgment on their claim for unpaid fringe benefit contributions and related damages.

**No successor liability for delinquent health insurance premiums against company that merely continued business operations of former employer.** In [Nutt v. Kees, No. 14-3364, F.3d](#), [2015 WL 4746127 \(8th Cir. Aug. 12, 2015\)](#), the Eighth Circuit reversed the district court's decision to hold the current employer liable for delinquent contributions, breach of fiduciary duty, and interference with protected rights under the doctrine of successor liability. In this case, Plaintiffs were saddled with \$233,000 in medical bills as a result of their employer failing to remit withheld funds from their paycheck to the health insurer. The employer, Osceola Healthcare, PLLC, sold the company to Jim Cooper and his company, Berryville Properties, LLC, which took title to the real property and assets when the sale closed. During the temporary lease period, Cooper assigned the lease to Osceola Therapy & Living Center (OTLC), a nursing-home operation company created by an individual that was independent from Cooper and Berryville Properties. OTLC is an independent entity that leased the property and assets by way of an assignment from the facility's actual purchasers. Because the defendants could not satisfy the judgment against them, the district court held OTLC liable. The Eighth Circuit noted that it has not yet determined whether to apply the federal common law doctrine of successor liability in the ERISA context. It further noted that it need not decide this issue in the present case because even if it assumes that successor liability applies in the ERISA context, the court concluded that the district court clearly erred in its factual findings and improperly weighed the equities when it held OTLC liable as the successor of the Osceola defendants. Specifically, the district court clearly erred by characterizing OTLC as a purchaser because OTLC did not buy the nursing home. The district court abused its discretion when it characterized OTLC as the

purchaser with the ability to take the potential liability to plaintiffs into account in negotiating the final acquisition price set at the closing. OTLC was not a party to the unlawful practices of Kees and the Osceola defendants, and OTLC operated the nursing home without any significant connection to these culpable parties. Mere continuation of business operations does not create liability

In [\*Iron Workers St. Louis Dist. Council Annuity Trust v. Innovative Concrete, LLC\*, No. 4:14CV02066 AGF, 2015 WL 4506623 \(E.D. Mo. July 23, 2015\)](#), the court granted default judgment to Plaintiff for \$2,331.19 in contributions for the period of June 1, 2014, through December 31, 2014, \$233.12 in liquidated damages, and \$206.42 in interest. The court also awarded attorneys' fees of \$2,000.00, court costs of \$466.57, and accounting costs of \$610.00.

In [\*Midwest Constr. & Distribution Indus. Benefit Trust v. Ferguson Enterprises, Inc.\*, No. CIV. 14-853 ADM/HB, 2015 WL 4255785 \(D. Minn. July 14, 2015\)](#), the court considered whether certain Ferguson employees were eligible to waive or opt out of health insurance benefit coverage under the Fund and, as a result, whether Ferguson was required to make contributions to the Fund on behalf of these individuals. The court found that the waiver defense raised here is not a defense precluded under § 515. Ferguson argued that the explicit terms of the SPD allow for individual waiver and therefore it is not required to provide contributions for those individuals who properly waived coverage under the CBA. The court acknowledged that the purpose of § 515 is to prevent contract formation defenses, but that it is not so narrow as to prevent Ferguson from raising this defense. However, the court determined that it need not rule on whether the CBA incorporated the SPD waiver language because, even if it did, the Fund remains entitled to collect contributions for the six individuals under the unambiguous language of the CBA.

In [\*Carpenters' Dist. Council of Greater St. Louis & Vicinity v. Neier Servs. Co.\*, No. 4:13-CV-1603 CAS, 2015 WL 3971070 \(E.D. Mo. June 30, 2015\)](#), the court denied Plaintiffs' motion seeking to collect a judgment against Neier Services Company's alleged alter ego, Pro Services Contractors, Inc., finding that Plaintiffs did not show that Pro Services Contractors, Inc. is the alter ego of defendant Neier Services Company, Inc.

In [\*Trustees of Indiana State Council of Roofers Health & Welfare Fund v. Browns Excavating, Inc.\*, No. 4:14 CV 82 PPS-PRC, 2015 WL 3658067 \(N.D. Ind. June 12, 2015\)](#), the court granted

default judgment against Defendant Browns Excavating, Inc. and ordered it to pay Plaintiff \$34,294.57 in delinquent contributions, audit expenses, attorney's fees, and costs.

