



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, 2016 and December 31, 2016. 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*

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I. *Attorneys' Fees*

A. First Circuit

In matter seeking deferred compensation benefits under an ERISA top hat plan, the court denied the plan administrator's request for attorneys' fees and granted Plaintiff's request because it found the denial of Plaintiff's application for benefits under the Plan was not only incorrect, it was plainly arbitrary and capricious. Plaintiff secured a reversal of the denial of his benefits request, an immediate award of a portion of those benefits, and remand to the plan administrator so he may fully and carefully consider how he will distribute the remaining deferred compensation to which Plaintiff is entitled. The court found that Plaintiff's victory was substantially more than "trivial" or "purely procedural." [Rhodes v. Holden Eng'g & Surveying, Inc., No. 16-CV-35-SM, 2016 WL 7052929 \(D.N.H. Dec. 5, 2016\)](#) (Judge Steven J. McAuliffe).

B. Second Circuit

In case involving a claim for benefits by a group of plaintiffs who work or have worked for Xerox Corporation, finding that the participants are entitled to a reasonable attorneys' fee and costs. Applying 2011 rates, the court awarded Plaintiffs \$4,711,430.70 in fees and \$174,174 in costs for the total amount of \$4,885,604.70. [Frommert v. Conkright, No. 00-CV-6311L, 2016 WL 7186489 \(W.D.N.Y. Dec. 12, 2016\)](#) (Judge David G. Larimer).

The court confirmed the arbitration award in favor of the pension fund. On attorneys' fees, the court held found that an associate with five years of experience was entitled to rate of \$225.00 per hour and junior associate with two years of experience was entitled to rate of \$150.00 per hour. The court further found that an award of attorneys' fees in amount of \$337.50 was reasonable. [Trustees of Empire State Carpenters Annuity, Apprenticeship, Labor-Management Cooperation, Pension & Welfare Funds v. Allied Design & Constr., LLC, No. 15CV3854JFBAKT, ___ F.Supp.3d ___, 2016 WL 6818881 \(E.D.N.Y. Nov. 18, 2016\)](#) (Judge Daniel Hammond).

Following lengthy and hard-fought litigation where the plan participants ultimately prevailed and sought attorneys' fees based on hourly rates ranging from \$250 to \$675 per hour, finding that knowledge of Defendants' attorneys' fees in this litigation is relevant and would be helpful to this court in determining the amount of fees that should be awarded to Plaintiffs' counsel. The court gives Defendants the opportunity to provide this information within 15 days, but if Xerox chooses not to provide this information, the court will proceed with the evidence that has been presented thus far, coupled with the court's own understanding of legal billing rates based on its thirty years' experience in dealing with

such issues. [Frommert v. Conkright, No. 00-CV-6311L, 2016 WL 6093998 \(W.D.N.Y. Oct. 19, 2016\)](#) (Judge David G. Larimer). *Frommert* was an intensely litigated case, including a trip to the Supremes and a couple trips up to the Second Circuit. The district court ultimately ordered an equitable remedy for Xerox's failure to provide adequate notice to Plan participants. Plaintiffs seek payment of attorneys' fees based on hourly rates ranging from \$250 to \$675 per hour. Defendants argued that any award should be no more than \$300 per hour for partners and \$200 for associates. In response, Plaintiffs pointed out that Xerox likely paid rates much higher than those Plaintiffs are seeking. The court found that knowledge of Defendants' attorneys' fees in this litigation is relevant and would be helpful to determining the amount of fees that should be awarded to Plaintiffs' counsel. The court gave Defendants the opportunity to provide this information within 15 days, but if Xerox chooses not to provide this information, the court will proceed with the evidence that has been presented thus far, coupled with the court's own understanding of legal billing rates based on its thirty years' experience in dealing with such issues. In legalese, the court said put up or shut up.

In consolidated class action alleging that fiduciaries of the Eastman Kodak Employees' Savings and Investment Plan breached their ERISA-mandated duties through imprudent management, oversight and administration of the Plan, the court grants Plaintiffs' counsel a reduced award of attorneys' fees of 25% of the common fund, for a total of \$2,425,000.00, plus the requested costs and expenses in the amount of \$119,100.88 and class representative awards of \$5,000.00 for each of the class representatives. [In re Eastman Kodak Erisa Litig., No. 12-CV-6051L, F.Supp.3d , 2016 WL 5746664 \(W.D.N.Y. Oct. 4, 2016\)](#) (Judge David G. Larimer).

Following reversal of long-term disability benefit termination, awarding prejudgment interest based on 4% per annum starting at the midpoint date for the period of delinquency for a total of \$1,171.35; applying the hourly rate of \$320 (although the rate of \$600 was requested) to 171.9 hours and awarding attorneys' fees of \$55,008.00. [Dunda v. Aetna Life Ins. Co., No. 6:15-CV-6232-MAT, 2016 WL 4831962 \(W.D.N.Y. Sept. 15, 2016\)](#) (Judge Michael A. Telesca).

In long-term disability case, finding that a "remand simpliciter" is sufficient to constitute "some success on the merits" under *Hardt* and an endorsement from the Court on the merits of the claim is unnecessary; failure to successfully argue for a *de novo* standard of review does not justify a reduction in Plaintiff's fee award; reducing time for hours where Plaintiff failed to provide sufficient contemporaneous documentation and awarding 71.24 hours at a rate of \$275 an hour for a total of \$19,591. [Valentine v. Aetna Life Insurance Company, No. 14CV1752JFBGRB, 2016 WL 4544036 \(E.D.N.Y. Aug. 31, 2016\)](#)

Following bench trial and order that Defendants breached their fiduciary duties under ERISA, awarding Plaintiffs' attorneys' fees in the amount of \$2,230,237.83 and costs in the amount of \$394,531.51, for a total of \$ 2,624,768.34. [Severstal Wheeling, Inc. Retirement](#)

[Committee et al., v. WPN Corporation et al., No. 10CIV954LTSGWG, 2016 WL 1611501 \(S.D.N.Y. Apr. 21, 2016\)](#) (Judge Laura Taylor Swain).

District judge awards less in prejudgment interest than that recommended by magistrate judge to prevailing LTD plaintiff. [Doe v. Unum Life Ins. Co. of Am., No. 12 CIV. 9327 \(LAK\), 2016 WL 749886 \(S.D.N.Y. Feb. 23, 2016\)](#) (Judge Lewis A. Kaplan). In this matter involving a long-term disability benefits claim, the Magistrate Judge awarded Plaintiff \$219,385.34 in attorneys' fees, \$946.12 in costs and \$138,803.31 in prejudgment interest for an aggregate award of \$359,134.77. Plaintiff filed objections to this award as it relates to the prejudgment interest calculation and the rate awarded for one attorney and paralegals. The Magistrate Judge concluded that prejudgment interest was appropriate and that (a) it should be calculated from a midpoint date in the delinquency period, (b) the delinquency period began on October 24, 2011 and concluded on the date of judgment, October 5, 2015, (c) he would apply the statutory New York State interest rate of 9 percent per annum, and (d) the total interest award therefore should be \$138,803.31. Plaintiff contends that while he was entitled to payments in installments commencing on October 24, 2011, the last installment was due 24 months later, such that interest for the period October 24, 2011 through October 25, 2013 may be computed from the midpoint of that period, but that interest from October 25, 2013 through October 5, 2015 should be payable on the entire amount that was delinquent by October 25, 2013. The court agreed with Plaintiff that interest should have been computed on the basis of 1,076 days times the appropriate interest rate. But, instead of applying the 9 percent per annum applied by the Magistrate Judge, the court reduced the rate closer to 4 percent since the prime and one year T-bill rates have been under 4 percent and 1 percent, respectively. Accordingly, the court reduced the interest award from \$138,803.31 to \$92,062.56.3. With respect to the applicable hourly rate, the court found that a \$600 hourly rate is appropriate for Plaintiff's attorney, Scott Riemer, and that \$355 was reasonable for Plaintiff's other attorney with five years of ERISA experience. The court granted Plaintiff an aggregate award of \$312,394.02.

Court awards a total of \$359,134.77 in attorneys' fees, costs, and 9% prejudgment interest in matter involving successful LTD litigant. [Doe v. Unum Life Ins. Co. of Am., No. 12CIV9327LAKAJP, 2016 WL 335867 \(S.D.N.Y. Jan. 28, 2016\)](#) (Magistrate Judge Andrew J. Peck). Following a \$780,756 judgment in Doe's favor, the Magistrate Judge issued a report and recommendation that Plaintiff's motion for attorneys' fees and cost be granted in part and Plaintiff awarded attorneys' fees, costs and prejudgment interest totaling \$359,134.77 (\$219,385.34 in attorneys' fees, \$946.12 in costs and \$138,803.31 in prejudgment interest). In granting Plaintiff's motion, the court rejected Unum's contention that Plaintiff should not be awarded any fees. The court explained that Plaintiff's judgment constitutes some degree of success on the merits and that courts in this Circuit routinely award fees to prevailing plaintiffs in ERISA actions based solely on their achieving some degree of success on the merits. The court found that a \$600 hourly rate is appropriate for Plaintiff's attorney, Scott Riemer, and that a \$355 hourly rate is appropriate for an attorney with five years of ERISA experience. The court also

found an hourly rate of \$200 for paralegal work to be reasonable. The court did reduce the time Plaintiff's attorneys expended on certain tasks. The court did not award approximately 47 hours Reimer's associate billed on the protective order which Plaintiff filed to preclude Unum's discovery demands. The court also awarded only \$71,271.94 in attorneys' fees for counsel's work on the trial briefs, which represents a twenty-five percent reduction in the fees requested. With respect to the preparation of "trial exhibits," the court found that the billing entries were vague and it could not readily determine how the various aspects of trial exhibit preparation were divided among counsel and staff. To account for this lack of clarity (and the excessive amount of hours involved regardless of the division of labor), the court awarded only \$21,413.55 in fees for the trial exhibit preparation, which represents a forty percent reduction in the fees requested. With respect to costs, the court awarded only \$946.12 and did not allow \$341.63 spent on FedEx and messengers. Lastly, the court awarded prejudgment interest at the rate of 9% simple interest per year on the \$780,756 judgment using a midpoint of 721 days after October 24, 2011 (the day Doe was to receive his first benefit payment).

C. Third Circuit

Following Plaintiffs' unopposed Motion for Final Approval of Class Action Settlement, granting Plaintiffs' motion for attorneys' fees and service awards, including 33% of the settlement amount, or \$11,000,000, in addition to \$91,055.47 in expenses incurred during litigation and \$45,000 for each of the three Class Representatives, for a total service award of \$135,000 (equal to 1.2% of the settlement amount). None of the roughly 9,500 class members objected to the Settlement or to the Class counsel's fee request. [Demaria v. Horizon Healthcare Servs., Inc., No. 2:11-CV-07298 \(WJM\), 2016 WL 6089713 \(D.N.J. Oct. 18, 2016\)](#) (Judge William J. Martini).

In unpaid contributions matter where the court ruled in Defendant's favor on issue as to whether pension fund payments had to be paid for Local 628's "personal holidays," awarding Plaintiffs \$8,452.50 in attorney's fees (\$21,217.50 was sought), \$1,180.33 in costs, \$995.67 in interest, and \$619.77 in liquidated damages. [Teamsters Health v. Courier-Post Co., No. 15-844 \(JS\), 2016 WL 3922634 \(D.N.J. July 18, 2016\)](#) (Judge Joel Schneider).

D. Fourth Circuit

In matter where Plaintiff sought benefits for both herself and her same-sex spouse, as a dependent spouse under Marshall County Coal Company's employee benefit plan, denying attorneys' fees related to the Resolution of Dispute ("ROD") process found under the CBA (pursued after the lawsuit was filed) since ERISA attorneys' fees are categorically unavailable for expenses incurred while exhausting administrative remedies. [Riggle v. The](#)

[Marshall County Coal Company, et al., No. 5:15CV169, 2016 WL 4014705 \(N.D.W. Va. July 26, 2016\)](#) (Judge Frederick P. Stamp).

Attorneys' fees not warranted where action was dismissed for lack of jurisdiction. [Ret. Comm. v. Magasrevy, No. 5:14-CV-408-FL, 2016 WL 589687 \(E.D.N.C. Feb. 10, 2016\)](#) (Judge Louise W. Flanagan). Defendant sought attorneys' fees under ERISA after the court dismissed Plaintiff's lawsuit on the basis that the court did not have personal jurisdiction over Defendant by virtue of the nationwide service of process provision. The court denied the fee motion. First, the court determined that Plaintiffs' action did not arise under any provision of ERISA, and as a result the court lacked subject matter jurisdiction and personal jurisdiction over the instant matter. As such, Plaintiffs' action was not an "action under this subchapter," for purposes of ERISA's attorney's fee provision, 29 U.S.C. § 1132(g)(1). Second, a fees claimant must show some degree of success on the merits, and in this case the court did not determine the merits of Plaintiff's claims or the merits of the underlying claims asserted by Defendant. Defendant's successful motion to dismiss for lack of personal jurisdiction does not qualify as a "complete success on the merits" under *Hardt*.

E. Fifth Circuit

In dispute over supplemental life insurance benefits, where the court found that Plaintiffs' claims were preempted by ERISA, and entered a judgment in favor of Minnesota Life, the court denied Minnesota Life's claim for attorney's fees under 29 U.S.C. § 1132(g)(1) since the five factors weigh against an award of fees in this case. [Maley v. Minnesota Life Ins. Co., No. A-15-CV-394-LY, 2016 WL 6651392 \(W.D. Tex. Nov. 10, 2016\)](#) (Magistrate Judge Andrew W. Austin).

Granting Defendant Plan's motion for attorneys' fees against the unsuccessful plaintiff in the amount of \$143,814, approximately 56% of his 2012 salary. The court approved rates of 262.8 hours on this case. These hours were multiplied by hourly rates of \$555 to \$750 for partners, \$290 to \$540 for associates, and \$275 to \$290 for paralegals. [Langley v. Howard Hughes Mgmt. Co., LLC, Separation Benefits Plan, No. CV H-13-3595, 2016 WL 6208585 \(S.D. Tex. Oct. 24, 2016\)](#) (Judge Lynn N. Hughes). In this case, the court issued a decision granting the defendant Plan's motion for attorneys' fees against the unsuccessful plaintiff after ruling against him on his claim for separation benefits. Although the court recognized that this case involved "no novel interpretations of ERISA law," the Plan's attorneys spent a lot of time fielding Langley's many "quarrelsome" claims and spending time on this case took time away from other cases. The Plan's attorneys spent 262.8 hours on this case, for which the court awarded rates of \$555 to \$750 for partners, \$290 to \$540 for associates, and \$275 to \$290 for paralegals. The court awarded a total of \$143,814 in fees, which it noted was approximately 56% of the plaintiff's 2012 salary. The Fifth Circuit's a rough neighborhood, in which I will not be trick-or-treating, or filing lawsuits.

Affirming fee decision of the district court and finding waived and unreviewable arguments made by Bruister Family L.L.C. supporting its claim that it cannot have a fee award rendered against it. [Thomas E. Perez, Secretary, Department of Labor, v. Bruister, No. 15-60765, F.App'x, 2016 WL 3194687 \(5th Cir. June 8, 2016\)](#) (Before DAVIS, JONES, and GRAVES, Circuit Judges).

F. Sixth Circuit

In matter to collect delinquent withdrawal liability payments from Defendant, and following order of default judgement against the Defendant in the amount of \$177,072.48, granting Plaintiffs' motion for attorneys' fees and awarding a total of \$16,251.00 in fees. Attorney rates awarded were \$200 and \$275/hour and \$130 for paralegal time. [Graphic Commc'ns Conference of the Int'l Bhd. of Teamsters Nat'l Pension Fund v. Adgravers, Inc., No. 16-CV-10562, 2016 WL 7010491 \(E.D. Mich. Dec. 1, 2016\)](#) (Judge Gershwin A. Drain).

The court ordered Plaintiff's attorney, Michael Grabhorn, to personally pay Standard \$3,726.00 in fees and costs based on his conduct in deposing Dr. Richard Semble. The attorney rates awarded were \$265 and \$220 per hour. [Graves v. Standard Ins. Co., No. 3:14-CV-00558-CRS-DW, 2016 WL 6824403 \(W.D. Ky. Nov. 17, 2016\)](#) (Judge Charles R. Simpson).

Following grant of summary judgment to Plaintiffs on their claim that Church's breached a fiduciary duty to the insured by failing to inform her that an evidence of insurability form would be required for the level of coverage she had selected, the court granted in part and denied in part Plaintiffs' motion for attorneys' fees and awarded a total of \$127,623.06 in attorneys' fees based on hourly rates of \$400 and \$225. [Van Loo v. Cajun Operating Co., No. 14-CV-10604, 2016 WL 6211692 \(E.D. Mich. Oct. 25, 2016\)](#) (Judge Laurie J. Michelson).

Court awards prejudgment interest rate of 5.48% and attorneys' fees and costs. [Schleben v. Carpenters Pension Trust Fund-Detroit & Vicinity, No. 13-CV-14464, 2016 WL 806707 \(E.D. Mich. Mar. 2, 2016\)](#) (Judge Laurie J. Michelson). After granting Plaintiff's motion for summary judgment on his anti-cutback claim, he moved for prejudgment interest and attorneys' fees. On prejudgment interest, the court found that the best way to prevent unjust enrichment is to split the difference and apply a prejudgment interest rate of 5.48%, which reflects an average of (a) the average "expected" rates of return from 2013–15 (7.66%) and (b) the Plan's stated "actual" rate of return (3.287%). The court found that this rate would not only neutralize Defendants' unjust enrichment but also more than compensate Plaintiffs for inflation and the lost interest value of the money withheld. The court found that the prejudgment interest rate of 5.48% should be applied in a "stream of benefits" method, which has been endorsed by the Sixth Circuit. The court awarded an hourly rate of \$475 per hour for three partners who worked on the case and \$250 per hour for a senior associate. The court found that a 20% across-the-board reduction is appropriate for the hours requested.

Court awards additional fees for work related to first motion for fees, work on appeal, and work in seeking fees. [Bunn Enterprises, Inc. v. Ohio Operating Engineers Fringe Benefit Programs, No. 2:13-CV-00357, 2016 WL 223717 \(S.D. Ohio Jan. 19, 2016\)](#) (Judge Algenon L. Marbley). The court granted in part and denied in part Defendants' second motion for attorneys' fees and costs incurred during this delinquent contributions action which resulted in the Court of Appeals affirming the court's grant of Defendants' motion for summary judgment. Defendants seek additional fees for work incurred in preparing the Funds' first motion for fees (and its appeal) as well as the instant fee motion. The court upheld hourly rates of \$525/535 for a 47-year practitioner, \$470 for a 27-year practitioner, and \$370/\$390 for a 13-year practitioner. The court awarded an hourly rate of \$125 for a paralegal. On hours reasonably expended, the court reduced Defendants' total request by 5% for insufficient documentation as well as for duplicative documentation. The court declined to further downward adjust the fees based on Plaintiffs' argument that there were too many people working on the case and it was an un-complex case. Lastly, the court granted "fees on fees" based on approximately 23.5 hours and \$8,741.25 in fees briefing and litigating for the recovery of fees.

G. Seventh Circuit

In this matter seeking prejudgment interest and attorneys' fees following administrative award of disability pension benefits (upon remand by the Seventh Circuit), the court found that Plaintiff is entitled to prejudgment interest as the Trustees' decision was arbitrary and capricious. The Trustees would have requested additional information leading to the approval of Plaintiff's application had they applied the right standard in 2010, as set forth by the Seventh Circuit. On attorneys' fees, the Plan conceded that it could not point to any case law which prevented Plaintiff from seeking attorney's fees after being awarded benefits after a remand from the Seventh Circuit. The court found that Plaintiff clearly achieved some degree of success on the merits in obtaining a remand and reconsideration of his application for disability benefits in light of the Trustees' arbitrary and capricious analysis. The court also found that Plaintiff would be entitled to attorney's fees even under the five factor test. [Cerentano v. United Maine Workers of Am. 1974 Pension Plan, No. 15-CV-874-SCW, 2016 WL 7117150 \(S.D. Ill. Dec. 7, 2016\)](#) (Magistrate Judge Stephen C. Williams).

Following the grant of summary judgment to Plaintiff, who sought long-term benefits for his deceased wife's disability due to Stage IV lung cancer, and remand to the administrator for further proceedings, the court awarded Plaintiff the full amount of attorneys' fees and costs requested totaling \$82,140.84. Plaintiff's award was based on the actual billing hourly rates of \$450 and \$280. [Kaiser v. United of Omaha Life Ins. Co., No. 14-CV-762-WMC, 2016 WL 6581355 \(W.D. Wis. Nov. 4, 2016\)](#) (Judge William M. Conley).

In long-term disability case, following a grant of summary judgment to Aetna, denying Aetna's motion for \$40,000 in attorneys' fees, but granting Aetna's request for \$17.50 in costs. [Geiger v. Aetna Life Ins. Co., No. 15-CV-3791, 2016 WL 5391206 \(N.D. Ill. Sept. 27, 2016\)](#) (Judge Amy J. St. Eve). involves Aetna Life Insurance Company's failed attempt to have Geiger pay \$40,000 in attorneys' fees following the court's grant of summary judgment in Aetna's favor on the disabled claimant's denied long-term disability claim. However, the court did grant Aetna's request for \$17.50 in costs.

In reviewing the court's opinion, it is unclear why Aetna believed that the court would award attorneys' fees against the losing claimant. Certainly, Aetna did achieve some "degree of success on the merits," but that's a minor hurdle to overcome in a claim for fees against a plan participant. In deciding to not exercise its discretion to award fees, the court determined that Geiger's position was substantially justified and taken in good faith. Indeed, Geiger had multiple doctors who diagnosed her with conditions affecting her back and ankles, and opined that those conditions were severe enough to require some surgery and pain medication. One doctor opined that Geiger had fairly significant necrosis and osteochondral pathology that would become very painful with prolonged standing and/or walking. On two previous occasions, Aetna had approved Geiger's disability claim and the Social Security Administration also found Geiger disabled under its rules.

Under a second applicable test for determining whether an award of fees is justified, the courts consider:

the degree of the offending parties' culpability or bad faith; 2) the degree of the ability of the offending parties to satisfy personally an award of attorney's fees; 3) whether or not an award of attorney's fees against the offending parties would deter other persons acting under similar circumstances; 4) the amount of benefit conferred on members of the pension plan as a whole; and 5) the relative merits of the parties' positions.

Considering these five factors, the court found that the first factor decidedly does not favor Aetna, the second, third, and fourth factors are neutral, and only the fifth factor slightly supports a fee award. For these reasons, the court had little trouble exercising its discretion to deny a fee award.

After previously granting summary judgment in favor of Plaintiff Board of Trustees of the Health and Welfare Department of the Construction and General Laborers' District Council of Chicago and Vicinity (the "Board") in this matter seeking to recover certain ERISA plan assets tendered to, and withheld by, Defendants Allison Enterprises, Inc. d/b/a Mid America Vision and its president and sole shareholder, Lawrence Silver, awarding the Board costs of \$7,896.29 and fees of \$336,793.12. [Bd. of Trustees of the Health v. Allison Enterprises, Inc., No. 12 C 4097, 2016 WL 4397972 \(N.D. Ill. Aug. 18, 2016\)](#) (Judge Charles P Kocoras).

Remand to claims administrator satisfies *Hardt's* “some degree of success on the merits.” [Hilderbrand v. Nat’l Elec. Benefit Fund, No. 13-3170, 2016 WL 614352 \(C.D. Ill. Feb. 16, 2016\)](#) (Judge Sue E. Myerscough). In the first ruling on summary judgment, the court found the NEBF violated ERISA by failing to give Hilderbrand a full and fair review of his claim for a disability pension benefit. The court granted summary judgment, in part, in favor of Hilderbrand and remanded the claim for benefits to the NEBF Trustees for a *de novo* benefits determination, thereby giving Hilderbrand another review of his claim for benefits. In a subsequent motion for summary judgment, the court found in favor of the NEBF Trustees. Hilderbrand filed a motion for attorneys’ fees for the success he achieved in obtaining a remand. The court found that Hilderbrand achieved some degree of success on the merits of his claim but that an award of attorneys’ fees is not appropriate under the facts of this case after applying the relevant five-factor test.

Plaintiff entitled to attorneys’ fees after securing remand to LTD insurer. [Kaiser v. United of Omaha Life Ins. Co., No. 14-CV-762-WMC, 2016 WL 379814 \(W.D. Wis. Jan. 29, 2016\)](#) (Judge William M. Conley). The court found Plaintiff eligible for an award of attorneys’ fees for winning a remand to the insurer for determination of disability under the terms of a long-term disability plan. Applying *Hardt v. Reliance Standard Life Insurance Company*, 560 U.S. 242 (2010) and the “substantial justification” test and the five-factor test in *Raybourne v. Cigna Life Ins. Co. of New York*, 700 F.3d 1076, 1089 (7th Cir. 2012), the court found that its decision finding that Defendants violated ERISA by acting arbitrarily and capriciously, and ordering remand to the Plan Administrator for further review, was all that Plaintiff could achieve in this court. Additionally, Defendants’ interpretation of the pre-existing condition clause was at odds with fairly settled Seventh Circuit case law, and rendered their posture during the case as a whole not substantially justified. The court found an award of attorneys’ fees and costs appropriate under 29 U.S.C. § 1132(g)(1) and directed Plaintiff to submit its fee request.

H. Eighth Circuit

Attorneys’ fees denied to successful long-term disability claimant. [Halley v. Aetna Life Ins. Co., No. 13 C 6436, 2016 WL 164339 \(N.D. Ill. Jan. 14, 2016\)](#) (Judge John Robert Blakey). Although Plaintiff prevailed on her Rule 52 motion for judgment on her denied claim for long-term disability benefits, the court declined to award Plaintiff his attorney’s fees under 29 U.S.C. § 1132(g)(1) by applying the two tests in the Seventh Circuit for analyzing whether attorney’s fees should be awarded to a party in an ERISA case. See *Kolbe Health & Welfare v. Medical College of Wisconsin*, 657 F.3d 496 (7th Cir. 2011). The first test weighs five factors: (1) the losing party’s culpability or bad faith; (2) the losing party’s ability to satisfy an award of attorney’s fees; (3) whether an award of attorney’s fees would deter others under similar circumstances; (4) the amount of benefit conferred on members of the ERISA pension plan as a whole; and (5) the relative merits of the parties’ positions. The second test asks whether the losing party’s position was “substantially justified.” The court found that while framed

differently, both tests essentially ask the same question: “was the losing party’s position substantially justified and taken in good faith, or was that party simply out to harass its opponent?” Although Defendant did not ultimately prevail, the court credited Defendant’s medical evidence that Plaintiff was theoretically capable of working and rejected Plaintiff’s response that he was not capable of working. The court had concluded that there were two tacit flaws in the vocational analysis of Plaintiff’s job but these subtle, yet significant, flaws do not show that Defendant was out to harass Plaintiff or that Defendant lacked a good faith basis to deny coverage. To the contrary, the court concluded that Plaintiff is, in fact, theoretically capable of working. Although this was not enough for Defendant to prevail, the court did not find that it warranted an award of attorneys’ fees.

I. Ninth Circuit

Following grant of summary judgment on all withdrawal liability claims against Defendants, pursuant to § 1132(g)(2), awarding professional fees of \$454,144.00 and costs of \$23,661.53. In this case, the hourly billing rates are \$235 to \$370 for junior and senior associates and \$400 for directors. [Bd. of Trustees v. Piedmont Lumber & Mill Co., No. 13-CV-03898-HSG, 2016 WL 4446993 \(N.D. Cal. Aug. 24, 2016\)](#) (Judge Haywood S. Gilliam, Jr.).

Following Ninth Circuit’s affirmance of the district court’s grant of default judgment against Defendants in the amounts of \$200,000 for ERISA violations, \$54,926 in pre-judgment interest, and \$221,251.63 in attorneys’ fees, granting Plaintiff’s motion to amend judgment, as modified, to add \$62,150.00 in attorney’s fees (based on hourly rate of \$250), \$4,888.46 in expenses and costs, \$209.26 in pre-judgment interest, and \$1,400.71 in post-judgment interest, together equaling \$68,648.43. Post-judgment interest will continue to accrue until the date of payment at a rate of 0.11 percent, compounded annually. [Lasheen v. Loomis Co., No. 201CV00227KJMEFB, 2016 WL 4161119 \(E.D. Cal. Aug. 4, 2016\)](#) (Judge Kimberly Mueller).

In matter seeking more than half a million dollars in unpaid benefits due under the terms of a collective bargaining agreement, where the court previously declined to adopt an exception to the general rule announced by the Ninth Circuit in *Cline v. Industrial Maintenance Engineering and Contracting Company* that unpaid benefits are not plan assets, denying The Principals’ motion for attorney’s fees in excess of \$130,000 after consideration of the *Hummel* factors. [Unite Here Health, et al., v. Craig Gilbert, et al., No. 213CV00937JADGWF, 2016 WL 3965186 \(D. Nev. July 22, 2016\)](#) (Judge Jennifer A. Dorsey).

In matter where Plaintiff prevailed on her claim for retirement benefits under the IBM Plan, granting in part Plaintiff’s motion for attorneys’ fees and prejudgment interest and awarding Plaintiff \$249,871.50 in attorneys’ fees (based on hourly rates of \$625 and \$650 for attorneys; \$180 for paralegals) and \$2,398.31 in prejudgment interest (5% prejudgment

interest on the \$47,966.10 judgment); reducing time spent by 10% to account for time spent on Plaintiff's unrelated and unsuccessful claim for statutory penalties. [Gurasich v. IBM Retirement Plan; International Business Machines Corporation, No. 14-CV-02911-DMR, 2016 WL 3683044 \(N.D. Cal. July 12, 2016\)](#) (Judge Donna M. Ryu).

In matter involving individual claim for long-term disability benefits, granting in part Plaintiff's motion for attorneys' fees based on hourly rates ranging from \$500-\$550 for attorney time. "An ERISA plaintiff who enjoys a degree of success on the merits of his case should recover his attorneys' fees, absent special circumstances and injustice." Court lacks authority to consider request for fees incurred during most recent appeal to the Ninth Circuit per Circuit Rule 39-1.8. [Barboza v. California Ass'n of Prof'l Firefighters, No. 2:08-CV-0519-KJM-EFB, 2016 WL 3125996 \(E.D. Cal. June 3, 2016\)](#) (Judge Kimberly Mueller).

In matter where Defendant unsuccessfully removed case to federal court arguing ERISA preemption, granting in part Plaintiff's request for attorney's fees and awarding \$8,556.90 in attorney's fees. [Bergen v. Tualatin Hills Swim Club, Inc., No. 3:16-CV-00052-HZ, 2016 WL 2736105 \(D. Or. May 11, 2016\)](#) (Judge Marco A. Hernandez).

Following private settlement of disability claim, court awards Plaintiff \$41,650.00 in attorney's fees and \$2,495.90 in costs. [Rangel v. Aetna Life Ins. Co., No. 515CV00303ODWKKX, 2016 WL 1449539 \(C.D. Cal. Apr. 12, 2016\)](#) (Judge Otis D. Wright II).

Attorneys' fees and costs awarded to trust funds for litigation which forced company to submit to an audit. [Trustees of the N. California Tile Indus. Pension Trust Fund v. Premier Stone & Tile, Inc., No. 14-CV-03560-WHO, 2016 WL 1182060 \(N.D. Cal. Mar. 28, 2016\)](#) (Judge William H. Orrick). The court awarded attorneys' fees to Plaintiff Trust Funds for fees and costs incurred in this litigation that forced Defendant Premier to submit to an audit. The court rejected Premier's objection that Plaintiffs did not prevail on the unpleaded but heavily investigated claim that companies related to, but legally-distinct from Premier, were the alter-ego of Premier. The court awarded the following hourly rates: John J. Davis Jr. (admitted 1975) \$650; Sara Grossman-Swenson (admitted 2008): \$350; David L. Barber (admitted 2013): \$250; and Alexander Ellebracht (not yet admitted): \$150. The court did not award all time sought due to its finding of block billing and inefficiencies by Plaintiffs' counsel. The court awarded Plaintiffs \$222,068 for attorneys' fees, \$6,547.86 for costs, and \$19,009.33 for auditor costs.

ERISA fee-shifting provision does not apply to nondischargeability action. [Bos v. Bd. of Trustees, No. 13-15604, ___ F.3d ___, 2016 WL 1161262 \(9th Cir. Mar. 24, 2016\)](#) (Before DIARMUID F. O'SCANLAIN and SANDRA S. IKUTA, Circuit Judges and LARRY A. BURNS,* District Judge). In an earlier opinion, the Ninth Circuit concluded that Bos was not a fiduciary under ERISA, and thus the Bankruptcy Code's "fiduciary" exception to discharge could not be applied to him. Bos moved for attorneys' fees under a fee-shifting provision under California law, California Civil Code § 1717 and, alternatively, under ERISA, 29 U.S.C. §

1132(g)(1). The Ninth Circuit rejected Bos’s fee petition. The court concluded that the action underlying Bos’s fee request—the nondischargeability proceeding that began in bankruptcy court—was not an action “on a contract” within the meaning of section 1717. Additionally, the court concluded that Bos’s attempt to invoke ERISA fails because the nondischargeability action was not an “action under” ERISA, and therefore § 1132(g)(1) does not make Bos eligible to recover fees. The court explained that § 1132(g)(1) makes a party eligible to recover fees if and only if the action that generated his fees meets the test for “arising under” jurisdiction incorporated into § 1132(e). In this case, there was no dispute that the Bankruptcy Code, not ERISA, grounds the Board’s cause of action since the Board’s adversary complaint neither cited ERISA nor alleged any violation of an ERISA plan; instead, the Board sought relief exclusively under the Bankruptcy Code. Furthermore, the nondischargeability claim in the Board’s adversary complaint did not necessarily depend upon resolution of any question under ERISA, let alone a “substantial” question. The Board could have won the relief it sought without any court ever needing to invoke ERISA. Although as the litigation unfolded, the meaning of an ERISA term came to assume a central role (i.e., whether Bos qualified as a “fiduciary” under the Bankruptcy Code, on the specific theory that Bos was a “fiduciary” under ERISA), the Board’s well-pleaded complaint did not require the court to construe an ERISA term. That it wound up doing so is not enough to make the nondischargeability proceeding an “action under” ERISA for jurisdictional purposes or for fee-shifting purposes.

Attorneys’ fees may be awarded for work done following defendant’s acceptance of responsibility for paying disputed claim. [Bryant v. Cigna Healthcare of California, Inc., No. 14-55251, ___ Fed.Appx. ___, 2016 WL 1085701 \(9th Cir. Mar. 21, 2016\)](#) (Before: FARRIS, CLIFTON, and BEA, Circuit Judges). Plaintiff-Appellant argued that the district court abused its discretion when it determined that she could not recover attorneys’ fees incurred after March 21, 2011, the date that CGLIC accepted responsibility for paying her claim. The district court based its decision on *McElwaine v. U.S. West, Inc.*, 176 F.3d 1167, 1174 (9th Cir.1999), where this court held that an ERISA claimant “should recover fees only for work up until the time she learned conclusively that U.S. West would pay her claim in full.” However, in this case, the court distinguished *McElwaine* on the critical fact that once Plaintiff achieved certainty regarding her claim, demonstrating her entitlement to fees remained to be achieved by further litigation. Entitlement to attorneys’ fees is a critical issue in ERISA actions and Plaintiff’s entitlement to attorneys’ fees depended on establishing that CGLIC received a claim in 2007. Absent that, Plaintiff would not have been able to show that she achieved “some success on the merits” as required by *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010). The court found that based on these circumstances, the district court abused its discretion when it denied attorneys’ fees corresponding to the work that was undertaken to ensure Plaintiff’s entitlement to those fees. The court found that the district court did not abuse its discretion when it refused to award attorneys’ fees that Plaintiff incurred pursuing the theory that CGLIC should have paid her directly since that work did not contribute to her success. The court also found that Plaintiff should only be awarded 120 hours for preparing the first appeal in this matter.

Following Rule 68 offer, court grants motion for attorneys' fees in part. [F. v. Blue Shield of California, No. 09-CV-2037-PJH, 2016 WL 1059459 \(N.D. Cal. Mar. 17, 2016\)](#) (Judge Phyllis J. Hamilton). In this putative class action involving the denial of residential treatment, and following Blue Shield's stipulation to entry of judgment in favor of Plaintiffs in the amount of \$79,954, Plaintiff moved for summary judgment on the issue of damages, costs, and attorneys' fees. The court granted the motion as to the amount of damages of \$79,954; denied requested costs in the amount of \$18,196, but without prejudice to submitting the costs post-judgment in a proper cost bill (except for costs incurred after Blue Shield made its Rule 68 offer); denied prejudgment interest at a rate of 15% but granted as to the request for prejudgment interest and post-judgment interest at the statutory rate; and granted in part and denied in part as to the amount of the attorney's fees. Plaintiff sought a total of \$725,801.27 but the court awarded reduced fees of \$339,298.07. The court awarded a San Francisco attorney in practice for 15 years the rate of \$650/hour. The court declined to award the same rate to Utah attorneys who also worked on the case since it found that the customary billing rates in Utah are significantly lower. The court awarded rates of \$450 and \$340 for the Utah attorneys, both of whom have been in practice for 30 years or more.

Post-judgment attorneys' fees denied to both parties. [Brasley v. Fearless Farris Serv. Stations, Inc., No. 1:08-CV-00173-BLW, 2016 WL 1032785 \(D. Idaho Mar. 14, 2016\)](#) (Judge B. Lynn Winmill). In this case, the court had awarded judgment in favor of Plaintiffs following a bench trial in 2010. The court then awarded \$390,153.60 plus costs in the amount of \$537.67. Six years later, Defendants finally complied with the Court's Judgment in what the court described as "more frustrating than almost any other case I have dealt with in my nearly 30 years as a judge." Both sides requested that the other pay for their attorneys' fees but the court denied both motions. The court was required to appoint a Special Master to resolve the issue of compliance with the Court's judgment, and that the Special Master ultimately recommended that the Qualified Plan be terminated and that Defendants pay Plaintiffs lump sum amounts – a concept neither party suggested or advocated. The court also denied Plaintiffs' request to require Defendants to pay the mediator fees that they had agreed to split. However, the court ordered Defendant to pay the bill of the actuary who acted under the direction of the Special Master.

Court awards most of attorneys' fees requested by prevailing LTD plaintiff. [Robertson v. Standard Ins. Co., No. 3:14-CV-01572-HZ, 2016 WL 406343 \(D. Or. Jan. 31, 2016\)](#) (Judge Hernandez). Plaintiff previously prevailed on her LTD and life insurance waiver-of-premium claims. She then moved for attorneys' fees totaling \$73,640.25 and costs totaling \$1,620.33. The court granted the motion in part and awarded \$43,526 in fees and \$420.08 in costs. The court reduced the requested hours by time spent on an unsuccessful motion to compel, some "duplicative" time spent by local counsel, time spent on clerical tasks, time described by "vague" time entries, and time spent on the fee petition for failing to follow Local Rule 7-1's requirement to meet and confer in good faith. The court applied an hourly rate of \$288.88 for an attorney who graduated from law school in 2003 and is based in Kentucky and a rate of \$336.34 for an

Oregon attorney with 22-23 years of ERISA experience. With respect to expenses, the court declined to award “copy/printing” fees where information about the copy charges was not provided. The court also declined to award \$168.75 in scanning expenses, the \$400 filing fee for Plaintiff’s action in Kentucky that she voluntarily dismissed, and \$100 for a *pro hac vice* application.

J. Tenth Circuit

Although Defendant abused its discretion in terminating disability benefits, attorneys’ fees are not merited under Section 1132(g)(1). “First, though DMBA’s interpretation of the Plan is unreasonable, it remains unclear whether DMBA acted entirely in bad faith. Second, a review of the administrative record does not reveal DMBA’s financial situation and, consequently, whether DMBA could satisfy an award of attorney’s fees. Third, an award of attorney’s fees could induce others to more thoroughly review their plans before denying a claimant benefits. Fourth, Mr. Black brought this suit to recover benefits owed to him, not to anybody else. Nor did Mr. Black seek to resolve any significant legal questions regarding ERISA. And fifth, DMBA’s interpretation was unreasonable, so the merits of Mr. Black’s position greatly outweighed the merits of DMBA’s.” [Black vs. Deseret Mutual Benefit Administrators, No. 2:15-CV-00695-TC, 2016 WL 5173246 \(D. Utah Sept. 21, 2016\)](#) (Judge Tena Campbell).

K. Eleventh Circuit

Denying United of Omaha’s motion for attorneys’ fees against the unsuccessful disability claimant, recognizing that “this was far from a one-sided frivolous case, rather it was one argued in good faith and based on medical evidence.” However, pursuant to Rule 54(d)(1) of the Federal Rules of Civil Procedure, costs other than attorneys’ fees shall be allowed in the amount of \$2,102.90, which are associated with subpoena fees, copies of medical records, and transcripts. [Horneland v. United of Omaha Life Ins. Co., No. 8:15-CV-1703-T-33TGW, 2016 WL 6125705 \(M.D. Fla. Oct. 20, 2016\)](#) (Judge Virginia M. Hernandez Covington).

II. *Breach of Fiduciary Duty*

A. U.S. Supreme Court

Complaint did not plausibly allege a breach of fiduciary duty claim related to the purchase and hold of employer’s stock. [Amgen Inc. v. Harris, No. 15-278, ___ S.Ct. ___, 2016 WL 280886 \(U.S. Jan. 25, 2016\)](#) (PER CURIAM). This is the U.S. Supreme Court’s second

disposition of this matter involving allegations that defendants breached their fiduciary duties by allowing participants to purchase and hold employer's stock despite knowing that its price was artificially inflated. The United States District Court for the Central District of California granted the fiduciaries' motion to dismiss, and the participants appealed. The United States Court of Appeals for the Ninth Circuit reversed and remanded. On remand, the District Court, entered an order dismissing action, and participants again appealed. On denial of petition for rehearing en banc, the Court of Appeals reversed and remanded. The fiduciaries petitioned for certiorari, which the U.S. Supreme Court granted, and then it vacated judgment and remanded it back to the Court of Appeals. The Court of Appeals reversed and remanded. The Supreme Court granted certiorari and held that to state claim for breach of fiduciary duty under ERISA, Plaintiffs were required to plausibly allege that a prudent fiduciary in the same position could not have concluded that alternative action of removing employer's stock from list of investment options would do more harm than good. The Court examined the complaint and did not find sufficient facts and allegations to state a claim for breach of the duty of prudence. The Court reversed the judgment of the Ninth Circuit and remanded for further proceedings. The Court leaves to the District Court in the first instance whether the stockholders may amend the complaint in order to adequately plead a claim for breach of the duty of prudence guided by the standards provided in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459, 189 L. Ed. 2d 457 (2014).

B. First Circuit

In putative class action matter where Plaintiffs alleged that Fidelity breached two fiduciary duties by using certain plan assets other than for the benefit of the plans, affirming dismissal of case and holding that “float” (interest earned on the cash paid out by the mutual funds) is not a plan asset; reserving decision on the issue as to whether Fidelity, in the absence of an express agreement about float, has engaged in prohibited transactions and acted disloyally. [In re Fid. ERISA Float Litig., No. 15-1445, ___ F.3d ___, 2016 WL 3748685 \(1st Cir. July 13, 2016\)](#) (Before Thompson, Circuit Judge, Souter, Associate Justice, and Kayatta, Circuit Judge). In this case, Plaintiffs allege that Fidelity breached its fiduciary duties under Section 404(a) (duty of loyalty) and Section 406(b) (prohibition on self-dealing) in its treatment of “float” while administering 401(k) defined-contribution retirement plans. Float, interest earned on the cash paid out by the mutual funds, could be earned by Fidelity at two points after a plan participant requested withdrawal of funds: (1) when the cash was in FICASH (an interest-bearing account owned and controlled by Fidelity) overnight, and, (2) for participants who opted to receive a paper check rather than an electronic transfer, when it sat in the disbursement account until the participant cashed her check. Plaintiffs allege that Prudential breached its fiduciary duties by using float, a plan asset, for purposes other than for the benefit of the 401(k) plans. The district court dismissed the action under Rule 12(b)(6), finding that float is not a plan asset. The First Circuit Court of Appeals affirmed the district court's decision. It rejected

Plaintiffs' argument that cash received in redemption of the mutual-fund shares are plan assets just because the mutual-fund shares are plan assets prior to redemption. The court noted that the redemption does not go, nor is intended to go, to the plan itself. Although Fidelity is in receipt of the funds via the withdrawal process by virtue of its fiduciary relationship with the plan, this relationship is not sufficient to confer plan-asset status on everything that comes within Fidelity's position. The court's decision reaches the same conclusion as the Eighth Circuit in [Tussey v. ABB, Inc., 746 F.3d 327 \(8th Cir. 2014\)](#). The court acceded to the Secretary of Labor's request to reserve decision on the issue as to whether Fidelity, in the absence of an express agreement about float, has engaged in prohibited transactions and acted disloyally.

C. Second Circuit

In a lawsuit by Board of Trustees of the Upstate New York Engineers Pension Fund against the Fund's investment manager, alleging breach of fiduciary duty in failing to advise the fund in 1998 that it had become imprudent to continue as a customer of Bernard L. Madoff Investment Securities LLC, the court affirmed the district court's dismissal of the Trustees' complaint for failure to state a claim and for failure to allege an actual injury sufficient to establish Article III standing. [Trustees of The Upstate New York Engineers Pension Fund v. Ivy Asset Management, Lawrence Simon, Howard Wohl, & Bank Of New York Mellon Corporation, No. 15-3124, ___ F.3d ___, 2016 WL 7157992 \(2d Cir. Dec. 8, 2016\)](#) (Before: Kearse, Jacobs, and Pooler, Circuit Judges). This case involves a lawsuit brought by the Board of Trustees of the Upstate New York Engineers Pension Fund against the fund's investment manager, alleging breach of fiduciary duty in failing to advise the fund in 1998 that it had become imprudent to continue as a customer of Bernard L. Madoff Investment Securities LLC ("BLMIS"). The Trustees also sued Bank of New York Mellon Corporation for knowingly participating in the fiduciary breach. The Second Circuit affirmed the district court's dismissal of the complaint for failure to state a claim and for failure to allege an actual injury sufficient to establish Article III standing.

The Trustees alleged that if warned, the fund would have withdrawn the full sum appearing on its 1998 BLMIS account statements; and that prudent alternative investment of that sum would have earned more than the fund's actual net withdrawals from its BLMIS account between 1999 and 2008. The court found that such comparable profit would have been extremely difficult to achieve as the Trustees have not claimed that any of the Plan's alternative investment options offered returns as high as 25 percent every year between 1998 and 2005. "The valid measure is a prudent alternative investment, not an alternative Ponzi scheme." Because the alleged breach of fiduciary duty does not result in a cognizable investment loss, there is no injury-in-fact sufficient for constitutional standing.

The Trustees also claimed additional losses: (1) the \$1.8 million in performance fees paid to Ivy Asset Management in connection with the Plan's BLMIS investment after 1998; and (2) the costs incurred responding to the unsuccessful clawback action filed by the Madoff

bankruptcy trustee and to the subpoenas issued by the United States Department of Labor and the Attorney General of the State of New York in their actions against Ivy, Lawrence Simon, and Howard Wohl. The court found that these losses do not come close to matching the extraordinary profits made by the Plan's BLMIS investment over and above what it could have made through a prudent alternative investment.

The court also found that the increase in pension benefits, which were increased in 1999 in partial reliance on the stated performance of the BLMIS investment, does not constitute a cognizable loss because the Complaint does not allege that the Plan has been or will be unable to pay the increased benefits to participants. On the Trustees' request for disgorgement of the \$200 million that Simon and Wohl shared when BNY Mellon acquired Ivy, the court found that there was no reasonable inference that Simon and Wohl's concealment of information about Madoff affected Ivy's acquisition price. Lastly, the court found that the Complaint fails to state a claim against BNY Mellon for participating in a breach of fiduciary duty by Ivy, Simon, and Wohl.

In putative class action alleging mismanagement of 401(k) Plan, the court found that the Complaint does not sufficiently allege that Deutsche Investment Management Americas Inc. and RREEF America, LLC provided investment advice to the Plan for a fee. Because the Complaint fails to allege that DIMA and RREEF are fiduciaries, the breach of fiduciary duty claims are dismissed as against them. [Moreno, et al. v. Deutsche Bank Americas Holding Corp., et al., No. 15 CIV. 9936 \(LGS\), F.Supp.3d , 2016 WL 5957307 \(S.D.N.Y. Oct. 13, 2016\)](#) (Judge Lorna G. Schofield).

In suit brought by the DOL alleging that Defendant First Bankers Trust Services, Inc. ("FBTS") violated ERISA by approving the sale of 49% of Maran, Inc., a private label denim manufacturer, to the Maran Employee Stock Ownership Plan for whom it served as independent trustee, denying both parties' motions for summary judgment. The court found that there are genuine issues of material fact relating to: (1) FBTS's true motivations driving its decisions to select Meyers, Harrison & Pia ("MHP") as valuation advisor; (2) MHP's independence; (3) the relevance of the Angelo Gordon offer; (4) the reasonableness of treating the financial information and projections provided by Huang as presumptively accurate; (5) the rigor with which FBTS reviewed and challenged MHP's methodologies; and (6) FBTS's failure to negotiate and ultimately approve the Transaction at the designated purchase price. [Thomas E. Perez, Sec'y of Labor, U.S. Dep't of Labor v. First Bankers Trust Services, Inc., No. 12-CV-8648 \(GBD\), 2016 WL 5475997 \(S.D.N.Y. Sept. 28, 2016\)](#) (Judge George B. Daniels).

Pension Trust Plan purchased a life insurance policy insuring the life of an employee of the company which established the Plan. MetLife allegedly overpaid the amount of death benefits owed and Defendants refused to return the amount to MetLife. MetLife sued for return of the overpaid money. The court found that this type of claim will not support a breach of fiduciary duty cause of action under ERISA § 502. Defendants did not owe

MetLife a fiduciary duty. MetLife is not suing on behalf of the Plan. [Metro. Life Ins. Co. v. Sicoli & Massaro Inc., No. 15 CIV. 7141 \(PGG\), 2016 WL 5390899 \(S.D.N.Y. Sept. 26, 2016\)](#) (Judge Paul G. Gardephe). **In case concerning a securities class action settlement agreement, finding that various ERISA plans are not “affiliates” of AIG for the purposes of a class action settlement agreement and that the district court erred by not considering the statutory limitations imposed on a sponsor’s control over an employee benefit plan under ERISA.** [Rothstein v. Am. Int’l Grp., Inc., No. 14-4067\(L\), ___ F.3d ___, 2016 WL 5075939 \(2d Cir. Sept. 20, 2016\)](#) (Before: POOLER and SACK, Circuit Judges, and FAILLA, District Judge).

Affirming the district court’s conclusion that the Complaint failed to plausibly allege that a prudent fiduciary could not conclude that freezing purchases or disclosing the alleged securities fraud would cause the Fund “more harm than good,” as is required to be alleged by *Fifth Third Bancorp*, 134 S. Ct. at 2473, and *Amgen Inc. v. Harris*, 136 S. Ct. 758 (2016) (per curiam). [Loeza et al. v. JPMorgan Chase & Co., et al., No. 16-222-CV, ___ F.A’ppx ___, 2016 WL 4703505 \(2d Cir. Sept. 8, 2016\)](#) (PRESENT: RALPH K. WINTER, DENNY CHIN, CHRISTOPHER F. DRONEY, Circuit Judges).

In suit where Plaintiffs allege that once Defendants learned that IBM’s stock price was artificially inflated, Defendants should have either disclosed the truth about Microelectronics’ value or issued new investment guidelines temporarily freezing further investments by the Fund in IBM stock, granting Defendants’ motion to dismiss the Amended Complaint for failure to state a claim: (1) Plaintiffs have plausibly pled that IBM’s Microelectronics unit was impaired and that the Plan fiduciaries were aware of its impairment; (2) Plaintiffs do not sufficiently plead that IBM was a *de facto* fiduciary; (3) although Plaintiffs’ proposed alternative actions would not necessarily conflict with the securities laws, the Amended Complaint fails to satisfy the second prong of *Dudenhoeffer’s* alternative-action test, that a prudent fiduciary in the same position could not have concluded that the alternative action would do more harm than good. [Jander v. Int’l Bus. Machines Corp., No. 15CV3781, 2016 WL 4688864 \(S.D.N.Y. Sept. 7, 2016\)](#) (Judge William H. Pauley, III).

Affirming judgment of the district court finding WPN and LaBow, named fiduciaries of two defined contribution plans sponsored for the employees of Severstal Wheeling, Inc., liable for breaches of their fiduciary duties arising under ERISA Section 3(21)(A)(ii); district court did not err in finding that they had been granted management control and authority – and thus were fiduciaries under Section 3(21)(A)(iii) of ERISA – regardless of whether they exercised the grant of discretionary authority. [Severstal Wheeling, Inc. Retirement Committee v. WPN Corporation, No. 15-2725, ___ F.App’x ___, 2016 WL 4533478 \(2d Cir. Aug. 30, 2016\)](#) (Present: ROSEMARY S. POOLER, GERARD E. LYNCH, SUSAN L. CARNEY, Circuit Judges).

In suit brought on behalf of ERISA employee benefit plans against twelve banks and their affiliates for losses caused by Defendants’ breach of fiduciary duties and participation in prohibited transactions arising from their alleged manipulation of the foreign currency (“FX”) markets for over a decade, dismissing the Complaint against the Moving Defendants as parties in interest for failing to plead a colorable violation of ERISA § 406 by any Plan fiduciary. [Allen v. Bank of Am. Corp., No. 15 CIV. 4285 \(LGS\), 2016 WL 4446373 \(S.D.N.Y. Aug. 23, 2016\)](#) (Judge Lorna G. Schofield).

Plaintiff Secretary of Labor brought suit against defendants First Bankers Trust Services, Inc. (“FBTS”), and Frank Firor, alleging defendants were fiduciaries to an employee stock ownership plan and caused the plan to purchase shares in the company at a price in excess of the shares’ fair market value. The Secretary and Firor – but not FBTS – reached a settlement, conditioned on the entry of a bar order that prevents the non-settling defendant FBTS from seeking indemnification or contribution from Firor. The court denied Firor’s motion for entry of a bar order and granted FBTS’s cross-motion for entry of a bar. [Perez v. First Bankers Trust Servs., Inc., No. 12 CV 8649 \(VB\), 2016 WL 2343889 \(S.D.N.Y. May 3, 2016\)](#) (Judge Briccetti).

Breach of fiduciary duty claims related to negotiation of life insurance premiums dismissed. [Hannan v. The Hartford Financial Services, Inc., No. 3:15-CV-0395 \(VLB\), 2016 WL 1254195, at \(D. Conn. Mar. 29, 2016\)](#) (Judge Vanessa L. Bryant). Plaintiffs, participants in the Family Dollar Stores Inc. Group Insurance Plan brought a purported class action against the Family Dollar Defendants and Hartford Financial Services, Inc. alleging ERISA breach of fiduciary duty, co-fiduciary liability, knowing participation in a breach of fiduciary duty against Hartford, prohibited transactions, and federal common law unjust enrichment based on the allegation that Defendants improperly negotiated a discount on the basic life insurance premium paid by Family Dollar; and that the Hartford offset some of this discount by increasing the supplemental life insurance premium charged to the Family Dollar employees who purchased supplemental coverage. Plaintiffs contend that this arrangement is an inappropriate “cross-subsidization and kickback scheme” that results in “overcharging” the employees who purchase supplemental coverage” with premiums that were “higher than called for” by “underwriting and actuarial pricing projections.” The court granted Defendants’ motion to dismiss because: (1) Hartford is not a fiduciary with respect to negotiation of Plan premiums; (2) even if Hartford could be liable for its role in negotiating the Plan and its basic and supplemental premium rate structure, the rate structure described in the Complaint is simply not a rate structure prohibited by ERISA; (3) Defendants did not violate fiduciary duties by omitting information that participants who purchased supplemental group life insurance coverage were being charged excessive premiums since plan administrators are under no obligation to disclose cost-containment mechanisms or financial incentives for cost savings; and (4) there was no misrepresentation here in the absence of allegations that certain statements about the Plan and premiums were false or misleading.

Beneficiaries of ESOP failed to state a claim for breach of fiduciary duty for continued investment in Lehman Brothers Holding, Inc. stock. [Rinehart v. Lehman Bros. Holdings Inc., No. 15-2229, F.3d , 2016 WL 1077009 \(2d Cir. Mar. 18, 2016\)](#) (Before JACOBS, WESLEY, and LIVINGSTON, Circuit Judges). Plaintiffs-Appellants are beneficiaries of an employee stock ownership plan (ESOP) and brought a putative class action under ERISA against their employer’s former director and members of employer’s benefit plan committee, alleging breach of fiduciary duties. The district court dismissed the- action for failure to state a claim and Plaintiffs-Appellants appealed. Plaintiffs alleged that the Plan Committee Defendants knew or should have known, based on publicly available information, that investment in Lehman had become increasingly risky, and that failing to consider the wisdom of continuing to invest in Lehman during this period constituted a breach of fiduciary duty. The Second Circuit held that the beneficiaries failed to state a claim that the members breached their duty of prudence based on public information. Second, the members did not have a fiduciary duty under ERISA to investigate material, nonpublic information regarding the risks of Lehman. Plaintiffs’ complaint failed because it did not explain in a non-conclusory fashion *how* Plaintiffs’ hypothetical investigation would have uncovered the alleged inside information. Even with the *Moench* presumption, Plaintiffs must allege facts that, if proved, would show that an adequate investigation would have revealed to a reasonable fiduciary that the investment at issue was improvident. Lastly, the former corporate director did not have a fiduciary duty under ERISA to investigate material, nonpublic information regarding risks of Lehman. ERISA does not impose a duty on appointing fiduciaries to keep their appointees apprised of nonpublic information. The Second Circuit affirmed the district court and concluded that Plaintiffs have not adequately shown that the Plan Committee Defendants should be held liable for their actions in attempting to meet their fiduciary duties under ERISA while simultaneously offering an undiversified investment option for employees’ retirement savings.

Inter-Account Method for allocation of Bernie Madoff estate does not violate ERISA’s anti-alienation provision. [In re Bernard L. Madoff Inv. Sec., LLC, No. 15 CIV. 1151 \(PAE\), 2016 WL 183492 \(S.D.N.Y. Jan. 14, 2016\)](#) (Judge Paul A. Engelmayer). Four groups of appellants from a Bankruptcy Court decision challenged decisions made by the court-appointed Trustee administering the estate of Bernard L. Madoff Investment Securities LLC (“BLMIS”) as to the mechanics by which funds in the BLMIS customer property estate are to be allocated among BLMIS’s customers. Subsets of appellants separately challenge the Trustee’s application of the Inter-Account Method to circumstances (1) where the transfer originated from a qualifying ERISA pension plan account, and (2) where the transfer was made to a claimant’s individual account from a shared account in which the claimant had invested. The court found that the anti-alienation provision does not apply to the Inter-Account Method because the Trustee is not a creditor seeking to collect against an inter-account transferee, or to garnish or levy on a pensioner’s benefits. Secondly, the anti-alienation provision protects vested ERISA pension plan benefits that have not been distributed. Here, the distribution of funds from the ERISA pension plan account has already occurred and the Trustee proposes to use the Inter-Account Method, in

relation to such distributions, to gauge the value of the transfer for the purpose of the measuring the transferee's net equity claim. The court rejected the ERISA-based objections to the Inter-Account Method and affirmed the Order of the Bankruptcy Court.

Breach of fiduciary duty claim related to the London Whale dismissed for failure to state a claim upon which relief can be granted. [In re Jpmorgan Chase & Co. Erisa Litig., No. 12 CIV. 04027 \(GBD\), 2016 WL 110521 \(S.D.N.Y. Jan. 8, 2016\)](#) (Judge George B. Daniels). Plaintiffs, a putative class of current and former employees of JPMorgan Chase & Co. who participated in the JPMorgan Chase 401(k) Savings Plan, brought this consolidated class action against Defendants JPMorgan Chase Bank, N.A. ("JPMC Bank"), JPMorgan Chase & Co. ("JPMorgan"), John Wilmot, and Douglas Braunstein (collectively, "Defendants") for breaching their duty of prudence under ERISA. Specifically, Plaintiffs allege that JPMorgan concealed risk-escalating trades made by its Chief Investment Office ("CIO"), the unit responsible for managing the synthetic credit portfolio. A trader named Bruno Iksil (known as "the London Whale"), operated that portfolio, which lost over \$6 billion. Plaintiffs assert that Defendants knew or should have known, based on inside information, that JPMorgan's concealment of the CIO's risk-escalating trades throughout the class period artificially inflated the price of JPMorgan stock. Defendants, as fiduciaries, therefore allegedly breached the duty of prudence under ERISA by continuing to offer Plan participants the option to invest in the Stock Fund during the class period and failing to publicly disclose the alleged misconduct. Defendants moved to dismiss Plaintiffs' Fourth Amended Class Action Complaint for failure to state a claim upon which relief can be granted. The court granted the motion, finding that Plaintiffs did not plead sufficient facts to plausibly allege that JPMC Bank and JPMorgan are *de facto* fiduciaries. The court also found that Plaintiffs have not adequately pleaded an imprudence claim against any defendant. First, both of Plaintiffs' proposed alternative actions would have required disclosure to the general public. Second, Plaintiffs failed to plausibly allege that a prudent fiduciary would not have viewed the public disclosure as more likely to harm than to help the fund.

D. Third Circuit

In putative class action brought by terminated Wawa employees alleging that Defendants Wawa Inc., its Employee Stock Ownership Plan Trustees, and its Plan Administrators violated ERISA by amending the Plan to eliminate Plaintiffs' right to own Wawa stock, forcing liquidation of Plaintiffs' Wawa stock at an unfair price, and misrepresenting Plaintiffs' rights under the Plan, largely denying Defendants' motion to dismiss all claims. [Pfeifer v. Wawa, Inc., No. CV 16-497, ___ F.Supp.3d ___, 2016 WL 5868098 \(E.D. Pa. Oct. 6, 2016\)](#) (Judge Paul S. Diamond). Plaintiffs allege that Wawa defendants violated ERISA by adopting an August 2015 plan amendment forcing former employee participants out of the Plan. Pursuant to the amendment, Defendants liquidated the Wawa stock held in the ESOP accounts of former Wawa employees in September 2015. On behalf of a proposed class of former employees, Plaintiffs allege both that former employees had the right to continue to hold Wawa

stock until age 68 and that the price paid for their stock in September 2015 was less than fair market value.

First, the Court held that Plaintiffs could proceed with their claim seeking to invalidate the August 2015 amendment under a unilateral contract theory. Citing *Kemmerer v. ICI Americas, Inc.*, 70 F.3d 281, 287 (3d Cir. 1995), the Court stated that a pension plan is a unilateral contract under which a trustee is required to determine benefits under the terms of the plan in effect when a participant terminates employment and any later amendments that diminish a participant's benefits are void. It was undisputed that the terms of the ESOP in effect when Plaintiffs left employment "granted them a valuable option to hold or sell Wawa stock and the Plan Amendment deprived Plaintiffs of that value."

The Court further stated that Wawa's reservation of a right to amend the Plan "at any time" did not necessarily give it authority to reduce Plaintiffs' benefits after they had completed performance. Citing *In re: New Valley Corp.*, 89 F.3d 143, 151-52 (3d Cir. 1996), the Court found that "[a]t a minimum, the Plan is ambiguous as to whether Wawa could amend the Plan 'after the participants' performance.'"

Second, the Court held that Wawa did not violate the anti-cutback rule, ERISA section 204(g), by eliminating Plaintiffs' right to own Wawa stock because the Department of Treasury has determined that the right to own a particular form of investment is not protected under the parallel IRC anti-cutback provision, 26 C.F.R. section 1.411(d)-(A-1)(d)(7). However, the Court ruled that Plaintiffs could proceed on their anti-cutback claim on the forced transfer of their individual accounts out of the ESOP because transfers without consent may violate the anti-cutback rule. See 26 C.F.R. section 1.411(d)(A-2)(a)(3)(v).

In addition, the Court allowed most of Plaintiffs' other claims to proceed, including claims for fiduciary violations arising out of defendants' valuation of Wawa stock for purposes of the September 2015 forced sale and a claim seeking to invalidate the Plan's indemnification provision pursuant to ERISA section 410.

Plaintiffs allege that the proposed Class has lost out on tens of millions of dollars in investment gains as a result of the September 2015 forced sale – a hard loss to swallow, even with a cup of Wawa's delicious house blend coffee.

Finding that Defendant Reppert, Inc. failed to engage an independent qualified public accountant to conduct an audit of the 401(k) Plan for plan years 2008 through 2011 as required by 29 U.S.C. § 1023(a)(3)(A). The 401(k) Plan did not qualify for an audit exemption for those years, because it had more than 120 participants at the beginning of the 2008 plan year and was thus not permitted to file a simplified annual report. [Askew v. R.L. Reppert, Inc., No. 11-CV-04003, 2016 WL 5661714 \(E.D. Pa. Sept. 30, 2016\)](#) (Judge James Knoll Gardner).

Finding no error in the District Court’s conclusion that all contributions from employers to multiple employer welfare arrangement providing health benefits were “plan assets” within the meaning of ERISA; affirming conclusion that Doyle breached his duty of loyalty to the Fund because he knew that these monies were not used to benefit plan participants, but vacating and remanding the judgment regarding Holloway’s liability for factual findings as to when Holloway knew or should have known that the Fund was being mismanaged or underfunded. [Secretary of Labor v. James Doyle, et al., F.App’x , 2016 WL 4395352 \(3d Cir. Aug. 18, 2016\)](#) (Before: JORDAN, HARDIMAN, and GREENAWAY, JR., Circuit Judges).

Finding that successful plan-participant plaintiff in ESOP litigation, who obtained assignments from two defendant plan fiduciaries of any claims they may have had against two fiduciary liability insurers, could not assert viable breach of fiduciary duty and other claims against the insurers because the assigned claims were released by the assignors as part of a confidential settlement agreement. [Sealey v. Beazley Ins. Co., Inc., No. 3:15CV768-DPJ-FKB, 2016 WL 4392624 \(S.D. Miss. Aug. 16, 2016\)](#) (Judge Daniel P. Jordan).

Dismissing breach of fiduciary duty claim because Plaintiff’s complaint does not demonstrate that the “appropriate equitable relief” available under § 1132(a)(3) is warranted, and Plaintiff’s § 1132(a)(3) and § 1132(a)(1)(B) claims against Defendant overlap factually and seek the same remedy. [Potts v. Hartford Life & Accident Ins. Co., No. CV 3:16-35, 2016 WL 4218384 \(W.D. Pa. Aug. 9, 2016\)](#) (Judge Kim R. Gibson).

In action where Plaintiffs seek disgorgement of fees paid to a law firm for representing Lawrence Koresko in ERISA litigation, granting law firm’s motion to dismiss for failure to state a claim under ERISA § 502(a)(3) since Plaintiffs have failed to allege that law firm had actual or constructive knowledge that funds rightfully belonging to an ERISA plan were wrongfully transferred to them. [Kalan v. Farmers & Merchants Trust Co. of Chambersburg, No. CV 15-1435, 2016 WL 3087360 \(E.D. Pa. June 2, 2016\)](#) (Judge Wendy Beetlestone).

Denying motion to dismiss Plaintiffs’ First Amended Complaint for failure to state a claim and for lack of personal jurisdiction in matter seeking disgorgement of fees against Defendant Samuels, Yoelin Kantor, LLP (“SYK”), a law firm, where Plaintiffs allege that SYK represented John J. Koresko and others in ERISA litigation, that SYK knew the payment for its services improperly transferred ERISA-plan assets, and that SYK thereby committed malpractice and breach of fiduciary duty. [Kalan v. Farmers & Merchants Trust Co. of Chambersburg, No. CV 15-1435, 2016 WL 2941041 \(E.D. Pa. May 20, 2016\)](#) (Judge Wendy Beetlestone).

Granting in part and denying in part Plaintiff's First Amended Complaint for failure to state a claim in matter seeking disgorgement of \$250,000 in fees against Defendant Christie Pabarue Morten & Young ("Christie Pabarue"), a law firm, that represented the Single Employer Welfare Benefit Plan Trust in 2011, where Plaintiff alleged that Pabarue knew the payment for its services improperly transferred ERISA plan assets. [Harvey Kalan, M.D., et al. v. Farmers & Merchants Trust Company of Chambersburg, et al., No. CV 15-1435, 2016 WL 2766490 \(E.D. Pa. May 13, 2016\)](#) (Judge Wendy Beetlestone).

§ 1132(a)(2) is an inappropriate vehicle for individual relief and claim for equitable estoppel fails. [Lees v. Munich Reinsurance Am., Inc., No. CV142532MASTJB, 2016 WL 164611 \(D.N.J. Jan. 13, 2016\)](#) (Judge Shipp). The court granted summary judgment in favor of Defendant on Count Two of the First Amended Complaint, where Plaintiff asserts that Defendant's failure to contribute the \$20,000 bonus to the Munich pension plan, due to Plaintiff for leaving Systems Management Specialists and returning to American Re-Insurance Company, violated §§ 1132(a)(2) and 1109 of ERISA. Plaintiff primarily seeks reformation of and/or contribution to the Munich Re pension plan. The court found that although styled as a claim under § 1132(a)(2) to restore the alleged \$20,000 bonus contribution to the Munich pension plan, Count Two of Plaintiff's First Amended Complaint truly seeks individual relief, Plaintiffs entitlement to pension credit for the period of October 28, 1996, through August 15, 1999. As such, this is not a claim brought on behalf of the Munich pension plan, and therefore, § 1132(a)(2) is an inappropriate vehicle for relief. Additionally, the court found that even if it were to construe Plaintiff's First Amended Complaint to assert a claim for equitable estoppel pursuant to § 1132(a)(3), such claim would fail. Here, there is no showing of fraud, of repeated misrepresentations over time, and no suggestion that Plaintiff was particularly vulnerable. Instead, Plaintiff relied on a single statement by two human resource personnel and concluded that a notation in his employee profile regarding his hire date confirmed he would receive pension credit. The court found that these facts do not constitute extraordinary circumstances under Third Circuit precedent.

E. Fourth Circuit

There is no genuine dispute that the 2013 Purchase would be a violation of § 1106(a), where Wilmington, the fiduciary, caused the ESOP, a plan, to purchase stock from a party in interest, employer Constellis. Wilmington failed to act as a reasonably prudent fiduciary to defeat summary judgment at this stage with respect to his § 1108(e) affirmative defense. With respect to whether Wilmington violated § 1106(b), there remains a material dispute over whether the exception in § 1108(b) applies, including whether Wilmington's fee was "necessary" to establish the ESOP, or if it could have been financed some other way. [Brundle v. Wilmington Trust, N.A., No. 115CV1494LMBIDD, 2016 WL 6542718 \(E.D. Va. Nov. 3, 2016\)](#) (Judge Leonie M. Brinkema).

Denying Defendant Marilyn Ward’s Motion to Dismiss Counts I, VII, VIII, IX, and X of the First Amended Complaint. Ward’s status as a directed trustee does not immunize her from liability. ERISA’s disclosure requirements do not nullify Ward’s fundamental trust law duty to disclose a conflict of interest. Marking payments with Plan assets is more than a “ministerial function.” [Perez v. Chimes D.C., Inc., No. CV RDB-15-3315, 2016 WL 6124679 \(D. Md. Oct. 20, 2016\)](#) (Judge Richard D. Bennett).

The Secretary sufficiently alleged that BCG’s fees were excessive, where he alleged that the Plan paid millions of dollars in excessive expenses, most of which benefitted the Plan’s third party administrator, FCE, and the plan representative, BCG, and that the Plan has spent millions of dollars more than would be reasonable for a partially self-funded plan of this size and nature. Further, the Secretary has sufficiently alleged that the Chimes defendants received payments and discounts from the BCG defendants in connection with the Plan’s retention of BCG. [Perez v. Chimes D.C., Inc., No. CV RDB-15-3315, 2016 WL 5938827 \(D. Md. Oct. 12, 2016\)](#) (Judge Richard D. Bennett).

Denying Defendants’ motion to dismiss the First Amended Complaint. The Secretary has sufficiently alleged that Defendants are plan fiduciaries; FCE Benefit Administrators and Ward’s alleged concealment of their illegal action does not invalidate the Secretary’s claims against the Chimes Defendants; Secretary has sufficiently alleged Defendants breached their fiduciary duties by receiving benefits in connection with the Chimes D.C., Inc. Health & Welfare Plan’s retention of FCE, by receiving payments and discounts from BCG and Ramsey in connection with the Plan’s retention of BCG, and by FCE’s receiving of payments from service providers. [Thomas E. Perez, Sec’y of Labor v. Chimes District of Columbia, Inc., et al., No. CV RDB-15-3315, 2016 WL 5815443 \(D. Md. Oct. 5, 2016\)](#) (Judge Richard D. Bennett).

Denying Defendants’ motion to dismiss the Secretary of Labor’s complaint against a health and welfare plan and its fiduciaries and service providers. On Count I for “excessive plan expenses,” the Secretary alleged that an independent broker had identified alternatives to FCE, but that the Chimes Defendants did not investigate those options. On Count II for “Chimes Defendants’ receipt of benefits in connection with the Plans retention of FCE,” the Secretary alleged that the Chimes Defendants exercised their authority to cause the Plan to retain and pay FCE and BCG as service providers. On Count IV for “FCE’s receipt of payments from service providers,” the Secretary alleged that FCE used payments from the Plan, which it negotiated, to third parties as a means by which FCE was able to obtain commissions and other payments from third parties. On Count V for “failure to prudently and loyally administer the Plan,” the Secretary adequately alleged that FCE was a fiduciary with respect to the services it provides to the Plan. On Count VI for “Plan’s reimbursement to Chimes DC for work of its full-time employee,” the Secretary alleged that Chimes DC and Bussone directed FCE to reimburse Chimes DC for this work using Plan assets and that FCE knowingly participated in this misconduct. [Secretary Perez](#)

[v. Chimes D.C., Inc., No. CV RDB-15-3315, 2016 WL 4993293 \(D. Md. Sept. 19, 2016\)](#) (Judge Richard D. Bennett).

Granting the Secretary's motion for default judgment against Defendants for failing to make employer contributions to the Global Research Services, LLC 401(k) Plan and failing to timely remit certain employee contributions to the Plan. [Perez v. Glob. Research Servs., LLC, No. 16-CV-229-ELH, 2016 WL 4203889 \(D. Md. Aug. 10, 2016\)](#) (Magistrate Judge J. Mark Coulson).

Release signed by Plaintiff, an experienced businessman, prevents Plaintiff from pursuing prohibited transaction claim related to ESOP. [Halldorson v. Wilmington Trust Retirement and Institutional Services Company, No. 115CV1494LMBIDD, ___ F.Supp.3d ___, 2016 WL 1643862 \(E.D. Va. Apr. 22, 2016\)](#) (Judge Leonie M. Brinkema).

Recommending grant of Secretary's amended motion for default judgment against Defendants who failed to remit certain contributions to pension plan to which they were fiduciaries. [Thomas E. Perez, Secretary Of Labor, United States Department Of Labor v. Brian Hicks, et al., No. 15-CV-1097-ELH, 2016 WL 1469759 \(D. Md. Apr. 15, 2016\)](#) (Magistrate Judge J. Mark Coulson).

29 U.S.C. § 1105(a) does not give rise to a cause of action by a co-fiduciary against a fiduciary for interference in the attempted remedy of the fiduciary's alleged breach of fiduciary duty. [Paasch v. Nat'l Rural Elec. Coop. Ass'n, No. 115CV01638GBLMSN, ___ F.Supp.3d ___, 2016 WL 1406055 \(E.D. Va. Apr. 8, 2016\)](#) (Judge Gerald Bruce Lee).

Fiduciary has shown by a preponderance of the evidence that a fiduciary acting with prudence would have divested funds at the same time and in the same manner. [Tatum v. R.J. Reynolds Tobacco Co., No. 1:02CV00373, 2016 WL 660902 \(M.D.N.C. Feb. 18, 2016\)](#) (Judge N. Carlton Tilley, Jr.). Plaintiff, individually and on behalf of all other persons similarly situated, brought this action alleging that Defendants R.J. Reynolds Tobacco Company and R.J. Reynolds Tobacco Holdings, Inc. (collectively "RJR") breached their fiduciary duties in managing the R.J. Reynolds Tobacco Capital Investment Plan. The Plan was created for Nabisco employees following a spin-off of the tobacco business and included among several investment options, two company-related funds. Shares in the Nabisco Funds were frozen on the date of the spin-off and on January 31, 2000, the units of the Nabisco Funds held by participants who had not sold prior to that date were eliminated from the Plan. The Fourth Circuit determined that under the ERISA prudence standard, RJR breached its fiduciary duty of procedural prudence to investigate the investment decision to eliminate the Nabisco Funds from the Plan. On remand from the Fourth Circuit affirming in part, vacating in part, and reversing in part this court's opinion after a bench trial on the issues, this court was instructed to review the

evidence to determine whether RJR has met its burden of proving by a preponderance of the evidence that a prudent fiduciary would have made the same decision. The Fourth Circuit also directed the district court to include in its review of all of the relevant evidence the previously-excluded testimony of Thomas Lys, one of Tatum’s experts, and the timing of the divestment “as part of a totality-of-the-circumstances inquiry.” Upon review of all of the circumstances prevailing at the time, the court determined that RJR has shown by a preponderance of the evidence that a fiduciary acting with prudence would have divested the Nabisco Funds at the time and in the manner that RJR did.

F. Fifth Circuit

In suit where Plaintiff alleges that Defendants breached their fiduciary duties to participants in Whole Food’s 401k plan by allowing employees to continue to invest in the company while the company’s stock was artificially inflated due to a widespread overpricing scheme, dismissing the claims against Defendants because although Plaintiff met the first part of the standard alleged in *Fifth Third* by proposing alternative actions for Defendants that would have been consistent with securities laws, Plaintiff has not plausibly alleged an alternative action that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it. [Martone v. Whole Foods Mkt., Inc., No. 1:15-CV-877 RP, 2016 WL 5416543 \(W.D. Tex. Sept. 28, 2016\)](#) (Judge Robert Pitman).

In putative class action alleging that BP and other plan fiduciaries breached their duty of prudence by allowing the plans to acquire and hold BP’s overvalued stock, which lost significant value after an explosion of an offshore oil rig operated by BP caused a massive oil spill, holding that participants and beneficiaries failed to adequately allege that no prudent fiduciary could have concluded that alternative actions would do more harm than good, and thus they failed to state claim that BP and other fiduciaries breached duty of prudence because they had unfavorable inside information yet allowed investment in ESOP. Reversed and remanded. [Whitley v. BP, P.L.C., No. 15-20282, ___ F.3d ___, 2016 WL 5387678 \(5th Cir. Sept. 26, 2016\)](#) (Before WIENER, CLEMENT, and COSTA, Circuit Judges).

In matter challenging an amendment to a 401(k) plan, holding that employer (Acme) and parent (Berkshire) did not violate retirement plans and did not breach their fiduciary duties, and employees stated a claim that amendment to ERISA plans was unreasonable. Specifically, the court affirmed dismissal of breach of fiduciary duty claims against Acme, where the court found that Acme acted akin to a settlor of a trust, rather than in a fiduciary capacity, when it implemented the amendment. The court also affirmed dismissal of derivative breach of fiduciary duty claim against Berkshire, but reversed district court’s dismissal of claim against Berkshire seeking to enforce a contractual commitment rather than a vested benefit under ERISA. [Hunter v. Berkshire Hathaway, Inc., No. 15-10854,](#)

[F.3d](#), 2016 WL 3710253 (5th Cir. July 11, 2016) (Before CLEMENT and OWEN, Circuit Judges, and JORDAN, District Judge).

In matter challenging the status of Defendants’ wealth accumulation plan (“WAP”) as a valid top hat plan and alleging claims for breach of fiduciary duty under section 1132(a)(2) and a claim for equitable relief under section 1132(a)(3), finding that (1) a class may not be certified under Rule 23 for failing to meet the commonality, typicality, and adequacy prongs; (2) Plaintiffs’ claims and requested relief are statute-based, not plan-based, and need not be exhausted administratively; and (3) “to the extent this case is governed by section 1113(1)(A) applicable to affirmative fiduciary breaches, and to the extent Plaintiffs are claiming that the forfeitures constituted breaches of a fiduciary duty, the unlawful forfeiture claims stemming from the WAP’s non-top hat status would appear brought well within any six-year limitations period.” [Tolbert v. RBC Capital Markets Corp., No. CV H-11-0107, 2016 WL 3034497 \(S.D. Tex. May 26, 2016\)](#) (Judge Keith P. Ellison).

Plaintiff’s claim is properly characterized as seeking equitable relief under § 502(a)(3) of ERISA but ERISA estoppel claim is foreclosed by the express terms of the Policy. [Barnette v. Sun Life Assurance Company of Canada, et al., No. CV 4:15-3720, 2016 WL 1384688 \(S.D. Tex. Apr. 7, 2016\)](#). Plaintiff brought a breach of fiduciary duty claim pursuant to § 502(a)(3), 29 U.S.C. § 1132(a)(3), alleging that Defendants mishandled Plaintiff’s late spouse’s request to port his life insurance and failed to inform him of his other options under the policy. Defendants moved to dismiss, which the court granted and denied in part. The court found that it is clear that Plaintiff’s request for monetary relief in the form of an equitable surcharge is consistent with a § 502(a)(3) claim and rejected Defendants’ contention that this theory of relief indicates that Plaintiff’s claim is effectively a § 502(a)(1)(B) claim. The court also found that Plaintiff’s request for reformation of the plan is a possible form of relief. But, the court determined that Plaintiff’s equitable estoppel claim fails because the Fifth Circuit has made clear that a party may not rely on an oral modification of a written plan’s terms.

G. Sixth Circuit

Defendants violated ERISA, §§ 404 (a)(1)(A) and (B), 406(a)(1)(C) and (D), and 406(b)(1) and (2), based on their admitted transfer of Plan assets to “parties in interest.” Violating ERISA § 406(a)(1)(D) is a *per se* violation. [Perez v. Eye Centers of Tennessee, LLC, No. 2:14-CV-0115, 2016 WL 6648854 \(M.D. Tenn. Nov. 10, 2016\)](#) (Judge Kevin H. Sharp).

Granting Plaintiffs’ motion for reconsideration and partially dismissing Count I only as it relates to allegations regarding both BCBSM’s obligation to pay Medicare-like Rates. [Saginaw Chippewa Indian Tribe of Michigan v. Blue Cross Blue Shield of Michigan, No. 16-CV-10317, 2016 WL 6276911 \(E.D. Mich. Oct. 27, 2016\)](#) (Judge Thomas L. Ludington).

ERISA Embezzlement conviction affirmed. Embezzlement from an ERISA plan occurs when a person “embezzles, steals, or unlawfully and willfully abstracts or converts” any money from an ERISA employee benefits plan for “his own use or ... the use of another.” 18 U.S.C. § 664. The government presented ample evidence to show that Defendant acted willfully with the specific intent to deprive the 401(k) plan of its funding. Evidence showed that Defendant withdrew money from Sommet’s clients’ accounts, took 401(k) contributions from the employee paychecks it processed, and yet failed to pass all of the designated funds to the 401(k) recipients Defendant also used the company account for a variety of non-client expenditures. [United States of America v. L. Brian Whitfield, No. 15-5668, F.App’x](#) , 2016 WL 5682708 (6th Cir. Oct. 3, 2016) (BEFORE: ROGERS, SUTTON, and COOK, Circuit Judges).

Following a federal grand jury indictment on three counts of embezzlement and theft from an employee pension or welfare benefit fund in violation of 18 U.S.C. § 664 and one count of embezzlement and theft from an employee health care benefit fund in violation of 18 U.S.C. § 669, finding that the total amount of restitution Gary Maurer owes to the victims in this matter is \$310,460.30 and recommending that a reasonable monthly payment amount for restitution is \$1,150.00. [United States v. Maurer, No. 3:15-CR-131, 2016 WL 5387696 \(S.D. Ohio Sept. 27, 2016\)](#) (Magistrate Judge Timothy S. Black).

Dismissing Medicare-like Rates (MLRs) claims because Plaintiff cannot establish that BCBSM had a fiduciary duty under ERISA to ensure payment of MLRs for healthcare services obtained by eligible plan participants; also dismissing state law claims based on complete ERISA preemption. [Saginaw Chippewa Indian Tribe of Michigan v. Blue Cross Blue Shield of Michigan, No. 16-CV-10317, 2016 WL 4124093 \(E.D. Mich. Aug. 3, 2016\)](#) (Judge Thomas L. Ludington).

In this criminal case in which the defendant, William C. Davis, pled guilty in 2007 to mail fraud, bank fraud, theft from a pension plan, and making a false statement in connection with an ERISA plan, denying Defendant’s motion for a reduced sentence under 18 U.S.C. § 3582(c)(2). [United States of Am., v. William C. Davis, No. 3:05CR744, F.Supp.3d](#) , 2016 WL 3962639 (N.D. Ohio July 22, 2016) (Judge James G. Carr).

Finding that Plaintiffs are entitled to summary judgment on their breach-of-fiduciary duty claim against Church’s where: (1) Church’s failed to provide Donna Van Loo an evidence of insurability (“EIF”) in 2008, the year she was entitled to fill one out in order to qualify for supplemental life insurance coverage past the guaranteed-issue threshold; (2) Church’s continued to make material misrepresentations to Van Loo, leading to a reasonable belief that coverage was effective; (3) Van Loo paid her premiums for the supplemental life insurance coverage; (4) the coverage never became effective because of Church’s failure to provide an EIF in 2008, when Van Loo’s health should have been evaluated. [Loo v. Cajun](#)

[Operating Co. d/b/a Church's Chicken, No. 14-CV-10604, 2016 WL 3137822 \(E.D. Mich. June 6, 2016\)](#) (Judge Laurie J. Michelson).