In [\*Raines v. Doran Const., Inc.\*, No. CIV. 15-1193 JNE, 2015 WL 3612982 \(D. Minn. June 8, 2015\)](#), an action to collect unpaid fringe benefit contributions due under a collective bargaining agreement, Defendant answered and asserted five counterclaims. Counts I, II, and III of the counterclaims seek the return of payments made by Defendant to the plans; count IV seeks an order that enjoins demands for money in violation of LMRA section 302; and count V seeks declarations that Defendant "is not and never was subject to any collective bargaining agreement" and that it "owes no contributions to the Funds under any collective bargaining agreement." The trustees moved to dismiss counts I, II, III, and IV of the counterclaims with prejudice. Under § 1103(c)(2)(A)(ii), the plan administrator initially determines (1) whether a contribution was made by a mistake of fact or law and (2) if so, whether the contribution should be returned. Defendant did not submit its claims for return of payments to the plans' administrators before it asserted its counterclaims so the administrators did not determine whether Defendant mistakenly made payments and whether any mistaken payments should be returned. The court concluded that dismissal of counts I, II, and III without prejudice and with leave to replead them after the plans' administrators make their determinations is appropriate.

In [\*Raines v. Integrity Acoustic Solutions, Inc.\*, No. CIV. 14-2900 PAM/JJK, 2015 WL 2402523, at \(D. Minn. May 20, 2015\)](#), the court found that the guaranty provision in the CBA is unambiguous and by signing the Agreement, an individual defendant agreed to be bound individually to the performance the corporation promised. Because the individual defendant agreed to be personally bound to the company's obligations under the CBA, he therefore qualifies as an employer for the purposes of ERISA.

In [\*Trustees of the Indiana State Council of Roofers Health & Welfare Fund v. Embry's Roofing, Inc.\*, No. 4:14-CV-00084-PPS, 2015 WL 2391136 \(N.D. Ind. May 19, 2015\)](#), the court granted the Fund's motion for default judgment against Embry's Roofing, where the Fund claimed that Embry's was a party to a CBA that required it to pay into the Fund and that Embry's didn't pay as agreed.

[\*Cement Masons Local 527 v. Innovative Concrete, LLC\*, No. 4:14-CV-1287 CAS, 2015 WL 1623785 \(E.D. Mo. Apr. 10, 2015\)](#) (finding that plaintiffs have established there is no genuine

dispute as to any material fact and that they are entitled to a judgment as a matter of law in the total amount of \$8,479.46).

In *Reed v. Greenworks, Inc.*, No. 12-72JJK, 2015 WL 364602 (D. Minn. Jan. 27, 2015), following a bench trial to determine whether Greenworks Landscaping Contracting, Inc. (“GLCI”) is liable for unpaid fringe benefit contributions pursuant to the terms of a 2007 collective bargaining agreement, the court found that GLCI did not breach the CBA by failing to make contributions to the Funds pursuant to the agreement in which Greenworks, Inc. (“GWI”) (the company from which GLCI had split into a separate entity) and Tom Grygelko (majority owner of GWI) are purported to have bound any company or entity owned or substantially under the control of GWI, or Tom Grygelko, as principals to the CBA. The court found that GLCI and its President, Karen Grygelko, were not signatories of the CBA and GLCI is an independent company, having separate ownership and management. The court also found that GLCI was not operated in a manner that indicated an effort by GLCI to take advantage of the benefits to be obtained under the CBA without incurring the obligation of an employer under the CBA. Finally, the court found that GLCI was not substantially controlled by Tom Grygelko or GWI.

#### I. Ninth Circuit

[\*Bd. of Trustees of the Ken Lusby Clerks & Lumber Handlers Pension Fund v. Lumber\*, No. 13-CV-03898-HSG, 2015 WL 5461561 \(N.D. Cal. Sept. 16, 2015\)](#). The court granted summary judgment to the Board on its withdrawal liability claim and found that it is entitled to (1) the withdrawal assessment of \$1,660,266; (2) prejudgment interest of \$545.84 per day beginning from January 28, 2011 and ending on the date of final judgment; (3) liquidated damages in an amount equal to the amount payable as prejudgment interest; and (4) reasonable attorneys’ fees and costs.