Breach of fiduciary duty claims dismissed as to former actuary and investment advisor who did not function as fiduciaries. [Ferguson v. Beard Pension Services, Inc., et al., No. 4:14CV01048, 2016 WL 1223271 \(N.D. Ohio Mar. 29, 2016\)](#) (Judge Benita Y. Pearson).

Plaintiff asserted that Beard Pension, Smallwood and Otermat serviced the pension plan as third-party administrators and breached their fiduciary duties by failing to prevent the unauthorized distribution of Plan assets. The court found that Otermat, the former plan actuary, was not a functional fiduciary. Otermat performed only actuarial tasks, and was never sent requests for distributions, never processed said requests, and never distributed funds. The court found that Otermat did not have authority over Plan assets, provide investment advice for a fee, or exercise discretion over Plan management. The court found that Smallwood's fiduciary status is conferred by way of the investment advisory services he rendered to the Plan but Plaintiff does not assert that Smallwood breached his fiduciary duty in rendering investment advice. The court found that the fact that Smallwood authorized Otermat to draft the Plan amendment allowing for in-service distributions does not demonstrate discretion over Plan management. However, with respect to Beard Pension, the court found that there remains a genuine issue of material fact as to whether Beard Pension was a plan fiduciary given its extensive administration of the plan.

H. Seventh Circuit

The court found that Plaintiff is entitled to a default judgment for Defendants' violations of their fiduciary duties under ERISA with respect to the Downey Inc. Profit Sharing Plan. [Perez v. Coffman, No. 15-CV-1394-JPS, 2016 WL 7168113 \(E.D. Wis. Dec. 8, 2016\)](#) (Judge J.P. Stadtmueller).

In matter where Plaintiff argued that Defendant's actions in billing personal materials to a client affected the ESOP's share value and Bayland's profitability, and that Bayland's profitability ultimately impacted Bayland's contribution to the plan, there is no breach of fiduciary duty where Defendants did not use Plan assets for their own benefit and Plaintiff does not indicate what type of harm he suffered. [Cashman v. Bayland Buildings, Inc., Steve Ambrosius, & Abraham Farley, No. 15-C-0808, 2016 WL 5921810 \(E.D. Wis. Oct. 11, 2016\)](#) (Judge William C. Griesbach).

Granting Plaintiffs' motion seeking reconsideration of the court's summary judgment ruling; finding that Linda Sunderlage was a fiduciary of the Professional Benefit Multiple Employer Welfare Benefit Plan & Trust within the meaning of 29 U.S.C. § 1002(21)(a) under the PBT Trust and 2002 and 2004 loans to Dufferin Capital were prohibited transactions under 29 U.S.C. § 1106. [Mintjal v. Trust, No. 08-CV-5681, 2016 WL 4493424 \(N.D. Ill. Aug. 26, 2016\)](#) (Judge Robert M. Dow, Jr.).

Reversing and remanding the district court’s dismissal of Plaintiffs’ claims of breach of fiduciary duty and prohibited transactions with respect to an ESOP transaction, finding that Plaintiffs’ allegations support an inference that GreatBanc breached its fiduciary duty, either by failing to conduct an adequate inquiry into the proper valuation of the shares or by intentionally facilitating an improper transaction: “they alleged that the stock value dropped dramatically after the sale (implying that the sale price was inflated), that the loan came from the employer-seller rather than from an outside entity (indicating that outside funding was not available), and that the interest rate was uncommonly high (implying that the sale was risky, or that the shareholders executed the deal in order to siphon money from the Plan to themselves).” [Allen v. Greatbanc Trust Co., No. 15-3569, F.3d , 2016 WL 4474730 \(7th Cir. Aug. 25, 2016\)](#) (Before WOOD, Chief Judge, and FLAUM and WILLIAMS, Circuit Judges).

In matter where the district court found in favor of Trachte ESOP participants on breach of fiduciary duty claim related to transaction which resulted in ESOP paying \$45 million for 100% of Trachte’s stock and incurring \$36 million in debt, affirming the district court and holding that: (1) the district court had the authority to order fiduciary Fenkell to indemnify the new Trachte ESOP trustees since that remedy is within the court’s equitable powers and is consistent with principles of trust law within which ERISA operates; (2) Fenkell and Alliance were acting as functional fiduciaries; and (3) restoration order, prejudgment interest award, attorneys’ fees and costs award, and contempt order were proper. [Chesemore, et al. v. Fenkell v. Alliance Holdings, Inc., et al., No. 14-3181, F.3d , 2016 WL 3924308 \(7th Cir. July 21, 2016\)](#) (Before KANNE and SYKES, Circuit Judges, and ELLIS, District Judge). In a class action matter alleging ERISA breach of fiduciary duty claims in connection with the transfer of pension accounts from the Alliance Holdings, Inc. ESOP to the Trachte ESOP. The transaction resulted in the Trachte ESOP paying \$45 million for 100% of Trachte’s stock and incurring \$36 million in debt. Following a bench trial, the district court issued a comprehensive opinion finding the defendants liable. It subsequently crafted a remedial order making the class and a subclass whole, and then awarded attorney’s fees and approved settlements among some of the parties. Defendant David Fenkell appealed and challenged the remedial order, the award of attorney’s fees, and the settlements by his codefendants. Fenkell challenged the district court’s order requiring him to indemnify his co-fiduciaries. The Seventh Circuit affirmed the district court and held that the court had the authority to order Fenkell to indemnify the new Trachte ESOP trustees since that remedy is within the court’s equitable powers and is consistent with principles of trust law within which ERISA operates. Additionally, even though Fenkell was not a trustee or other named fiduciary of the new Trachte ESOP, he and Alliance were acting as functional fiduciaries with respect to the transactions at issue and could be ordered to indemnify the co-fiduciaries. Lastly, the court affirmed the district court’s restoration order, prejudgment interest award, attorneys’ fees and costs award, and contempt order. This matter was handled by our colleague Joseph Barton of Cohen Milstein and

more information about the case may be found here: <http://www.cohenmilstein.com/case-study/trachte-esop-litigation>.

Granting the summary judgment motion of Intervenor Defendant Acuity, A Mutual Insurance Company, and declaring that Acuity has no duty to defend or indemnify its insureds, Defendants Bayland Buildings, Inc., Steven Ambrosius and Abraham Farley, on the claims asserted against them by Plaintiff and former Bayland employee Michael Cashman. [Cashman v. Bayland Buildings, Inc., Steve Ambrosius, Abraham Farley, Defendants, Acuity, A Mutual Insurance Company, Intervenor Defendant., No. 15-C-808, 2016 WL 2766643 \(E.D. Wis. May 12, 2016\)](#) (Judge William C. Griesbach).

I. Eighth Circuit

Party may waive right to assert that jury's findings give rise to collateral estoppel where ERISA and non-ERISA claims are tried together. [Blue Cross Blue Shield of Minnesota v. Wells Fargo Bank, N.A., No. 14-3457, ___ F.3d ___, 2016 WL 1104749 \(8th Cir. Mar. 22, 2016\)](#) (Before RILEY, Chief Judge, SMITH and SHEPHERD, Circuit Judges). In this case, employee benefit plan administrators brought suit against the defendant bank that operated a securities lending program, alleging ERISA breach of fiduciary duty claims. Other plaintiffs brought state common law claims. Following a bench trial, the district court dismissed the ERISA claims, and the administrators appealed. They sought to reverse the district court's judgment that it was bound by collateral estoppel and thus required to find against the ERISA Plaintiffs. As part of the trial plan, at the same time as the jury heard the non-ERISA claims, the court sat as the finder of fact for the ERISA fiduciary duty claims. Testimony that was specific to the ERISA Plaintiffs was not heard by the jury. The trial plan also provided that the court could hear the testimony for ERISA Plaintiffs at the conclusion of the jury trial so as not to interject the possibility of juror confusion and error. The ERISA and common-law plaintiffs' claims were heard by the court and the jury at the same time and on the same evidence, and the parties agreed that Wells Fargo's fiduciary duties were virtually identical for both ERISA and non-ERISA Plaintiffs, for purposes of this case. While the bench trial for the ERISA claims continued, the jury had returned a verdict that Metlife did not breach a fiduciary duty. The district court determined that it was bound by the jury's verdict for purposes of the ERISA claims based on collateral estoppel. The district court found that waiver of collateral estoppel was not possible because the jury's determination of a factual issue precluded the court from deciding that same factual issue in a different way. But, the Tenth Circuit case the district court relied on did not determine whether issue preclusion could be waived. Additionally, the ERISA Plaintiffs are separate from common-law plaintiffs. ERISA Plaintiffs bring equitable claims, and the trial plan stated that the judge would sit as finder of fact on ERISA Plaintiffs' breach of fiduciary duty claims. Therefore, concerns which generally may require conformity between the findings of a judge and jury in a single plaintiff's or single group of plaintiffs' trial do not apply here to the same extent.

The Eighth Circuit held that the adoption of a trial plan in which the administrators' claims, in bench trial, would be heard simultaneously with other plaintiffs' claims before a jury did not preclude the finding that the bank waived its right to assert that the jury's findings gave rise to collateral estoppel. The Eighth Circuit vacated and remanded the matter to the district court to determine whether the parties waived the application of collateral estoppel.

Investment services provider did not owe any fiduciary duty to ensure reasonableness of fees associated with accounts in initial 401(k) investment menu. [McCaffree Fin. Corp. v. Principal Life Ins. Co., No. 15-1007, ___ F.3d ___, 2016 WL 98332 \(8th Cir. Jan. 8, 2016\)](#) (Before RILEY, Chief Judge, BYE and GRUENDER, Circuit Judges). Plaintiff, the plan sponsor of a 401(k) plan, brought a class action against Defendant, an investment services provider, alleging that Defendant breached its fiduciary duties under ERISA and engaged in prohibited transactions by charging grossly excessive fees to participants in Plaintiff's 401(k) plan. The district court granted Defendant's motion to dismiss, with the Eighth Circuit affirmed. The court held that Defendant did not owe any fiduciary duty to ensure reasonableness of fees associated with accounts in the initial investment menu, and Plaintiff did not plead any connection between any fiduciary duty Defendant may have owed and excessive fees it allegedly charged.

J. Ninth Circuit

The court granted summary judgment in favor of Defendants on Plaintiff's claim that the Plan Administrator breached a duty to provide Plaintiff with complete and accurate information regarding retirement benefits and the process for obtaining them when HR allegedly knew of the participant's cancer diagnosis. The court found that the Plan and the Honeywell Retirement Service Center did not have a procedure, or the authority, to terminate a participant's employment or complete a participant's application for retirement benefits on behalf of a participant that would enable a participant to obtain retirement benefits "immediately" or that would expedite the time required for verification and approval of the retirement application. Thus, there was no process that the Plan Administrator should have disclosed. Further, there is no make-whole monetary relief available under ERISA Section 502(a)(3) which would entitle Plaintiff to an amount equivalent to the monetary benefit she would have received under the Plan. [Angichiodo v. Honeywell Pension & Sav. Plan, & Salaried Employees Pension Plan of AlliedSignal, Inc., No. CV-15-00097-PHX-NVW, 2016 WL 7178666 \(D. Ariz. Dec. 9, 2016\)](#) (Judge Neil V. Wake).

Finding for the Secretary of the DOL in this ERISA enforcement action concerning the handling of the California Pacific Bank Employee Stock Ownership Plan and its termination. [Perez v. California Pac. Bank, No. 13-CV-03792-JD, 2016 WL 6157502 \(N.D. Cal. Oct. 24, 2016\)](#) (Judge James Donato).

In matter alleging that the value of the proposed class members’ retirement accounts would have been greater had Defendants chosen alternative funds and/or investment options with either higher returns or lower administrative and management fees, granting Defendants’ motion to dismiss the Complaint where the court found that the facts as pled do not raise a plausible inference that Defendants breached their fiduciary duties and/or duties of loyalty and prudence. [White v. Chevron Corporation, et al., No. 16-CV-0793-PJH, 2016 WL 4502808 \(N.D. Cal. Aug. 29, 2016\)](#) (Judge Phyllis J. Hamilton).

In matter alleging that former spouse concealed pension plan benefits during divorce proceedings, finding that Plaintiff alleges a viable prohibited transaction and breach of fiduciary duty claim, where she alleges that: (1) the “hidden” Rollover IRA’s are covered by the ERISA framework; (2) Defendant failed to disclose the Lockheed Martin Pension Plan and Rollover IRAs, which constituted a fiduciary acting adversely to the interests of a plan’s beneficiary in a transaction; (3) Defendant was a fiduciary pursuant to ERISA § 3(21)(A) at the time of the divorce proceedings; (4) by concealing the Lockheed Pension Plan and other Rollover IRAs during the divorce proceedings in state court, Defendant was dealing with the assets in his own interest and for his own account, which was a “clear breach” of his fiduciary duty under ERISA. [Vyas v. Vyas, No. CV1502152RSWLDFMX, 2016 WL 4071941 \(C.D. Cal. July 28, 2016\)](#) (Ronald S.W. Lew).

In matter alleging violation of Section 1106(b)(1), which prohibits self-dealing, or dealing with the assets of the fund in the fiduciary’s own interest, certifying for interlocutory appeal the fundamental question of whether Defendant TLIC can be considered a fiduciary at all under the law, since whether TLIC could be a fiduciary is fundamental to all other questions in the case, as no classes would be certified and no legal dispute over prohibited transactions would arise if there were no fiduciary duty owed by Defendants. [Santomenno v. Transamerica Life Ins. Co., No. CV1202782DDPMANX, 2016 WL 2851289 \(C.D. Cal. May 13, 2016\)](#) (Judge Dean D. Pregerson).

Beneficiaries forfeited failure to monitor retail-class mutual funds claim where they never asserted the argument until at the U.S. Supreme court; they asserted only that ERISA excuses an otherwise time-barred lawsuit where the effects of a past breach continue into the future. [Tibble v. Edison Int’l, No. 10-56406, ___ F.3d ___, 2016 WL 1445220 \(9th Cir. Apr. 13, 2016\)](#) (Before: ALFRED T. GOODWIN and DIARMUID F. O’SCANNLAIN, Circuit Judges, and JACK ZOUHARY, District Judge).

Motion for judgment on the pleadings granted in part on issue of whether certification of pension fund as being in “critical” status was breach of fiduciary duty. [Reyes v. Bakery & Confectionery Union & Indus. Int’l Pension Fund, No. 14-CV-05596-JST, ___ F.Supp.3d ___, 2016 WL 1109308 \(N.D. Cal. Mar. 22, 2016\)](#) (Judge Jon S. Tigar). This is a putative class action under ERISA and the Pension Protection Act of 2006 (“PPA”), challenging an amendment

to the “Golden 80” and “Golden 90” adjustable benefits by the Bakery and Confectionary Union and Industry International Pension Fund (the “Pension Fund”), a multi-employer defined benefit pension plan. The Pension Fund’s first attempt to implement this amendment was invalidated by a district court in New York, which found that the amendment violated ERISA’s “anti-cutback rule.” On this second attempt, the Pension Fund argues that the amendment is valid under the PPA’s provisions regarding funds that have been certified as being in “critical” status. In their First Amended Complaint, Plaintiffs make four claims against Defendants: (1) Defendants improperly notified Plaintiffs of the amendment, (2) Defendants were unreasonable in their certification of the Pension Fund as being in a “critical status,” (3) Trustees breached their fiduciary duty by certifying the Pension Fund was in a “critical status” when they knew this to be untrue, and (4) Trustees breached their fiduciary duty because the amendment favors some participants over others. Defendants moved for Judgment on the Pleadings, which the court granted in part and denied in part. The court did not dismiss Count I because the amendment failed to follow the 30-day notice requirement set out by 29 U.S.C. § 1085(e)(8)(C). However, the court dismissed Counts II, III, and IV. The court dismissed Count II because Plaintiffs failed to plausibly allege with specificity that any part of the certification process was unreasonable or that it did not meet the requirements of section 1085(b), and while Plaintiffs have named only the Fund and the Fund’s Trustees as Defendants, the PPA assigns responsibility for the certification solely to the actuary, not to funds or their trustees. Because it may be possible for Plaintiffs to allege additional facts that suggest Defendants violated some kind of duty in relation to the certification of the Fund as critical, the court granted Plaintiffs leave to amend Count II. On Count III, the court similarly concluded that Plaintiffs failed to plausibly allege that the certification was unreasonable or otherwise invalid. On Count IV, the court found that the changes made by Defendants appear to be the types of changes contemplated and authorized by the statute.

Motion for judgment on the pleadings denied as to a breach of fiduciary duty claim brought by same-sex surviving spouse against FedEx for interpreting pension plan in a manner that violates Title I of ERISA. [Schuett v. Fedex Corp., No. 15-CV-0189-PJH,](#)

[F.Supp.3d](#) , 2015 WL 9628588 (N.D. Cal. Jan. 4, 2016) (Judge Phyllis J. Hamilton). This case involves a denial of a qualified joint and survivor annuity to a surviving same-sex spouse. The Plan provides for payment of the benefit to a Spouse (defined in 1 U.S.C.A. § 7) as the time of the plan participant’s death. Here, Plaintiff and her now deceased spouse/plan participant were married in a civil ceremony on June 19, 2013 before Plaintiff’s wife died on June 20, 2013. On June 26, 2013, the U.S. Supreme Court declared § 3 of DOMA unconstitutional. On June 28, 2013, the Ninth Circuit lifted its stay directing California officials to stop enforcing Prop 8. On September 18, 2013, the Superior Court of California issued an Order declaring that Plaintiff and her wife were married on June 19, 2013. FedEx denied benefits to Plaintiff on the basis that she was not a spouse at the time of her wife’s death.

After unsuccessfully exhausting administrative remedies, Plaintiff filed suit alleging three causes of action in the alternative– (1) a claim for benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (against all defendants); (2) a claim of breach of fiduciary duty under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (against FedEx Corporation and FedEx RAC), for failure to administer the Plan in accordance with applicable law; and (3) a claim of breach of fiduciary duty under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (against FedEx Corporation), for failure to inform and/or for providing misleading communications. The third cause of action was based on the claim that FedEx did not inform the plan participant that Plaintiff would have been eligible for a reduced benefit if she retired before she died so the plan participant did not choose to retire although she would have.

Defendants filed a motion for judgment on the pleadings which the court granted in part and denied in part. With respect to the ERISA § 502(a)(1)(B) claim, the court found that Plaintiff and her spouse were married on June 19, 2013, but because at the time of their marriage DOMA was in effect and the Plan did not recognize same-sex marriages, FedEx did not abuse its discretion in interpreting the Plan as not requiring payment of a spousal survivor annuity to Plaintiff. The court denied the motion as to Count II because Plaintiff adequately alleged that FedEx violated Title I of ERISA by acting contrary to applicable federal law and failing to provide Plaintiff with a benefit mandated by ERISA, and that she is entitled to pursue equitable relief to remedy that violation. Title I of ERISA provides that each covered pension plan shall provide that “in the case of a vested participant who dies before the annuity starting date and who has a surviving spouse, a qualified preretirement survivor annuity shall be provided to the surviving spouse of such participant.” 29 U.S.C. § 1055(a)(2). The court saw no basis at this stage of the case and under the facts alleged in the complaint for denying retroactive application of *Windsor*. Although the court discussed Defendants’ argument that Plaintiff could not resort to § 502(a)(3) because she had an adequate remedy under § 502(a)(1)(B), the court did directly rule or address this issue. It did note Plaintiff’s contention that she is not foreclosed from seeking relief under both provisions because the first cause of action seeks Plan benefits whereas the second cause of action seeks a survivor benefit as mandated by ERISA. Plaintiff further contented that if she succeeds on both claims, she will recover only one survivor benefit but that at the pleading stage she should be permitted to pursue both claims. The court granted Defendants’ motion as to Count III because Plaintiff was neither a participant nor beneficiary and lacks standing to bring an action for breach of fiduciary duty. Because Plaintiff’s spouse did not choose to retire before her death, Plaintiff could not be a beneficiary under the provision of the Plan that provides benefits to beneficiaries after the retirement of the participant.

K. Tenth Circuit

Plaintiff has not shouldered its burden to establish the four requirements for a preliminary injunction to enjoin the DOL from taking any action to adopt or enforce the DOL’s Amendment to and Partial Revocation of Prohibited Transaction Exemption (“PTE”) 84-

24, as it applies to fixed indexed annuity sales. Thus, PTE 84-24 will apply to transactions occurring on or after April 10, 2017. [Mkt. Synergy Grp., Inc. v. United States Dep't of Labor, No. 16-CV-4083-DDC-KGS, 2016 WL 6948061 \(D. Kan. Nov. 28, 2016\)](#) (Judge Daniel D. Crabtree).

A consultant is not a functional-fiduciary for purposes of an ERISA breach of fiduciary duty claim where she does not exercise discretionary authority in administering a pension plan, including by making a calculation of benefits at the request of a plan participant. [Lebahn v. Nat'l Farmers Union Unif. Pension Plan, No. 15-3201, ___ F.3d ___, 2016 WL 3670007 \(10th Cir. July 11, 2016\)](#) (Before HOLMES, MURPHY, and BACHARACH, Circuit Judges).

For breach of fiduciary duty claim, oral misrepresentations can override the written SPDs' unambiguous terms. [Fulghum v. Embarq Corp., No. 07-2602-EFM, 2016 WL 1060207 \(D. Kan. Mar. 15, 2016\)](#) (Judge Eric F. Melgren). In this matter, Plaintiffs, on behalf of themselves and a certified class, alleged that Defendants violated ERISA by eliminating retirees' medical and life insurance benefits. On Defendants' motion for summary judgment on two of the seventeen Plaintiffs' breach of fiduciary duty claim, the court found that Defendants had an affirmative duty to provide complete information regarding Plaintiffs' retiree benefits based on information they knew or should have known and that the Reservation of Rights clauses in the SPDs do not necessarily shield Defendants from breach of fiduciary duty liability if they made oral material misrepresentations. The court found that Plaintiffs can rely upon oral misrepresentations. The court further found that there appear to be questions of fact as to the content of the actual oral statements and whether Defendants made misrepresentations is a disputed fact precluding summary judgment.

L. Eleventh Circuit

In suit brought by National Association for Fixed Annuities (“NAFA”) under the Administrative Procedure Act, and the Regulatory Flexibility Act, challenging three final rules promulgated by the Department of Labor on April 8, 2016 which substantially modify the regulation of conflicts of interest in the market for retirement investment advice under ERISA and the Internal Revenue Code, the court denied NAFA's motions for a preliminary injunction summary judgment and granted the Department's cross-motion for summary judgment. [Nat'l Ass'n for Fixed Annuities v. Perez, No. CV 16-1035 \(RDM\), ___ F.Supp.3d ___, 2016 WL 6573480 \(D.D.C. Nov. 4, 2016\)](#) (Judge Randolph D. Moss).

In a putative class action seeking to enforce a promise of permanent life insurance policies for Allstate retirees, on Allstate's motion to dismiss, finding that Plaintiffs' § 502(a)(3) claims for breach of fiduciary duty are not subject to dismissal for failure to allege misrepresentations or omissions on the part of Allstate; the claims are not barred by the applicable statute of limitations; Plaintiffs adequately alleged facts sufficient to support a

legal finding that Allstate was a fiduciary and acted as such when communicating with Plaintiffs about the employee benefit plan; state law breach of contract claims are preempted by ERISA. [Turner v. Allstate Insurance Company, No. 2:13-CV-685-WKW, 2016 WL 5445068 \(M.D. Ala. Sept. 27, 2016\)](#) (Judge W. Keith Watkins).

Affirming the district court's dismissal of the Plan's complaint against Zenith (former third-party administrator) for failing to state a claim for breach of fiduciary duties or self-dealing under ERISA because Zenith was not a fiduciary of the plan (it's activities were ministerial in nature), and, in any event, the claims were time-barred pursuant to the six-year statute of limitations in 29 U.S.C. § 1113(1). [Carolinas Electrical Workers Retirement Plan, et al. v. Zenith American Solutions, Inc., No. 15-14046, __ F.App'x __, 2016 WL 4547168 \(11th Cir. Sept. 1, 2016\)](#) (Before MARCUS, MARTIN, and ANDERSON, Circuit Judges).

In ESOP litigation, dismissing Plaintiff's duty-of-prudence claim to the extent that the alleged breach is Defendants' imprudent decision to hold Company Stock since the limitations period ran in early-to-mid 2012, well before Plaintiff filed her Complaint; dismissing Plaintiff's duty-of-loyalty claim because of lack of factual allegations of what Defendants failed to disclose and what special circumstances warranted disclosure; denying Defendants' motions to dismiss Plaintiff's duty-of-prudence claim on the failure-to-investigate basis - *Dudenhoeffer* does not require that the alternative-action requirement apply to every potential prudence claim; denying dismissal of Plaintiff's duty-to-monitor claim. [Brannen v. First Citizens Bankshares Inc., No. 6:15-CV-30, 2016 WL 4499458 \(S.D. Ga. Aug. 26, 2016\)](#) (Judge J. Randal Hall).

M. D.C. Circuit

[Coburn v. Evercore Trust Company, N.A., No. 16-7029, __ F.3d __, 2016 WL 7480257 \(D.C. Cir. Dec. 30, 2016\)](#) (Before: HENDERSON and ROGERS, Circuit Judges, and EDWARDS, Senior Circuit Judge). The court affirmed the district court's grant of Evercore's motion to dismiss the complaint for failure to state a claim, where Plaintiff alleged that Evercore should have recognized from publicly available information alone that continued investment in J.C. Penney common stock was "imprudent." The district court also rejected Plaintiff's alternative argument that pursuant to *Tibble v. Edison International*, __ U.S. __, 135 S. Ct. 1823 (2015), Evercore violated its fiduciary "duty to monitor" investments and remove imprudent ones. The Court of Appeals affirmed and explained that *Fifth Third Bancorp v. Dudenhoeffer*, __ U.S. __, 134 S. Ct. 2459 (2014) disposed of the "risk-based" claims through its broad rule that allegations that a fiduciary should have recognized from publicly available information alone that the market was over- or undervaluing stock are implausible as a general rule.

The court denied National Association for Fixed Annuities’ (“NAFA’s”) renewed motion for a preliminary injunction staying the applicability date of three new Department of Labor rules regulating conflicts of interest in the market for retirement investment advice. The court concluded that NAFA is not entitled to an injunction pending appeal or while its members transition to the new rules since the likelihood of success on the merits prong weighs heavily against NAFA. Enjoining the rule would delay the protection of retirement investors from conflicted advice and potential losses to their retirement savings and interfere with the implementation of three regulations that were lawfully adopted after nearly six years of study, public comment, and consideration. NAFA failed to carry its heavy burden of showing that its members are “certain” to sustain injuries that are so extraordinary that preliminary relief is warranted. [Nat’l Ass’n for Fixed Annuities v. Perez, No. CV 16-1035 \(RDM\), F.Supp.3d , 2016 WL 6902113 \(D.D.C. Nov. 23, 2016\)](#) (Judge Randolph D. Moss).

III. *Church Plan Status*

A. Seventh Circuit

Pension plan maintained by non-profit corporation affiliated with two Christian denominations is not an ERISA-exempt church plan. [Stapleton v. Advocate Health Care Network, No. 15-1368, F.3d , 2016 WL 1055784 \(7th Cir. Mar. 17, 2016\)](#) (Before BAUER, KANNE, and ROVNER, Circuit Judges). The Seventh Circuit considered whether a pension plan established by a church-affiliated organization, such as a hospital, is a “church plan” exempt from ERISA’s requirements. Here, Defendant Advocate maintains a non-contributory, defined-benefit pension plan that covers substantially all of its employees. Advocate is not a church, nor was its predecessor. Advocate was formed in 1995 as a 501(c)(3) non-profit corporation from a merger between two health systems—Lutheran General HealthSystem and Evangelical Health Systems. The court agreed with the district court in finding that the pension plan at issue is not a church plan that would be exempt from ERISA. Specifically, a plan cannot qualify as a church plan merely by being maintained by a church-affiliated organization because then the “established by a church” requirement of 29 U.S.C. § 1002(33)(A) would become meaningless. The court concluded that the text of ERISA is not ambiguous, but regardless, the legislative record does not suggest an intent to allow a church-affiliated corporation to claim the exemption for a plan unless the church itself has established the plan, as required by the original definition of a church plan in subsection (33)(A) of ERISA. The court also declined to give deference to contrary IRS private letter rulings that conflict with the plain language of the statute and fail to consider the relationship between the definitions of a church plan in subsections (33)(A) and (33)(C)(ii). Lastly, the court rejected Advocate’s constitutional claim under the First Amendment. The court affirmed the opinion of the district court.

IV. *Class Certification*

A. Ninth Circuit

Denying reconsideration of September 19, 2016 order granting class certification and denying alternative motion to certify an interlocutory appeal under 28 U.S.C. § 1292(b). [Wit v. United Behavioral Health, No. 14-CV-02346 JCS, 2016 WL 5930576 \(N.D. Cal. Oct. 12, 2016\)](#) (Magistrate Judge Joseph C. Spero).

V. *Class Action Settlements*

A. Second Circuit

In suit alleging that Defendants violated ERISA by significantly underfunding the St. Francis Hospital and Medical Center Pension Plan, the court granted the motion for final approval of the class action settlement, certified the Class for settlement purposes, determined that the notice provided to the class was appropriate and sufficient, granted the motion to award \$800,000 in attorney’s fees to Class Counsel, granted the motion to award \$19,711.71 as reimbursement of litigation expenses to Class Counsel, and granted the motion to award Plaintiff \$2,000 as a case contribution or incentive award in recognition of her efforts on behalf of the Class. [Kemp-DeLisser v. Saint Francis Hosp. & Med. Ctr., No. 15-CV-1113 \(VAB\), 2016 WL 6542707 \(D. Conn. Nov. 3, 2016\)](#) (Judge Victor A. Bolden).

In securities class action lawsuits against corporation, employee benefit plans, sponsored by corporation and which held shares of corporation, were not corporation’s “affiliates” excluded from settlement class under settlement agreement. [Rothstein v. Am. Int’l Grp., Inc., No. 14-4067\(L\), ___ F.3d ___, 2016 WL 5075939 \(2d Cir. Sept. 20, 2016\)](#) (Before: POOLER and SACK, Circuit Judges, and FAILLA, District Judge).

In uncontested motion, granting class certification of “all persons who were participants in the ESOP when Atrium terminated the ESOP effective July 1, 2012 and/or beneficiaries of such ESOP participants or at any time thereafter. Excluded from the Plaintiff Class are the individual Defendants and their immediate families; the officers and directors of Defendant Atrium Funding, Atrium and Dejana Affiliate Companies; and legal representatives, successors, and assigns of any such excluded persons.” [Kindle v. Dejana, No. 14CV6784SJFARL, 2016 WL 1642648 \(E.D.N.Y. Apr. 25, 2016\)](#) (Judge Feuerstein).

B. Third Circuit

Because Plaintiffs have not shown that common questions of law or fact would predominate over individual disputes, denying class certification of proposed class including beneficiaries under ERISA-governed employee welfare benefit plans that were insured by group life insurance policies issued by Prudential that contained the payment language, “Life Insurance is normally paid to the Beneficiary in one sum” and Prudential “retained their death benefits” in a Prudential Alliance Account. [Huffman v. Prudential Ins. Co. of Am., No. 2:10-CV-05135, 2016 WL 5724293 \(E.D. Pa. Sept. 30, 2016\)](#) (Judge Joseph F. Leeson).

Court finally approves class action settlement in matter involving the termination of retiree welfare benefits. [Zanghi v. Freightcar Am., Inc., No. CV 3:13-146, 2016 WL 223721 \(W.D. Pa. Jan. 19, 2016\)](#) (Judge Kim R. Gibson). After ten years of litigation, the court finally approved a class action settlement in this case concerning the rights of retirees to continued medical coverage and life insurance benefits. In exchange for the dismissal of the released claims, Defendants will make a one-time payment of \$32,750,000, the balance of which after attorneys’ fees (\$1,272,068.77) and costs (\$27,931.23) will be contributed to a Voluntary Employee Beneficiary Association (VEBA). The VEBA will thereafter be managed by a committee of independent trustees. With the settlement funds, the VEBA will provide various categories of benefits, which include reimbursement for past healthcare expenses, a death benefit, and continuing healthcare benefits.

C. Fourth Circuit

Certifying class: All Trojan Horse Ltd 401(k) Plan participants who contributed to the Plan through payroll deduction from January 1, 2011, through the date of entry of this order. Granting Plaintiffs’ motion for summary judgment, finding that Ascensus was under an express fiduciary duty to administer funds once received and had a further duty to ensure that those contributions were being made. Its failure to do so is a breach of fiduciary duty. Unpaid Plan contributions are Plan assets. Entering judgment against Ascensus, the non-appearing defendants and cross-defendants in the amount representing the unpaid contributions to the Plan, \$2,985,914.27. [Longo v. Trojan Horse Ltd., No. 5:13-CV-418-BO, 2016 WL 5118281 \(E.D.N.C. Sept. 20, 2016\)](#) (Judge Terrence W. Boyle).

An administrator may amend deferred compensation plan, including specifically by authorizing the administrator to amend the rate at which participants’ deferred income accounts are credited with future earnings. Class defined as “Participants in the Plan who

retired as of December 31, 2012, had elected to receive distributions of deferred income during retirement in installments, and for whom the amount or manner of their benefit payment was altered by the 2012 Amendment; and the Beneficiaries of those Participants” does not meet Rule 23 requirements for class certification. [Plotnick v. Computer Scis. Corp. Deferred Comp. Plan for Key Executives, No. 1:15-CV-01002, ___ F.Supp.3d ___, 2016 WL 1704158 \(E.D. Va. Apr. 26, 2016\)](#) (Judge T.S. Ellis, III).

D. Fifth Circuit

In retirement-plan dispute brought by current and former participants and beneficiaries of Verizon’s pension plan, affirming the district court’s dismissal of the claims of the Transferee Class for failure to state a claim as well as dismissal of the sole claim of the Non-Transferee Class for lack of constitutional standing; [Spokeo, Inc. v. Robins, —U.S.—, 136 S.Ct. 1540, 194 L.Ed.2d 635 \(2016\)](#) does not affect the court’s previous conclusion that a plaintiff’s bare allegation of incursion on the purported statutory right to “proper plan management” under ERISA is insufficient to meet the injury-in-fact prong of Article III standing. [Lee v. Verizon Commc’ns, Inc., No. 14-10553, ___ F.3d ___, 2016 WL 4926159 \(5th Cir. Sept. 15, 2016\)](#) (Before BENAVIDES, SOUTHWICK, and COSTA, Circuit Judges). *Lee* involves a certified class action of a retirement-plan dispute brought by current and former participants and beneficiaries of Verizon’s pension plan, wherein they allege ERISA violations by the pension plan sponsors and administrators as a result of a plan amendment and subsequent annuity purchase in December of 2012. There are two certified classes: the Transferee Class comprising Plan participants whose retirement-benefit obligations were transferred to the annuity, and the Non-Transferee Class comprising Plan participants whose retirement-benefit obligations remained with the Plan. The Fifth Circuit affirmed the district court’s dismissal of the claims of the Transferee Class for failure to state a claim as well as dismissal of the sole claim of the Non-Transferee Class for lack of constitutional standing. In so doing, it held that [Spokeo, Inc. v. Robins, —U.S.—, 136 S.Ct. 1540, 194 L.Ed.2d 635 \(2016\)](#) does not affect the court’s previous conclusion that a plaintiff’s bare allegation of incursion on the purported statutory right to “proper plan management” under ERISA is insufficient to meet the injury-in-fact prong of Article III standing. The court further found that any theory of standing based on the pursuit of injunctive relief has been waived.

E. Sixth Circuit

Court certifies class of alleged mislabeled independent contractors. [Jammal v. Am. Family Ins. Grp., No. 13 CV 437, 2016 WL 815576 \(N.D. Ohio Mar. 2, 2016\)](#) (Judge Donald C. Nugent). The Second Amended Complaint alleges that Defendants attempted to avoid compliance with the requirements of ERISA by mislabeling its sales people as “independent contractors” while treating them for all practical purposes as employees. The court granted

Plaintiff's motion for class certification of three classes, two relating to termination benefits, and one relating to Health/Dental/Life/Disability benefits:

(1) Termination Benefits Class: Each person who signed an American Family Agent Agreement and (1) was an active agent as of February 28, 2013, or (2) is a former agent whose Agent Agreement was terminated on or after February 8, 2007.

(2) Termination Benefits Breach of Fiduciary Duty Class: Each person who signed an American Family Agent Agreement and (1) was an active agent as of February 28, 2013, or (2) is a former agent whose Agent Agreement was terminated on or after February 8, 2010.

(3) Termination Benefits Class: Each person who signed an American Family Agent Agreement and (1) was an active agent as of February 28, 2013, or (2) was a former agent whose became a full-time American Family Agent and came off an agent financing program on or after February 28, 2007.

Class action settlement approved. [Sims v. Pfizer, Inc., No. 1:10-CV-10743, 2016 WL 772545 \(E.D. Mich. Feb. 24, 2016\)](#) (Judge Thomas L. Ludington). This case involved a challenge to Pfizer's change of healthcare plan provided to class members. The parties reached a settlement of the claims. The court held a fairness hearing and approved the class action settlement. The settlement provides for substantial restoration of the prior healthcare plan subject to agreed-upon modifications, payment of \$750,000 to settle the class members' monetary claims, and payment of class counsel's fees, costs, and expenses in the amount of \$549,161.37.\

F. Seventh Circuit

Certifying the following Classes: (a) All individuals who sponsored benefit plans providing themselves and any of their employees with healthcare coverage obtained by the purchase of insurance coverage or administration of self-funded plans by Defendant, HCSC, or through a benefit plan underwritten, administered or otherwise provided by Defendant, HCSC, in the States of Illinois, Texas, Montana, New Mexico and Oklahoma. (b) All individuals and their beneficiaries who are or, at all times relevant to this cause of action, were recipients of health care coverage provided to them and their beneficiaries through their employers by health care coverage plans underwritten, administered, or otherwise provided by Defendant HCSC in the States of Illinois, Texas, Montana, New Mexico and Oklahoma. (c) All individuals and their beneficiaries who, at all times relevant to this cause of action, obtained health care coverage by individual purchase of such coverage from Defendant, HCSC, or through a benefit plan underwritten, administered, or otherwise provided by Defendant, HCSC, but not subject to ERISA in the States of Illinois, Texas, Montana, New Mexico and Oklahoma. (d) All individuals and their beneficiaries who are, or at all times relevant to this cause of action, were covered by health care

insurance solely within the borders of the State of Illinois and therefore are protected by the power of the Illinois Department of Insurance to regulate policies issued within its borders by a health care insurer such as Defendant HCSC. [Priddy v. Healthcare Servs. Corp., No. 14-3360, F.Supp.3d , 2016 WL 5923412 \(C.D. Ill. Oct. 11, 2016\)](#) (Judge Richard Mills).

G. Ninth Circuit

In matter alleging wrongful denial of coverage for mental health and substance use disorder treatment by Defendant United Behavioral Health (“UBH”), granting class certification of the following Classes:

The *Wit* Guideline Class

Any member of a health benefit plan governed by ERISA whose request for coverage of residential treatment services for a mental illness or substance use disorder was denied by UBH, in whole or in part, on or after May 22, 2011, based upon UBH’s Level of Care Guidelines or UBH’s Coverage Determination Guidelines. The *Wit* Guideline Class excludes members of the *Wit* State Mandate Class, as defined below.

The *Wit* State Mandate Class

Any member of a fully-insured health benefit plan governed by both ERISA and the state law of Connecticut, Illinois, Rhode Island or Texas, whose request for coverage of residential treatment services for a substance use disorder was denied by UBH, in whole or in part, on or after May 22, 2011, based upon UBH’s Level of Care Guidelines or UBH’s Coverage Determination Guidelines and not upon the level-of-care criteria mandated by the applicable state law. The *Wit* State Mandate Class shall only include denials governed by Illinois law that occurred on or after August 18, 2011, denials governed by Connecticut law that occurred on or after October 1, 2013, and denials governed by Rhode Island law that occurred on or after July 10, 2015. The *Wit* State Mandate Class excludes members of the *Wit* Guideline Class, as defined above.

The *Alexander* Guideline Class

Any member of a health benefit plan governed by ERISA whose request for coverage of outpatient or intensive outpatient services for a mental illness or substance use disorder was denied by UBH, in whole or in part, on or after May 22, 2011, based upon UBH’s Level of Care Guidelines or UBH’s Coverage Determination Guidelines. The *Alexander* Guideline Class excludes any member of

a fully insured plan governed by both ERISA and the state law of Connecticut, Illinois, Rhode Island or Texas, whose request for coverage of intensive outpatient treatment or outpatient treatment related to a substance use disorder.

[Wit et al. v. United Behavioral Health, No. 14-CV-02346 JCS, F.R.D. , 2016 WL 4990514 \(N.D. Cal. Sept. 19, 2016\)](#) (Magistrate Judge Joseph C. Spero).

In certified class action challenging Blue Shield’s denial of artificial disc replacement surgery on the basis of it being “investigational,” granting Blue Shield’s motion on the issue that abuse of discretion is the proper standard of review but denying the motion as it relates to the decision on the merits because (1) triable issues remain regarding the extent and effect of Blue Shield’s structural bias and (2) it is unclear whether the evidence upon which Blue Shield relies is part of the administrative record to which the court must limit its merits review. [Escalante v. California Physicians’ Serv., No. CV1403021DDPPJWX, 2016 WL 4086765 \(C.D. Cal. July 29, 2016\)](#) (Judge Dean D. Pregerson).

In action challenging T-Mobile’s adoption of a uniform policy excluding any coverage for Applied Behavior Analysis (“ABA”) therapy to treat Autism Spectrum Disorder, including any coverage that may be medically necessary, granting unopposed motion for class certification but denying preliminary approval of the settlement agreement. The proposed Settlement Agreement provides prospective relief following a “best practice” model for delivery of ABA therapy, as well as a settlement fund of \$676,935.00 to address claims for reimbursement for any members who paid for ABA services out-of-pocket, attorneys’ fees, costs, claims administration costs, and an incentive award, but the court found that the Released Claims are phrased too broadly and appear to preclude class members from bringing any claims that the Named Plaintiff could bring, even if those claims are beyond the scope of the pertinent factual basis. The court recommends that the released claims relate only to T-Mobile’s denials of coverage for ABA therapy. The court also questioned \$10,000 incentive award. [A.D. v. T-Mobile USA, Inc. Employee Benefit Plan, et al., No. 2:15-CV-00180-RAJ, 2016 WL 3882919 \(W.D. Wash. July 18, 2016\)](#) (Judge Richard A. Jones).

In putative class action lawsuit against Standard Insurance Company alleging that Standard unlawfully offset workers’ compensation benefits against disability benefits under an ERISA-governed welfare plan, granting Standard’s Motion for Partial Summary Judgment and Plaintiff’s Motion for Class Certification. [Leon v. Standard Ins. Co., No. 215CV07419ODWJC, 2016 WL 2595999 \(C.D. Cal. May 5, 2016\)](#) (Judge Otis D. Wright, II).

H. Eleventh Circuit

Granting certification of class satisfying all of the requirements of Rule 23(a) and Rule 23(b)(1)(B), defined as follows: All persons, other than Defendants and members of their

immediate families, who were participants in or beneficiaries of the SunTrust Banks, Inc. 401(k) Savings Plan (the “Plan”) at any time between May 15, 2007 and March 30, 2011, inclusive (the “Class Period”) and whose accounts included investments in SunTrust common stock (“SunTrust Stock”) during that time period and who sustained a loss to their account as a result of the investment in SunTrust Stock. Appointed class representatives are Plaintiffs Erwin, Fish, Trau, and Smothermon. Co-lead Class Counsel are the law firms of Kessler Topaz Meltzer & Check, LLP, Stull, Stull & Brody and Squitieri & Fearon, LLP. Liason Class Counsel is the law firm of Holzer & Holzer, LLC. [In re Suntrust Banks, Inc. ERISA Litig., No. 1:08-CV-03384-RWS, 2016 WL 4377131 \(N.D. Ga. Aug. 17, 2016\)](#) (Judge Richard W. Story).

VI. *Disability Benefit Claims*

A. First Circuit

[Troiano v. Aetna Life Ins. Co., No. 16-1307, __F.3d__, 2016 WL 7321575 \(1st Cir. Dec. 16, 2016\)](#) (Before Lynch, Lipez, and Barron, Circuit Judges). The disability plan administrator may offset the disability payments by the gross (pre-tax) amount of Social Security income rather than by the net (post-tax) amount of Social Security income. The plain language of the Plan allows for offsets by other income that is payable to the beneficiary and supports Aetna’s decision to offset the LTD benefits by the full amount of SSDI benefits for which she is eligible, rather than by the amount left over after she has paid income taxes. The district court did not abuse its discretion in denying Rule 56(d) discovery, especially where this case was a matter of interpreting Plan language.

In matter involving denied long-term disability benefits, (1) finding that Plaintiff’s ERISA Section 502(a)(1)(B) claim naming Sedgwick (the plan administrator) and Dr. Matos (internal doctor employed by company who recommended denying benefits) survives Defendants’ motion to dismiss since taking all well pleaded facts in the complaint as true, Sedgwick and Dr. Matos evidenced control over the Committee’s decisions; (2) dismissing Section 502(a)(3) claim since Plaintiff can seek redress in Section 502(a)(1)(B); (3) finding that Section 510 claim survives motion to dismiss where Plaintiff alleged that Defendants specifically contracted with outside physicians to justify the denial of benefits and it can be inferred from the facts in the amended complaint that Defendants were trying to prevent Plaintiff from attaining his vested right to LTD benefits; (4) dismissing request for \$500,000 in extra-contractual damages; and (5) finding no right to a jury trial on ERISA claims. [Brown v. Sedgwick Claims Mgmt. Servs., Inc., No. 15-1435 \(JAG\), 2016 WL 4273193 \(D.P.R. Aug. 11, 2016\)](#) (Judge Garcia-Gregory).

Concluding that the language of a disability insurance plan supports Aetna’s decision to offset 50% of the settlement proceeds resulting from a general release for injuries from a car accident since they amount to “other income benefits” that can be offset against disability benefit payments. [Harding v. Aetna Life Ins. Co., No. 2:15-CV-411-DBH, 2016 WL 3983242 \(D. Me. July 25, 2016\)](#) (Judge D. Brock Hornby).

In matter where the reason for Plaintiff’s denial of a bonus and termination of employment was in dispute, finding that it was unreasonable for Unum to rely on perfunctory explanations offered by the employer in three telephone conversations to determine the basis of Plaintiff’s loss of income, and remanding to Unum to conduct a more thorough inquiry into the relationship between Plaintiff’s injury and his income loss. [Host v. First Unum Life Ins. Co., No. CV 13-11578-GAO, 2016 WL 3814807 \(D. Mass. July 13, 2016\)](#) (Judge O’Toole).

Because Plaintiff cannot show that he was prejudiced by his lack of information about Aetna’s appeal process, Aetna is entitled to judgment on Plaintiff’s 29 U.S.C. § 1133(2) claim to the extent that claim is based upon an asserted violation of 29 C.F.R. § 2560.503-1(h)(2)(iii) (requiring provision of “claims procedures”). Further, Plaintiff identified no evidence that Aetna failed to take into account, and has identified no prejudice that resulted from Aetna’s alleged violation of 29 C.F.R. § 2560.503-1(h)(2)(iv) (requiring administrator to take into account all of the information submitted in support of a claim), such that there is no basis for a determination that Aetna failed to provide Plaintiff with a full and fair review of his appeal, as required by 29 U.S.C. § 1133(2). [Gary Hopper v. Aetna Life Ins. Co., No. 14-CV-450-LM, 2016 WL 2888972 \(D.N.H. May 16, 2016\)](#) (Judge Landya McCafferty).

Football Degenerative benefits awarded to retired football player with diffuse axonal injury. [Solomon v. Bert Bell/Pete Rozelle NFL Player Ret. Plan, No. CV MJG-14-3570, 2016 WL 852732 \(D. Md. Mar. 4, 2016\)](#) (Judge Marvin J. Garbis). The court found that the Bert Bell/Pete Rozelle NFL Player Retirement Plan and the NFL Player Supplemental Disability Plan abused its discretion in denying Plaintiff “Football Degenerative” benefits, which are paid for disabilities stemming from a player’s football career that manifest within 15 years of retirement. The Plan had awarded Plaintiff the lesser “Inactive” benefits, which are paid for disabilities not stemming from a player’s football career, or if stemming from a player’s football career, that did not manifest within 15 years of retirement. The court found the evidence support Plaintiff’s claim for Football Degenerative benefits to be “overwhelming,” including an MRI showing white matter changes in the deep white matter of both parietal lobes, medical records and letters detailing Plaintiff’s impairment, and Plaintiff’s diagnosis of diffuse axonal injury. Although ordinarily a court finding improperly denied benefits would remand the case for further proceedings, neither party sought a remand so the court awarded benefits to Plaintiff.

LTD denial not supported by substantial evidence and remanded to Liberty for further proceedings. [Tracia v. Liberty Life Assurance Co. of Boston, No. CV 13-13248-JGD, 2016 WL 552463 \(D. Mass. Feb. 10, 2016\)](#) (Magistrate Judge Dein). Plaintiff, impaired by chronic regional pain syndrome and degenerative disc disease, among other medical conditions, sought disability benefits from defendant Liberty Life Assurance Company of Boston (“Liberty”). Liberty paid benefits for the first 12 months during the “Own Occupation” period, but then terminated benefits when the definition of disability changed to “unable to perform, with reasonable continuity, the Material and Substantial Duties of Any Occupation.” In ruling on the parties’ motions for summary judgment, the court found that Liberty deprived Plaintiff of a full and fair review of his claim and that its decision to deny his request for benefits was unreasonable, but that the matter must be remanded to Liberty for further administrative proceedings. The court found that it was well within Liberty’s discretion to require objective evidence showing that Plaintiff lacked the ability to engage in gainful work activity, but that Liberty never informed Plaintiff what evidence was required to make the necessary showing in light of his subjective symptoms, and it relied on the opinions of reviewing physicians who never examined Plaintiff or otherwise obtained objective evidence regarding the effect that Plaintiff’s pain had on his ability to engage in work-related functional activities. Under these circumstances, the court found that its decision to deny Plaintiff’s claim for LTD benefits was not supported by substantial evidence.

B. Second Circuit

The relevant date for determining which version of the Plan applies is the date of the final disability determination. Since Plaintiff’s claim was not vested under the Plan, the court applied a Plan amendment involving discretionary authority that became effective after Plaintiff began receiving benefits. Aetna’s denial letter did not comply with the standard imposed by ERISA requiring that a plan administrator’s notice letter be written in a manner calculated to be understood by the participant. The court granted Plaintiff’s motion for summary judgment only to the extent that the denial of LTD benefits is reversed. Matter remanded to Aetna for further administrative proceedings. [Standish v. Fed. Express Corp., No. 6:15-CV-6226\(MAT\), 2016 WL 6821849 \(W.D.N.Y. Nov. 18, 2016\)](#) (Judge Michael A. Telesca).

It was not arbitrary and capricious for Unum to determine that Plaintiff’s failure to present a physical etiology for her cognitive dysfunction was one ground on which to deny her claim. It is not an abuse of discretion for Unum to engage in a “feedback loop claims approach,” which involves Unum’s claims personnel reviewing the findings of their colleagues. Here, where a number of claims reviewers delved into Plaintiff’s medical records and determined that they did not support her claim for an organically- or physically-based cognitive condition that rendered her completely disabled from her job, Unum’s failure to seek an IME was not arbitrary and capricious. [Correia v. Unum Life Ins.](#)

[Co. of Am., No. 14 CIV. 7690 \(KPF\), 2016 WL 5462827 \(S.D.N.Y. Sept. 29, 2016\)](#) (Judge Katherine Polk Failla).

Granting Defendants’ motion for summary judgment and finding that Defendants did not reach an unreasonable or arbitrary and capricious decision in denying Plaintiff disability pension benefits under § 4.4 of the Plan because he did not become Totally and Permanently Disabled, if at all, until more than two years after his employment ended, when the Social Security Administration certified that he had a permanent disability and awarded him disability insurance benefits. [Anthony v. Local 295/Local 851 - IBT Employer Grp. Pension Trust Fund Bd. of Trustees, No. 13CV5730DLIMDG, 2016 WL 5314654 \(E.D.N.Y. Sept. 22, 2016\)](#) (Judge Dora L. Irizarry).

For claimant with degenerative disc disease, ordering reinstatement of long-term disability benefits and finding that Aetna’s termination of benefits was arbitrary and capricious where: (1) the Plan did not require “objective medical evidence” and Aetna previously approved payment of benefits to Plaintiff without requiring a showing of “objective medical evidence;” (2) Aetna did not consider the SSA’s finding of disability although it had those records available to it; and (3) Aetna failed to order an independent medical examination where Plaintiff’s claim for benefits stood or fell on the credibility of her subjective complaints. [Dunda v. Aetna Life Ins. Co., No. 6:15-CV-6232-MAT, 2016 WL 3552187 \(W.D.N.Y. June 30, 2016\)](#) (Judge Michael A. Telesca).

“Thus, in light of Dr. Gibson’s notes identifying plaintiff as disabled, the lack of peer-to-peer review, and the reliance on an ambiguous third-party report of Dr. Gibson’s opinion, the Court finds that Aetna’s conclusion that plaintiff had the ability to work on a full-time basis with accommodation is not based on evidence a reasonable mind might accept as adequate. The Court does not suggest that Aetna should have made a different decision but will remand the matter to enable Aetna to complete its determination with a competent evaluation of plaintiff’s capacity by her treating physicians.” [Mirto v. Aetna Life Insurance Company, Yale New Haven Health System Long Term Disability Plan, No. 3:14CV1640 \(WWE\), 2016 WL 2851542 \(D. Conn. May 13, 2016\)](#) (Judge Warren W. Eginton).

In LTD matter where Plaintiff, a former truck driver who suffers from chronic, unexplained, and unpredictable syncope, or sudden loss of consciousness, the court granted summary judgment in favor of Defendants because Plaintiff did not establish that the independent, third-party claims administrator had a conflict of interest or that the denial of his claim was arbitrary and capricious. “Thus, under ERISA’s highly deferential standard of review, the Court cannot revisit the final claim determination.” [Jones v. PepsiCo, Inc., No. 15-CV-01426 \(SN\), F.Supp.3d , 2016 WL 2642676 \(S.D.N.Y. May 6, 2016\)](#) (Magistrate Judge Sarah Netburn).

Plan fiduciaries properly delegated discretionary authority to Aetna to review long-term disability appeals. [Dwinnell v. Fed. Express Long Term Disability Plan, No. 3:14-CV-01439 \(JAM\), 2016 WL 901562 \(D. Conn. Mar. 9, 2016\)](#) (Judge Jeffrey Alker Meyer). The parties cross-moved for partial summary judgment on the standard of review applicable to Plaintiff’s long-term disability claim. Here, Plaintiff claimed that no deferential review should apply in this case because Aetna was not properly appointed with fiduciary authority under the Plan to conduct the administrative appeal review of the denial of her claim. The FedEx Plan delegates key responsibilities to four different entities: (1) the Administrator, (2) the Committee, (3) the Claims Paying Administrator, and (4) the appeal committee. The company’s Retirement Plan Investment Board approved a proposal to outsource remaining long-term disability appeals to Aetna in July 2008. Plaintiff argued that the procedures followed were not sufficient to constitute a valid appointment of Aetna as the appeal committee under the Plan. The court concluded that the Plan allowed the Administrator to appoint the appeal committee and that it allowed the Administrator to appoint Aetna as the appeal committee. Although it was the Retirement Planning Investment Board—and not the Administrator—that approved the selection of Aetna, the court concluded that the Committee was within its own delegated authority from the Administrator when it acted upon the recommendation of FedEx management personnel to approve Aetna to serve in place of the Benefit Review Committee as the appeal committee. This is because Section 6.2 of the Plan identifies the Committee as a named fiduciary under the Plan, with responsibility “to perform the administrative duties hereunder” and to assume “general administrative power” over the Plan and “with such other powers as may be necessary to perform its duties hereunder” the Plan. The court concluded that as a matter of law that Aetna was validly appointed as the appeal committee with fiduciary and discretionary authority in that capacity under the Plan and granted Aetna’s motion.

Claims dismissed due to ERISA preemption, jury demand struck, but claimant entitled to discovery. [Murphy v. First Unum Life Insurance Company, No. 15-CV-820 \(SJF\)\(SIL\), 2016 WL 526243 \(E.D.N.Y. Feb. 9, 2016\)](#) (Judge Sandra J. Feuerstein). Plaintiff filed a multi-count complaint against First Unum for its denial of her long-term disability benefit claim. First Unum moved to dismiss. The court granted First Unum’s motion, in part, including dismissal of Counts I (breach of contract), III (bad faith and punitive damages) and IV (negligence and punitive damages) because of ERISA preemption. The court struck Plaintiff’s jury demand and found that the arbitrary and capricious standard of review applies to the administrator’s benefits decision. The court denied First Unum’s motion for a declaration that Plaintiff is not entitled to discovery beyond the administrative record. The court ordered that Plaintiff is permitted to conduct discovery into the extent of Defendant’s conflict of interest, but not into the merits of Defendant’s decision to terminate Plaintiff’s LTD benefits.

C. Third Circuit

For Plaintiff with severe vision problems caused by proliferative diabetic retinopathy, ReliaStar did not abuse its discretion in denying Plaintiff’s long-term disability claim, where it: (1) did not require an IME, and instead largely relied on Dr. Michaelson’s independent medical record review; (2) did not adopt the opinion of Plaintiff’s treating doctor, who first opined Plaintiff could not work *after* ReliaStar terminated her benefits and did not respond to Dr. Michaelson’s letter setting forth his opinion that Plaintiff could return to work; and (3) ReliaStar identified numerous available occupations that Plaintiff could do even in light of Dr. Michaelson’s restrictions. [Moustafa v. Reliastar Life Ins. Co., No. CV 15-2531, 2016 WL 6662685 \(D.N.J. Nov. 8, 2016\)](#) (Judge John Michael Vazquez).

An “Appointment of Claim Fiduciary” contract where LifeCare, as Plan administrator, appointed Life Insurance as Claim Fiduciary and gave Life Insurance “the authority, in its discretion, to interpret the terms of the Plan, including the Policies; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact” constitutes a delegation of discretionary power warranting an arbitrary and capricious standard of review. Life Insurance was not arbitrary and capricious in denying Plaintiff LTD benefits for major depression and anxiety. Even though SSA found her disabled, SSA did not have Defendant’s peer review report. Plaintiff does not have a private right of action under Section 503; Defendant’s alleged procedural violations do not entitle Plaintiff to attorneys’ fees. [Gailey v. Life Ins. Co. of N. Am., No. 1:15-CV-564, 2016 WL 6082112 \(M.D. Pa. Oct. 17, 2016\)](#) (Judge John E. Jones III).

Aetna did not act arbitrarily and capriciously in denying Plaintiff’s claim for short-term and long-term disability benefits, where Aetna found that there was no objective evidence in the medical records showing that Plaintiff’s chronic daily headaches were sufficiently severe or intense as to preclude work, and where Plaintiff was eventually diagnosed with multiple sclerosis. [Ackaway v. Aetna Life Ins. Co., No. CV 14-1300, 2016 WL 5661724 \(E.D. Pa. Sept. 30, 2016\)](#) (Judge Edward G. Smith).

In applying the terms of a Rehabilitation Provision, Reliance did not abuse its discretion by interpreting “earnings” to include the amount Plaintiff’s employer applied to cover the shared overhead before physically distributing any earnings to Plaintiff, even though Plaintiff’s employment agreement provides that Plaintiff’s compensation is calculated by subtracting her “shared expenses” from her “gross collections.” [Patrick v. Reliance Standard Life Ins. Co., No. CV 15-169-SLR/SRF, 2016 WL 5662138 \(D. Del. Sept. 29, 2016\)](#) (Judge Sue L. Robinson).

Sun Life did not abuse its discretion in determining that Plaintiff is not disabled from her psoriatic arthritis and inability to use a keyboard. Ability to find employment is only

relevant if Plaintiff first met her burden of proving she was unable to perform her own occupation. Although Plaintiff's vocational consultant, Charles Kinkaid, claimed that Plaintiff was "unemployable" because she could not perform keyboarding, she was of "advanced work age," and because her skills and experience were obsolete, his findings were premature because no finding was ever made that Plaintiff was unable to perform her own occupation as a Programmer Analyst/Network Administrator. Sun Life obtained medical reviews from Dr. Lawrence J. Albers, a psychiatrist and neurologist; Dr. Rajendra Marwah, a rheumatologist; and Dr. Jose Perez, an internist. Sun Life's motion for summary judgment granted. [Drach v. Sun Life Assurance Co. of Canada, No. 15-5467 \(NLH/KMW\), 2016 WL 5417191 \(D.N.J. Sept. 28, 2016\)](#) (Judge Noel L. Hillman).

Granting Liberty Life's motion for summary judgment since its determination was supported by substantial evidence with respect to (1) Plaintiff's capability for sedentary work; (2) the existence of alternative occupations consistent with a sedentary work capacity; (3) Liberty Life's consideration of the diagnoses, restrictions, and limitations provided by Plaintiff's treating physicians; (4) Liberty Life's consideration of Plaintiff's self-reported symptoms of pain; and (5) the reasons that Liberty Life's determination differed from the Social Security Administration's disability finding. The court rejected Plaintiff's argument that *de novo* review should apply because Liberty Mutual, rather than Liberty Life, made the claims decision. [Shatto v. Liberty Life Assurance Co. of Boston, No. CV 14-5653, 2016 WL 5374106 \(E.D. Pa. Sept. 26, 2016\)](#) (Judge Stengel).

Finding that the Plan's decision to terminate Plaintiff's long-term disability benefits was not arbitrary and capricious where "new medical evidence" supported a termination of benefits and Liberty Life had approved the LTD claim before it had received Plaintiff's LTD application, supporting medical information, or neuropsychological evaluations; although records supported Plaintiff's complaints of fatigue, the record lacked any valid or reliable evidence that neurocognitive or psychiatric symptoms are causing functional impairment. [Swanberg v. PNC Fin. Servs. Grp., Inc., No. CV 2:15-544, 2016 WL 4493684 \(W.D. Pa. Aug. 26, 2016\)](#) (Judge Joy Flowers Conti).

Fund did not abuse its discretion in denying Plaintiff's claim for disability retirement benefits, where the Plan required that Plaintiff have "become totally and permanently disabled," and must have accrued "at least [130] Pension Credits in the [60] consecutive months immediately preceding [the employee's] date of disablement," and the Trustees used the disability date on Plaintiff's Social Security Award letter as the date of disablement rather than an earlier date advanced by Plaintiff. [Aristone v. New Jersey Carpenter's Pension Fund \(Plan No. 001\), No. CV 15-5709 \(JBS/KMW\), 2016 WL 4265718 \(D.N.J. Aug. 11, 2016\)](#) (Judge Jerome B. Simandle).

Dismissing breach of fiduciary duty claims against employer and Unum because the amended complaint does not demonstrate that the “appropriate equitable relief” available under § 1132(a)(3) is warranted since Plaintiff’s § 1132(a)(3) and § 1132(a)(1)(B) claims against AHL and Unum overlap factually, and seek the exact same remedy, however, *Varity* did not establish any bright line rule precluding § 1132(a)(3) and § 1132(a)(1)(B) claims from being asserted simultaneously; dismissing Plaintiff’s claims for declaratory judgment under § 1132(a) generally since Plaintiff is entitled to no further relief pursuant to his claim for declaratory judgment than he would be should he prevail on his claim for recovery of benefits. [Boyles v. Am. Heritage Life Ins. Co., No. 3:15-CV-274, 2016 WL 4031295 \(W.D. Pa. July 26, 2016\)](#) (Judge Kim R. Gibson).

Affirming summary judgment in favor of National Life Insurance Company based on language contained in a Rider for Residual Disability Income Benefit and finding that Rider could be construed to mean that residual disability benefits are subject to a changing standard in the determination of what the term “occupation” means. The Rider provides that: “Until an income benefit, for any period of continuous disability, has been paid to the Insured’s 55th birthday, or for 120 months, whichever is longer, occupation means the occupation of the Insured at the time such disability begins. Thereafter it means any occupation for which the Insured is or becomes reasonably fitted by education, training or experience.” [Bowerman v. National Life Insurance Company, No. 15-1129, ___ F.App’x ___, 2016 WL 3626811 \(3d Cir. July 7, 2016\)](#) (BEFORE: FUENTES, SMITH, and NYGAARD, Circuit Judges).

On Plaintiff’s long-term disability claim, vacating the district court’s grant of summary judgment in favor of Defendants due to factually intense inquiry of issue of whether the medical information that Plaintiff provided on administrative appeal was different or less substantial than the medical information that MetLife originally accepted in support of his claim. Temporal proximity of claim termination and MetLife’s discovery of its \$10,000/month underpayment raises a reasonable inference that monetary concerns were a factor in MetLife’s claim decision. Failure to order an IME is a factor to consider in determining whether decision was arbitrary or capricious. [Reed v. *Citigroup Inc, As Plan Sponsor Of The Citigroup Disability Plan; Metropolitan Life Insurance Company, a New York Corp., No. 15-2094, ___ F.App’x ___, 2016 WL 3626816 \(3d Cir. July 7, 2016\)](#) (Before: FUENTES, VANASKIE and SCIRICA, Circuit Judges).

Denying cross-motions for summary judgment on long-term disability claim and remanding the claim to Aetna to determine whether Plaintiff’s use of oxycodone would have prevented her from performing her duties in the national economy. “Avoidance of even unrealized risks is fundamental to many job duties. A truck driver who developed a condition—or required a medication—that carried a risk of narcolepsy or seizures might

reasonably be barred from doing his job even if he presently showed no signs of suffering those symptoms, and there would be little question that his medical issue was keeping him from performing his material duties.” [Fultz v. RR Donnelley & Sons Co. Long Term Disability Plan, No. CV 15-0319, 2016 WL 3078192 \(E.D. Pa. June 1, 2016\)](#) (Judge Jeffrey L. Schmehl).

Denying Plaintiff’s motion to remand long-term disability claim to Liberty Life based on SSDI award, and denying alternative motion to augment the Administrative Record with discovery as to alleged conflicts of interest in the Plan. [O’Conner v. PNC Fin. Servs. Grp., Inc., No. CV 15-5051, 2016 WL 2941196 \(E.D. Pa. May 20, 2016\)](#) (Judge Michael M. Baylson).

Plan provision stating “[t]he Plan Administrator has appointed the Insurance Company [Cigna] as the named fiduciary for deciding claims for benefits under the Plan, and for deciding any appeals of denied claims” is insufficient to invoke an arbitrary and capricious standard of review. On *de novo* review, the court found overwhelming and unanimous medical evidence that Plaintiff suffered from a mental impairment that precluded her from doing her specific job as a hospital account manager with Quest Diagnostics. “Defendant relied on unreasonable inferences made from isolated and out-of-context notations in the medical record, an incomplete paper review by a psychiatrist who never examined Plaintiff, and a lack of information about Plaintiff’s job demands.” [Levine v. Life Ins. Co. of N. Am., No. CV 14-7050, 2016 WL 1621918 \(E.D. Pa. Apr. 21, 2016\)](#) (Judge Rufe).

On *de novo* review of denial of long-term disability benefits, court finds in favor of Unum Provident. [McCann v. Unum Provident, et al., No. CV 11-3241 \(MLC\), 2016 WL 1161261 \(D.N.J. Mar. 23, 2016\)](#) (Judge Mary L. Cooper). This case involved *de novo* review of Provident Life’s decision to deny long-term disability benefits to a radiologist (with a subspecialty in interventional radiology) claiming disability from obstructive sleep apnea, a mildly dilated ascending aortic root aneurysm (“aortic aneurysm”), hypertension, and obesity. The court granted summary judgment in Unum’s favor, finding that Provident Life terminated McCann’s Total Disability benefit payments, at least in part because McCann failed to provide objective evidence of job related restrictions and limitations. McCann’s own doctor disclaimed his view that McCann qualified for disability after his cardiac condition remained stable for nearly two years. With respect to Plaintiff’s occupational classification, the court agreed with Provident Life that the CPT codes during the three years preceding the onset of Plaintiff’s claim of total disability were representative of all of the work that Dr. McCann performed, and are therefore dispositive under the Policy. Although Dr. McCann was trained in interventional radiology, the diagnostic duties associated with his occupation accounted for 91% of the procedures he performed each week during the three-and-a-half-year period preceding his application for disability leave.

Competing affidavits as to applicable version of LTD policy creates genuine issue of material fact. [Baker v. Sun Life & Health Ins. Co., No. 15-1525, Fed.Appx. , 2016 WL 1077738 \(3d Cir. Mar. 18, 2016\)](#) (Before McKEE, Chief Judge, AMBRO, and SCIRICA, Circuit Judges). In this matter involving the denial of long-term disability benefits, the record before the court included competing affidavits and two versions of a Sun Life policy, one with the grant of discretionary authority, and one without. The court found that this obviously creates a genuine issue of material fact as to whether the applicable policy contains the discretionary grant, and there is therefore a disputed issue about which standard of review to apply. When the district court addressed the question of which standard of review to apply, it considered Sun Life’s proffered affidavit over Plaintiff’s proffered affidavit but it did not provide a rationale for failing to consider Plaintiff’s affidavit. The district court incorrectly stated that “there is only one affidavit confirming the contents of the entire policy, which includes the grant of discretionary authority.” Although the district court mentioned in a footnote that it would also have upheld Sun Life’s denial of Plaintiff’s total disability claim under a de novo standard of review, the court found that the district court only analyzed Sun Life’s denial of benefits to determine if it was arbitrary and capricious. Moreover, the district court did not even attempt to address Plaintiff’s partial disability claims under a de novo standard of review. Because genuine issue of material fact exists with respect to the threshold issue of the contract provisions and the appropriate standard of review, the court did not address the merits of Plaintiff’s claims. The court vacated the decision of the district court, retained jurisdiction, and remanded the matter to the district court for further proceedings.

Counterclaim for recoupment of benefits paid under a reservation of rights not subject to dismissal. [Steiner v. Cigna Life Ins. Co. of New York, No. 15-CV-0391 \(KM\), 2016 WL 916687 \(D.N.J. Mar. 10, 2016\)](#) (Judge Kevin McNulty). Plaintiff brought a Section 1132(a)(1)(B) claim alleging that Defendant wrongfully determined, after eleven years of payments, that Plaintiff was no longer disabled. After CLICNY denied benefits, Plaintiff appealed. CLICNY agreed to continue payment of benefits while Plaintiff underwent an independent medical exam. In response to Plaintiff’s lawsuit, CLICNY filed a counterclaim alleging that it paid the interim benefits pursuant to a reservation of rights and that it could recoup these interim benefits in the event the appeal was denied. The Counterclaim asserts that if the court determines that Plaintiff is not entitled to LTD benefits after they were terminated, CLICNY is entitled to repayment and/or restitution of the amount of LTD benefits that CLICNY paid to him under a reservation of rights, plus interest. Plaintiff contended that any reservation of rights must appear in the Plan documents, but the court found this argument too broad. The court found that the counterclaim presents, at the very least, an issue of fact unsuitable for resolution without development of a record in discovery. The court denied Plaintiff’s motion to dismiss the counterclaim.

Denial of LTD benefits for claimant with Lyme disease is not an abuse of discretion, where denial supported by opinions of three infectious disease specialists. [Ryan v. PNC Fin. Servs.](#)

[Grp., Inc., No. CV 14-1048, 2016 WL 374273 \(W.D. Pa. Feb. 1, 2016\)](#) (Judge Nora Barry Fischer). The court granted summary judgment in favor of the defendant, a self-funded welfare benefit plan providing long-term disability benefits administered by Liberty Life Assurance Company of Boston. Plaintiff claimed disability as a result of symptoms related to Lyme disease. The court found that three reviewing infectious disease specialists interpreted Plaintiff's IGG/IGM Western Blot test results to be inconclusive, at best, for Lyme disease because the tests lack a positive result on the IGG portion of the test. Further, the reviewing physicians all generally noted that for individuals suffering illness for over a month, a negative IGG2 in combination with a positive IGM tends to mean that the IGM is a false-positive. Additionally, the physicians found that the physical and cognitive ailments complained of by Plaintiff were non-specific to Lyme disease. The court found that Defendant's decision to rely on three reviewing physicians over Plaintiff's treating doctor was not an abuse of discretion. The court found that Plaintiff had ample time to supplement her medical record during the appeals process, and was informed of the exact nature of testing for which Liberty was looking when reviewing her claims. Liberty explicitly stated that it would be helpful if Plaintiff provided evidence of psychological consultations, neuropsychological testing, and formal occupational assessments. However, Plaintiff did not submit neuropsychological testing results nor did she explain her failure for doing so to the court.

Aetna did not abuse its discretion in denying short-term disability benefits. [Marchegiani v. Aetna Life Insurance Co. & URS Federal Services, No. 3:14-CV-00568, 2016 WL 231025 \(M.D. Pa. Jan. 19, 2016\)](#) (Judge Robert D. Mariani). The court granted summary judgment in favor of Defendants on Plaintiff's claim for short-term disability benefits. The court found that Aetna did not abuse its discretion in denying Plaintiff's claim because it was supported by "significant evidence." This evidence included three physicians—one affiliated with Aetna (Mendelsohn) and two independent (Brusch and Burstein)—who reviewed the medical files and all came to the same conclusion that Plaintiff was not sufficiently disabled to warrant continued STD benefits. Other facts the court found compelling were that hospital discharge notes reported that Plaintiff was "back to her baseline" and that testing during her hospitalization showed no abnormalities; that an evaluation concluded that Plaintiff had average neuropsychological functioning and recommended that Plaintiff "consider a gradual return to gainful employment;" that no objective testing supported Plaintiff's subjective complaints; and that doctor's notes indicated that Plaintiff behaved normally during her examinations. The court found that all of these are facts of record available to Aetna provide substantial evidence to justify its denial, even if the physicians had never invoked them.

D. Fourth Circuit

Defendant's interpretation of the term "permanently" in long-term disability plan—the inability to perform job functions last more than several months—is not unreasonable. Defendant did not abuse its discretion in denying Plaintiff benefits where the evidence

showed that Plaintiff was only temporarily disabled from June 25, 2012 to December 26, 2013. [Pitts v. SCANA Corp. Health & Welfare Plan, No. 8:15-CV-01988-JMC, 2016 WL 5956282 \(D.S.C. Oct. 14, 2016\)](#) (Judge J. Michelle Childs).

Liberty Life abused its discretion in denying former wine salesman long-term disability benefits where it: (1) ignored or failed to consider important evidence of Plaintiff’s actual physical job duties in making its determination of his “Own Occupation;” (2) failed to consider the alternate DOT occupation of “Driver/Sales Worker;” and (3) had a clear conflict of interest under *Glenn v. MetLife*, due to its dual roles of administering the plan and making the benefits determination. [Sapp v. Liberty Life Assurance Company Of Boston, No. 1:16-CV-105, 2016 WL 5660449 \(E.D. Va. Sept. 28, 2016\)](#) (Judge Liam O’Grady).

Determining that Unum did not abuse its discretion in deciding that Plaintiff could do full-time sedentary, where it had a total of four consulting physicians review her medical records and considered the treating opinions of her doctors. “While Unum made some mistakes with its denial of Allen’s second appeal—namely, the Facebook profile mix-up—these mistakes do not negate the full and fair review Allen received before the second appeal ... and, in any event, are harmless.” [Allen v. UNUM Life Insurance Company of America, No. 3:15-CV-219-JAG, 2016 WL 4571451 \(E.D. Va. Sept. 1, 2016\)](#) (Judge John A. Gibney, Jr.).

Denying Plaintiff’s motion to reconsider dismissal of her cause of action for improper claims procedure pursuant to 29 U.S.C. §§ 1132(a)(3) and 1133 since her allegations that during the final appeal process, Defendants “flagrantly abused their discretion in a self-interested manner by ignoring the conclusions of their own external reviewer” and that they have a pattern and practice of “tr[ying] to deny their responsibility as primary payer” do not suggest that Defendants violated the procedural requirements set forth in 29 U.S.C. §§ 1133. [Perkins v. US Airways, Inc., No. 6:14-CV-2577-BHH, 2016 WL 4208099 \(D.S.C. Aug. 10, 2016\)](#) (Judge Bruce Howe Hendricks).

Denying [LINA’s](#) motion for partial summary judgment on the standard of review where the documents in the record do not evidence a clear intent to grant LINA discretionary authority as a matter of law because the Appointment of Claim Fiduciary form’s (“ACF”) grant of discretionary authority, also recited in plan summaries within the Policies’ Insurance Certificates, is not considered part of “the benefit plan” under [Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 \(1989\)](#). [Pettit v. Life Ins. Co. of N. Am., No. CV RDB-15-2694, 2016 WL 3668022 \(D. Md. July 11, 2016\)](#) (Judge Richard D. Bennett).

Affirming district courts order granting judgment to Hartford Life & Accident Insurance Company in suit challenging Hartford’s denial of long-term disability benefits. [Henderson v. Hartford Life & Acc. Ins. Co., No. 15-1344, ___ F.App’x ___, 2016 WL 1581400 \(4th Cir. Apr. 20, 2016\)](#) (Before WYNN and DIAZ, Circuit Judges, and DAVIS, Senior Circuit Judge).

LTD claim remanded to Hartford to obtain complete Functional Capacity Evaluation or less strenuous Independent Medical Evaluation. [Tortora v. Hartford Life & Accident Ins. Co., No. CV 6:15-2471-HMH, 2016 WL 462431 \(D.S.C. Feb. 8, 2016\)](#) (Judge Henry M. Herlong, Jr.). Plaintiff argued, and the court agreed, that Hartford abused its discretion by failing to obtain a completed FCE or IME. While Plaintiff's long-term disability claim was pending, Hartford ordered an FCE, which was terminated early due to his heart rate and blood pressure remaining too high to continue with the FCE. Hartford instructed the medical facility that conducted the incomplete FCE to schedule another FCE but it was never conducted. Hartford did not obtain an IME, a less strenuous examination. Instead, Hartford obtained another independent physician peer review report, and later affirmed its termination decision of Plaintiff's LTD benefits. In the appeal denial letter, Hartford stated it discontinued its efforts to obtain a completed FCE or any other independent assessment of functionality based on the claim history of unsuccessful attempts to measure Plaintiff's level of functionality. The court found that the administrative record as a whole is inadequate to conduct a meaningful review. Hartford argued that it was not required to obtain a completed FCE or IME but the court found that the Policy does not expressly bar a file review by an independent peer physician in lieu of an FCE or IME. The court cited to other courts that have found that the failure to conduct a physical examination – especially where the right to do so is specifically reserved in the plan – may, in some cases, raise questions about the thoroughness and accuracy of the benefits determination. The court found that Hartford relied on two independent peer medical file reviews that are inconsistent with the treating physician's diagnosis and Hartford failed to conduct an FCE or IME to address the relevant and lingering questions regarding Plaintiff's functionality. While it is not an abuse of discretion to deny benefits when conflicting medical reports exist, there is a requirement for there to be adequate materials and substantial evidence upon which the benefits decision must rely. The court concluded that substantial evidence did not exist and a more deliberate and principled reasoning process should have been conducted in order to obtain adequate materials for several reasons. The court remanded the case to Hartford for further consideration and denied Plaintiff's request that the court award retroactive benefits and attorneys' fees pending remand.

E. Fifth Circuit

The court found that United's decision to deny Plaintiff's long-term disability benefits based on her conditions of fibromyalgia and Chronic Fatigue Syndrome was supported by substantial evidence from Dr. Britt Daniel's IME and by the peer reviews from Dr. Adam Raff, Dr. Jeffrey Sartin, Dr. Paul Howard, and Dr. Michael R. Villanueva. United did not need to follow SSA's determination of Plaintiff's disability because United examined evidence that was not available to the SSA when it found Plaintiff disabled. [Shindoll v. United of Omaha Life Ins. Co., No. 4:15-CV-00759, 2016 WL 7188837 \(E.D. Tex. Dec. 12, 2016\)](#) (Judge Amos L. Mazzant).

The court found that Unum did not abuse its discretion in denying Plaintiff's long-term disability claim. Plaintiff worked as a telephone operator before leaving work due to transient ischemic attacks, rheumatoid arthritis, diabetes mellitus, and heart problems. The court explained that ERISA does not require a plan administrator to have an independent doctor perform a physical examination, nor does it require plan administrators to accord special deference to the opinions of treating physicians. The court found that the record contains substantial evidence from which Unum could have found plaintiff was not disabled under the terms of the Plan. [Bellard v. Unum Life Ins. Co. of Am., No. CV 15-0428, 2016 WL 7108577 \(W.D. La. Dec. 5, 2016\)](#) (Judge Rebecca F. Doherty).

Following *Amara*, a plaintiff can alternatively plead ERISA Section 502(a)(1)(B) and Section 502(a)(3) claims. Because there is a possibility that the breach of fiduciary duty claims regarding deliberate misrepresentations are sufficiently distinct from the claims requesting enforcement of the plan so as not to effectively constitute "repackaging" of the latter, the court denies Defendants' motion to dismiss the Section 502(a)(3) claim. [Currier v. Entergy Corporation Employee Benefits Committee et al., No. CV 16-2793, 2016 WL 6024531 \(E.D. La. Oct. 14, 2016\)](#) (Judge Lance M. Africk). a case involving a denied disability benefit claim, the court denied Defendants' motion to dismiss Currier's Section 502(a)(3) claim in light of *Amara*. The weight of the recent authority provides that a plaintiff can alternatively plead a Section 502(a)(3) claim. In this case, the court could not determine at the motion to dismiss stage whether Currier's breach of fiduciary duty claims regarding deliberate misrepresentations are sufficiently distinct from the claims requesting enforcement of the plan so as not to effectively constitute "repackaging" of the latter.

The disability plan specifically and clearly grants discretionary authority to Prudential. The court rejected Plaintiff's argument that section 8.3(b) of the Plan says nothing about allocating the right and discretion to interpret the terms and conditions of the Plan, such that the power is reserved by the Plan exclusively to the Committee, and not Prudential. The court distinguished the Plan Administrator and the Claims Fiduciary. [Hudson v. Prudential Insurance Co. of America, No. 6:15-CV-1204, 2016 WL 6038033 \(W.D. La. Oct. 13, 2016\)](#) (Judge Rebecca F. Doherty).

Denial of benefits to permanently paralyzed claimant on four different occasions, including on the basis of missing a 180-day limit for filing an appeal that was not included in the policy, suggests that the denial was procedurally unreasonable and an abuse of discretion. [Hughes v. Life Ins. Co. of N. Am., No. CV 15-2941, 2016 WL 5231811 \(E.D. La. Sept. 22, 2016\)](#) (Judge Eldon E. Fallon).

In suit involving a disability plan issued to Plaintiff out of Chicago, Illinois, and governed under Illinois law, but where Plaintiff worked out of the policyholder's Houston, Texas location, finding that the grant of discretionary authority found in the Plan's Appointment of Claim Fiduciary form is rendered void by 50 Ill. Adm. Code § 2001, which is not

preempted by ERISA. [Brasseur v. Life Ins. Co. of N. Am., No. 4:15-CV-03570, 2016 WL 4702587 \(S.D. Tex. Sept. 8, 2016\)](#) (Judge Kenneth M. Hoyt).

Unum abused its discretion in terminating Plaintiff's long-term disability benefits by relying solely on the Dictionary of Occupational Titles to substantially alter the description of Plaintiff's job occupation, after UNUM already settled its definition of Plaintiff's occupational requirements in an earlier review; two equivocal and apparently hurried record reviews of a six-minute surveillance video that at one point shows Plaintiff on his hands and knees does not constitute substantial evidence of Plaintiff's capacity to frequently crawl on a sustained, full-time basis; and Unum may offset against LTD benefits "franchise fees" Plaintiff received from his wholly held corporation. [Marcades v. UNUM Life Ins. Co. of Am., No. CV 15-1144, 2016 WL 4418807 \(E.D. La. Aug. 18, 2016\)](#) (Judge Stanwood R. Duval, Jr.).

Granting summary judgment in favor of Unum Life Insurance Company of America and finding that the disability policy at issue is governed by ERISA, and Plaintiff's claim for penalties and attorney's fees under La. R.S. § 22:1821 is preempted by ERISA. [Mayfield v. UNUM Life Ins. Co. of Am., No. CV 15-5553, 2016 WL 4261771 \(E.D. La. Aug. 12, 2016\)](#) (Judge Carl J. Barbier).

Abuse of discretion review applies where discretionary language contained in SPD that was expressly incorporated into the Plan and Prudential did not abuse its discretion in denying LTD benefits to claimant with Multiple Sclerosis where its own doctors disagreed about whether claimant was disabled. [Burell v. Prudential Ins. Co. of Am., No. 15-50035, ___ F.3d ___, 2016 WL 1426092 \(5th Cir. Apr. 11, 2016\)](#) (Before STEWART, Chief Judge, and BARKSDALE and PRADO, Circuit Judges).

F. Sixth Circuit

Conflict of interest factor is entitled to greater weight due to LINA's inconsistent position on Plaintiff's SSDI claim and award. LINA's termination of benefits was arbitrary and capricious where it inadequately considered Plaintiff's SSDI award, relied on two faulty peer reviewers' opinions not based on a physical examination, misinterpreted a functional capacity analysis, relied on a faulty transferrable skills analysis, and cherry-picked statements from a treating doctor's visit notes. Court found Plaintiff disabled and remanded for an order reinstating benefits. [Calhoun v. Life Insurance Company of North America, No. 15-3470, ___ F.App'x ___, 2016 WL 7241398 \(6th Cir. Dec. 15, 2016\)](#) (BEFORE: DAUGHTREY, ROGERS, and WHITE, Circuit Judges). In *Calhoun*, a long-term disability case, the 6th Circuit Court of Appeals determined that Life Insurance of North America ("LINA") acted arbitrarily and capriciously in denying Calhoun long-term disability benefits, reversed the

district court's judgment in LINA's favor, and remanded the case to the district court for an order reinstating Calhoun's benefits.