**Successor employer can be held liable for withdrawal liability if it took over the business with notice of liability and there is substantial continuity in the business operations.** In [\*Resilient Floor Covering Pension Trust Fund Bd. of Trustees v. Michael’s Floor Covering, Inc.\*, No. 12-17675, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5295091 \(9th Cir. Sept. 11, 2015\)](#), the Ninth Circuit considered two related issues: (1) whether a successor employer, both generally and in the construction industry in particular, can be subject to withdrawal liability under the Multiemployer Pension Plan Amendments Act (“MPPAA”); and (2) if so, what factors are most relevant to determining whether a construction industry employer is a successor for purposes of imposing MPPAA withdrawal liability. The court concluded that a construction industry successor employer can be subject to MPPAA withdrawal liability, so long as the successor took over the business with notice of the liability. The court held that the most important factor in

assessing whether an employer is a successor for purposes of imposing MPPAA withdrawal liability is whether there is substantial continuity in the business operations between the predecessor and the successor, as determined in large part by whether the new employer has taken over the economically critical bulk of the prior employer's customer base. The district court held that Defendant was not liable as a successor employer after weighing continuity of the workforce as the most important factor and applying an incorrect test to determine whether there was continuity of the workforce. The Ninth Circuit reversed and remanded for further proceedings applying the correct standards.

**ERISA preempts and does not authorize a health plan's claim for reimbursement of medical expenses.** In [\*Oregon Teamster Employers Trust v. Hillsboro Garbage Disposal, Inc.\*, No. 13-35555, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 5202383 \(9th Cir. Sept. 8, 2015\)](#), a self-funded health plan brought suit against an employer and employees of a separate company, which had common ownership with the employer, asserting claims for breach of contract, restitution, and specific performance, arising out of the health plan's payment of health care benefits on behalf of the separate company's employees. In affirming the district court's grant of summary judgment in Defendants' favor, the Ninth Circuit held that: (1) ERISA preempted breach of contract claim because analysis of the terms of an ERISA plan is required to resolve claim; (2) claim seeking specific performance of reimbursement provision was not cognizable under ERISA's equitable catchall provision because it seeks "legal relief"; (3) claim seeking restitution was not cognizable under ERISA's equitable catchall provision because health plan did not show that benefits were paid as a result of "fraud or wrongdoing"; and (4) district court did not abuse its discretion in denying Plaintiff leave to file amended complaint.

[\*Bd. of Trustees for the Laborers Health & Welfare Trust Fund for N. California v. Michael Heavey Constr., Inc.\*, No. C 15-00411 WHA, 2015 WL 5241759 \(N.D. Cal. Sept. 8, 2015\)](#). The court adopted the report and recommendation granting Plaintiff's default judgment in the amount of \$217,587.23 for unpaid trust fund contributions, liquidated damages, interest, and attorneys' fees and costs. The court denied Defendant's motion to set aside the default judgment.

In [\*Bd. of Trustees of the Laborers Health & Welfare Trust Fund for N. California v. Lineation Markings Corp.\*, No. 14-CV-00575-HSG, 2015 WL 4999850 \(N.D. Cal. Aug. 21, 2015\)](#), the court granted Plaintiff's motion for default judgment and awarded \$162,777.63 in unpaid contributions, damages, and attorneys' fees, as well as an injunction ordering Defendant to submit its books and records for an audit by Plaintiff and retain jurisdiction over the case.

In [\*Bd. of Trustees of the Laborers Health & Welfare Trust Fund for Northern California v. Contractors Chem., Inc.\*, No. 14-CV-04159-JD, 2015 WL 4692440 \(N.D. Cal. Aug. 6, 2015\)](#), the Court granted plaintiff's motion for default judgment against Contractors Chemical in the amount of \$11,520.80 for unpaid contributions, \$19,154.58 for interest and liquidated damages, and \$9,782.16 for attorneys' fees and costs.

In [\*S. City Motors, Inc. v. Auto. Indus. Pension Trust Fund\*, No. 15-CV-01068-JST, 2015 WL 4638251 \(N.D. Cal. Aug. 4, 2015\)](#), the court granted Defendant's motion to stay pending arbitration and motion to dismiss as to the fraudulent inducement/concealment, negligent representation/concealment, equitable estoppel, and declaratory relief claims, and denied as to the restitution of mistaken contributions.