On the standard of review, the Court gave more weight to LINA's financial conflict of interest due to its seemingly inconsistent positions that were both financially advantageous: LINA assisted Calhoun with his receipt of Social Security Disability Insurance ("SSDI") benefits and yet failed to address the SSDI award adequately when LINA terminated his LTD benefits claim.

On the merits of the claim, the Court also found that LINA's treatment of the SSDI award weighs in favor of concluding that LINA acted arbitrary and capriciously. LINA encouraged Calhoun to apply for SSDI, financially benefitted from his receipt of SSDI, and then failed to explain why it is taking a position different from the SSA on the question of disability. The Court explained that even if LINA never assisted with Calhoun's arguments or strategy before the SSA, it certainly encouraged Calhoun to apply for SSDI benefits through its "Social Security Assistance Program," where LINA arranged and paid for Calhoun's representation before the SSA. LINA also would have penalized Calhoun by reducing his benefits if he had not pursued a SSA claim. On LINA's argument that it "received no net-benefit from the Social Security Award" because the plan allowed LINA to reduce Calhoun's monthly benefits by his assumed Social Security award if he did not pursue the SSA claim, the Court explained that LINA did benefit financially by Calhoun's pursuit and receipt of SSDI because if his claim had been denied, LINA would not have been able to reduce its monthly payments to him. Lastly, LINA's consideration of the SSDI award was inadequate. LINA noted that it considered the award but rejected it because it was "in receipt of more current medical information than the [SSA] had at the time of their initial determination." The court found that LINA failed to identify the "more current medical information" on which it relied in reaching a contrary decision and also failed to explain why this information warranted the conclusion that Calhoun was not totally disabled. Moreover, the Court found that the evidence post-dating the SSA decision—the peer reviews, the additional video surveillance, and the second and third transferrable-skills analyses—is not substantial evidence supporting the conclusion that LINA's decision was the result of a deliberate, principled reasoning process.

LINA obtained file reviews by Dr. David Trotter and Dr. Elena Antonelli. The Court found that LINA's reliance on file reviews in denying Calhoun's claim also weighs in favor of finding that the decision arbitrary and capricious. Dr. Trotter did not physically examine Calhoun as part of his review, but he nevertheless concluded that there is no credible evidence indicating Calhoun is unable to perform full time sedentary or light level work and he nowhere explained why he believed that the medical evidence did not support Calhoun's claim. The Court found Dr. Antonelli's review similarly inadequate for a number of reasons. Dr. Antonelli noted that a March 2012 functional-capacity analysis "likely reflects the minimum abilities of [Calhoun]" but she did not justify how the evaluation's findings—which concluded that Calhoun would require at least one break every hour for 5-10 minutes from sustained sitting and could

stand for only 15-20 minutes –would justify the conclusion that Calhoun could work on a full-time basis.

The Court reasoned that “[p]articularly because LINA was subject to a conflict of interest, LINA’s decision to utilize file reviews and forego a physical examination, its reliance on the file reviews despite the inadequacies with the reviews, and its failure to explain why it was crediting the file reviewer opinions over that of a treating physician collectively weigh in favor of finding that LINA’s denial of Calhoun’s claim was arbitrary and capricious.”

On the other evidence supporting LINA’s termination of benefits –the transferrable-skills analyses, the third round of video surveillance, and doctor visit notes – the Court found all of this evidence to be either discredited or inadequate to explain the termination of Calhoun’s benefits. The transferrable-skills analyses were based solely on the Trotter and Antonelli file reviews. The video surveillance is not inconsistent with Calhoun’s reported limitations, nor does it demonstrate that Calhoun is capable of working on a full-time basis. In six days of surveillance, PhotoFax viewed a total of less than thirty minutes of notable activity. Lastly, LINA cherry-picked statements in Calhoun’s doctor visit notes and ignored statements supporting his claim. And although a physical-ability assessment accompanying the functional-capacity analysis indicated that Calhoun could sit “frequently,” the Court noted that this capacity to sit does not establish that he can work on a full-time basis, especially with his demonstrated restrictions in standing and walking. The district court found “troubling several aspects of LINA’s review of [Calhoun’s] claim,” but nevertheless found in favor of LINA because it felt “constrained by the extremely deferential arbitrary and capricious standard.” The 6th Circuit explained that “[t]his deferential standard of review, however, does not serve as a ‘rubber stamp’ for the plan administrator’s decision.” Because the objective medical evidence supported Calhoun’s disability, the Court remanded this case to the district court for reinstatement of Calhoun’s disability benefits from the date that they were terminated.

The court granted Prudential’s motion for judgment on the administrative record, finding that its denial of long-term disability benefits was supported by three different “independent” reviewing physicians. The court rejected Plaintiff’s argument that Prudential erred by only requesting records for the previous twelve months. Plaintiff’s last day of work was March 26, 2012 and the records retained by Prudential comprised of time periods both before and after Plaintiff’s last day of work. “Second, a long range review of Plaintiff’s medical records could actually result in an arbitrary and capricious review. For example, had Prudential sought medical records for the past ten years, the records would have shown that Plaintiff worked with her diagnosed conditions for almost ten years before filing her claim. Armed with this information, the Administrator could have more easily dismissed Plaintiff’s claim for benefits without a reasoned, deliberate review.” [Maher v. Prudential Ins. Co. of Am., No. 1:14CV2777, 2016 WL 7227881 \(N.D. Ohio Dec. 14, 2016\)](#) (Judge Christopher A. Boyko).

Liberty Life did not act arbitrarily or capriciously in denying Plaintiff's LTD benefits under its "Any Occupation" disability review, where the record shows that Liberty evaluated the conclusions of six medical experts who supported the claim that Plaintiff could engage in full-time employment. Although Liberty did not mention Plaintiff's age in any of its denial letters, each of the experts did note his age in conducting their reviews. The court found that there was no record evidence contradicting Liberty's vocational assessment that Plaintiff possesses transferable skills that could enable him to obtain light or sedentary work. Liberty expressly discussed the Social Security Administration's determination and there are no explicit findings by the SSA that Liberty was required to specifically address. [Leppert v. Liberty Life Assurance Co. of Boston, No. 16-3387, ___ F.App'x ___, 2016 WL 6958641 \(6th Cir. Nov. 29, 2016\)](#) (BEFORE: DAUGHTREY, CLAY, and COOK, Circuit Judges).

The court concluded that there was no Permanent Total Disability ("PTD") benefit available under the Chrysler LLC's Voluntary Group Accident Insurance Program, thus there was no wrongful denial of PTD benefits to Plaintiff. Here, the 2002 SPD included a PTD benefit, but a SPD issued in 2007 did not include a PTD benefit. No SMM was required to be issued because a new SPD was issued in 2007 and the MetLife Certificate of Insurance does not contain a PTD Benefit. [Butler v. FCA US, LLC, No. 14-14752, 2016 WL 6679828 \(E.D. Mich. Nov. 14, 2016\)](#) (Judge Sean F. Cox).

In lawsuit alleging wrongful denial of long-term disability benefits under ERISA Section 502(a)(1)(B), the court granted partial summary judgment to Liberty on Plaintiff's ERISA Section 1132(a)(3) claims for breach of fiduciary duty and "make whole relief" since Plaintiff failed to set forth evidence of an injury separate and distinct from the denial of her benefits. [Milby v. Liberty Life Assurance Co. of Boston, No. 313CV00487CRSCHL, 2016 WL 6699281 \(W.D. Ky. Nov. 14, 2016\)](#) (Judge Charles R. Simpson).

In denying Plaintiff's short-term disability benefits claim, the Plan abused its discretion where it failed to make a reasonable effort to speak with treating physicians, selectively reviewed and misinterpreted Dr. Friedman's report (a reviewing physician for the Plan), made credibility determinations about Plaintiff's continuous reports of pain without having her physically examined, and relied heavily on non-treating physician consultants, including Dr. Jamie Lee Lewis. [Filthaut v. AT&T Midwest Disability Benefit Plan, No. 15-CV-12872, 2016 WL 6600038 \(E.D. Mich. Nov. 8, 2016\)](#) (Judge Gershwin A. Drain).

Where the only question is whether Connelly was disabled before coverage ended in July 2011, Standard did not arbitrarily deny his long-term disability claim, where the two statements of Connelly's treating physicians recalling his condition were recorded over a year after coverage ended and the records contemporaneous to that July 2011 time frame provide little or no support for the claim that Connelly was being treated for severe Crohn's disease flare-ups. His diagnosis during the coverage period is not determinative of

whether those conditions prevented him from working before coverage ended. [Connelly v. Standard Insurance Company, No. 16-3036, ___ F.App'x ___, 2016 WL 5754176 \(6th Cir. Oct. 4, 2016\)](#) (BEFORE: SUTTON and STRANCH, Circuit Judges; STEEH, District Judge).

On *de novo* review of Plaintiff's long-term disability benefit denial, granting Plaintiff's motion for judgment. Plaintiff worked in the operation of welding machinery and became disabled due to lumbar radiculopathy, rotator cuff syndrome, and a number of other conditions. The court found that the transferable skills analyses (TSAs) and paper review conducted by UDC are unreliable. United failed to give the treating doctor opinions due consideration and unreasonably gave great weight to a medical opinion that was neither the result of treatment nor examination. One of the jobs listed in the TSA, surveillance-system monitor, was taken over by Homeland Security. Further, casinos security monitoring jobs now require more experience and qualifications, and usually involve more than sedentary work. [Mokbel-Aljahmi v. United of Omaha Life Ins. Co., No. 15-12537, 2016 WL 5661585 \(E.D. Mich. Sept. 30, 2016\)](#) (Judge Victoria A. Roberts).

It was not arbitrary and capricious for Liberty Life to fail to address any potentially applicable federal safety regulations in determining whether Plaintiff was disabled under the Policy. [Rothe v. Duke Energy Long Term Disability Plan, No. 1:15CV211, 2016 WL 5661686 \(S.D. Ohio Sept. 30, 2016\)](#) (Judge Michael R. Barrett).

Plaintiff is entitled to prejudgment interest because benefits incorrectly were withheld and he is entitled to prejudgment interest up to the entry of this Order. The court adopts the interest rate method it employed in *Pipefitters Local 636 Fund v. Blue Cross Blue Shield of Michigan*, No. 04-73400, 2012 WL 3887174 (E.D. Mich. Sept. 7, 2012), *aff'd sub nom. Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Michigan*, 722 F.3d 861 (6th Cir. 2013) for determining prejudgment interest, which awards interest based on five-year Treasury rates plus one percent, in accordance with MCL § 600.6013. [Rochow v. Life Ins. Co. of N. Am., No. 04-73628, 2016 WL 5476240 \(E.D. Mich. Sept. 29, 2016\)](#) (Judge Arthur J. Tarnow).

There is no financial conflict of interest where Sedgwick makes independent claims decisions and AT&T funds the disability plan. The Plan's use of an "objective" standard is appropriate. Although Plaintiff was diagnosed with Grave's disease and hyperthyroidism, the only evidence her doctor provided regarding any impairment was her high blood pressure, which was insufficient to show that she could not work anymore. The Plan did not abuse its discretion in denying Plaintiff's short-term disability benefits. [Logan v. AT&T Umbrella Benefit Plan No. 3, No. 4:15CV1205, 2016 WL 5462972 \(N.D. Ohio Sept. 28, 2016\)](#) (Judge Benita Y. Pearson).

Granting Reliance's Motion for Judgment on the Administrative Record, finding that it did not abuse its discretion in terminating Plaintiff's LTD claim after it had paid the claim for

about six years. Reliance took a position contrary to SSA but the SSA decision was based on different facts and incomplete information. Also, Reliance could consider Plaintiff's Facebook posts detailing several vacations and participation in paranormal investigations, even though its denial of Plaintiff's claim and appeal did not reference its social media investigation. Plaintiff could have provided objective evidence of her disability caused by fibromyalgia and chronic fatigue syndrome via a functional capacity evaluation. However, she failed to satisfy her burden to show that she remained totally disabled. [Austin-Conrad v. Reliance Standard Life Ins. Co., No. 4:14-CV-00127-JHM, 2016 WL 5400366 \(W.D. Ky. Sept. 26, 2016\)](#) (Judge Joseph H. McKinley, Jr.).

Plaintiff's alleged injury—the denial of benefits—can be remedied by Section 502(a)(1)(B) and no discovery is necessary to make this determination. Because Plaintiff has failed to offer any evidence to show an injury separate and distinct from the denial of benefits or show why the remedy under Section 502(a)(1)(B) is inadequate, the court grants Liberty Life's motion for partial summary judgment and dismisses Plaintiff's Section 502(a)(3) claim. [Owens v. Liberty Life Assurance Company of Boston, No. 4:15CV-00071-JHM, 2016 WL 4746212 \(W.D. Ky. Sept. 12, 2016\)](#) (Judge Joseph H. McKinley, Jr.).

Granting MetLife's motion for summary judgment since Plaintiff supplied no records indicating that he had been treated by a specialist in psychiatry at the time of the alleged onset date and did not establish disability resulting from anxiety beginning on the alleged onset date; rejecting Plaintiff's argument that his lack of income rendered him unable to afford medical care since the Plan required him to have already been under the regular care of a psychiatrist at the time of the alleged disability onset. [Young v. Metro. Life Ins. Co., No. 2:15-CV-11028, 2016 WL 4926169 \(E.D. Mich. Sept. 16, 2016\)](#) (Judge Marianne O. Battani).

Reliance bears the burden to show that the Mental and Nervous Disorder Limitation applies to the claim. For the Mental and Nervous Disorder Limitation to apply, the mental disability must be a "but-for" cause of the total disability. In other words, the limitation will not apply if physical disabilities independently render the claimant totally disabled. Claim denial was not based on substantial evidence where Reliance: (1) relied solely on file reviews for a claim involving a mental illness component; (2) failed to consult with a medical professional with relevant expertise; (3) arbitrarily refused to consider the opinions of treating physicians; and (4) offered shifting rationales in support of its denial over the course of the appeals process. Matter remanded for determination of whether physical disabilities entitle Plaintiff to benefits. [Okuno v. Reliance Standard Life Ins. Co., No. 15-4043, ___ F.3d ___, 2016 WL 4655741 \(6th Cir. Sept. 7, 2016\)](#) (Before: DAUGHTREY, CLAY, and STRANCH, Circuit Judges). Reliance Standard terminated Okuno's long-term disability benefits on the basis that depression and anxiety "contributed to" Okuno's disabling conditions. The district court found in favor of Reliance on cross motions for judgment on the administrative record, but the Sixth Circuit reversed and remanded the case for further proceedings. The Sixth Circuit noted that every federal circuit to consider the meaning of the phrase "caused by or

contributed to by,” in the Mental or Nervous Disorders Limitation has read it to exclude coverage only when the claimant’s physical disability was insufficient to render him totally disabled. The Sixth Circuit agreed with Okuno that because her physical ailments, including Crohn’s disease, narcolepsy, and Sjogren’s syndrome, are disabling when considered apart from any mental component, she is entitled to recover long-term disability benefits.

The court determined that Reliance acted arbitrarily and capriciously in determining that Okuno’s physical conditions were not disabling. Reliance’s decision was not based on substantial evidence where it relied solely on file reviews for a claim involving a mental illness component, failed to consult with a medical professional with relevant expertise, arbitrarily refused to consider the opinions of treating physicians, and offered shifting rationales in support of its denial over the course of the appeals process.

After having represented hundreds of participants suffering from disabling physical conditions, I can say that it’s very common for people to develop depression and anxiety as a result of constant pain or fatigue, being unable to work, and losing many social connections. If the mere presence of a psychiatric impairment limited receipt of disability benefits, most people would be denied benefits beyond the limitation’s maximum pay period (which is typically only two years). Disability claimants are often fearful to have their depression or other mental condition treated lest the insurance company attempt to claim that their disability is subject to a limited pay period. This is the last thing people should be worrying about when they are physically unable to work. Thanks to the Circuit Courts for making this battle easier.

Granting United of Omaha’s motion for summary judgment where the court determined there are inconsistencies in Plaintiff’s medical records that suggest he is downplaying his capabilities, including that during a Functional Capacity Evaluation, Plaintiff claimed that as a result of his back pain he needed help dressing, putting on socks, and undergarments, yet, at a another Independent Medical Examination, Plaintiff was able to dress and undress without difficulty, and walk across the examination room without difficulty. [Gayer v. United of Omaha Life Ins. Co., No. 15-11202, 2016 WL 4608174 \(E.D. Mich. Sept. 6, 2016\)](#) (Judge Denise Page Hood).

Determining that Hartford did not abuse its discretion when it denied Plaintiff’s long-term disability claim, where Hartford Life relied upon the opinions of three file reviewers and two of Plaintiff’s own doctors to conclude that the objective evidence in Plaintiff’s file did not support a finding of disability. Hartford’s determination that Plaintiff’s disability was pre-existing was not arbitrary and capricious where there is evidence in the administrative record that Plaintiff’s back condition and associated pain existed during the relevant time period. [Wilson v. Hartford Life & Accident Ins. Co., No. 14-CV-14741, 2016 WL 4537832 \(E.D. Mich. Aug. 31, 2016\)](#) (Judge Laurie J. Michelson).

LINA’s denial of long-term disability benefits was not an abuse of discretion. Although SSA found Plaintiff disabled, LINA was operating on more current and complete information than SSA because it had nearly nine months of additional information and the

SSA standards are not binding on LINA. Under the Plan's own terms, LINA had to consider whether Plaintiff could retrain into a new position, which it determined that he could based on his prior managerial experience. [Kemper v. Life Ins. Co. of N. Am., No. CV 15-82-DLB-CJS, 2016 WL 4573911 \(E.D. Ky. Aug. 31, 2016\)](#) (Judge David L. Bunning).

Finding that termination of LTD benefits was not arbitrary and capricious; Liberty Life was not responsible for obtaining medical records; whether Plaintiff would be able to find a job is not the standard for disability under the policy; Liberty Life did not totally ignore the available opinions of Plaintiff's treating physicians and they appeared to have similar opinions about Plaintiff's functional capacity; a file review, versus a physical examination, was sufficient in this case. [Demeritt v. Liberty Life Assurance Co. of Boston, No. 1:15CV146, 2016 WL 4494398 \(S.D. Ohio Aug. 26, 2016\)](#) (Judge Michael R. Barrett).

Affirming summary judgment in favor of the Plan and finding that Plaintiff had not furnished objective medical evidence establishing her disability from her chronic pain condition, where several of her treating physicians indicated that she could work and Dr. Philip Marion (alleged independent doctor retained through GENEX), concluded that no medical information supports Plaintiff's inability to work. [Saunders v. Procter & Gamble Health and Long-Term Disability Benefit Plan, No. 16-3043, F.App'x , 2016 WL 4435643 \(6th Cir. Aug. 23, 2016\)](#) (BEFORE: BATCHELDER and KETHLEDGE, Circuit Judges; LEVY, District Judge).

Ordering Aetna to pay Plaintiff the long-term disability benefits for which he is qualified under the Total Disability definition of the Plan, and finding that: (1) Aetna relied on file reviews which disregarded the extensive complaints of severe pain recognized by Plaintiff's treating physicians; (2) Aetna's physicians, Dr. Martin Mendelssohn, Dr. James Wallquist, and Dr. John P. Shallcross are all repeat players among ERISA benefit plan administrators, which is a factor weighing against Aetna; and (3) Aetna did not adequately explain why the SSA's decision to award Plaintiff SSDI benefits should be distinguished. [Mendez v. FedEx Express, No. 15-CV-12301, 2016 WL 4429598 \(E.D. Mich. Aug. 22, 2016\)](#) (Judge Judith E. Levy).

Following previous remand to the district court to award Plaintiff disability retirement benefits, affirming the district court's decision in favor of the Plan Administrator, which found Plaintiff entitled to \$0 after offsetting his previous Workers' Compensation redemption against the disability retirement benefits owed him; rejecting Plaintiff's claims that Means forfeited this offset defense by failing to plead it or brief it on summary judgment since Plaintiff had notice of the offset defense and ample opportunity to rebut it. [Kennard v. Means Industries, Inc., No. 15-1872, F.App'x , 2016 WL 4410576 \(6th Cir. Aug. 19, 2016\)](#) (BEFORE: MOORE and COOK, Circuit Judges; GWIN, District Judge).

Concluding that United of Omaha’s termination of long-term disability benefits was not arbitrary and capricious where substantial evidence supported its determination that Plaintiff’s specific pattern of disabling narcotic use meets the definition of “Substance Abuse” under the plan. In this case, Plaintiff’s lupus and fibromyalgia were treated with opiates under her physicians’ supervision but an IME concluded that her disability was caused by opioid hyperalgesia. [Blount v. United Of Omaha Life Insurance Company, No. 3:15-CV-00876, 2016 WL 4191725 \(M.D. Tenn. Aug. 8, 2016\)](#) (Judge Aleta A. Trauger).

Affirming district court’s dismissal of Plaintiff’s long-term disability claim, finding that Unum’s reliance on medical opinions from at least 11 doctors (5 said she could work and five others declined to opine because they were not actually treating her) and surveillance evidence showing Plaintiff driving, walking, smoking, using her cell phone, and doing other routine activities, all without assistance and showing no obvious symptoms of dizziness, tremors, or pain, was not an abuse of discretion. [Crox v. UNUM Group Corp., No. 15-6006, ___F.App’x ___, 2016 WL 3924245 \(6th Cir. July 21, 2016\)](#) (Before: BOGGS, SILER, and BATCHELDER, Circuit Judges).

Granting U.S. Life’s motion for entry of judgment on the administrative record on Plaintiff’s long-term disability claim. [Temponeras v. United States Life Ins. Co. of Am., No. 1:14-CV-700, 2016 WL 2594846 \(S.D. Ohio May 5, 2016\)](#) (Judge Sandra S. Beckwith).

Plaintiff’s purported state law negligence *per se* claim, construed as one brought pursuant to ERISA, has not set forth a viable claim for relief against AllMed Healthcare Management, Inc.; granting motion to dismiss. [Hackney v. Allmed Healthcare Management, Inc., No. 3:15-CV-00075-GFVT, 2016 WL 1726098 \(E.D. Ky. Apr. 28, 2016\)](#), judgment entered, No. 3:15-CV-00075-GFVT, 2016 WL 1728963 (E.D. Ky. Apr. 28, 2016) (Judge Gregory F. Van Tatenhove).

“[T]he TPA’s reliance on file reviews that improperly questioned plaintiff’s credibility and which did not sufficiently support the denial of benefits, its rejection of the opinions of plaintiff’s treating medical providers, its failure to adequately consider the number and nature of plaintiff’s medications, and its failure to consider the specific requirements of plaintiff’s job lead to the conclusion that the denial of plaintiff’s claim for benefits was arbitrary and capricious. Stated differently, it was the ‘cumulative effect’ of these factors, rather than any single factor, that results in a finding that the TPA’s decision was arbitrary and capricious.” [Groth v. Centurylink Disability Plan, No. 2:13-CV-1238, 2016 WL 1621724 \(S.D. Ohio Apr. 25, 2016\)](#) (Magistrate Judge Norah McCann King).

Plaintiff’s Section 1132(a)(3) claim does not allege an injury separate and distinct from the denial of benefits or that the remedy afforded by Congress under Section 1132(a)(1)(B) is

otherwise inadequate. [Klein v. Aetna Inc. Long Term Disability Benefits Plan Defendant, No. 3:15-CV-00742-GNS, 2016 WL 1629376 \(W.D. Ky. Apr. 22, 2016\)](#) (Judge Greg N. Stivers).

Termination of long-term disability benefits to claimant with systemic lupus erythematosus (SLE) and fibromyalgia is not an abuse of discretion; state law claims dismissed as preempted by ERISA. [Brookbank vs. Anthem Life Insurance Company, No. 1:15-CV-165, 2016 WL 1611380 \(S.D. Ohio Apr. 20, 2016\)](#) (Judge Karen L. Litkovitz).

Because claim for breach of contract under § 1132(a)(1)(B) provides adequate relief for Plaintiff's only alleged injury, Hartford's denial of his disability benefits, his claims for breach of fiduciary duty and disgorgement must fail as a matter of law. [Davis v. Hartford Life & Accident Insurance Company, No. 3:14-CV-00507-TBR, 2016 WL 1574151 \(W.D. Ky. Apr. 19, 2016\)](#) (Judge Thomas B. Russell).

Liberty Life abused its discretion by failing to consider diagnoses -- pudendal neuralgia and pelvic floor muscle dysfunction -- associated with pain while sitting and treating doctor's letter. [Cannon v. PNC Financial Services Group and Affiliates Long Term Disability Plan, No. 15-6010, ___F.App'x___, 2016 WL 1381874 \(6th Cir. April 7, 2016\)](#) (Before: MERRITT, SUHRHEINRICH, and DONALD, Circuit Judges).

United of Omaha Life Insurance Company acted arbitrarily and capriciously in denying Lyme disease disability claim; remedy is remand for full and fair review. [Myers v. Mutual of Omaha Life Insurance Company, No. 4:14CV2421, 2016 WL 1223278 \(N.D. Ohio Mar. 29, 2016\)](#) (Judge Benita Y. Pearson). The court found that United of Omaha Life Insurance Company abused its discretion in denying Plaintiff's claim for long-term disability benefits, where Plaintiff suffers from chronic active Lyme disease. Dr. Joseph, Plaintiff's treating doctor, informed Defendant that Plaintiff consistently reported Lyme disease symptoms that varied in severity by month yet were nonetheless being actively treated by him and resulted in workplace restrictions. Although United was not required to accept Dr. Joseph's conclusions, it must explain why it chose to believe its non-treating physicians, Ms. Beumer-Anderson and Dr. Crossley. Although the court agreed with United that a plan administrator is permitted to choose between two competing views of disability and have that decision upheld under arbitrary and capricious review, the court's review is not only the insurer's conclusion, but also its reasoning. Here, the court took issue with United's reasoning since it denied benefits based on a selective review of Dr. Joseph's treatment notes, quoting language favorable to the non-disability assessment while inadequately explaining its basis for rejecting Dr. Joseph's observations favorable to Plaintiff. Because the court found this "perversion of process" enough to justify remand, it did not find it necessary to also determine whether United's decision was also borne of a conflict of interest. The court remanded the claim to the plan administrator to consider all the evidence of Lyme disease. Because United only selectively addressed portions of Dr.

Joseph's treatment notes, the court found it impossible to determine whether Plaintiff will ultimately be found to be disabled.

MetLife was arbitrary and capricious by ignoring reliable, objective evidence from Plaintiff's treating physicians. [Zuke v. Am. Airlines, Inc., No. 15-3465, Fed.Appx., 2016 WL 1258220 \(6th Cir. Mar. 31, 2016\)](#) (BOGGS and DONALD, Circuit Judges; HOOD, District Judge). The Sixth Circuit vacated the district court's judgment in favor of the Plan and MetLife and remanded the case to allow MetLife to make a full and fair inquiry on Plaintiff's long-term disability benefit claim. The court found that MetLife acted arbitrarily and capriciously by ignoring reliable, objective evidence from Plaintiff's treating physicians on her condition. In denying the LTD benefits, MetLife stated that there were no measurements of range-of-motion restrictions; no specific physical examinations to indicate functional impairment; and no neurological and motor strength testing. But, the court found that Plaintiff provided all of that information in the medical records. The court found that making factually incorrect assertions in combination with selectively reviewing a claimant's records supports a finding that the plan administrator acted arbitrarily and capriciously. Here, the Plan's conclusion that there was no objective evidence directly contradicts the record: Plaintiff's cervical and lumbar MRIs indicate "fairly extensive degenerative disc disease" and a "new disc herniation;" Plaintiff's positive Spurling test results indicate radicular pain; and finally, the record contains a physician's notes on the reduced range of motion over the right shoulder. The court also found that MetLife dismissed objective findings related to Plaintiff's pain and ignored key objective evidence. Without examining Plaintiff or providing any supporting evidence of its own, MetLife made conclusory credibility determinations questioning Plaintiff's treating physician's findings such as "the records did not [include] documentation of any neurological abnormalities, which would cause the claimant impairment" and "returning to work would, in fact, likely ameliorate Plaintiff's ongoing complaints of pain."

Termination of LTD benefits to hourly employee not eligible for LTD coverage is not arbitrary and capricious; court may consider extra-record affidavit to determine applicable standard of review. [Justice v. Reliance Standard Life Ins. Co., No. 2:15-CV-134, 2016 WL 1175210 \(E.D. Tenn. Mar. 24, 2016\)](#) (Judge J. Ronnie Greer). Reliance Standard terminated Plaintiff's long-term disability benefit payments when it discovered that Plaintiff, as an hourly employee, was not covered for LTD benefits under his former employer's plan and that Defendant had mistakenly been paying LTD benefits which Plaintiff was not entitled to receive. Defendant produced a copy of the LTD benefits policy, but it only has the signature of Reliance Standard's executives and not a signature of a policyholder executive. Some of the letters from Defendant's employee claims adjuster were printed on letterhead of Matrix, a company with the same parent company as Defendant, as opposed to Reliance Standard letterhead. However, the claims adjuster submitted an affidavit stating that the wrong letterhead was used due to a computer coding glitch, but that she, as an employee of Reliance Standard only, made the benefits eligibility decision. Magistrate Judge Corker found that the arbitrary and

capricious standard of review should apply because the submitted plan gave the requisite discretionary authority to Defendant to determine benefit eligibility and because Reliance Standard, not another entity, made the final eligibility determination. Plaintiff filed objections to the Report and Recommendation, which the court overruled. The court found that it was proper to consider the extra-record affidavit which verified the applicability of the LTD policy as well as confirmed that a Reliance Standard employee made the benefits appeal decision. The court rejected Plaintiff's argument that the affidavit fails to meet the business records requirement of FRE 803(6) and cannot be considered. The court found that the affidavit did not have to meet the business records exception in order for the court to consider the submitted plan because a copy of that plan was already before the court in the administrative record. Further, the affidavit sufficiently showed that the affiant has personal knowledge of her employment history, her appeal determination of Plaintiff's disability claim, and Reliance Standard's computer system.

Denial of LTD benefits is an abuse of discretion where Liberty Life relied on faulty paper reviews and in-person medical evaluation and failed to consider mental health component of claim. [Brainard v. Liberty Life Assurance Company of Boston, No. CV 6: 14-110-DCR, 2016 WL 1171542 \(E.D. Ky. Mar. 24, 2016\)](#) (Judge Danny C. Reeves). The court found that Liberty Life's decision to deny Plaintiff benefits was arbitrary and capricious. Plaintiff was injured in an automobile accident and began experiencing neck and back pain. He alleged that the pain, combined with depression and side effects of medication, left him unable to do his job at Community Trust Bancorp, where he worked as a branch manager. In denying Plaintiff's second appeal, Liberty relied, in part, on the file review conducted by psychiatrist, Dr. Sanjay Chandragiri, who opined that there are no psychiatric diagnoses supported by medical evidence. The court found that Dr. Chandragiri failed to consider important evidence submitted to Liberty Life months before his report. The court further found that Liberty Life had no apparent reason to credit Dr. Chandragiri's report over Plaintiff's psychiatrist's objective findings and personal examination of Plaintiff. The court rejected Liberty Life's contention that because Plaintiff never mentioned depression in his initial telephone interview with Liberty Life that it was not required to consider his depression. The court noted that the Sixth Circuit concluded in another case that a plaintiff's failure to initially list a resulting illness or injury does not excuse a plan administrator from considering it. The court also rejected Liberty Life's reliance on the SSA's rejection of Plaintiff's claims of depression when it concluded that Plaintiff was not disabled. The court reasoned that the arbitrary and capricious standard still requires Liberty Life to reach a reasoned decision based on all of the medical evidence before it. Liberty Life also had Plaintiff evaluated in person by Dr. Ellen Ballard, who concluded that Plaintiff would be capable of light physical activity since she is unable to explain the severity of his symptoms but if he is having to use large quantities of pain medication to treat his pain then this could affect this ability to work. Dr. Ballard noted that Plaintiff was not taking large quantities of pain medication at the present time. One of Plaintiff's treating doctors notified Liberty Life that Plaintiff was taking more pain medication with side effects that hampered his ability to work. As a result, the court found that Dr. Ballard's report was entitled to significantly less weight. On Plaintiff's second appeal,

Liberty Life had Plaintiff's claim reviewed by Dr. Howard Grattan. The court found that Liberty Life's reliance on his report inappropriate where it contained eleven pages of a report and outline summarizing the medical evidence and only a half-page of analysis. Neither Dr. Ballard nor Dr. Grattan addressed all of Plaintiff's mental health issues. Since the court found that Liberty Life did not address whether Plaintiff is incapable of performing the material and substantial duties of *any* occupation with reasonable continuity, the court remanded the claim back to Liberty Life.

Denial of LTD benefits not an abuse of discretion; miscalculation of benefits claim dismissed for failure to exhaust. [Leppert v. Liberty Life Assurance Co. of Boston, No. 2:14-CV-1207, 2016 WL 1161957 \(S.D. Ohio Mar. 24, 2016\)](#) (Judge James L. Graham). Plaintiff, in his late fifties, was employed by Triumph Aerospace Systems repairing aircraft windows before he became disabled from osteoarthritis and joint problems. He filed a claim for LTD disability benefits, which Liberty Life approved on the basis that he could not perform his own occupation. Plaintiff subsequently became eligible to receive SSDI benefits, but Liberty Life denied his LTD claim when the definition of disability changed to the inability to perform "any occupation." The court concluded that Liberty did not act arbitrarily and capriciously in determining that Plaintiff was no longer entitled to disability benefits under the Policy. Specifically, Liberty Life relied on several expert medical opinions and the findings of a certified rehabilitation counselor. The court found that Liberty Life was not obligated to demonstrate that a suitable position at a particular wage existed in a given geographic area and was available for Plaintiff's immediate hire. Liberty Life was also not bound by the Social Security Administration's determination. Liberty Life stated in its appeal denial letter that it had considered the fact that Plaintiff had been awarded social security disability income, that this award was not determinative of Plaintiff's entitlement to benefits under the Policy, and that Liberty had considered additional medical and vocational reviews, as well as more current medical records, that were not considered by the Social Security Administration. On Plaintiff's second count alleging that Liberty Life miscalculated his benefits, the court dismissed it without prejudice for failure to exhaust administrative remedies.

Although state law bars discretionary language in the disability policy, it does not bar grants of discretion in the Summary Plan Description or Plan Document. [Rose v. Liberty Life Assurance Co. of Boston, No. 3:15-CV-28-DJH-CHL, 2016 WL 1178801 \(W.D. Ky. Mar. 23, 2016\)](#) (Judge David J. Hale). The issue before the court is which standard of review it should apply in its examination of Liberty Life's decision to deny Plaintiff's long-term disability benefits. The policy documents do not contain discretionary language because Michigan law prohibits discretionary clauses in such policies. But, the Plan Document and Summary Plan Description (SPD) contain clear grants of discretion. The court agreed with the reasoning in *Hess v. Metro. Life. Ins. Co.*, 91 F. Supp. 3d 895, 900 (E.D. Mich. 2015) and *Markey-Shanks v. Metro. Life Ins. Co.*, No. 1:12-CV-342, 2013 U.S. Dist. LEXIS 102412, at *17 (W.D. Mich. July 23, 2013), and concluded that Michigan Administrative Code Rule 500.2202 does not bar grants of discretion in an SPD or plan document. Because the SPD and Plan Document in this case

expressly grant discretionary authority to Liberty Life with respect to denial of benefits, the court concluded that the denial of Plaintiff's claim should be reviewed under the arbitrary and capricious standard. The court rejected Plaintiff's judicial-estoppel argument based on the assertion that Liberty Life conceded in previous cases that the Michigan administrative rules apply to insurance policies. Here, Liberty Life did not dispute that the rules apply to the policy, rather, it contends that the rules do not bar the grant of discretion in the SPD and Plan document.

Disability plan properly offset retirement benefits a claimant was eligible to receive but did not receive because he withdrew his application. [Abbott v. Ford Motor Co. Salaried Disability Plan, No. 14-CV-11778, 2016 WL 1104464 \(E.D. Mich. Mar. 22, 2016\)](#) (Judge Matthew F. Leitman). The court found in favor of Defendant on the issue of whether it properly reduced disability benefits by an amount that Plaintiff was eligible to receive in retirement benefits. The Plan provides that (1) disability benefits may be reduced by the amount of retirement benefits a participant is eligible to receive, and (2) it is presumed that a participant is eligible to receive retirement benefits unless he proves otherwise by applying for, and being denied, such benefits. Here, Plaintiff did not present to the Appeals Committee proof that he had applied for, and been denied, retirement benefits. Thus, the court found that the Appeals Committee had every right under the Plan to uphold (1) the presumption that Plaintiff was eligible for retirement benefits, and (2) the reduction to Plaintiff's disability benefits by the amount of retirement benefits to which he was presumptively entitled. The court rejected Plaintiff's argument that the Appeals Committee should have excused his withdrawal of his application for retirement benefits because he was suffering from a serious mental illness at the time of the withdrawal. First, Plaintiff never asked the Appeals Committee to excuse the withdrawal of his application for retirement benefits on the basis that he suffered from a mental illness. Second, the case law that Plaintiff relies upon is inapposite because each of the cases Plaintiff cited addressed whether a plaintiff's failure to take an affirmative action by a specified deadline should be excused due to a mental illness. Here, Plaintiff, while represented by counsel, did timely file his application for retirement benefits but he later withdrew his application.

Disability claim properly denied under plan's exclusion for work-related illnesses. [Foltz v. Barnhart Crane & Rigging, Inc., No. 15-5907, Fed.Appx. , 2016 WL 796965 \(6th Cir. Feb. 29, 2016\)](#) (Before KEITH, COOK, and McKEAGUE, Circuit Judges.) The court affirmed the district court's grant of judgment to the Fund on Plaintiff-Appellant's claim for disability benefits on the basis that his illness was work-related. Plaintiff's illness was listed as acute respiratory distress syndrome (ARDS) due to chemical pneumonitis. On the claim form, his daughter answered "Yes (possibly)" when asked whether Plaintiff's disability was due to his occupation. On the attending physician's statement, the nurse practitioner noted that the primary diagnosis was ARDS and the secondary diagnoses were chemical pneumonia and acute renal failure and that the condition was due to injury or illness arising out of Plaintiff's employment. The Fund's plan includes an exclusion whereby no benefits will be payable for charges incurred

as the result of a disease or sickness or illness for which benefits are payable under any Worker's Compensation Act or any Occupational Disease Act or any such similar law. The court found that the only evidence in the administrative record supports the conclusion that Plaintiff's illness was work-related and covered by the Tennessee Workers' Compensation Law, rather than the Fund's insurance plan.

Claims administrator without final authority to determine a claim is not a proper party to a benefits claim. [Corey v. Sedgwick Claims Mgmt. Servs., No. 1:15 CV 1736, 2016 WL 775382 \(N.D. Ohio Feb. 29, 2016\)](#) (Judge Patricia A. Gaughan). On Plaintiff's short and long-term disability claims against Defendants Sedgwick Claims Management Services and Eaton Corporation Disability Plan for U.S. Employees, the court dismissed the denial of benefits claims against Sedgwick for not being a proper party. The court found that while Sedgwick had the authority to make a first and second-level determination on Plaintiff's claim, the Benefits Committee was the entity to which plaintiff appealed Sedgwick's denial and was the entity that retained final authority to determine if a claim should be paid. Under *Briscoe v. Fine*, Sedgwick is not a fiduciary with respect to Plaintiff's denial of benefits claims. Plaintiff also brought a breach of fiduciary duty claim against Defendants for not allowing Plaintiff "access to proceed with his Long Term Disability application—win or lose." Plaintiff claims that Defendants' failure to provide him with the long term disability application led to the denial of such benefits, and his breach of fiduciary duty claim seeks redress for that injury. The court found that this claim aims to redress the same injury as the denial of benefits claim and is not permitted.

Termination of benefits based on mischaracterization of FCE results is an abuse of discretion. [Coulter v. Aetna Life Ins. Co., No. 14-CV-14404, 2016 WL 759341 \(E.D. Mich. Feb. 26, 2016\)](#) (Judge Mark A. Goldsmith). The court found that Alcoa's Benefits Appeals Committee abused its discretion in upholding Aetna's termination of Plaintiff's long-term disability benefits because it rested on a mischaracterization of the medical evidence that was the basis for a reviewing physician's conclusion that Plaintiff was not disabled under the terms of the plan. The reviewing physician mischaracterized a prior FCE as showing Plaintiff qualified to perform "light-to-medium" work, when in fact it showed Plaintiff capable only of "sedentary" work. The court found that this error impacts the vocational inquiry required by the "any occupation" standard and undermines the reasonableness of the Committee's final decision, particularly when the other medical evidence of record suggests that she cannot. The court found that remand is required so that the plan administrator can consider Plaintiff's claim for benefits anew, without mischaracterization of Plaintiff's capabilities.

Aetna did not abuse its discretion in denying "any occupation" benefits to former sales compliance consultant; Michigan state law does not void discretionary language. [Mendelblatt v. Aetna Life Ins. Co., No. 14-CV-12140, 2016 WL 692526 \(E.D. Mich. Feb. 22, 2016\)](#) (Judge Gerald E. Rosen). In this dispute involving a denied long-term disability benefit claim under the "any occupation" definition of disability, the court determined that the arbitrary and capricious standard governs its review. The group policy in question here was issued on

March 30, 2007, which is before the effective date of Michigan Administrative Code R. 500.2201-2202, and was never revised thereafter in any respect. Mich. Admin. Code R. 500.2202 does not apply to policies that were not amended on or after June 1, 2007. Thus, the court concluded that Mich. Admin. Code R. 500.2202 does not void the discretionary clause in the Auto Club LTD Plan. The court found that Aetna did not abuse its discretion in denying benefits. Here, surveillance and an investigation showed Plaintiff being “active”, including golfing 20 times in 2 months with golf scores ranging from 75 to 88. When this information was presented to Plaintiff’s doctor, he expressed “surprise” to Aetna and stated that he would not be doing any further disability evaluations for Plaintiff. The court found that not all of Plaintiff’s treating physicians supported his total disability, and in any event, Aetna is not required to accord any special deference to treating physicians’ opinions. Further, the court found nothing inherently improper with relying on a file review, even one that disagrees with the conclusions of a treating physician. Although the Auto Club LTD Plan gave the administrator the right to require Plaintiff to undergo a physical examination, it did not mandate that a physical examination be performed. Lastly, the court found that Aetna sufficiently explained why it was not giving Plaintiff’s SSDI award significant weight, including that there are substantial differences between the SSA’s and the Plan’s working definitions of disability. Additionally, the SSA Medical-Vocational Guidelines allow for a presumption of disability based upon a claimant’s age, prior work experience, education, and restriction to sedentary work. The court granted Aetna’s motion for entry of judgment on the administrative record and denied Plaintiff’s motion.

Termination of LTD benefits an abuse of discretion; remand to Aetna for further consideration. [Bishop v. Aetna Life Ins. Co., No. 5:15-CV-104-KKC, 2016 WL 591765 \(E.D. Ky. Feb. 12, 2016\)](#) (Judge Karen K. Caldwell). The court concluded that Aetna’s decision to terminate Plaintiff’s long-term disability benefits at the “any occupation” definition of disability was an abuse of discretion and remanded the claim to Aetna for further consideration. Aetna’s denial letters did not accurately quote the LTD Plan definition of disability when explaining why it was not following the Social Security Administration’s finding of disability. The court found that the evidence strongly suggests that Aetna did not actually rely on the Plan language when terminating Plaintiff’s benefits, but manufactured the argument after-the-fact to shore up its decision for litigation. Although the court found that the “or may reasonably become” language in the LTD Plan definition is a plausible explanation for distinguishing Aetna’s determination from the SSA’s determination, the fact that the language was not included in the letter led the court to question whether Aetna’s decision was part of a principled reasoning process. Regardless, Aetna’s failure to fully notify Plaintiff of the grounds for its decision hampered his appeal of the termination of benefits. The court found that this deficiency does not make Aetna’s decision arbitrary and capricious in and of itself, but it is a factor that colors the remainder of the court’s analysis. The court found that Aetna’s reliance on the “potential” jobs identified in a vocational report was based on a mischaracterization such that its denial of benefits was not based on substantial evidence. Aetna cited four jobs as those that Plaintiff could do but the

report had clearly indicated that Plaintiff would require additional training in tools and materials in order to perform those jobs. Aetna did not actually analyze whether it would be reasonable for Plaintiff to train in tools and materials. With respect to a paper review, the court found that the report itself showed no major flaws and the fact that it was not based on an in-person evaluation was not reason alone to discount it. However, the court found that Aetna's failure to provide another vocational expert with all relevant information strongly suggested that Aetna wanted the vocational report to find that occupations were available for Plaintiff.

Denial of LTD benefits not arbitrary and capricious where medical records did not show that claimant complained of fatigue or cognitive impairment as of the date of disability.

[Slaton v. Standard Ins. Co., No. 3:14-CV-269, 2016 WL 316864 \(S.D. Ohio Jan. 26, 2016\)](#)

(Judge Walter H. Rice). The court upheld Standard's decision denying Plaintiff's long-term disability benefit claim, where Plaintiff, a former practicing attorney, claimed to be disabled due to fatigue and cognitive difficulties stemming from multiple sclerosis. Plaintiff needed to submit satisfactory written proof that as of January 1, 2012—the date he claims that he became unable to work full-time — he was “disabled” as that term is defined in the Plan. The court found that there is absolutely no evidence in his medical records that he ever complained about any fatigue or decreased ability to concentrate before March 16, 2012, more than two months later. Absent documentation of such subjective complaints in the record as of the claimed date of disability, the court could not find that Standard acted in an arbitrary and capricious manner in failing to give those complaints more weight, or in failing to order an independent medical examination to better assess Plaintiff's credibility. The court explained that if there was any evidence that Plaintiff actually experienced fatigue or decreased cognitive ability prior to January 1, 2012, the outcome of this case might be different. However, under the circumstances presented here, the court found that Standard's decision to deny long-term disability benefits was not arbitrary or capricious.

G. [Seventh Circuit](#)

Aetna did not act arbitrarily and capriciously in terminating Plaintiff's benefits based on her PTSD diagnosis. The fact that Aetna found that Plaintiff was disabled under the terms of the plan for more than five years does not mean that Aetna acted arbitrarily and capriciously. Aetna's termination was “well-founded” and relied properly on the reports of three reviewing physicians. The court noted that the record contains to formal measurements of how Plaintiff's self-reported severe symptoms affected her functional capabilities. [Jacowski v. Kraft Heinz Foods Co., No. 15-CV-657-BBC, 2016 WL 6693588 \(W.D. Wis. Nov. 14, 2016\)](#) (Judge Barbara B. Crabb).

Determining that Principal Life Insurance Company abused its discretion in denying Plaintiff's claim for long-term disability benefits by concluding that his squamous cell carcinoma was a preexisting condition that was not covered under the group policy, where

Plaintiff was not diagnosed with throat cancer until *after* the relevant lookback period, but during the relevant period Plaintiff saw several doctors who examined and treated the swelling on his neck that was later diagnosed as squamous cell carcinoma; awarding Plaintiff benefits and denying Principal's request for a remand to decide whether Plaintiff is disabled since by failing to list Plaintiff's lack of a qualifying disability as a reason for its claim denial, Defendant is foreclosed from raising that issue now. [Langdon v. Principal Life Ins. Co., No. 14-CV-6980, 2016 WL 4720025 \(N.D. Ill. Sept. 9, 2016\)](#) (Judge Robert M. Dow, Jr.).

Denying Sun Life's motion for judgment on the pleadings on the basis that McKeown had failed to cooperate during the claim review process by not providing Sun Life with the SSA claim file and the raw data from a neuropsychological examination, finding that material issues of fact exist as to whether McKeown has presented sufficient proof of her claim to warrant a favorable appeal determination. [McKeown v. Sun Life Assurance Co. of Canada, No. 16 C 748, 2016 WL 4720048 \(N.D. Ill. Sept. 9, 2016\)](#) (Judge John Z. Lee).

Summary judgment granted in favor of Plaintiff, and finding that: (1) Plaintiff's treating physicians believed that her symptoms precluded her from working, and Aetna asserted no plausible ground for suspecting that their conclusions were the product of faulty assessment methods; (2) the opinions of Plaintiff's treating physicians were based in part on her reported pain, but they also had support in objective medical evidence such as Plaintiff's diminished grip strength in her right hand; Owstry Neck Index, MRI, and Spurling test results; and conspicuously decreased cervical and bilateral lateral flexion; (3) Aetna's reliance on a flawed medical review by a doctor who was doing an increasing amount of medical reviews for Aetna and MES is a factor to be weighed in the abuse-of-discretion analysis; (4) Aetna's termination of benefits when Plaintiff was awaiting another surgery and its failure to consider postponing the termination of benefits is troubling. [Alvarado v. Aetna Life Ins. Co., No. 14 CV 4717, 2016 WL 4678305 \(N.D. Ill. Sept. 6, 2016\)](#) (Judge Rebecca R. Pallmeyer).

Liberty Life abused its discretion in terminating Plaintiff's long-term disability benefits for injuries she sustained after falling off of a horse, twice. After Liberty Life decided Plaintiff was entitled to benefits it hired Dr. Eddie Sassoon to review the same medical records and issue an opinion. Dr. Sassoon opined Plaintiff could sit up to eight hours in an eight-hour workday and Liberty Life adopted his opinion even though it conflicted with the decision reached by Liberty Life just a couple of weeks before. Dr. Sassoon did not explain his conclusion in light of Plaintiff's doctor's opinion that Plaintiff had "no ability to [return to work] given her marked pain." Liberty Life failed to provide Plaintiff with a reasoned explanation for discounting her doctor's conclusion, so its decision was arbitrary and capricious. [Aberg v. Charter Commc'ns, Inc., No. 15-CV-571, 2016 WL 4444808 \(E.D. Wis. Aug. 23, 2016\)](#) (Magistrate Judge William E. Duffin).

In lawsuit brought by unrepresented claimant, granting MetLife’s motion to dismiss and finding that: (1) DeVooght’s state law claims are preempted by ERISA; (2) Defendants Joyce Allen and Ann Marie Hess (MetLife employees) cannot be individually liable; and (3) DeVooght’s jury demand should be stricken. [Devooght v. Metro. Life Ins. Co., No. 415CV04108SLDJEH, 2016 WL 4370031 \(C.D. Ill. Aug. 15, 2016\)](#) (Judge Sara Darrow).

Vacating and remanding district court decision in favor of Plaintiff, finding that Plaintiff had not met the Plan’s “Active Work” requirements entitling her to long-term disability coverage. Further, the district court did not nail down exactly when Plaintiff met the definition of disability and also misconstrued the definition. The policy states that if one’s occupation requires a license, it is as broad as the scope of the license. The issue was whether Plaintiff could find any work in the same specialty or another, or generally – as a lawyer. The issue is not whether Plaintiff is capable of working as a litigation partner in a big law firm. [Cheney v. Standard Insurance Company & Long Term Disability Insurance, No. 15-1794, ___ F.3d ___, 2016 WL 4011171 \(7th Cir. July 27, 2016\)](#) (Before WOOD, Chief Judge, and MANION and ROVNER, Circuit Judges).

On *de novo* review following a bench trial where Plaintiff testified in person and the parties submitted the deposition testimony of Plaintiff’s primary internal medicine physician, and Dr. Manoj Mehta, a consulting physician for United of Omaha, the court found that Plaintiff is entitled to long-term disability benefits for being unable to perform the material duties of “Mechanical-Design Engineer, Products.” The court rejected Defendant’s argument that Plaintiff’s ability to use her computer six to eight hours a day, at home on a reclining sofa, is evidence of ability to perform the intellectual demands of a highly skilled professional occupation on a full-time basis. [Wonsowski v. United of Omaha Life Ins. Co., No. 15 C 3795, 2016 WL 3088141 \(N.D. Ill. June 2, 2016\)](#) (Magistrate Judge Geraldine Soat Brown).

Standard Insurance LTD Policy was not “offered or issued” in the State of Illinois within the meaning of Section 2001.3 of Title 50 of the Illinois Administrative Code, where Genco, a Delaware corporation with its principal place of business in Pennsylvania, negotiated the Standard policies insuring the Genco Plan in Pennsylvania; all negotiations and decision-making regarding the LTD Policy occurred outside the State of Illinois; the LTD Policy and its associated Certificates of Insurance were delivered by Standard to Genco in Pennsylvania; and Genco paid all the premiums from its Pennsylvania office; abuse of discretion review applies to LTD claim. [Nasalroad v. Standard Ins. Co., No. 15-CV-895-SMY-DGW, ___ F.Supp.3d ___, 2016 WL 1667335 \(S.D. Ill. Apr. 26, 2016\)](#) (Judge Yandle).

Insurer abused discretion in denying long-term disability benefits; remand for further consideration of claim. [Clark v. Cuna Mut. Long Term Disability Plan, No. 14-CV-412-WMC,](#)

[2016 WL 1060344 \(W.D. Wis. Mar. 15, 2016\)](#). In this case, Plaintiff claimed disability based on the following medical conditions: lumbar radiculopathy, herniated nucleus pulposus (lumbar), degenerative disc disease, disc collapse, foraminal stenosis, chronic lower back pain, right-sided lower extremity pain, recurrent disc herniation at L5-S1, depression, and residual right nerve root tension and weakness in the right lower extremity. The court found that Defendants acted arbitrarily and capriciously in denying Plaintiff's long-term disability benefits and remanded to the administrator for further proceedings. The court found that Defendants' use of Dr. Stewart Russell to conduct the review of their decision to terminate Plaintiff's benefits, and again on the second voluntary appeal of that decision, did not violate ERISA's regulations since Defendant did not retain the same doctor for both the adverse benefit determination and for the appeal of that decision. But, the court did find that Defendants acted arbitrarily and capriciously by failing to offer a reasoned explanation for rejecting medical opinions that Plaintiff was not capable of working and strong evidence supporting disability, including multiple failed surgeries, Plaintiff's complaints of back pain, Plaintiff's doctor's assessment of his condition as continuing, and MRI findings. The court also found that Defendants created a "moving target" by discounting a July 2012 MRI because it did not demonstrate disability as of January 2012. On remand, the court instructed Defendants to consider whether the July 2012 MRI is likely to have reflected Plaintiff's condition as of January 2012 in light of the continuity of evidence in his medical record at those two times.

Insurer abused its discretion and remand is appropriate remedy for insurer to consider SSDI award. [Green v. Sun Life Assurance Co., No. 14 C 4095, 2016 WL 861236 \(N.D. Ill. Mar. 7, 2016\)](#) (Judge John Z. Lee). In this case, Plaintiff, a former pharmaceutical representative, became disabled by occipital neuralgia and neck pain, as well as depression and anxiety. The court held that Sun Life abused its discretion in denying Plaintiff's claim for long-term disability benefits, but remanded the claim back to Sun Life for further determination. The court found that Sun Life failed to adequately explain why Plaintiff was not continuously unable to perform the essential tasks, functions, skills, or responsibilities of her occupation during the 180-day Elimination Period and the subsequent twenty-four months. Additionally, Sun Life did not explain why it rejected the SSA ALJ's determination that Plaintiff was disabled even though the notice of award of SSDI benefits, the SSA claim file, and the ALJ's determination were in the administrative record. The court found that this was not a "clear cut case" and on remand Sun Life should review the SSA claim file and the ALJ's rationale and determine whether the combined effects of Plaintiff's physical and psychological impairments, as well as the medications used to treat them, caused her to be totally disabled during the time period in question.

Abuse of discretion to deny LTD claim on basis of pre-existing condition exclusion. [Kaiser v. United of Omaha Life Ins. Co., No. 14-CV-762-WMC, 2016 WL 379814 \(W.D. Wis. Jan. 29, 2016\)](#) (Judge William M. Conley). Plaintiff filed suit seeking long-term disability benefits for his deceased wife's disability caused by Stage IV lung cancer. Defendants denied benefits on the

basis that the disability fell within the preexisting condition coverage exception of the long-term disability insurance plan. The court granted summary judgment to Plaintiff, finding that Defendants acted arbitrarily and capriciously in invoking the pre-existing condition provision to deny benefits. During the “look-back” period, Plaintiff’s wife injured her shoulder and received a diagnosis and treatment consistent with rotator cuff impingement. There was no concern or suspicious of cancer or metastasis from a primary lung cancer. After the look-back period, Plaintiff’s wife was diagnosed with metastatic cancer and filed for long-term disability less than a month after the diagnosis. The court found that the relevant inquiry is whether a doctor’s visit for shoulder pain, prescription of pain medication, subsequent referral to physical therapy, and one physical therapy session were “for” the wife’s cancer. The court found that medical care was not for the cancer. Further, the fact that Plaintiff’s wife was eventually diagnosed with cancer, and that her shoulder pain “in retrospect” was caused by her cancer, is not material to a determination of whether her medical care providers suspected cancer at the time of treatment. The court remanded the claim to determine the question of disability.

Plan terms do not exclude posthumous application for disability benefits. [Alderman v. Cent. Pension Fund of the Int’l Union of Operating Engineers & Participating Employers, No. 1:14-CV-94-TLS, 2016 WL 183552 \(N.D. Ind. Jan. 14, 2016\)](#) (Judge Theresa L. Springmann). In this case the Central Pension Fund of the International Union of Operating Engineers and Participating Employers (the “Plan”) denied Plaintiff’s application for posthumous disability benefits following her husband’s death. While her husband was alive, Plaintiff had called the Plan on her husband’s behalf and was informed on two occasions that he could not apply for disability benefits until he was awarded Social Security Disability Insurance (“SSDI”) benefits. However, the husband was not awarded SSDI benefits until after his death, at which time Plaintiff submitted a claim on his behalf. The Plan denied the claim on the basis that the application must be filed *by the Participant* and that Plaintiff was not a *Participant*. The court found that the Plan abused its discretion by interpreting Participant in this manner since, among other reasons, the statutory definition of Participant including “former employee,” along with allowing that person’s beneficiaries to qualify as a participant, shows that being alive is not an absolute requirement to fit within the definition. Further, under the federal regulations for ERISA premium rates, “participant” is defined as encompassing deceased individuals with surviving beneficiaries. The court determined that because the Plan denied Plaintiff’s application for disability benefits based on a perceived procedural deficiency, it remanded the matter to the Plan’s administrator to consider the substance of the Plaintiff’s application.

Court will vacate judgment which is a condition of parties’ private settlement on appeal. [Lundsten v. Creative Community Living Services, Inc., et al., No. 13-C-108, 2016 WL 111431 \(E.D. Wis. Jan. 11, 2016\)](#) (Judge Rudolph T. Randa). In a series of orders in this case, the court addressed the appropriate standard of review and held that the denial of LTD benefits was arbitrary and capricious. Both sides appealed, and while the appeal was pending, the parties entered a settlement agreement conditioned upon the court’s judgment being vacated. The court

granted the parties' joint motion for an indicative ruling that the court would grant their request to vacate the judgment as a condition of the settlement pursuant to Fed. R. Civ. P. 62.1. The court found that the public's interest in preserving judicial resources favors vacatur. Regarding precedent, the court's opinions will still be citable for persuasive weight.

Aetna abused its discretion in denying claims; matter remanded for full and fair review. [Maiden v. Aetna Life Insurance Company, et al., No. 3:14-CV-901, 2016 WL 81489 \(N.D. Ind. Jan. 6, 2016\)](#) (Judge Philip P. Simon). In this matter seeking review of a denial of LTD benefits and waiver of life insurance premium benefits, the court denied Defendants' motion to dismiss the disability plan as a defendant. The court found that Aetna's notices to Plaintiff did not substantially comply with ERISA's disclosure requirements and the shortcomings in Aetna's pre-appeal letters could have left—and apparently did leave—significant gaps in Plaintiff's understanding of what information was needed to perfect his claim. The court found that Aetna's failure to provide Plaintiff with adequate information about why his claim had been denied before Aetna's internal review prevented Plaintiff from receiving a full and fair opportunity for review, and for this reason alone Plaintiff is entitled to summary judgment. Further, the court found that Aetna should have reviewed the compound effect of Plaintiff's physical impairments and his psychiatric issues, and its failure to do so was an arbitrary and capricious exercise of Aetna's discretion. The court found that Aetna inexplicably disregarded the opinions of treating physicians and ignored evidence supporting disability while cherry-picking evidence to support a denial. Aetna used consultants with an incentive to affirm. "I put quotations marks around the word "independent" because one might reasonably wonder just how independent the reviewers—Dr. Malcolm McPhee and Dr. Leonard Schnur—really are. Their bread has been buttered by Aetna before; each of them has been hired by Aetna multiple times to conduct these kinds of disability reviews." The court found that it's clear that Aetna abused its discretion and Maiden must be given another opportunity to prove his claim.

H. Eighth Circuit

In disability pension dispute, the court found in favor of the plan administrator, who denied Plaintiff benefits because he did not become disabled after reaching 45 years of age as required by the Plan. Because the SPD terms do not qualify as plan terms, the court rejected the argument that the plan administrator's decision was an abuse of discretion because it contradicted statements made in the SPD. The rule of *contra proferentum* is preempted by ERISA and does not apply in this case. [Jones v. Kohler Co. Pension Plan, No. 4:14-CV-00083 KGB, 2016 WL 7030445 \(E.D. Ark. Dec. 1, 2016\)](#) (Judge Kristine G. Baker).

Dismissing Plaintiff's lawsuit for failing to exhaust administrative remedies, where the Court found that Reliance's 90 days to make a decision was tolled pursuant to 29 C.F.R. § 2560.503-1(i)(4), which allows for tolling in the event that the Plan requires further information necessary to deciding a claim. The deadline was tolled on two occasions when

Reliance requested information and also an independent medical examination. The court dismissed the lawsuit so that Reliance could conduct the examination. The court also stated that it would consider any claim for fees and costs incurred by Reliance for Plaintiff's prematurely-filed lawsuit. [Warmbrodt v. Reliance Standard Life Ins. Co., No. 4:16-CV-70 SNLJ, 2016 WL 5933988 \(E.D. Mo. Oct. 12, 2016\)](#) (Judge Stephen N. Limbaugh, Jr.).

Defendants' decision to deny Plaintiff's long-term disability claim was not arbitrary and capricious, where it was based on two medical reviews of her claim by Drs. Matthew Lundquist (Internal Medicine/Occupational Medical Physician) and Roy Sanders (Psychology). The court denied Plaintiff's request for remand on the basis that medical records arising after the administrative record closed vindicates her doctor's opinion that Plaintiff is disabled. [Thompson v. ConAgra Foods, Inc., No. 1:14-CV-00041 KGB, 2016 WL 5886883 \(E.D. Ark. Oct. 7, 2016\)](#) (Judge Kristine G. Baker).

On standard of review, finding that Plaintiff waived the conflict of interest issue by not addressing it earlier when the court gave Plaintiff an opportunity to file a motion for expanded discovery concerning conflicts of interest, and in any event, there is no conflict of interest where Ascension Health delegated discretionary authority to Sedgwick; concluding that substantial evidence supported Sedgwick's determination that Plaintiff could return to a sedentary job and granting summary judgment to Defendants. [Kraus v. Ascension Health Long Term Disability Plan & Sedgwick Claims Management Services, Inc., No. 4:15 CV 718 JMB, 2016 WL 4061880 \(E.D. Mo. July 29, 2016\)](#) (Magistrate Judge John M. Bodenhausen).

Granting judgment in favor of Defendant, finding no abuse of discretion where substantial evidence supports long-term disability denial and despite SSA decision awarding benefits. [Mohorne v. Deere & Company, No. 13-CV-2086-LRR, 2016 WL 1464571 \(N.D. Iowa Apr. 14, 2016\)](#) (Judge Linda R. Reade).

Denial of long-term disability benefits is not an abuse of discretion. [Ganter v. Sun Life Assurance Company of Canada, et al., No. 1:14-CV-1064, 2016 WL 1268288 \(W.D. Ark. Mar. 31, 2016\)](#). Plaintiff worked as a licensed practice nurse before claiming disability due to a fractured back, daily headaches, and pain, numbness, and tingling shooting down her neck and back. On abuse of discretion review of Sun Life's decision to deny Plaintiff's long-term disability claim, the court found that Sun Life reasonably based its denial on the opinions of reviewing physicians Dr. Staci Ross (neuropsychologist), Dr. Steven Graham (neurologist), and Dr. Calvin Fuhrmann (internal and pulmonary medicine), along with the medical examination notes from Plaintiff's treating physicians. The court explained that while the treating physicians' opinions were that Plaintiff should remain off work, the objective evidence does not reflect that Plaintiff has any functional impairment. The court found the record unclear as to how Plaintiff's pain affected her ability to work and her treating doctors did not offer a test or explanation showing that Plaintiff is functionally impaired from performing her job. In her appeal to Sun Life, Plaintiff included ten medical journal articles showing that there is no direct correlation

between the level of abnormality on an MRI image and the level of pain and disability experienced by the patient, and that a physical examination of the patient, in addition to consideration of MRI images, is necessary for medical diagnosis. The court noted that the Eighth Circuit has held that no physical examination of a claimant is required and plan administrators have discretion to deny benefits based upon their acceptance of the opinions of reviewing physicians over the conflicting opinions of the claimant's treating physicians unless the record does not support the denial. The court found that Plaintiff did not suffer from a disability as defined by the plan is reasonable and supported by substantial evidence.

Following plaintiff's success on appeal on the issue of timeliness, district court finds in favor of Hartford on the merits of LTD claim. [Mulholland v. Mastercard Worldwide, et al., No. 4:13-CV-01329-JCH, 2016 WL 1223456 \(E.D. Mo. Mar. 29, 2016\)](#) (Judge Jean C.

Hamilton). The district court previously determined that Plaintiff's long-term disability benefit claim was time-barred but the Eighth Circuit reversed and remanded for consideration of the merits. The court determined that Hartford's decision to terminate Plaintiff's benefits was supported by a reasonable explanation, including that two reviewing physicians both opined that Plaintiff presented no restrictions or limitations that would have prevented her from working. The physicians, Dr. Lowe (internal medicine) and Dr. Rummler (psychiatry) issued a peer review report identified the data and records they reviewed and relied upon in reaching their conclusions, and Plaintiff did not contest the accuracy of the data or records summarized therein. The court concluded that Hartford's decision did not constitute an abuse of discretion and granted Defendants' motion for summary judgment.

Abuse of discretion for failing to consider effect of narcotic use on RN license and claimant's age and lack of computer skills. [Mackey v. Liberty Life Assurance Co. of Boston, No. 3:15-CV-3004, 2016 WL 915271 \(W.D. Ark. Mar. 7, 2016\)](#) (Judge Timothy L. Brooks).

The court determined that Liberty Life abused its discretion in denying "any occupation" long-term disability benefits to a claimant who had worked as a registered nurse for twenty years. Specifically, the court found that Liberty Life abused its discretion by failing to accept or investigate a vocational analyst's claim that mere use of narcotics prohibited Plaintiff from utilizing her RN license. The vocational analyst had contacted an employee of the Nursing Board who interpreted a regulation implementing the Nurse Practice Act of Arkansas as prohibiting nurses from taking controlled substances during working hours. Liberty Life disregarded this interpretation and found that Plaintiff would only be prohibited from utilizing her RN license if her narcotic usage created a secondary impairment. The court found that the proper remedy is to remand the case to Liberty Life for further evaluation. On remand, the court instructed Liberty Life must either obtain proof of a different interpretation from the Nursing Board, or defer to the Board employee's interpretation of the regulation. Liberty Life must also thoroughly consider how Plaintiff's age and lack of computer skills would affect her ability to become reasonably fitted to perform the material and substantial duties of the occupations identified by Liberty Life's vocational report.

District court decision in favor of long-term disability claimant reversed and remanded.

[Whitley v. Standard Ins. Co., No. 15-1524, ___ F.3d ___, 2016 WL 853298 \(8th Cir. Mar. 4, 2016\)](#) (Before LOKEN, MURPHY, and COLLOTON, Circuit Judges). The Eighth Circuit reversed and remanded the district court’s grant of summary judgment in Plaintiff-Appellee’s favor. Plaintiff-Appellee is a long-term disability plan participant who claims disability as a result of post-concussive disorder. The parties disputed whether Plaintiff’s “Own Occupation” was family medicine physician rather than an emergency room physician. On the standard of review, the Eighth Circuit found that Plaintiff presented no evidence that Standard’s claims review process was biased, and the record established that the medical professionals who reviewed Plaintiff’s claim were independent consultants, not Standard employees, and that their compensation was not based on their findings. The court found that these circumstances reduced the financial conflict factor “to the vanishing point.” The district court first ruled that Standard abused its discretion in determining that Plaintiff’s Own Occupation was family medicine, not emergency medicine, but the Eighth Circuit disagreed. Although Standard’s initial decision was based in part on a determination that Plaintiff’s Own Occupation was family medicine, the Eighth Circuit concluded that Standard’s final decision took into consideration Plaintiff’s ability to work in an emergency room setting. As to the main issue, the district court concluded that Standard abused its discretion in discontinuing benefits because its “consulting physicians totally dismiss, without support, the recommendation of Whitley’s treating physicians that she should return to work on a part-time basis, with supervision, to determine whether or not she can perform her job duties.” The Eighth Circuit found that there were conflicting expert opinions and where there is a conflict between a claimant’s treating physicians and the administrator’s reviewing physicians, the administrator has discretion to deny benefits unless the record does not support denial. The court concluded that in view of the conflicting opinions contained in the administrative record, Standard’s decision to deny Plaintiff’s claim based on its “independent consultants” was not an abuse of discretion.

Claim denial under stringent definition of disability must be upheld, even if illusory.

[Anderson v. Sappi Fine Paper N. Am., No. CV 14-428 ADM/LIB, 2016 WL 335861 \(D. Minn. Jan. 27, 2016\)](#) (Judge Ann D. Montgomery). The court granted summary judgment to Defendant on Plaintiff’s claim seeking disability retirement benefits. Plaintiff has a well-documented history of bilateral clubfeet and injuries to her shoulder, knees, hands, wrists, ankles, and feet. She continued to work at Sappi’s industrial paper mill as a carton line operator by “suck[ing] it up” and dealing with the pain. However, following a foot injury, combined with her long-term feet and knee problems, Plaintiff had to stop work altogether because she could not stand or walk for any significant period. The Social Security Administration found her disabled under its rules. She applied for disability retirement benefits, which Defendant denied. Under the Plan, an individual is entitled to disability retirement benefits if they have a “Total and Permanent Disability,” which is defined as: a physical or mental disability as a result of which a Member is *wholly and continuously unable to engage in any occupation or perform any work for any kind of compensation of financial value* Defendant denied Plaintiff’s claim upon finding that since

she was able “to engage in any occupation or perform any work for any kind of compensation of financial value,” she was not entitled to disability retirement benefits. Plaintiff argued that Defendant’s promise to pay disability benefits is illusory because nobody is able to demonstrate they meet the Plan’s definition of disabled. The court found that Plaintiff’s contention has merit but that rewriting a single provision in an otherwise enforceable contract is not recognized in the Eighth Circuit. Although exceedingly difficult to meet, the law does not compel Defendant to have a more favorable definition of disabled nor does the law does not even require Defendant to have a plan at all. The court acknowledged that this result may seem harsh considering the extent of Plaintiff’s well-documented, multiple medical conditions and amazing perseverance to work through her pain to stay employed at the mill for over thirty years, but Defendant’s stringent definition of disability is permissible. Since Plaintiff did not meet her burden in establishing disability, the court could not overturn Defendant’s denial.

I. Ninth Circuit

[*Arko v. Hartford Life And Accident Insurance Co.*, No. 14-17287, __F.App’x__, 2016 WL 7422946 \(9th Cir. Dec. 23, 2016\)](#) (Before: THOMAS, Chief Judge; and GILMAN (U.S. 6th) and FRIEDLAND, Circuit Judges). The court affirmed the district court’s ruling in favor of Hartford on Plaintiff’s long-term disability benefit claim denial. The court found that the record lacks any evidence that Plaintiff was permanently disabled in 2000, and because of large gaps in the medical records (no records for 5 of the 11 years of claimed disability), determining whether Plaintiff was continuously disabled is “impossible.” Further, some of the information that Plaintiff provided to his physicians contradicts his claim that he was disabled during all of this period. Lastly, the court declined to address Plaintiff’s argument that Hartford violated 29 C.F.R. § 2560.503-1(h)(3)(v) by failing to have a medical professional examine the medical records since Plaintiff waived this argument by failing to raise it at any stage of the proceedings in the district court.

The Court found that ERISA preempts California Insurance Code section 10110.6 because section 10110.6 regulates FedEx’s self-funded plan. Although two district court decisions go the other way: *Thomas v. Aetna Life Ins. Co.*, 2:15-cv-01112-JAM-KJN, 2016 WL 4368110 (E.D. Cal. Aug. 15, 2016 and *Williby v. Aetna Life Ins. Co.*, 2:14-cv-04203 CBM(MRWx), 2015 WL 5145499 (C.D. Cal. Aug. 31, 2015), the court noted that the Ninth Circuit has yet to decide this issue. “[T]he Court declines to deviate from [*FMC Corp v. Holliday*, 498 U.S. 52 (1990)] and finds that because ERISA preempts section 10110.6 under the Deemer Clause, section 10110.6 does not void the discretionary clause in the self-funded ERISA plan.” On the merits of the claim, the court found that Aetna did not abuse its discretion in discounting Plaintiff’s subjective complaints of pain where it was not supported by objective findings. The court entered judgment in favor of Defendants. [*Martin v. Aetna Life Ins. Co.*, No. CV 15-7355-RSWL-FFMX, 2016 WL 6997484 \(C.D. Cal. Nov. 30, 2016\)](#) (Judge Ronald S.W. Lew). Judge Ronald Lew of the Central District of

California parted ways with his colleagues on the bench by holding that ERISA preempts California Insurance Code section 10110.6 because section 10110.6 regulates FedEx's self-funded plan. Judge Lew noted that two decisions from C.D. Cal. go the other way: [*Thomas v. Aetna Life Ins. Co.*](#), 2:15-cv-01112-JAM-KJN, 2016 WL 4368110 (E.D. Cal. Aug. 15, 2016 (rejecting argument that the Deemer Clause prevents courts from applying section 10110.6 to self-funded plans) and [*Williby v. Aetna Life Ins. Co.*](#), 2:14-cv-04203 CBM(MRWx), 2015 WL 5145499 (C.D. Cal. Aug. 31, 2015) (finding that section 10110.6 applies to self-funded plans because by its plain language it applies to any insurance policy, contract, certificate or agreement, and an ERISA plan is a contract). The court noted that the Ninth Circuit has yet to decide this issue, and despite *Thomas* and *Williby*, the court declined to deviate from [*FMC Corp v. Holliday*](#), 498 U.S. 52 (1990), which held that that the Deemer Clause exempts self-funded ERISA plans from state laws that regulate insurance under the Saving Clause. Relying on *Holliday*, the court held that because ERISA preempts section 10110.6 under the Deemer Clause, section 10110.6 does not void the discretionary clause in the self-funded ERISA plan. If you're on the left side of the v. (except in reimbursement/subrogation lawsuits), the opinion only gets worse from there. The court goes on to justify Aetna's decision to discount Plaintiff's subjective complaints of pain simply because there were no remarkable "objective" findings. Plaintiff claimed disability based on wrist and thumb pain but the court noted normal nerve conduction tests, no swelling, normal range of motion, normal strength, and normal sensation.

Vacating the part of the judgment denying Plaintiff his long term disability benefits and remanding the case for further proceedings consistent with this opinion. "We agree with this commonsense conclusion and hold that an employee who cannot sit for more than four hours in an eight-hour workday cannot perform 'sedentary' work that requires 'sitting most of the time.'" The court declined to decide whether the district court properly excluded extra-record evidence submitted by Plaintiff. [*Armani v. Nw. Mut. Life Ins. Co.*](#), No. 14-56866, F.3d , 2016 WL 6543523 (9th Cir. Nov. 4, 2016) (Before: Dorothy W. Nelson and Richard A. Paez, Circuit Judges, and Elaine E. Bucklo,** Senior District Judge). The court held that the district court erred by refusing to apply the Dictionary of Occupational Titles ("DOT") requirement for sedentary work to its *de novo* review of Armani's long-term disability claim. Northwestern Mutual determined that Armani could perform work at the "sedentary" level even though every physician and chiropractor who treated Armani determined that he could not sit for more than four hours a day. Armani argued that he was unable to perform any occupation classified as sedentary, because, by definition, "sedentary" requires an ability to sit for six hours. The district court rejected Armani's proposed definition of "sedentary" work on the basis that it was drawn from the Social Security context, but the Ninth Circuit found that this was erroneous. The court acknowledged that other courts evaluating ERISA claims and interpreting the DOT have consistently held that an employee who cannot sit for more than four hours in an eight-hour workday cannot perform work classified as "sedentary." Agreeing with this "commonsense conclusion," the court held that an employee who cannot sit for more than

four hours in an eight-hour workday cannot perform “sedentary” work that requires “sitting most of the time.”

Following a reversal and remand to the plan administrator by the Ninth Circuit, the district court found that the Plan did not abuse its discretion in terminating Plaintiff’s disability pension benefits. On remand, the Plan’s support included six different board certified specialists, five of whom found that Plaintiff had never been “totally disabled” as defined by the Plan, and Plaintiff’s social media posts which suggested that Plaintiff had recovered from her depression sufficiently enough to work. [Hoffman v. Screen Actors Guild-Producers Pension Plan, et al., No. 2:16-CV-01530-R-AJW, 2016 WL 6537531 \(C.D. Cal. Nov. 2, 2016\)](#) (Judge Manuel L. Real).

Denying Petition for Panel Rehearing; memorandum disposition filed on July 25, 2016 is withdrawn and replaced with the memorandum disposition submitted simultaneously with this Order. The court held that the district court did not err in not applying equitable tolling or equitable estoppel to Lee’s claim for retaliatory discharge. [Lee v. ING GROEP, N.V., et al, No. 14-15848, F.App’x , 2016 WL 6311867 \(9th Cir. Oct. 28, 2016\)](#) (Before: FARRIS, O’SCANNLAIN, and CHRISTEN, Circuit Judges).

Affirming the district court’s judgment, after a trial on the administrative record, in favor of United of Omaha Life Insurance Company. The district court did not err by concluding that United used the proper definition of “Usual Occupation” in denying Plaintiff’s claim and it did not err by finding Plaintiff was not totally disabled by fibromyalgia from performing the substantial and material duties of her Usual Occupation. The district court clearly erred by finding that Plaintiff’s fibromyalgia was a pre-existing condition not covered under the Plan, but the error was harmless. [Leslie v. United of Omaha Life Insurance Company, No. 14-56775, F.App’x , 2016 WL 6247131 \(9th Cir. Oct. 26, 2016\)](#) (Before: TALLMAN, PARKER, and CHRISTEN, Circuit Judges).

***De novo* review applies, where the disability plan documents—the Group Policy (Group Contract) and the Certificate of Insurance—do not contain a clear and unambiguous grant of discretion, and only the employer Summary Plan Description (prepared by Blue Shield) contains a grant of discretion. A SPD is not a “plan document.” Even if the SPD were a “plan document,” any grant of discretion would be voided by operation of California Insurance Code § 10110.6. [Murphy v. California Physicians Serv., No. 14-CV-02581-PJH, F.Supp.3d , 2016 WL 5682567 \(N.D. Cal. Oct. 3, 2016\)](#) (Judge Phyllis J. Hamilton).**

California Insurance Code section 11010.6 applies to this case and so does a *de novo* standard of review, notwithstanding that Montoya alleged that Reliance abused its discretion and conducted discovery on Reliance’s conflict of interest. The court granted Montoya’s motion for summary judgment because Reliance erred in limiting its physical IME to a certain date, therefore ignoring evidence of Montoya’s worsening condition, and

Reliance erred in relying on out-of-date DOT occupational titles of Caseworker/Social Services and Clinical Therapist to determine the “fingering” requirements for someone who held Montoya’s position as a mental health therapist. [Montoya v. Reliance Standard Life Ins. Co., No. 14-CV-02740-WHO, 2016 WL 5394024 \(N.D. Cal. Sept. 27, 2016\)](#) (Judge William H. Orrick).

On motion seeking (1) a determination whether the Plan is governed by the laws of Texas and (2) a determination whether the Policy Interpretation clause is valid and enforceable in Washington, ordering additional briefing on whether a single document may qualify as both a SPD and a plan document. [Flaen v. McLane Co., Inc., No. C15-5899BHS, 2016 WL 4992650 \(W.D. Wash. Sept. 19, 2016\)](#) (Judge Benjamin H. Settle).

In matter seeking LTD benefits where the claimant died during pendency of the action, granting Plaintiff’s motion under Rule 25(a) to substitute the claimant’s mother as the proper party; denying United of Omaha’s motion for summary judgment on the issue of timeliness of the lawsuit because the court cannot conclude as a matter of law that it was reasonably possible for Plaintiff to submit the LTD proof of loss form within 90 days. [Chalfant v. United of Omaha Life Ins. Co., No. 15-CV-03577-HSG, 2016 WL 4539453 \(N.D. Cal. Aug. 31, 2016\)](#) (Judge Haywood S. Gilliam).

Holding that MetLife abused its discretion in denying Plaintiff’s claim for long-term disability benefits under the plan’s “any occupation” standard because it did not find that Plaintiff’s mental capacity was affected in any way by the medications he was taking for his physical pain, and improperly rejected the credibility of his complaints of fatigue and difficulty concentrating based on the opinions of two financially conflicted Independent Physician Consultants who did not examine him and did not explain why they rejected his credibility; remanding the case to the district court, with instructions to remand to MetLife to re-evaluate the merits of Plaintiff’s long-term disability claim. [Demer v. IBM Corp. LTD Plan; Metro. Life Ins. Co., No. 13-17196, ___ F.3d ___, 2016 WL 4488006 \(9th Cir. Aug. 26, 2016\)](#) (Before: Jay S. Bybee and Morgan Christen, Circuit Judges, and [Edward M. Chen](#), District Judge). Demer was employed by IBM as a Lead Internal Auditor before symptoms related to severe multi-level degenerative disc disease and pain medications rendered him unable to do his job. MetLife paid long-term disability (“LTD”) benefits for “own occupation” disability but then denied benefits at the “any occupation” disability transition. MetLife’s denial relied in large part on the opinion of an independent physician consultant (“IPC”), Dr. Elyssa Del Valle (internal medicine), who conducted only a paper review of Demer’s file. Demer appealed and MetLife denied the appeal in reliance on the pure paper review opinions of two different IPCs, Dr. Marcus Goldman (psychiatry), and Dr. Dennis S. Gordan (physical medicine and rehabilitation). MetLife accepted Dr. Gordan’s physical capacity assessment and did not place any limitations as a result of Demer’s use of pain medication.

Demer filed suit and in the course of the litigation conducted discovery which showed

that in 2009 and 2010, Dr. Del Valle performed more than 250 reviews each year and earned more than \$125,000 each year; for the same time period, Dr. Gordan performed between 200–300 reviews each year and earned more than \$175,000 each year.

On summary judgment, the district court found in favor of MetLife after applying abuse of discretion review with no skepticism. The district court relied on the declarations from two MetLife employees, Gregory Hafner and Laura Sullivan, who describe the alleged affirmative steps taken by MetLife to reduce its structural conflict. Plaintiff objected to the court’s consideration of these declarations since the employees were not disclosed as a witness in MetLife’s Rule 26 initial disclosures. The court noted that “MetLife did not explain its failure to identify witnesses in its mandatory initial disclosures; on the other hand, Mr. Demer did not explain his failure to take a 30(b)(6) deposition on the structural conflict issue.” The court declined to resolve the issue because it found that even assuming that there is no residual structural conflict (i.e., because of affirmative steps taken by MetLife to insulate its claims department), some skepticism is warranted because of the financial conflict of the IPCs upon whom MetLife relied.

The court noted that it is Demer’s burden to produce evidence of a financial conflict sufficient to warrant a degree of skepticism. Once such evidence is produced, the burden then shifts to MetLife to produce evidence that there is no conflict. The court concluded that Demer satisfied his burden of production by offering evidence that the IPCs have earned a substantial amount of money from MetLife and have performed a substantial number of reviews for the company as well. “The magnitudes of these numbers, particularly when combined, raise a fair inference that there is a financial conflict which influenced the IPCs’ assessments, and thus such conflict should be considered as a factor in reviewing MetLife’s decision for abuse of discretion.” The court noted that MetLife could have maintained records of its reviewers’ findings on claims to show their neutrality in practice. Because it did not, MetLife missed an opportunity to negate any inference of a financial conflict of interest. The court found that the financial conflict warrants some weight under Ninth Circuit precedent in *Abatie* and *Montour*.

With respect to the merits of the claim, the court noted that implicit in each IPC’s opinion – and therefore MetLife’s decision – was a conclusion that Demer’s complaints of fatigue and difficulty concentrating were not credible. But, the IPCs had little basis for rejecting Demer’s credibility and they never explained specifically why they rejected Demer’s cognitive complaints. With respect to Demer’s physical complaints, the court found that Dr. Gordan’s assessment conflicted with other assessments in the record and the evidence indicated that Demer’s condition did not improve, and may have deteriorated, over time.

The Court remanded Demer’s claim back to MetLife for further consideration. On remand, MetLife may re-open the record to consider additional evidence regarding Demer’s mental limitations. The court explained that a retrospective evaluation may be difficult given the passage of time, but not necessarily impossible (analogizing to retrospective evaluations in the Social Security context).