**Unpaid contributions by employers to employee benefit funds are not ERISA plan assets, and Plaintiff did not engage in defalcation since he had no fiduciary responsibilities.** In [\*Bos v. Bd. of Trustees\*, No. 13-15604, \\_\\_\\_ F.3d \\_\\_\\_, 2015 WL 4568015 \(9th Cir. July 30, 2015\)](#), the Ninth Circuit considered whether an employer's contractual requirement to contribute to an employee benefits trust fund makes it a fiduciary of unpaid contributions. Plaintiff was owner and president of Bos Enterprises, Inc., which was a member of the Modular Installers Association, an employer association. As president, Plaintiff agreed that the company would be bound by the Carpenters' Master Agreement, and several trust agreements. Plaintiff eventually filed bankruptcy and the bankruptcy court entered judgment, concluding that Plaintiff had committed defalcation while acting as a fiduciary of the Funds and that the \$504,282.59 debt to the Funds was therefore nondischargeable. The district court affirmed the bankruptcy court on the same grounds and entered an order to that effect. Plaintiff appealed and argued that the bankruptcy court and district court erred in concluding that he was a "fiduciary" under 11 U.S.C. § 523(a)(4). The Ninth Circuit agreed with the view taken by the Sixth and Tenth Circuits, finding that it comports with the limited approach it takes in recognizing fiduciary status, particularly in the § 523(a)(4) context. The court reasoned that a typical employer never has sufficient control over a plan asset to make it a fiduciary for purposes of § 523(a)(4). Even if a plan document could convert an unpaid contribution into some type of plan asset, such an "asset" could legally be classified in only one of three ways which does not give the employer the requisite control over such plan asset: (1) the contractual right to collect payments once they become due; (2) the unpaid past-due contributions; (3) amounts which the employer must eventually contribute to the plan, but which are not yet due, thus avoiding the problem of the act of wrongdoing creating the fiduciary status. The Ninth Circuit reversed and remanded the district court and held that unpaid contributions by employers to employee benefit funds are not ERISA plan assets, and Plaintiff did not engage in defalcation since he had no ERISA fiduciary responsibilities.

In [\*Burns v. Romero Gen. Constr.\*, No. 13-CV-05647-JSC, 2015 WL 4498197 \(N.D. Cal. July 23, 2015\)](#), after Defendants failure to make payments as set forth in the Stipulation for Entry of Judgment and upon Plaintiff's motion, the court entered judgment in Plaintiffs' favor and against Defendants in the total amount of \$101,888.15, allocated as follows: (1) \$49,289.48 in unpaid principal installment payments and interest; (2) \$45,121.26 in liquidated damages; (3) \$24.00 in interest and \$1,752.52 on the late-paid April 2015 contribution to the Trust Funds; and (4) \$5,701.70 in post-settlement attorneys' fees and costs.

In [\*Bd. of Trustees of The Teamsters Local 631 Sec. Fund For S. Nevada v. Grand Expo \(USA\), Inc.\*, No. 2:14-CV-02017-MMD, 2015 WL 4113218 \(D. Nev. July 8, 2015\)](#), the court granted Plaintiffs Trust Funds motion for default judgment against Defendant Grand Expo (USA), Inc. The court ordered Defendant to deliver or make available to the Trust Funds all paper and documentation necessary for their auditing purposes and pay \$3,300.50 for attorneys' fees and costs.

In [\*Bd. of Trustees of the Nat. Roofing Indus. Pension Fund v. A.W. Farrell & Son, Inc.\*, No. 2:13-CV-825 JCM VCF, 2015 WL 3422722 \(D. Nev. May 28, 2015\)](#), Plaintiff made the following claims and request for relief: (1) AWF failed to comply with Plaintiff's request to audit AWF's records in order to ascertain whether payments were promptly and correctly made to the employee benefit plan trust funds for Local 162; (2) this failure violated provisions of the CBAs governing the employee benefit plans, thus constituting a breach of contract; and (3) accordingly, the court should grant an injunction ordering AWF to submit to an audit, pay any necessary contributions, and pay any associated damages. The court denied AWF's motion for partial summary judgment as to the periods prior to June 27, 2007, and after July 31, 2012; granted AWF's motion to submit supplemental briefing, and denied its motion for partial summary judgment regarding the 2010–2012 CBA.

[\*Cascade Pension Trust v. Bob Fisher Elec., Inc.\*, No. 6:14-CV-01920-MC, 2015 WL 1802217 \(D. Or. Apr. 20, 2015\)](#) (granting default judgment of \$117,474.90 in unpaid contributions; interest on the unpaid contributions equal to \$24,643.08 as of December 1, 2014, plus an additional \$38.6219 each day thereafter until paid in full; \$24,643.08 in liquidated damages; \$6839.20 in attorney's fees, court costs, and audit costs, and interest on interest on these amounts from the date judgment is entered until paid in full at the rate of 0.24 percent per annum).