In ruling in favor of long-term disability claimant disabled by chronic renal failure, finding that: (1) Cal. Ins. Code 10110.6 renders the Plan’s grant of discretion unenforceable even though it was not part of an insurance policy or certificate; (2) isolated and out-of-context medical notes cited by MetLife are insufficient to establish that it had a reasonable basis for concluding that Plaintiff was not disabled or in compliance with his treatment plan; (3) MetLife’s decision to forego an in-person examination of Plaintiff underscores the result-driven nature of MetLife’s decision to terminate Plaintiff’s benefits; (4) MetLife did not properly address SSA’s determination of Plaintiff’s disability and the reasons proffered in litigation are deemed waived; (5) Plan’s limitation of Chronic Fatigue Syndrome does not apply to Plaintiff’s claim and MetLife waived that argument since it did not articulate it in any of its denial letters; and (6) Plaintiff is entitled to reinstatement of his LTD benefits.

[Lin v. Metro. Life Ins. Co., No. C 15-2126 SBA, 2016 WL 4373859 \(N.D. Cal. Aug. 16, 2016\)](#) (Judge Sandra Brown Armstrong). The court ruled in favor of the long-term disability claimant with chronic renal failure, and found that Section 10110.6 renders the Plan’s grant of discretion unenforceable even though it was not part of an insurance policy or certificate. The court noted that the Ninth Circuit has yet to reach this issue, but federal district courts, including numerous judges from the district, have consistently rejected Defendants’ argument that Section 10110.6 is inapplicable where the grant of discretion is in an integral part of the ERISA welfare benefit plan’s document.

Concluding that Cal. Ins. Code Section 10110.6 applies to self-funded plans in the same way it applies to insured plans and effectively bars the court from applying the abuse of discretion standard of review; denying summary judgment to both parties because there is a genuine issue of material fact as to whether Plaintiff met her burden of proving with sufficient objective evidence that she was disabled and that resolution of competing facts should be reserved for a trier of fact. [Thomas v. Aetna Life Ins. Co., No. 215CV01112JAMKJN, 2016 WL 4368110 \(E.D. Cal. Aug. 15, 2016\)](#) (Judge John A. Mendez).

The court concluded that Section 10110.6 applies to self-funded plans in the same way it applies to insured plans and effectively bars the court from applying the abuse of discretion standard of review. By its plain language, Section 10110.6 applies to “contracts,” which would include self-funded ERISA plans. The court noted that the legislative history of Section 10110.6 demonstrates that the California legislature was concerned over how a discretionary clause, even in a self-funded plan, “deprives California insureds of the benefits for which they bargained...” The court applied *de novo* review to the claims decision but decided that there were genuine issues of material fact precluding summary judgment to either party. To my knowledge, *Thomas* is the only decision applying Section 10110.6 to a self-funded plan.

On *de novo* review of Plaintiff’s long-term disability claim denial, admitting into evidence a “Physical Capacities Questionnaire” completed by an Independent Medical Evaluator that was not before the plan administrator at the time it made the decision to terminate LTD

benefits; taking judicial notice of O*Net job description; concluding that Plaintiff had not proven “Total Disability” within the meaning of the LTD policy and relying on IME’s opinion that Plaintiff’s subjective complaints exceeded his objective examination findings; finding that the present tense wording of the “Any Occupation” definition does not preclude additional on-the-job training in the five alternative occupations identified by Reliance Standard; determining that Plaintiff’s pre-disability salary does not disqualify alternative occupations that pay minimum wage; finding that alleged procedural irregularities in the appeal do not bear on the Court’s *de novo* review. [Haber v. Reliance Standard Life Ins. Co., No. CV149566MWFMANX, 2016 WL 4154917 \(C.D. Cal. Aug. 4, 2016\)](#)

Holding that Reed and CAFS abused their discretion in denying Plaintiff’s LTD claim because they failed to provide Plaintiff with a meaningful opportunity to provide evidence that would satisfy their “as-yet-unexplained interpretation” of the term “Objective Medical Findings;” reversing the district court’s grant of summary judgment in favor of the Plan because it is unclear how the term “Objective Medical Findings” applies in the mental-health context and whether Plaintiff’s evidence meets the Plan’s definition of that term; remanding case to the district court to determine whether to take new evidence or remand this case to the Plan’s administrator for a new decision. [Scoles v. Intel Corporation Long Term Disability Benefit Plan, an employee welfare benefit plan, No. 13-36167, ___ F.App’x ___, 2016 WL 4056402 \(9th Cir. July 29, 2016\)](#) (Before: PREGERSON, BEA, and OWENS, Circuit Judges).

Denial of long-term disability benefits for refusal to attend a neuropsychological evaluation is not an abuse of discretion where the terms of the disability plan provide that refusal to attend an IME is a sufficient basis to terminate benefits. [Lee v. ING GROEP, N.V., et al., No. 14-15848, ___ F.App’x ___, 2016 WL 3976532 \(9th Cir. July 25, 2016\)](#) (Before: FARRIS, O’SCANNLAIN, and CHRISTEN, Circuit Judges).

In matter where Plaintiff seeks both STD and LTD benefits for disability caused by chronic fatigue syndrome, Lyme disease, or an unspecified illness which causes extreme fatigue and inability to concentrate, denying both parties’ motions for judgment on the administrative record and remanding the claim to Unum to further develop the record; finding that, on *de novo* review, Plaintiff’s failure to meet his burden of proof is because Unum failed to ask him for additional testing; finding that Unum appears to conflate the issue of Plaintiff’s work ability with whether he has been properly diagnosed and the proper response would have been for Unum to inform Plaintiff of the necessary testing rather than simply denying his claim. [Bunger v. Unum Life Ins. Co. of Am., No. 2:15-CV-01050-RAJ, 2016 WL 3912986 \(W.D. Wash. July 20, 2016\)](#) (Judge Richard A. Jones).

Denying Plaintiff's motion seeking a declaration that disability policy's "discretionary clause" is "void and unenforceable in its entirety" under Cal. Ins. Code § 10110.6 since the University of California disability policy is not governed by ERISA and there is no actual controversy; denying Plaintiff's motion seeking a declaration that disability policy's offset provision and recoupment provisions violate Section 407 of the Social Security Act. [Dao v. Liberty Life Assurance Co. of Boston, No. 14-CV-04749-SI, 2016 WL 3595686 \(N.D. Cal. July 5, 2016\)](#) (Judge Susan Illston).

Abuse of discretion review applies where Plan documents vest the Plan Administrator with discretionary authority and Plan Administrator delegated the discretionary authority to the "the Divisional Vice President, Benefits" and decision was made by the "Divisional Vice Present, Benefits and Wellness" (affidavit attests that the title changed after the Plan delegation). Giving moderate weight to the structural conflict of interest, and finding an abuse of discretion, where the Plan Administrator failed to respond to findings from a Functional Capacity Evaluation and the Plan Administrator was informed of Plaintiff's SSDI award but did not request the decision nor considered it in the final decision. Appropriate remedy is a remand to the Plan Administrator to make an initial determination in light of all of the evidence that it should have considered in the first instance, but no reinstatement of benefits. [Gorbacheva v. Abbott Labs. Extended Disability Plan, No. 5:14-CV-02524-EJD, 2016 WL 3566979 \(N.D. Cal. June 30, 2016\)](#) (Judge Edward J. Davila).

On *de novo* review of Unum's denial of long-term disability benefits to a claimant impaired by radiculopathy and spondylolisthesis, finding in favor of Plaintiff and concluding that: (1) Unum unreasonably favored in-house consultants' opinions over examining physicians' opinions; (2) Unum insisted on additional diagnostic evidence and examinations to establish continuing disability when it was not necessary; (3) Unum overlooked records that conflicted with its conclusions; (4) Unum dismissed evidence of pain as merely subjective and unreliable contrary to Ninth Circuit precedent; (5) Unum terminated benefits despite a lack of evidence of a change in condition; and (6) Unum inappropriately discounted SSA's disability determination. [Backman v. Unum Life Ins. Co. of Am., No. 14-CV-05433-YGR, 2016 WL 3180016 \(N.D. Cal. June 8, 2016\)](#) (Judge Yvonne Gonzalez Rogers). A case involving *de novo* review of a long-term disability benefit claim denial. Backman worked as an accounting manager before becoming disabled by symptoms related to degenerative disc disease. The court found that Backman established entitlement to disability at the time her benefits were terminated. The court also found that the foundation for Unum's decision is undermined by a number of factors, including that:

- Unum favored in-house consultants' opinions over examining physicians' opinions and courts generally give greater weight to doctors who have actually examined the claimant versus those who only review the file, especially when they are employed by the insurer as here;

- Unum insisted on additional diagnostic evidence and examination to establish continuing disability when Plaintiff was following her doctor's treatment plan and was already deemed "permanent and stationary;"
- Unum overlooked records that conflicted with Unum's conclusions;
- Unum dismissed evidence of pain as merely subjective and unreliable but the Ninth Circuit has held that “the lack of objective physical findings” is insufficient to justify denial of disability benefits for conditions that lack objective physical evidence;
- Unum terminated benefits despite a lack of evidence of a change in Plaintiff's condition; and
- Unum inappropriately discounted the Social Security Administration's determination that Plaintiff is disabled.

Although Backman may have also prevailed under an arbitrary and capricious review standard, this case highlights the value of de novo review for plan participants.

On Defendants’ Rule 12 Motion to Dismiss, (1) dismissing breach of fiduciary duty claim against Defendants based on their “failure to monitor” the claims process since there is no alleged underlying breach of fiduciary duty; (2) finding that per *Cyr and Spinedex*, Plaintiff’s employer and the plan administrator and the plan sponsor are proper defendants; (3) finding that the amended complaint “relates back” to the original action since the new Defendants knew or should have known they were proper defendants in the case. [Dahmen v. Liberty Mut. Grp., Inc., No. 2:15-CV-76-SAB, 2016 WL 3072256 \(E.D. Wash. May 31, 2016\)](#) (Judge Stanley A. Bastian).

Finding that MetLife’s failure to issue a timely denial violated ERISA, and has both prejudiced Plaintiff and disrupted the litigation. Exercising authority under *Pannebecker v. Liberty Life Assur. Co. of Boston*, 542 F.3d 1213 (9th Cir. 2008) and ordering MetLife to bring Plaintiff current on his benefits and pay back benefits, with interest, to Plaintiff from the beginning of the “any occupation” period on February 11, 2013, to the present, with interest accruing at the applicable U.S. Treasury bill rate on February 11, 2013. Remanding to MetLife for a determination that complies with ERISA of Plaintiff’s benefits under the “any occupation” provision of the Plan and ordering MetLife to continue paying benefits so long as they continue to remain due under the Plan, unless and until MetLife issues a denial that fully complies with ERISA. [Tash v. Metro. Life Ins. Co., No. SACV1401914AGRNBX, 2016 WL 2944074 \(C.D. Cal. May 19, 2016\)](#) (Judge Andrew Guilford).

Plaintiff cannot assert a § 502(a)(3) claim to enjoin Defendant from ever again serving as fiduciary to the Plan. The appropriate avenue for recovering unpaid LTD benefits and prejudgment interest under an ERISA plan is § 502(a)(1)(B), not § 502(a)(3). Plaintiff cannot seek attorneys’ fees and costs under § 502(a)(3), where it is available under § 502(g)(1). The court denied Defendant’s motion to dismiss Plaintiff’s requests for disgorgement, surcharge, and other make-whole relief on the basis that such relief is

duplicative of his § 502(a)(1)(B) claim. At motion to dismiss stage, the court cannot find that disgorgement of profits constitutes the type of extracontractual damages foreclosed as a matter of law by *Russell and Sokol*. [Englert v. The Prudential Insurance Company of America, No. 15-CV-04814-HSG, 2016 WL 2770526 \(N.D. Cal. May 13, 2016\)](#) (Judge Haywood S. Gilliam, Jr.).

Sedgwick abused its discretion by denying Plaintiff long-term disability benefits without fully considering her restrictions and failing to develop the factual record necessary to make the finding that Plaintiff could work as a Customer Specialist. Sedgwick did not consider whether Plaintiff could work as a Customer Specialist without a conventional computer mouse and did not investigate whether both voice activated software and a foot mouse could actually be used to test for or work the Customer Specialist position. [Thornton v. Sedgwick CMS, No. CV 14-7942 DSF \(SHX\), 2016 WL 2731657 \(C.D. Cal. May 10, 2016\)](#) (Judge Dale S. Fischer).

“In summary, Drs. Swotinsky, Allison, and Duvall evaluated Mr. Pearson’s health with more complete information than his previous doctors had. Furthermore, Mr. Pearson's activity level undermines his reports of debilitating pain. The court accordingly concludes that Mr. Pearson has not demonstrated that he was incapable of performing the material duties of his job, and that he is therefore not disabled under the terms of the LTD policy.” [Pearson v. Aetna Life Ins. Co., No. C15-0245JLR, 2016 WL 2745299 \(W.D. Wash. May 10, 2016\)](#) (Judge James L. Robart).

No dismissal of disability claim for failure to exhaust where Defendants failed to demonstrate that any plan document expressly requires a claimant to exhaust administrative remedies. [Lin v. Metro. Life Ins. Co., No. C 15-2126 SBA, 2016 WL 1611036 \(N.D. Cal. Apr. 22, 2016\)](#) (Judge Sandra Brown Armstrong).

Cal. Ins. Section 10110.6 renders void discretionary clause found in the Plan itself, but not in the policy of insurance. On *de novo* review, claimant is disabled by Chronic Fatigue Syndrome. Court expanded administrative record to include a doctor’s declaration since Hartford failed to give Plaintiff notice that its consultants had unsuccessfully tried to contact the doctor. Court also considered Plaintiff’s SSDI decision, which was rendered one year after Hartford’s final decision. [Nagy v. Grp. Long Term Disability Plan for Employees of Oracle Am., Inc., No. 14-CV-00038-HSG, 2016 WL 1611040 \(N.D. Cal. Apr. 22, 2016\)](#) (Judge Haywood Gilliam). The court held that California Insurance Code Section 10110.6 renders void a discretionary clause found in the long-term disability plan itself, even though it was not contained in the policy of insurance. On *de novo* review of the claim denial, the court determined that the claimant is disabled by Chronic Fatigue Syndrome. In coming to this conclusion, the court considered a post-final decision declaration by the claimant’s treating

doctor since Hartford failed to give the claimant notice that its consultants had unsuccessfully tried to contact the doctor. The court also considered Plaintiff's Social Security Disability Insurance decision, which was rendered one year after Hartford's final decision. The Court's determination of the standard of review follows the weight of authority that does not permit an insured disability plan from escaping a State's ban on discretionary clauses in insurance policies by simply putting the discretionary language in the Plan document.

Plan Administrator with no authority to administer LTD claim is not a proper defendant and disability policy did not unambiguously require loss of income to occur simultaneously with disabling injury; reverse summary judgment in favor of Sun Life. [Anderson v. Sun Life Assur. of Canada, Inc., No. 13-17594, ___ F.App'x ___, 2016 WL 1359170 \(9th Cir. Apr. 6, 2016\)](#) (Before: McKEOWN, WARDLAW, and TALLMAN, Circuit Judges).

Plan participant who terminated employment was no longer "Covered Person" entitled to claim disability benefits. [Perez-Jones v. Liberty Life Ass'n Co. of Boston, No. 14-55455, ___ F.App'x ___, 2016 WL 1320516 \(9th Cir. Apr. 5, 2016\)](#) (Before: FARRIS, CLIFTON, and BEA, Circuit Judges). The Ninth Circuit affirmed the district court's determination that Plaintiff waived her right to receive long-term disability benefits by signing a severance agreement and accepting a severance package provided by her then-employer. However, the court found that the district court erred in finding that the waiver provision in the severance agreement covers Plaintiff's claim. This is because the severance agreement waives only claims Plaintiff had "up until the day [she] sign[ed]" the severance agreement, not future claims. Plaintiff was back to work from disability at the time she signed the agreement and thus had no claim to further long-term disability benefits and no ERISA claim to waive. The court affirmed the district court's decision on the basis that Plaintiff is not a "participant" in the long-term-disability plan entitled to bring an ERISA claim. Plaintiff no longer worked for the long-term-disability plan's sponsor at the time she sought long-term disability benefits because she had already signed a severance agreement and terminated her employment. Thus, she was not a "Covered Person" under the terms of the plan entitled to claim benefits. The court found that the long-term disability plan's provision for "successive periods of disability" did not give Plaintiff a claim to vested benefits and that she is not a "participant" in the long-term disability plan by virtue of her misunderstanding of the plan's terms, even if Liberty Life or her then-employer misinformed her as to the effect of the severance agreement on her ability to claim long-term disability benefits.

Sedgwick unreasonably denied short-term disability claim; remand for further consideration. [Elson vs. United Health Group Inc., et al., No. 214CV01554GMNNJK, 2016 WL 1169455 \(D. Nev. Mar. 22, 2016\)](#) (Judge Gloria M. Navarro). On the contested issue of whether the governing disability plan document adequately conferred discretionary authority to the claims administrator, Sedgwick, the court found that incongruities made it such that the court cannot discern whether the Plan was ever amended during the relevant period, and if so, whether UnitedHealth followed the Plan's amendment process. Nevertheless, the court found this issue immaterial to the analysis because Defendants unreasonably denied Plaintiff's STD claim in at

least four ways: (1) Sedgwick dismissed medical opinions from Plaintiff's treating physicians without explanation; (2) Sedgwick demanded objective evidence of a condition for which there are no objective tests and ignored what objective evidence did exist; (3) Sedgwick failed to engage in a "meaningful dialogue" with Plaintiff regarding her claim; and (4) Sedgwick's review did not adhere to the terms of the Plan, which required that Plaintiff not be able to perform the material aspects of her occupation with reasonable continuity. The court granted Plaintiff's motion for judgment under FRCP 52 in part and remanded the claim to Sedgwick for further administrative review.

Administrator's communication following California Department of Insurance complaint rendered exhaustion of administrative remedies futile. [Carey v. United of Omaha Life Ins. Co., No. 14-55483, Fed.Appx. , 2016 WL 1085703 \(9th Cir. Mar. 21, 2016\)](#) (Before REINHARDT, MURGUIA, and OWENS, Circuit Judges). The Ninth Circuit held that Plaintiff was not required to exhaust his administrative remedies for the denial of his long-term disability benefits because he qualifies for the futility exception to the exhaustion requirement. Under the futility doctrine, a claimant does not have to exhaust administrative remedies if doing so would be futile. Here, Plaintiff demonstrated that the exception applies by showing that a further request for review would have been futile. After United denied Plaintiff's LTD benefits, he filed a complaint with the California Department of Insurance (DOI), stating that his benefits were improperly denied. The DOI then sent a letter to United, asking United to "reevaluate" Plaintiff's claim for benefits and United responded in a letter to Plaintiff that it had "review[ed] all of the documentation in [Carey's] file" and was "unable to approve [his] LTD claim." In litigation, United disclaimed that it had conducted a substantive review, rather its letter simply summarized the history of United's initial claim decision. The court found that the imprecision in United's communications would have led a person in Plaintiff's position to believe that United had reviewed the substance of his case and decided anew that he was not entitled to benefits. The court further found that the plain language of the communications indicated to Plaintiff that pursuing a further request for review—thinking that one had already occurred—would have been futile. Although United argued that Plaintiff cannot establish futility because its letter informed Carey that he could appeal the results of the review it conducted after receiving the DOI inquiry, the court found that the language did not suggest to the ordinary reader that the appeal would be conducted by an outside body or by a different body within United that might, on the basis of the same evidence that United had already twice rejected, find good cause to come to an opposite conclusion. The court concluded that the district court abused its discretion by holding that exhaustion would not have been futile and granting summary judgment in favor of United. The court did not address Plaintiff's arguments regarding whether the DOI could act as his representative in the administrative appeals process.

Pension fund did not abuse its discretion in denying pension plan benefits. [Finley v. Carpenters Pension Trust Fund for N. California, No. 213CV1132GEBEFBPS, 2016 WL 1060169 \(E.D. Cal. Mar. 17, 2016\)](#) (Judge Edmund F. Brennan). In this matter involving the

denial of disability pension plan benefits, Plaintiff challenged Defendants decision finding that he was not working in covered employment for certain periods of time, the result of which was to reduce the amount of his monthly disability benefits. Specifically, he challenged the denial of Future Service Eligibility (“FSE”) credits for several periods of time and he also challenged Defendants’ determination of the date of his eligibility for disability pension benefits. The court determined that Defendants reasonably interpreted the language of the pension plan in determining the effective date for Plaintiff’s disability pension and that he was not entitled to receive FSE credits during certain absences from work. With respect to which version of the Plan applies to Plaintiff’s claim, the court found that Plaintiff was not eligible to start receiving a disability pension until January 2009, which fell during the period governed by the 2007 version of the Plan. With respect to the date Plaintiff was eligible to receive disability pension benefits, the court found that Defendants reasonably concluded that Plaintiff was not eligible for benefits until after he was entitled to receive social security disability benefits. The Plan provides that disability benefits under the Plan “begin after you have been disabled for 6 full months and continue as long as you are eligible for Social Security Disability Benefits.” Lastly, with respect to FSE credits for the disputed periods of time, the court found that Plaintiff was not absent from covered employment due to a disability, as required by section 6.04 of the Plan, and he was not entitled to receive FSE credits. The court denied Plaintiff’s motion for summary judgment and granted the Pension Fund’s cross-motion for summary judgment.

Employing a nurse case manager, and not a doctor, to conduct a medical review on appeal does not violate ERISA’s regulations where it did not prevent the full development of the record. [Anderson v. Life Ins. Co. of N. Am., No. CV-15-00428-PHX-GMS, 2016 WL 777704 \(D. Ariz. Feb. 29, 2016\)](#) (Judge G. Murray Snow). The court found that Plaintiff failed to meet her burden of proof that she was not able to do sedentary work over the relevant time period and is not entitled to either short term or long term disability benefits. The court explained that on *de novo* review, the court does not consider the process by which LINA reached its conclusions, except to the extent that the record is not complete as a result of LINA’s actions. In assessing an appeal from a group health plan’s adverse benefit determination “that is based in whole or in part on a medical judgment,” the plan must “consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment,” 29 C.F.R. § 2560.503–1(h)(3)(iii), “who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual,” 29 C.F.R. § 2560.503–1(h)(3)(v). Plaintiff argued that LINA violated § 2560.503–1(h)(3)(iii) when it employed an Appeal Nurse Claim Manager, and not a “qualified physician,” to review Plaintiff’s STD appeal. Although the court could remand the claim to take additional evidence if Plaintiff was denied a “full and fair review” because of some procedural irregularity, the court found that LINA’s use of an Appeal Nurse Claim Manager (rather than a doctor) did not prevent the full development of the record. If a claimant asserts that the record is not complete due to a procedural inadequacy, then the claimant can put forth additional facts which it asserts are necessary to provide a full review of the record, but

Plaintiff did not do so here. Consequently, the court considered the appeal on the record provided.

Surveillance video does not demonstrate that disability claimant is capable of working full time. [Young v. United of Omaha Life Insurance Company, No. 2:15-CV-00120-JLQ, 2016 WL 755639 \(E.D. Wash. Feb. 25, 2016\)](#) (Judge Justin L. Quackenbush). On *de novo* review, the court determined that Plaintiff was disabled from her regular occupation of Database Systems Engineer as a result of symptoms attributable to cervical spine degeneration, notwithstanding surveillance which showed Plaintiff going to healthcare appointments and once going to church. The court found that Plaintiff's ability to walk for 30 minutes with her dog does not contradict her claim of inability to work full-time in her regular occupation. The court further found that virtually all of the medical evidence supported Plaintiff's claim, including the initial report from Defendant's retained expert, Dr. Zoltani. Mutual of Omaha posed questions to Dr. Zoltani which reflected that it was taking an "advocacy position" towards a conclusion of non-disability, "and the responses unfortunately show the 'independent' medical examiner acquiescing to Defendant's advocacy."

Aetna's short-term disability claim denial is entitled to little deference and it abused its discretion. [Mason v. Fed. Express Corp., No. 3:14-CV-0107 JWS, 2016 WL 706163 \(D. Alaska Feb. 22, 2016\)](#) (Judge John W. Sedwick). The court found that Aetna Life Insurance Company abused its discretion in denying Plaintiff's claim for short-term disability benefits, where the evidence in the record shows that Plaintiff suffers from a permanent disability resulting from a rare autoimmune disease known as Stiff Person Syndrome ("SPS"). In so doing, the court made a number of findings. First, on the standard of review, the court found that there was evidence of significant conflict of interest and procedural irregularities which entitles Aetna to little deference. Aetna sought "clarification" from one doctor who found Plaintiff disabled and the doctor's supplemental report was "influenced" by Aetna's suggestive request for "clarification." Aetna did not seek the same "clarification" from other peer reviewers who found Plaintiff was not disabled. Procedural irregularities included deficient notices and failing to engage in a good faith exchange of information. Because the standard of review is for abuse of discretion, the court found that a bench trial on the record would be improper so it resolved the parties' motions under Rule 56. The court determined that FedEx Trade is not a proper party to this action because it does not exercise any control over the plan as an administrator or otherwise; it is just a sponsoring employer. FedEx Trade is also not the Plan administrator for purposes of Plaintiff's document penalty claim under Section 1132(c). The court concluded that Plaintiff is disabled because he suffers from a combination of painful spasms and the negative side effects from the medication he takes for those spasms. The court granted summary judgment to Plaintiff on his short-term disability benefits claim.

Reliance Standard abused its discretion by rejecting subjectively-reported limitations and denying Any Occupation benefits. [Williams v. Reliance Standard Life Ins. Co., No. 3:15-CV-00589-HZ, 2016 WL 738225 \(D. Or. Feb. 22, 2016\)](#) (Judge Hernandez). In this matter Plaintiff

challenged Reliance Standard's denial of long-term disability benefits when the LTD policy required that he be disabled by "Any Occupation" after two years of payment. After detailing all of the medical evidence the court found that Defendant's determination can be supported only if it was reasonable to reject the limitations acknowledged by Plaintiff's treating practitioners, both IME neurologists, and the scores of other specialists who have examined him. Here, objective testing has failed to establish a specific diagnosis for Plaintiff's symptoms, but the record clearly shows that Plaintiff's report of symptoms has been consistent since their inception. Plaintiff's doctors find that Plaintiff's subjective symptoms are disabling. The court found that given the policy language and controlling case law, Defendant's rejection of Plaintiff's subjective complaints was not reasonable just because there was no objective medical evidence establishing them. First, the policy itself does not require that "sickness" be established by only objective medical evidence, nor does it require that the inability to perform the material duties of Any Occupation be established by objective medical evidence. Second, where symptoms, like pain, cannot be objectively measured, an insurer cannot arbitrarily reject subjectively-reported limitations. The court found that a heightened abuse of discretion review was warranted due to procedural irregularities, including that the denial letter did not identify any specific information or explanation of the necessity of such information. Specifically, Defendant telling Plaintiff that he could perform light work was not enough to tell Plaintiff that he had to provide proof that he was incapable of light duty work. The court granted Plaintiff's motion for summary judgment and denied Reliance Standard's motion.

Motion to dismiss for failure to disclose LTD claim in bankruptcy petition denied where evidence plausibly suggests such omission was inadvertent; benefit claim and equitable relief claims permitted to proceed at this stage. [McGlasson v. Long Term Disability Coverage for All Active Full-Time & Part-Time Employees, other than those classified by the Employer as Pilots, who are U.S. residents & whose Total Annual Cash Comp. is between \\$60,000 & \\$199,999, excluding temporary & seasonal Employees, an ERISA benefit plan, et al., No. 2:15-CV-01512 JWS, 2016 WL 540835 \(D. Ariz. Feb. 11, 2016\)](#) (Judge John W. Sedwick). In this lawsuit for denied long-term disability benefits, Defendants seek dismissal of Count I (claim for benefits) based upon judicial estoppel because Plaintiff failed to disclose his claim for LTD benefits in his bankruptcy petition. After Defendants filed the motion to dismiss, Plaintiff reopened the bankruptcy petition and argued that judicial estoppel should not be applied because the omission was not intentional. Defendants also seek dismissal of Counts II and III (brought under Section 1132(a)(3)) arguing that Plaintiff is not seeking "appropriate equitable relief" but, rather, is improperly repackaging his benefits-denial claim. The court found that Plaintiff's evidence is sufficient at this stage to show that there was no intent to conceal his LTD claim in the bankruptcy proceedings on the part of Plaintiff. The court found that it was plausible that Plaintiff's omission of his potential claims against Defendants was mistaken or inadvertent since he disclosed them to his attorney and listed his LTD benefits in the financial affairs section of the bankruptcy petition. The court concluded that it cannot dismiss Plaintiff's claim for benefits pursuant to a Rule 12(b)(6) motion based on such a dispute but this does not preclude the parties

from pursuing further factual development for further adjudication as to whether judicial estoppel applies. With respect to Plaintiff's Section 1132(a)(3) claims, the court also declined to dismiss these claims. The court found the relief requested for Prudential's violation of § 1132(a)(3), in addition to an injunction, is a surcharge to compensate him for extra-contractual losses suffered as a result of Prudential's breach. The court distinguished *Rochow* as not addressing the situation in this case. Moreover, Plaintiff specifically alleged that additional monetary relief is necessary to make him whole, and the court cannot determine whether this is true at the motion-to-dismiss stage. The court concluded that it should wait for a more fully developed record and summary judgment before deciding whether the relief sought by Plaintiff under Counts II and III is duplicative of the relief sought by Plaintiff under Count I.

Court remands to MetLife consideration of “any occupation” benefits where MetLife terminated LTD benefits nine days short of “any occupation” period, mishandled the claim, and later admitted liability for “own occupation” period. [Hantakas v. Metro. Life Ins. Co., No. 214CV00235TLNKJN, 2016 WL 374562 \(E.D. Cal. Feb. 1, 2016\)](#) (Judge Troy L. Nunley). In this long-term disability dispute, Plaintiff was employed by Kaiser Permanente as Assistant Director of Imaging in the Radiology Department of Kaiser Permanente Hayward, until May 26, 2010, when severe pain and sciatica rendered her unable to perform the material duties of her job. MetLife paid Plaintiff LTD benefits until nine days short of the full 24-month “own occupation” period, relying on a file review conducted by MetLife Medical Director, Dr. Veena Vani, who claimed that Plaintiff had “no objective exam findings to show ongoing impairment to preclude sedentary work.” Plaintiff, through her attorney, administratively appealed MetLife's termination of benefits. On appeal, MetLife obtained a file review from Dr. Robert Lee Waltrip and sent it to Plaintiff's physicians. When MetLife did not make a timely decision, Plaintiff filed suit. MetLife then decided that it would pay Plaintiff the 9 days left in the own occupation period and agreed to pay Plaintiff's attorney \$13,500 in fees. MetLife requested that the court remand the claim to MetLife to make a determination about Plaintiff's eligibility for benefits under the “any occupation” definition of Total Disability under the Plan. Plaintiff opposed the remand. The court granted MetLife's request, agreeing with MetLife that no decision has been reached about Plaintiff's eligibility for benefits under the “any occupation” definition. All communications between MetLife and Plaintiff have been about her eligibility for benefits during the initial 24 month “own occupation” period. The court rejected Plaintiff's argument that MetLife's determination that Plaintiff cannot perform her own “sedentary” occupation is exactly the same as being unable to perform “any occupation.” Although the court agreed that MetLife failed to follow appropriate claim procedures as to Plaintiff's appeal of the denial of her “own occupation” benefits, the failure to follow ERISA claim procedures for the initial appeal does not impute to MetLife's decision under the “any occupation” standard. The court also rejected Plaintiff's argument that the Social Security Administration's decision that Plaintiff is disabled requires MetLife to approve her “any occupation” claim. Because MetLife never considered Plaintiff's eligibility under the more stringent “any occupation” standard for extended benefits, the court found that there is nothing for it to review until MetLife makes a decision.

Accordingly, the court remanded the matter to MetLife to decide Plaintiff's eligibility for "any occupation" benefits. The court acknowledged the mishandling of Plaintiff's claim and required MetLife to file a realistic and expedient timeline for their decision of Plaintiff's LTD claim. The court decided to stay the case pending MetLife's decision in order to prevent any further prejudice to Plaintiff.

Denial of LTD claim beyond 24-month limitation for Mental Disorders is not an abuse of discretion. [Nelson v. Standard Insurance Company, et al., No. 13CV188-WQH-MDD, 2016 WL 184400 \(S.D. Cal. Jan. 13, 2016\)](#) (Judge Williams Q. Hayes). In this putative class action against Defendants related to Standard's administration of the Countrywide Financial Corporation Group Long Term Disability Plan, the court granted summary judgment to Standard on Plaintiff's individual claim for additional LTD benefits beyond the Plan's 24-month limit for disabilities caused by a Mental Disorder. The court found that the determination that Plaintiff's inability to work was caused or contributed by her major depressive disorder and that major depressive disorder was a Mental Disorder subject to the 24-month limit under the Policy was reasonable, well-supported by the record, and consistent with the express terms of the Policy. The court rejected Plaintiff's contention that her disability was caused by sleep apnea and her depression was caused by her inability to work. The court found that Standard reasonably relied upon specific provisions of the policy, objective testing from Plaintiff's treating physicians, medical records from treating physicians showing mild sleep apnea, and the opinions of two reviewers (Dr. Douglas T. Brown and Dr. William Herzberg) consistent with the medical records provided by Plaintiff. Further, no treating physician report in the record opined that Plaintiff's sleep disorders were disabling.

Prevailing claimant entitled to prejudgment interest at the rate set out in 28 U.S.C. § 1961, not at the Oregon statutory rate. [Culp v. Metropolitan Life Insurance Company, No. 3:14-CV-01133-PK, 2016 WL 96150 \(D. Or. Jan. 8, 2016\)](#) (Judge Anna J. Brown). On Defendants' objections to the Magistrate Judge's recommendation that Plaintiff is entitled to prejudgment interest at the Oregon statutory rate, the court declined to adopt the Magistrate Judge's recommendation and awarded prejudgment interest at the rate set out in 28 U.S.C. § 1961. The court explained that Plaintiff does not point to any evidence in the record to establish that he suffered the loss of his ability to invest money in funds at a rate of return higher than that earned on T-Bills or that he had to borrow money at a higher rate to compensate for lost benefits. Plaintiff relied on a case from the Western District of Tennessee (*Warden v. MetLife*) to support his claim that the rate of prejudgment interest should be determined under state law unless MetLife can demonstrate that it overcompensates Plaintiff. The court found that this case relies on a Sixth Circuit case that does not support an award of prejudgment interest at the state's rate, rather, it noted that a district court may look to state law for guidance. The court pointed to other decisions from this court declining to award prejudgment interest in ERISA benefits cases at the Oregon statutory rate or at rates different from the one set out in § 1961.

J. Tenth Circuit

MetLife’s conflict of interest is a factor that weighs against affirming MetLife’s interpretation in this case, where it allowed a medical director to single-handedly interpret the scope of an undefined Plan term without documenting any rationale. MetLife’s interpretation of the Plan’s schizophrenia exclusion is unreasonable where it required the precise diagnosis of schizophrenia (Plaintiff was diagnosed with schizoaffective disorder), since its interpretation is inconsistent with the DSM, inconsistent with other Plan exclusions, analogous case law does not support MetLife’s interpretation, and MetLife’s interpretation undermines public policy. Claim remanded to MetLife to decide and Plaintiff awarded attorney’s fees. [Duncan v. Metro. Life Ins. Co., No. 2:15-CV-626TS, 2016 WL 6651317 \(D. Utah Nov. 10, 2016\)](#) (Judge Ted Stewart). Duncan was diagnosed with Schizoaffective Disorder. Her long-term disability plan caps benefits due to disability caused by a mental or nervous condition at two years unless the condition is attributable to schizophrenia, dementia, or organic brain disease. MetLife denied Duncan’s long-term disability benefits based on its interpretation that the schizophrenia exclusion does not include schizoaffective disorder. The court found that MetLife’s decision was arbitrary and capricious. On the standard of review, the court found that MetLife’s hiring of outside doctors has little effect on MetLife’s conflict of interest since its interpretation of schizophrenia is the sole issue before the court. MetLife allowed a medical director to interpret the scope of an undefined Plan term without documenting any rationale. The court found that the procedural irregularities in MetLife’s interpretative process “heighten the likelihood that MetLife made its interpretation in part to avoid a substantial payment of benefits ...” As such, the court found that MetLife’s conflict of interest is a factor that weighs against affirming MetLife’s interpretation in this case.

On the merits of MetLife’s interpretation, the court found that the “schizophrenia” exclusion is ambiguous. The Plan does not define schizophrenia. The DSM-5, however, uses the term schizophrenia to refer both to a specific disorder and to a spectrum of disorders, including schizoaffective disorder. Plus, the Plan’s exclusion for schizophrenia precedes an exclusion for dementia, which is a general term that includes many neurocognitive disorders. The court found that MetLife’s interpretation is unreasonable because it is inconsistent with the DSM and with other Plan exclusions. Additionally, the potential overlap between schizophrenia and schizoaffective disorder is so great that it is not reasonable for MetLife to rely only on the name of the diagnosis to define the scope of the exclusion. The court also found that MetLife’s interpretation undermines public policy because it is unduly restrictive.

Although the court found that MetLife abused its discretion, it remanded the claim to MetLife to remedy its deficiencies. But, the court did award Duncan attorney’s fees and costs and directed Duncan to submit an affidavit detailing reasonable attorney’s fees.

Plaintiff is not estopped from arguing her ADA claim on the basis that it is fundamentally inconsistent with her ERISA claim, where Plaintiff has made no clear assertion that she cannot perform the essential functions of her position with an accommodation. Even if the facts Plaintiff alleges to support her ERISA and ADA claims conflict, Rule 8(d)(3) provides that a party may state as many separate claims or defenses as it has, regardless of consistency. [Anderson-Posey v. Unum Life Insurance Company Of America & CVS Pharmacy, Inc., No. 16-CV-0086-CVE-FHM, 2016 WL 5955902 \(N.D. Okla. Oct. 13, 2016\)](#) (Judge Claire V. Eagan).

Deseret Mutual Benefit Administrators abused its discretion in limiting disability benefits for Plaintiff, disabled by a severe, systemic yeast infection (systemic candidiasis or candida), on that basis that it qualified as chronic pain or a fatigue-related illness under the insurance plan, which limits coverage for such disabilities to twelve months. DMBA unreasonably interprets the Plan where it takes the position that the 12-month limitation applies as long as the primary symptoms of an illness are pain and fatigue. Court interprets provision as allowing employees Plan benefits while they seek a diagnosis for their pain or fatigue in the event the employee's pain or fatigue is caused by a condition not limited to twelve months of coverage. [Black vs. Deseret Mutual Benefit Administrators, No. 2:15-CV-00695-TC, 2016 WL 5173246 \(D. Utah Sept. 21, 2016\)](#) (Judge Tena Campbell).

United of Omaha did not abuse its discretion in interpreting disability plan terms to find that Plaintiff became disabled no earlier than July 2nd when disabling injury occurred on July 1st (the be same day that Plaintiff's salary was reduced from \$83,150 to \$54,995), thus entitling Plaintiff to a smaller monthly benefit amount. [Greggory B. Owings v. United of Omaha Life Insurance Company, No. 15-CV-1108-EFM, 2016 WL 1660550 \(D. Kan. Apr. 27, 2016\)](#) (Judge Eric F. Melgren).

Procedural irregularity in communicating first-level appeal denial warrants remand to claims administrator. [Messick v. McKesson Corp., No. 15-4019, Fed.Appx. , 2016 WL 624861 \(10th Cir. Feb. 17, 2016\)](#) (Before TYMKOVICH, Chief Judge, KELLY and LUCERO, Circuit Judges). In this matter, Plaintiff filed suit for short-term disability benefits after LINA exceeded the maximum time for deciding his first-level appeal. However, LINA had timely denied the appeal but misaddressed the denial letter. After Plaintiff learned that the first-level appeal had been denied, he argued for *de novo* review, or in the alternative, a remand of his claim to LINA. The court determined that misaddressing the administrative appeal decision does not constitute a serious procedural error warranting *de novo* review, but that the appropriate remedy is a remand to LINA so that Plaintiff may pursue his second-level administrative appeal.

Denial of benefits based on incomplete analysis of disability claimant's job requirements is an abuse of discretion. [McMillan v. AT&T Umbrella Benefit Plan No. 1, No. 14-CV-717-GKF-FHM, 2016 WL 528230 \(N.D. Okla. Feb. 9, 2016\)](#) (Judge Gregory Frizzell). Plaintiff brought suit seeking judicial review of the denial of his claim for short-term and long-term

disability under the AT&T Umbrella Benefit Plan No. 1. He contended that the plan administrator denied his claim without considering his ability to perform the cognitive and travel requirements of his position. The court agreed that the administrator denied Plaintiff's short-term disability claim based on an incomplete understanding of his job duties and, consequently, that its decision was arbitrary and capricious. In denying STD benefits, Sedgwick, the claims administrator, relied exclusively on the reports of its PAs, none of which expressly considered Plaintiff's ability to perform the cognitive or travel requirements of his position. One doctor concluded that neuropsychological records did not reveal a cognitive abnormality so severe as to render Plaintiff disabled, but the report does not contain any discussion (or recognition) of the cognitive requirements of Plaintiff's position. Rather, the doctor described Plaintiff's duties as sedentary with sitting, typing and talking requirements but these requirements are incomplete. The court remanded Plaintiff's claim back to Sedgwick for further determination.

K. Eleventh Circuit

[*Earley v. Liberty Life Assurance Company Of Boston*, No. 16-12934, __F.App'x__, 2016 WL 7406314 \(11th Cir. Dec. 22, 2016\)](#) (Before JORDAN, ROSENBAUM, and EDMONDSON, Circuit Judges). The court affirmed the district court's denial to reopen under Rule 60(b)(6) the *pro se* plaintiff's dismissed ERISA claim for long-term disability benefits. Plaintiff claimed that his medical condition, including suffering from two strokes, constitutes sufficient "extraordinary circumstances." The court found that Plaintiff's first stroke occurred more than six months after the court dismissed with prejudice his ERISA claim so his medical condition had no bearing on the failure in his original and amended complaints to state a claim under ERISA or on Plaintiff's failure to comply otherwise with court orders. On this record, the court cannot conclude that the district court's ruling constituted an abuse of discretion.

This court remanded to Defendant the long-term disability claim for Plaintiff, a registered nurse, who allegedly became disabled from her occupation following a total abdominal hysterectomy. The court found that the Dictionary of Occupational Titles requires Plaintiff to be able to perform medium duties, but Defendant's denial letter supports that the lesser "sedentary" duty standard was applied. On remand, Defendant must evaluate the evidence provided and apply the medium duty standard that the parties agree must be applied here, and if necessary, the "any occupation" disability standard in the Plan.

[*Graham v. Life Ins. Co. of N. Am.*, No. 1:15-CV-3240-WSD, 2016 WL 6958151 \(N.D. Ga. Nov. 28, 2016\)](#) (Judge William S. Duffey, Jr.).

In matter challenging denial of "any occupation" disability benefits to claimant with lumbar degenerative disease and obesity, finding that: (1) Novelis, the former employer not charged with any decisionmaking responsibility, is entitled to judgment on the administrative record as to Plaintiff's termination of benefits claim against it; (2) Liberty acted reasonably in relying on its medical reviewer's report since the opinion was similar to

that of Plaintiff's doctors; (3) Liberty cannot be held liable under § 1132(c)(1) as a fiduciary of Novelis for failing to respond to Plaintiff's document requests; and (4) any claim based on Liberty's delay in sending Plaintiff the curriculum vitae of all of the experts consulted fails. [Hallman v. Liberty Life Assurance Co. of Boston, No. 3:15-CV-49 \(CDL\), 2016 WL 6662706 \(M.D. Ga. Nov. 10, 2016\)](#) (Judge Clay D. Land).