**Double-breasted claims dismissed but CBA circumvention theory claims survive.** In [\*Slack v. Int'l Union of Operating Engineers\*, No. C-13-5001 EMC, F.Supp.3d](#), 2015 WL 1188636 (N.D. Cal. Mar. 16, 2015), Plaintiffs, members of a local union in the International Union of Operating Engineers, filed their second amended complaint against the Trustees of three different trusts. The SAC accuses Defendants of breaching their fiduciary duties and engaging in prohibited transactions based on the following: (1) deciding that the Pension Fund should invest in the Longview Ultra Construction Loan Investment Fund, which resulted in a \$50 million loss; (2) allowing employers who are signatories to collective bargaining agreements (“CBA”) to engage in improper double-breasted operations; and (3) allowing employers to write off millions in contributions owed to the Trusts without any legitimate basis. With respect to the double-breasted claims, the court found that Plaintiffs alleged enough to meet the single employer threshold, but not the alter ego test under Ninth Circuit law. The court dismissed with prejudice the claims based on the double-breasting theory. Under the CBA circumvention theory, Plaintiffs argued that the signatory employer should have been making contributions to the Trusts based on the work of nonunion employees because, though nonunion, the employees still performed covered work defined by the CBA. The court denied Defendants’ motion to dismiss the claims based on the circumvention theory because a reasonable inference can be made that if there is a covered operation, then there are employees doing covered work. The court denied dismissal of a claim based on improper write-offs, where all but approximately \$40k of a \$3-million dollar delinquency owed by one employer who was not insolvent was written off.

In *Carpenters Pension Trust Fund for N. California v. Walker*, No. 12-CV-01447-WHO, 2015 WL 224940 (N.D. Cal. Jan. 16, 2015), the court found that defendants K & M Industries, Inc. (“K & M”) and D & B Engineered Applications, Inc. (“D & B”) are “trades or businesses” so as to render them control group members pursuant to 29 U.S.C. § 1301(b)(1). Both K & M and D & B have an economic nexus to the operations of Rollie French, Inc. (“RFI”), a company that terminated a collective bargaining agreement with the plaintiff Pension Fund. Because this establishes that they were “trades or businesses” under section 1301(b), the court found that they are jointly and severally liable for RFI’s withdrawal liability along with the other members of the control group.

In *Trustees of the IBEW/NECA Sound & Commc’ns Health & Welfare Trust v. Netversant Solutions II LP*, No. C-14-00611-RMW, 2015 WL 124633 (N.D. Cal. Jan. 8, 2015), Plaintiffs sought a default judgment against Defendant for failing to make timely monthly contributions to trusts for fringe benefits for its covered employees. The court concluded that Plaintiffs are entitled to their entire requested liquidated damages award of \$23,000.39, comprised of \$4,600.08 in statutory liquidated damages and \$18,400.31 in contractual damages.

J. Tenth Circuit

In *Richards v. Acme Heating & Air Conditioning, Inc.*, No. 2:13CV34 DAK, 2015 WL 339702 (D. Utah Jan. 26, 2015), the court granted Plaintiffs' motion for summary judgment against Acme Heating for employee benefit plan contributions in the total amount of \$45,831.76, plus interest, liquidated damages, audit fees, costs of suit and attorneys' fees. The court also granted Plaintiffs' motion for summary judgment against Fidelity as the payment bond surety on the construction project upon which the employee benefit plan contributions were earned by employees of Acme Heating, in the total amount of \$45,831.76, plus interest, costs of suit and attorneys' fees.

K. D.C. Circuit

In *Fanning v. Wellman Dynamics Corp.*, No. CV 14-1867 (RJL), F.Supp.3d, 2015 WL 4090346 (D.D.C. July 6, 2015), the court granted default judgment to Plaintiff and awarded the following based on its agreement with Plaintiff's damage calculations: \$49,816.59 for unpaid contributions due to the Central Pension Fund for the period June 2014 through February 2015, pursuant to 29 U.S.C. § 1132(g)(2)(A); \$43,725.44 for liquidated damages, which is 15 percent of the total amount of unpaid or late-paid contributions to the Central Pension Fund, pursuant to 29 U.S.C. § 1132(g)(2)(C)(ii) and the Declaration of Trust, Fanning Decl. Ex. B § 4.5(b); \$3,538.71 for interest assessed at a rate of 9 percent per annum on the unpaid or late-paid contributions, pursuant to 29 U.S.C. § 1132(g)(2)(B) and the Declaration of Trust, Fanning Decl. Ex. B § 4.5(c); and \$2,733.00 for attorneys' fees and legal costs, pursuant to 29 U.S.C. § 1132(g)(2)(D).