Affirming the district court's affirmation of Prudential's decision to deny Plaintiff's long-term disability benefits claim, where the only support of Plaintiff's claim of cognitive impairment was "a scribble" in doctor's notes that read, "Not able to make decisions." In contrast, each of the two doctors that Prudential consulted concluded that the scribble is unsupported and insufficient to evince cognitive impairment. Additionally, for four years, Plaintiff successfully performed the same duties without receiving bad performance reviews. [Ramdeen v. Prudential Insurance Company of America, et al., No. 16-11179, ___ F.App'x ___, 2016 WL 6134819 \(11th Cir. Oct. 21, 2016\)](#) (Before WILSON, JORDAN, and JULIE CARNES, Circuit Judges).

Plaintiff was a financial sales professional with AXA who experienced neck and back pains stemming from injuries suffered in 2003. He regularly worked 70 to 75 hours per week until July 2008, but, due to the pain from the injuries, reduced his workload to 60 hours per week through February 2009, and then 45 hours and below per week thereafter. He was considered a full-time employee during the relevant period since he met his sales goals as a sales associate. Plaintiff applied for LTD benefits in the fall of 2008, but MetLife denied his claim in October 2009. The court found that MetLife properly concluded that being "Disabled" required a functional limitation, and that being "Disabled" and "Active at Work" were not overlapping periods under the LTD Plan. MetLife did not act unreasonably in determining that Plaintiff was not functionally limited where MetLife had his claim reviewed by four independent physician consultants who attempted to contact Plaintiff's past physicians before making their findings. MetLife also hired vocational consultants who found that Plaintiff could successfully perform his duties. [German v. Metro. Life Ins. Co., No. 15-60392-CIV, 2016 WL 5661628 \(S.D. Fla. Sept. 30, 2016\)](#) (Judge Marcia G. Cooke).

Granting motion for judgment to Aetna where denial of long term disability benefits was supported by hired consultants who only did paper reviews of the claim and where sufficient medical evidence supported the decision. Plaintiff's gastroenterologist made no determination that Plaintiff was disabled, Plaintiff's endocrinologist concluded that Plaintiff's diabetes was not disabling and that her diabetes was stable, and Plaintiff's one doctor who claimed that she was disabled noted in a phone call with a reviewing doctor that he did not consider Plaintiff to be disabled. [Kendrick v. Aetna Life Insurance Company, No. CV415-074, 2016 WL 5024223 \(S.D. Ga. Sept. 16, 2016\)](#) (Judge William T. Moore).

Dismissing employer, Honda, from lawsuit for short-term disability benefits since Honda did not play any role in administrating Plaintiff's claim or otherwise controlling the short-term disability group plan. [Dempsey v. Sedgewick Claims Mgmt. Servs., Inc., No. 4:16-CV-1003-VEH, 2016 WL 4530130 \(N.D. Ala. Aug. 30, 2016\)](#) (Judge Virginia Emerson Hopkins).

Affirming Mutual of Omaha's decision to deny Plaintiff's long-term disability claim based on the plan's pre-existing condition provision where Plaintiff's physician's statement listed the diagnosis as "sciatica" and "back pain/spasm," and indicated that Plaintiff's symptoms first appeared after a fall which occurred prior to the plan's look-back period, the fall had resulted in later-discovered fractures to Plaintiff's spine, Plaintiff sought treatment for back pain before, during, and after the look-back period, including having prescriptions for Tramadol, Hydrocodone, and Volatren filled. [Horneland v. United of Omaha Life Ins. Co., No. 8:15-CV-1703-T-33TGW, 2016 WL 4441680, at \(M.D. Fla. Aug. 23, 2016\)](#) (Judge Virginia M. Hernandez Covington).

Where disability policy provides that no benefits are payable for a loss caused or contributed to by use of alcohol, intoxicants, or drugs, except as prescribed by a physician, and where Plaintiff suffered a disabling brain injury while intoxicated, finding that Defendant failed to conduct a sufficient investigation that would allow the administrator to reasonably find a causal link between Plaintiff's alcohol consumption and his fall and reversing Defendant's decision to deny Plaintiff's LTD benefits. [Prelutsky v. Greater Georgia Life Ins. Co., No. 1:15-CV-628-WSD, 2016 WL 4177469 \(N.D. Ga. Aug. 8, 2016\)](#) (Judge William S. Duffey, Jr.)

Granting summary judgment in favor of Defendants on Plaintiff's long-term disability claim and finding that: (1) there is no conflict of interest where Aetna determines benefit eligibility but FedEx funds the Plan; (2) Aetna reasonably interpreted SSA's findings that Plaintiff could walk 1 hour and sit 4 hours to mean that she could work at least five hours a day in a combination of sedentary and light physical settings; (3) Aetna considered a favorable compensation and pension review at the VA OPC but later records showed improvement in Plaintiff's condition; and (4) Aetna reasonably relied on peer review reports by Drs. John-Paul Rue and Martin Mendelssohn. [Mercado v. Fed. Express Corp., No. 15-21472-CIV, 2016 WL 3905719 \(S.D. Fla. July 19, 2016\)](#) (Judge Marcia G. Cooke).

Denying Plaintiff's motion under Rules 59 and 60 of the Federal Rules of Civil Procedure from the Order granting summary judgment in favor of Lincoln on Plaintiff's **long-term disability** claim, where Plaintiff makes essentially the same arguments as she does in her summary judgment motion and does not identify any clerical errors. [Till v. Lincoln Nat'l Life Ins. Co., No. 2:14-CV-721-WKW, 2016 WL 3667593 \(M.D. Ala. July 7, 2016\)](#) (Judge W. Keith Watkins).

Granting summary judgment in favor of Aetna on Plaintiff's long-term disability claim, where Aetna's decision was supported by an independent medical examination performed by Dr. Leonard Cosmo and a peer review performed by Dr. Wendy Weinsten that found that Plaintiff did not have a Total Disability and was able to work twenty-five hours a week. [Street v. Aetna Life Ins. Co., No. 8:15-CV-388-T-24 MAP, 2016 WL 2961556 \(M.D. Fla. May 23, 2016\)](#) (Judge Susan C. Bucklew).

Lincoln did not abuse its discretion in denying long-term disability benefits to claimant with multilevel degenerative disc disease, where it relied on reviews by a registered nurse and two board-certified independent medical consultants. [Till v. Lincoln Nat'l Life Ins. Co., No. 2:14-CV-721-WKW, F.Supp.3d , 2016 WL 1631796 \(M.D. Ala. Apr. 25, 2016\)](#) (Judge W. Keith Watkins).

Voluntarily accepted submissions post-final appeal does not expand the scope of the administrative record. [Blair v. Metropolitan Life Insurance Company, No. 4:13-CV-1789-VEH, 2016 WL 808135 \(N.D. Ala. Mar. 2, 2016\)](#) (Judge Virginia Emerson Hopkins). On August 22, 2013, Plaintiff initiated this long-term disability benefits case against Defendant Metropolitan Life Insurance Company ("MetLife") in the Circuit Court of Etowah County, which was removed to this court on the basis of federal preemption. Prior to that, on April 3, 2012, Plaintiff had filed an essentially indistinguishable long-term disability benefits case against MetLife in Etowah County, which action MetLife similarly removed to federal court ("Blair I"). On May 12, 2014, this case ("Blair II") was stayed and administratively closed while the Eleventh Circuit considered the merits of an appeal in Blair I. The Eleventh Circuit decided Blair I in favor of MetLife in an unpublished opinion—*Blair v. Metlife*, 569 F. App'x 827 (11th Cir. 2014), cert. denied, 135 S. Ct. 1414, 191 L. Ed. 2d 364 (2015)—issued initially on June 23, 2014, by the Eleventh Circuit and subsequently entered as a mandate in Blair I. In Blair I, the Eleventh Circuit found that MetLife did not violate ERISA but not considering certain evidence submitted as part of Plaintiff's "second appeal" to MetLife, which MetLife agreed to review as a courtesy. The court lifted the stay and reinstated Blair II and considered Plaintiff's motion to amend the complaint, MetLife's renewed motion to dismiss, and other motions. The court found that the Eleventh Circuit's opinion in Blair I means that Plaintiff's LTD claim asserted in Blair II is not plausible under ERISA. They are substantially identical ERISA lawsuits and seek redress from MetLife's final denial of Plaintiff's LTD claim. The court adopted as persuasive authority the Eleventh Circuit's unpublished decision in Blair I, which instructs that once a final denial of an ERISA claim has occurred and the claims administrator has advised the plaintiff that she has exhausted her administrative remedies, a plaintiff's subsequent submissions in support of her finally-determined benefits claim, even if voluntarily accepted by the administrator, do not expand the scope of the record for determining ERISA liability. The court rejected Plaintiff's efforts to create a plausible ERISA claim by asserting waiver on the part of MetLife by virtue of its voluntary decision to undergo a second courtesy review of Plaintiff's LTD Claim. "The court

strongly doubts that the Eleventh Circuit will ever apply waiver to sustain an ERISA benefits claim premised upon an insurer's willingness to undergo a courtesy review of supplemental records, which non-mandatory process is then circumvented by a plaintiff's intervening appeal to federal court in a related action the challenges the final denial of the same long-term disability claim." The court also found that because Section 502(a)(1)(B) adequately addresses Plaintiff's benefits-related injury under ERISA, her LTD claim cannot be salvaged by resorting to ERISA's conditional catchall provision by invoking waiver, judicial estoppel, or any other equitable doctrine against MetLife.

Denial of disability benefits is not *de novo* wrong where Plaintiff failed to provide evidence supporting cognitive impairment. [Ramdeen v. Prudential Ins. Co. of Am., No. 615CV139ORL28TBS, 2016 WL 715791 \(M.D. Fla. Feb. 19, 2016\)](#) (Judge John Antoon II).

The court found that Prudential's denial of Plaintiff's long-term disability claim was not *de novo* wrong because Plaintiff did not meet his burden of establishing disability from his regular occupation as a Broker/Dealer Services Unit Manager as a result of a stroke and resulting cognitive impairment. Plaintiff argued that the court should afford some leniency regarding his failure to file supportive documentation because he was unrepresented during the administrative process. The court rejected this argument as without merit since the LTD Plan contains clear headings and easy-to-understand explanations of the requirements for eligibility. Further, Prudential complied with 29 C.F.R. § 2560.503-1(g)(1)(i)-(iii), and its notifications of denial detailed the reasons for denial, contained references to the Plan provisions, and thoroughly explained Plaintiff's appeal rights. When Plaintiff failed to submit additional evidence with his second appeal, Prudential notified him in writing that he could still submit additional information, but Plaintiff did not do so. The court found no evidence that Plaintiff's alleged cognitive condition prevented him from properly presenting his claim and appeal. On Plaintiff's short-term disability claim, the parties agreed that the STD benefits at issue fall under the "payroll practice" exception to ERISA and governed by ordinary contract principles. The court found that Defendant did not breach the STD policy when it terminated Plaintiff's STD benefits. Specifically, Defendant did not breach the STD policy by awaiting Prudential's final decision as to the LTD benefits claim before denying Plaintiff's second appeal for STD benefits or by failing to order an independent neuropsychological evaluation. Because Plaintiff was awarded SSDI benefits after Defendant conducted its reviews and ultimate determination, the court found the SSDI award irrelevant.

L. D.C. Circuit

In dispute alleging improper denial of short-term and long-term disability plan benefits, affirming the district court's grant of summary of judgment in favor of Defendants and holding that: (1) the Court of Appeals had jurisdiction to consider on appeal Appellant's challenge to the order denying her motion for reconsideration even though she designated only the summary judgment order and failed to specifically designate the order denying the

motion for reconsideration in her notice of appeal, because she gave notice in five contemporaneous appellate filings that her appeal included a challenge to the denial of her motion for reconsideration; (2) short-term disability plan was “payroll practices plan,” and thus was exempt from ERISA, because the employer dispensed benefits pursuant to that plan from its general assets and the plan was entirely separate from the employer’s ERISA-covered employee benefits plan; (3) deferential arbitrary and capricious standard of review applied in assessing administrator’s denial of the claim for long-term disability benefits where the plan unambiguously gave the administrator sole authority to construe the terms of the plan; and (4) short-term disability benefits plan did not relate to ERISA-covered long term disability plan in such way as to preempt any state-law relief because there was nothing in the LTD plan that had any bearing on the merits of the state-law breach of contract claim. [Foster v. Sedgwick Claims Mgmt. Servs., Inc., ___ F.3d ___, No. 15-7150, 2016 WL 6956669 \(D.C. Cir. Nov. 29, 2016\)](#) (Before: Rogers and Tatel, Circuit Judges, and Edwards, Senior Circuit Judge).

Concluding that Plaintiff’s salary for purposes of calculating her disability benefit was based on her hourly rate assuming a 40-hour workweek even though she had worked reduced hours in the weeks leading up to her date of disability; remanding matter to Reliance Standard to determine eligibility for benefits under the “any occupation” definition of disability; awarding 60% of attorneys’ fees requested (\$72,240) and post-judgment interest of .27%. [Marcin v. Reliance Standard Life Ins. Co., No. CV 13-1308 \(ABJ\), ___ F.Supp.3d ___, 2016 WL 4148175 \(D.D.C. Aug. 4, 2016\)](#) (Judge Amy Berman Jackson).

VII. *Discovery*

A. First Circuit

Court grants request for discovery in part. [Nicholas v. Cigna Life Ins. Co. of New York, No. 14-CV-14117-ADB, 2016 WL 755612 \(D. Mass. Feb. 25, 2016\)](#) (Judge Burroughs). In this matter involving a denial of LTD benefits, the court granted in part and denied in part Plaintiff’s motion to take limited focused discovery. The court denied Plaintiff’s requested interrogatories 1-3, which concern the track record of Dr. Darrin Campo. CLICNY represented that it does not keep track of past LTD claims by medical reviewer and that it would need to manually review each claim file to obtain the information requested. The court found that this would be burdensome, especially in light of Dr. Campo’s certifying at the end of his medical report that he has “no direct or indirect financial incentive for a particular determination.” The court denied discovery targeted at CLICNY’s general policy and procedures, since the administrative record already contains a substantial collection of such documents. The court also denied discovery of performance evaluations for an Appeal Claim Manager, since this falls beyond the “narrowly tailored” discovery permitted in an ERISA benefit-denial case. The court ordered CLICNY to:

(1) report the total compensation paid to MES Solutions in 2011 and explain CLICNY's basis for determining how much to compensate MES Solutions in 2011; (2) explain the basis or method for compensating Dr. Campo and explain what input, if any, CLICNY has into which doctors are selected by MES Solutions to evaluate CLICNY's LTD benefit claims; and (3) produce documents showing CLICNY's procedures, if any, to prevent or mitigate the effect of structural conflicts. The court explained that this limited discovery will fill the existing gaps in the administrative record and help the court to determine the significance of the conflict in this case.

B. Second Circuit

In long-term disability benefit dispute, the court adopts the approach by other courts permitting conflict of interest discovery in the absence of any evidence of in the record that conflict tainted the decision making. The court declines to apply the “reasonable chance” standard to the extent that it would require Plaintiff to point to specific evidence in the administrative record that Hartford’s structural conflict affected its decision just to gain entitlement to discovery on that very issue. The court limited discovery to document requests and a deposition of a representative of Hartford pursuant to Fed. R. Civ. P. 30(b)(6), without prejudice to Plaintiff later seeking to depose other witnesses. [Chau v. Hartford Life Ins. Co., No. 1:14-CV-8484-GHW, 2016 WL 7238956 \(S.D.N.Y. Dec. 13, 2016\)](#) (Judge Gregory H. Woods).

In long-term disability dispute, the court found that Plaintiff is entitled to conflict of interest discovery, where she alleged that: (1) after finding Plaintiff disabled for seven years, Prudential terminated Plaintiff’s benefits without identifying a single medical finding that showed her impairments had changed or improved, (2) in 2011, a medical review by Prudential’s John Leclerq determined that Plaintiff’s disability would not improve and that Prudential should “pay through the maximum duration date of 11/15/2038”; (3) although Plaintiff had been found to be disabled for many years by numerous physicians, both employed by Prudential and otherwise, Prudential had another insurance medical examination performed in 2014 by Dr. William Head Jr., who Plaintiff alleges is “notorious for aggressively seeking to sell his IME opinion to whomever is willing to pay for it”, (4) Dr. Head’s November 13, 2014 report never explained how any of Plaintiff’s records showed that Plaintiff’s condition had improved enough that she had regained the ability to do full time work, (5) Dr. Head’s report was rejected in March 2015 by Dr. Armistead Williams III, who had previously treated Plaintiff, and (6) in April 2015, Prudential terminated Plaintiff’s benefits in reliance solely on Dr. Head’s report. Plaintiff is directed to serve revised discovery requests that are less broad and is entitled to four depositions. [Kostas v. Prudential Insurance Company of America, No. 16-CV-1033 \(VSB\), 2016 WL 5957306 \(S.D.N.Y. Oct. 13, 2016\)](#) (Judge Vernon S. Broderick).

Finding that the following facts satisfy the good cause standard for discovery outside of the administrative record: (1) after Plaintiff's Social Security claim had been denied, which increased Prudential's liability, Prudential reevaluated Plaintiff's medical condition even though Prudential had previously concluded that Plaintiff had reached maximum medical improvement and could not do any sedentary work; (2) a non-examining medical consultant who only works for Prudential concluded that Plaintiff could do sedentary work without identifying any medical records to support that conclusion; and (3) Prudential terminated Plaintiff's benefits without identifying any medical finding that demonstrated her functioning had improved. But, Plaintiff's current discovery requests are overbroad and the parties are required to meet and confer to limit the scope of the requests. [Shelton v. Prudential Ins. Co. of Am., No. 16-CV-1559 \(VEC\), 2016 WL 3198312 \(S.D.N.Y. June 8, 2016\)](#) (Judge Valerie Caproni).

In enforcement of judgment action stemming from ERISA class action litigation, Government properly withheld documents under FOIA Exemption 5, which prevents disclosure of inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency. [Welby, Brady & Greenblatt, Llp v. The United States Department of Health and Human Services & Sylvia Matthews Burwell, Sec'y, , No. 15-CV-195 \(NSR\), 2016 WL 1718263 \(S.D.N.Y. Apr. 27, 2016\)](#) (Judge Nelson S. Roman).

Court permits discovery regarding disability reviews done by doctor employed by University Disability Consortium. [Feltington v. Hartford Life Ins. Co., No. 14CV6616ADSAKT, 2016 WL 1056568 \(E.D.N.Y. Mar. 15, 2016\)](#) (Judge A. Kathleen Tomlinson). In this matter involving a denial of long-term disability benefits, Plaintiff moved to seek certain discovery beyond the administrative record. The court denied Plaintiff's request for the court to order Hartford to produce a witness under Federal Rule of Civil Procedure 30(b)(6) to testify regarding Hartford's handling of correspondence it received from Plaintiff after Hartford issued its decision on administrative appeal and closed Plaintiff's file. Instead, the court ordered Hartford to produce responsive information regarding whether Hartford has an internal procedure for reopening or reconsidering closed claims, and if such a procedure exists, what that procedure is and whether that procedure was applied or followed with regard to Plaintiff's claim. The court also denied Plaintiff's request to depose the doctor retained by Hartford to review Plaintiff's medical documentation on appeal since the court found that Plaintiff did not show that there is a reasonable chance that deposing the doctor will lead to admissible evidence which satisfies the good cause standard. However, the court did order Hartford to respond to an interrogatory with information regarding: (1) the number of times Hartford received a medical review of a long-term disability claim from Dr. Neal Small of University Disability Consortium; and (2) the number of times Dr. Small found the claimant to be disabled.

C. Third Circuit

Although the formation of a plan as a tax-qualified plan is a settlor activity and is not subject to the fiduciary exception of the attorney-client privilege, analyzing options for potential plan amendments to comply with tax-qualified requirements is a settlor function to which the attorney-client privilege applies. Documents reflecting legal advice regarding communications with beneficiaries are also subject to the fiduciary exception. [Romero v. Allstate Ins. Co., No. 01-3894, 2016 WL 6568078 \(E.D. Pa. Nov. 4, 2016\)](#) (Magistrate Judge Marilyn Heffley).

In matter involving the denial of partial hospitalization benefits for an eating disorder and other related mental health benefits, denying Movant New Jersey Department of Banking and Insurance’s motion to quash subpoena Plaintiff served upon non-party HMSPermedion, Inc., finding that even if the Health Care Quality Act’s confidentiality provision is read to preclude the participant from accessing her administrative file it will be preempted by ERISA. “If the confidential mandate of the New Jersey Health Care Quality Act is read to prevent Plaintiff from accessing her complete record, it will directly conflict with the rights granted by ERISA regarding a full and fair review. The provision will be preempted by ERISA and Plaintiff will be permitted to examine the documents. Alternatively, a reading of the Health Care Quality Act that takes into account the drafters’ intention to protect the privacy interests of the plan participant will afford Plaintiff access to the documents in question.” [B. v. Horizon Blue Cross Blue Shield of New Jersey, No. 14CV01153CCCCLW, 2016 WL 5791402 \(D.N.J. Sept. 30, 2016\)](#) (Magistrate Judge Cathy L. Waldor).

Discovery beyond administrative record denied where Plaintiff did not establish a good faith basis for discovery on conflict of interest. [Hilbert v. Lincoln Nat’l Life Ins. Co., No. 1:15-CV-0471, 2016 WL 727584 \(M.D. Pa. Feb. 24, 2016\)](#) (Judge Sylvia H. Rambo). This matter involves a dispute over long-term disability benefits. Plaintiff moved to compel extra-record discovery regarding the impact of Lincoln National’s structural conflict of interest. The court denied the motion because it found that Plaintiff failed to establish any good faith basis for alleging bias or other irregularity in Lincoln National’s decision-making process that affected her claim or that raises a reasonable suspicion of misconduct. “The court will not grant Plaintiff’s request to conduct discovery outside the administrative record simply because she hopes that it may lead to some proof of bias after a long and costly search.”

D. Fourth Circuit

In suit by a health care service provider against Aetna Health and Life Insurance Company for underpayment of a claim made on behalf of an individual who received services from

Upper Bay, finding that Upper Bay fails to justify its request for discovery of matters extrinsic to the administrative record and denying its motion for limited discovery. [Upper Bay Surgery Ctr., LLC v. Aetna Health & Life INS. Co., No. JKB-15-2992, 2016 WL 2939739 \(D. Md. May 20, 2016\)](#) (Judge James K. Bredar).

E. Fifth Circuit

In lawsuit involving a denied disability benefit claim, the court granted Plaintiff's motion to strike Defendants' expert witness Justin Robbins, M.D., since his report was not before the Administrator when she denied Plaintiff's claim. The report was dated after Plaintiff already filed suit. Because Defendants cannot prove that an exception should apply, the report should not be included in the administrative record. [Hutchings v. Lyons, No. 4:15-CV-00538, 2016 WL 5942319 \(E.D. Tex. Oct. 13, 2016\)](#) (Judge Amos L. Mazzant, III).

Court grants in part and denies in part motion to compel responses to discovery requests related to MetLife's conflict of interest. [Curtis v. Metro. Life Ins. Co., No. 3:15-CV-2328-B, 2016 WL 687164 \(N.D. Tex. Feb. 19, 2016\)](#) (Judge David L. Horan). In this case challenging the denial of long-term disability benefits, Plaintiff moved to compel MetLife to respond to a number of interrogatories and requests for production of documents aimed at determining the procedural irregularities and MetLife's conflicts of interest in processing Plaintiff's claim. The court analyzed the amendments to FRCP 26(b) and 26(c), effective December 1, 2015, which requires that discovery be proportional to the needs of the case and authorizes protective orders to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense. The court found that the amendments to Rule 26 do not alter the burdens imposed on the party resisting discovery. Further, just as was the case before the December 1, 2015 amendments, under Rules 26(b)(1) and 26(b)(2)(C)(iii), a court can – and must – limit proposed discovery that it determines is not proportional to the needs of the case. The court found that the amendments to Rule 26(b) and Rule 26(c)(1) also do not alter the basic allocation of the burden on the party resisting discovery to – in order to prevail on a motion for protective order or successfully resist a motion to compel – specifically object and show that the requested discovery does not fall within Rule 26(b)(1)'s scope of relevance (as now amended) or that a discovery request would impose an undue burden or expense or is otherwise objectionable or properly subject to a protective order. Relying on the Fifth Circuit decision in *Crosby* and the relevant rules, the court granted Plaintiff's motion in part. The court determined that MetLife is required to supplement its answer to more fully describe the policy and methods used to determine compensation for the claims and appeals specialists who handled Plaintiff's claim, such as any policy or method for determining and calculating bonuses, pay increases, or gain sharing. However, the court did not permit discovery regarding compensation of supervisors up to the head of the claims department (whom MetLife has represented is not involved in

individual claims decisions), because this is not proportional to the needs of the case. The court also required MetLife to respond to an interrogatory explaining how the policy and methods used to determine compensation for the claims and appeals specialists who handled Plaintiff's claim take account of the items listed in (a)-(h) of Interrogatory No. 7. Regarding discovery of MetLife's outside medical consultants and claims handlers, the court required MetLife to generally describe what, if any, methods MetLife uses to monitor or impose quality assurance measures on the outside medical consultants or independent physician consultants involved with Plaintiff's claims. But, the court determined that Plaintiff is not entitled to responses to discovery requests regarding performance evaluations. The court did not require MetLife to respond to discovery related to claims consistency or its organizational chart. For a number of MetLife's unsupported objections, the court found those objections to be waived and overruled. The court ordered each party to bear its own costs in relation to the motion and that MetLife must file a supplemental appendix attaching an amended privilege log by February 24, 2016 and to respond to the discovery requests by March 11, 2016.

F. Sixth Circuit

Granting Liberty Life's motion for trade secret protection of the following documents: (a) customized claims handling policies, procedures, and exceptions;(b) bonus plan for employees, as reflected in Liberty's Variable Incentive Plan;(c) organizational structure of its claims and appeals units;(d) contracts with third party vendors;(e) contracts, including financial compensation, with its consulting physicians; and (f) training curricula provided to specific employees. [Owens v. Liberty Life Assurance Co. of Boston, No. 415CV00071JHMHBB, 2016 WL 7238816 \(W.D. Ky. Dec. 14, 2016\)](#) (Magistrate Judge H. Brent Brennenstuhl).

In long-term disability dispute, the court denied Liberty Life's motion for a protective order and overruled its objections to the Magistrate Judge's Supplemental Order requiring Liberty Life to answer an interrogatory regarding the file reviewers who actually participated in the determination of Plaintiff's claim and limited the discovery request to the previous ten years. Neither the proportional language in Fed. R. Civ. P. 26(b)(1) nor the fact that Liberty Life would have to perform a time-consuming, file-by-file review of numerous claim files warranted a reversal of the Magistrate's discovery order. [Owens v. Liberty Life Assurance Co. of Boston, No. 4:15CV-00071-JHM, 2016 WL 6156182 \(W.D. Ky. Oct. 21, 2016\)](#) (Judge Joseph H. McKinley, Jr.).

For purposes of the fiduciary exception to the attorney-client privilege, adopting the majority view that the employer/administrator has the burden of demonstrating counsel's communications concerned non-administrative/non-fiduciary matters or personal representation in potential or pending litigation. The fiduciary exception also applies to work product protection and Defendants bear the burden of demonstrating each of the

documents at issue were prepared in anticipation of litigation. Documents that were utilized in the context of preparing a response to the OIG's request for information and materials which is an act of plan administration are within the scope of the fiduciary exception. The court granted in part and denied in part Plaintiffs' motion to compel production of allegedly privileged documents and submission of more complete privilege logs. [Durand v. Hanover Ins. Grp., Inc., No. 3:07-CV-00130-HBB, 2016 WL 6089739 \(W.D. Ky. Oct. 17, 2016\)](#) (Magistrate Judge H. Brent Brennenstuhl). This case, which involved a lengthy discussion on the application of the fiduciary exception to the attorney-client privilege. The court adopted the majority view in finding that the employer/administrator has the burden of demonstrating counsel's communications concerned non-administrative/non-fiduciary matters or personal representation in potential or pending litigation. The court also held that the fiduciary exception applies to work product and the party asserting the privilege bears the burden of demonstrating that disputed documents were prepared in anticipation of litigation.

Court will not disturb the magistrate judge's ruling that discovery is permitted based on the allegation that Liberty Life had a conflict of interest. With respect to the discovery permitted by the Magistrate Judge: (1) overruling Liberty Life's objection that permit Scott-Warren to seek discovery of the insurance company's answer to the complaint and affirmative defenses; (2) modifying the order and requiring Liberty Life to answer the statistical data interrogatories beginning on November 5, 2009, and, only with regarding claims submitted by Dr. Tal Jiva (and not about other CompPartners' other reviewers who were not involved in Plaintiff's claim); and (3) "Liberty Life must answer questions concerning is connections, contractual or otherwise, to CompPartners and Dr. Tal Jiva and the financial payments paid to them annually, along with information concerning any documentation of administrative processes designed only to check the accuracy of grant of claims. But Liberty Life is not required to provide any response regarding the credibility or professional backgrounds of CompPartners or Dr. Tal Jiva. Liberty Life is not required to provide documents pertaining to other claimants because those documents are not relevant to Scott-Warren's claims, and they would contain confidential information that could raise serious HIPPA concerns and would make production of documents far more burdensome than potentially relevant. Additionally, as discussed above, the Court will modify the relevant time period to begin on November 5, 2009." [Suzette Scott-Warren v. Liberty Life Assurance Co. of Boston, No. 314CV00738CRSCHL, 2016 WL 5661774 \(W.D. Ky. Sept. 29, 2016\)](#) (Judge Charles R. Simpson).

In life insurance dispute where applicability of ERISA is contested, ordering that Plaintiff is entitled to discovery regarding the contents of the Gannett benefits website at the time that he utilized it in 2011 through the time that the lawsuit was filed in 2013, as well as the ability of Gannett, Xerox, and/or any website administrator that may currently be employed by Gannett, to produce copies of the website as it appeared during that time

period. [Masterson v. Xerox Corporation, et al., No. 3:13-CV-692-DJH, 2016 WL 4926439 \(W.D. Ky. Sept. 14, 2016\)](#) (Magistrate Judge Colin Lindsay).

In long-term disability case, where Liberty seeks protection of personnel documents or information regarding training provided to specific employees who were decisionmakers with respect to Plaintiff's LTD claim and documents and information that contain confidential, proprietary and/or trade secrets, denying Liberty Life's motion for entry of a protective order of confidentiality since Liberty failed in its motion to sufficiently demonstrate that the documents are confidential commercial information for which disclosure will cause a clearly defined and very serious injury and that there is good cause for entry of a protective order. [Owens v. Liberty Life Assurance Co. of Boston, No. 415CV00071JHMHBB, 2016 WL 4523889 \(W.D. Ky. Aug. 29, 2016\)](#) (Magistrate Judge H. Brent Brennenstuhl).

Liberty is not entitled to reconsideration of the portion of the prior order granting discovery under Plaintiff's interrogatory number 15 seeking information about the nature of Liberty Life's relationship with medical opinion providers since Liberty was aware that it would have to review a significant number of files in order to respond to interrogatory number 15 when it advanced its initial opposition to Plaintiff's motion for discovery. [Owens v. Liberty Life Assurance Co. of Boston, No. 415CV00071JHMHBB, 2016 WL 4499098 \(W.D. Ky. Aug. 26, 2016\)](#) (Magistrate Judge H. Brent Brennenstuhl).

In matter involving denial of long-term disability benefit, denying Principal's motion to alter or amend the court's minute order regarding Plaintiff's discovery requests. With respect to statistical data involving third party vendors for peer review or independent medical evaluations, Principal objected that production of the records would require between 20,540-30,810 man hours reviewing individual claim files. The court reiterated that compliance with these discovery requests is only expected to the extent that contractual relationships with vendors/reviewers grant Principal access to these third parties' compilations of the requested data. [Card v. Principal Life Ins. Co., No. CV 5:15-139-KKC, 2016 WL 3982806, \(E.D. Ky. July 22, 2016\)](#) (Judge Karen K. Caldwell).

In long-term disability benefit matter: (1) ordering that Defendant need not respond to any discovery requests that are expressly related to the previously dismissed disgorgement claim; (2) noting that Plaintiff's instruction at the top of her discovery requests informing Defendant to contact counsel for any clarification before the expiration of the 30-day response deadline adds obligations beyond the scope of Rules 33 and 34 and any court orders; (3) denying motion to compel as to interrogatories seeking identifying information about each person involved in the LTD claim and appeal denial and Liberty Life's performance review procedures for disability claim unit personnel; (4) granting motion to

compel interrogatories seeking material factual basis for each affirmative defense stated in Liberty Life's answer to the complaint, information in its possession regarding any incentive, bonus, or reward programs or systems for disability claims personnel, information regarding Defendant's relationship with third party, CompPartners, and the specific reasons and documents supporting claim and appeal denial; (5) granting request for production of documents relating to Liberty Life's training materials and manuals utilized by the LTD claims unit in processing Plaintiff's claim, the long-term disability claims unit organizational structure, and the contracts, draft reports, final reports, authorization to affix a physician signature to a final report, dictated opinions, correspondence, emails, notes, diary entries, and statistical reports relating to third-party CompPartners; and (6) denying request for production of documents seeking compensation and performance reviews for LTD personnel. [Scott-Warren v. Liberty Life Assurance Company of Boston, No. 3:14-CV-738-CRS-CHL, 2016 WL 3866617 \(W.D. Ky. July 13, 2016\)](#) (Magistrate Judge Colin Lindsay).

Finding that Plaintiff is entitled to take a Rule 30(b)(6) deposition of Liberty Life's designated representative(s) on the topics consistent with the court's rulings as to Plaintiff's written discovery requests (noted above); reminding parties that the general rule is that the deposition of a corporation by its agents and officers should be taken at the corporation's principal place of business; denying request for sanctions for failure to appear at noticed deposition. [Scott-Warren v. Liberty Life Assurance Company of Boston, No. 3:14-CV-738-CRS-CHL, 2016 WL 3876660 \(W.D. Ky. July 13, 2016\)](#) (Magistrate Judge Colin Lindsay).

In a long-term disability matter, ordering that the deposition of [Hartford's](#) Rule 30(b)(6) designee be taken in the corporation's principal place of business and deposition of its two employees be taken in their respective places of residence. Regarding permissible topics of discovery, the court permitted limited inquiry into: Hartford's training of claims personnel to comply with the ERISA claim regulations; and any incentive, bonus, or reward programs or systems that Hartford has for its disability claims personnel (but not compensation paid to specific employees). Court denied discovery into: further inquiry into Hartford's claims unit organizational structure; Hartford's reduction of monthly benefits by "Other Income Benefits" as well as its collection practices related to these benefits; and Hartford's earnings and profits for its disability claims unit, including its use of claim closure targets and tracking of reserves. [Davis v. Hartford Life & Accident Insurance Company, No. 3:14-CV-00507-TBR, 2016 WL 3843478 \(W.D. Ky. July 13, 2016\)](#) (Judge W. Keith Watkins).

Insurer's inherent conflict supports request for discovery; pre-trial conference to address permissible scope of discovery. [Card v. Principal Life Insurance Company, No. CV 5:15-139-KKC, 2016 WL 1298723 \(E.D. Ky. Mar. 31, 2016\)](#) (Judge Karen K. Caldwell). In this dispute involving the denial of long-term disability benefits and the parties' discovery impasse, the court

found that Principal Life's inherent financial conflict of interest gives the court reason to be skeptical of Principal's disability determination and entitles Plaintiff to some discovery on the conflict. Defendant challenged many of Plaintiff's requests and interrogatories. Consistent with the recently amended Federal Rules of Civil Procedure, the court believed that a pretrial conference would provide the best forum for expediting disposition of this action and address the permissible scope of discovery. The court reminded the parties of their duty under the amended rules to secure the just, speedy, and inexpensive determination of every action.

Limited discovery permitted in ERISA disability case. [Proffitt v. Metro. Life Ins. Co., No. 3:14-CV-1576, 2016 WL 880520 \(M.D. Tenn. Mar. 8, 2016\)](#) (Judge John S. Bryant). In this matter involving a denial of disability benefits, Plaintiff moved to be allowed to conduct discovery. The court found that Plaintiff met the local threshold for obtaining limited discovery by alleging that (1) MetLife's investigation into the Plaintiff's disability claims was inadequate and/or (2) MetLife's inherent conflict of interest influenced its decision to deny the Plaintiff's disability claims. The court permitted the following revised interrogatory:

State whether MetLife had, at any time relevant to this case, any type of incentive, bonus, or reward program or system, formal or informal, **based on the value or number of medical and/or disability claims that are denied or terminated**, for any employees involved in any meaningful way in reviewing medical claims, and please describe what factors and information is relied upon to calculate any such bonuses.

The court did not permit an interrogatory asking MetLife to define the term "objective clinical findings" as it relates to Plaintiff's disability claim since it is not pertinent to establishing bias or a lack of procedural due process. The court did permit the following revised request for production:

For any MetLife employees involved in any meaningful way in reviewing Mr. Proffitt's disability claim, including the employees who signed the denial letters, please provide copies of any documents which show any type of incentive, bonus, or reward program or system, formal or informal, **based on the value or number of medical and/or disability claims that are denied or terminated**, for said employees, and all documents showing how such bonus was calculated.

Lastly, the court found that three requests to admit or deny were outside the scope of ERISA discovery and MetLife need not respond to them.

Discovery of plan administrator's alleged bias and conflict of interest is permitted. [Christman v. CoreSource, Inc., et al., No. 2:14-CV-1913, 2016 WL 491830 \(S.D. Ohio Feb. 9, 2016\)](#) (Magistrate Judge Terence P. Kemp). In this case, Plaintiff is a plastic and reconstructive surgeon who treated a patient for substantial injuries sustained in a motor vehicle accident. The patient's mother is a participant in the relevant employee welfare benefit plan and she assigned her plan rights to Plaintiff. Reid is the plan's administrator, and CoreSource, Inc. is the plan's

claims processor. The plan paid Plaintiff only a small portion of the services it provided to the patient. Plaintiff filed a motion to compel, asserting that he is entitled to conduct discovery beyond the administrative record concerning Reid's alleged bias and conflict of interest. The court granted the motion to the extent that Plaintiff is allowed limited discovery only into Reid's alleged bias and conflict of interest. In granting the motion, the court found that the administrative record possesses enough evidence of bias or conflict of interest to justify the requested discovery. Specifically, communications plausibly showed that Reid offered a false reason for delaying a decision because it was working to find a basis upon which to deny Plaintiff's claim. Additionally, Reid's use of Ellis Consulting, which resulted in Reid reversing CoreSource's initial processing of the claim, appeared to have led to a departure from the typical administration of a claim.

Court permits substantial conflict of interest discovery in LTD case. [Sim v. Reliance Standard Life Ins. Co., No. 1:15-CV-390, 2016 WL 319868 \(S.D. Ohio Jan. 26, 2016\)](#)

(Magistrate Judge Karen L. Litkovitz). In this matter involving a denial of long-term disability benefits, Plaintiff moved for discovery and to supplement the administrative record. The court found that discovery is warranted in this case given the structural conflict of interest (Reliance served as both the Plan administrator and the payor of benefits) and because Defendants' finding that Plaintiff was not totally disabled is contrary to the Social Security Administration's finding that plaintiff was totally disabled. The court found the following topics within the permissible scope of discovery:

- Incentive, bonus, or reward programs or systems, formal or informal, for any employees involved in any meaningful way in reviewing disability claims;
- Policies, informal or formal, that reward claims denials;
- Contractual connections and the historic relationship between Reliance and the reviewers, vocational professionals, and/or vendors utilized in Plaintiff's claim;
- Financial payments made annually to the reviewers, vocational professionals, and/or vendors utilized in Plaintiff's claim;
- Data regarding the number of claim files sent to the reviewers, vocational professionals, and/or vendors utilized in Plaintiff's claim, and the number of denials which resulted;
- Data regarding the number of times Reliance vocational professionals, employees, vendors, reviewers, and/or personnel classify a regular occupation as sedentary, found disability claimants able to work at a sedentary occupation, or found claimants to be not disabled from their regular occupation or any occupation;
- Data regarding the number of claims received by legacy employees of the Plan, and the number of denials;
- Documentation of administrative processes designed to check the accuracy of grants of claims;

- Policies and procedures regarding the processing and adjudication of claims, and the gathering of claims information, and to ensure the fair and proper administration of Plaintiff's claim;
- An explanation of the factual basis of Reliance's defenses;
- Information regarding Plaintiff's duties at the time he became disabled; and
- A specimen application for benefits, to include the Employer Section.

Based on the court's ruling that Plaintiff is entitled to discovery of those portions of the claims manual and other statements of guidance upon which Defendants relied, the court denied Plaintiff's motion to supplement the record as moot. The court explained that it will consider any such documents that Plaintiff presents as evidence of Defendants' conflict of interest or bias and it is inappropriate for portions of the claims manual and statements of guidance upon which Defendants did not rely to be made part of the administrative record.

G. Seventh Circuit

[*Suson v. PNC Financial Services Group, et al.*, No. 15C10817 \(N.D. Ill. Nov. 28, 2016\)](#). This decision follows a discovery dispute and motion to compel information and documents pertaining to Suson's short-term disability ("STD") claim. Suson was twice awarded STD benefits following an absence from work due to disability and a failed attempt to return to work. Following exhaustion of her STD benefits, the PNC Plan denied Suson's claim for LTD benefits. In the transition process, Suson's attorney made attempts to obtain the STD claim file and was given assurances that the LTD department would review the entire STD claim file. In addition, in Suson's administrative appeal of her denied LTD claim, she pointed out that PNC's STD plan approved her STD benefits. At issue in the motion to compel is a request for admission of fact that PNC has the authority to direct Hewitt Associates to produce a STD claim file to the claim administrator of the Plan and document requests seeking the complete file considered to approve Suson's STD benefits and documents disclosing the eligibility criteria for STD benefits. The court granted Plaintiff's motion to compel discovery pertaining to her STD benefits. It explained that the administrator knew about Plaintiff's STD benefits and even though the STD files were not part of the administrative record, "they were only a phone call away."

In ESOP matter, Defendants moved to compel on various documents the Secretary withheld due to various privileges: attorney-client, government investigative file, government deliberative process, work product, and common interest. Counsel for the Secretary instructed the department's investigator, Charles Visconti, not to answer various questions at his deposition. The court denied Defendants' motion to compel the deposition testimony of Mr. Visconti. The court also granted in part and denied in part Defendants' motion to compel the production of documents. [*Perez v. Mueller*, No. 13-CV-1302, 2016 WL 6882851 \(E.D. Wis. Nov. 22, 2016\)](#) (Magistrate Judge William E. Duffin).

In long-term disability benefit matter, granting Plaintiff’s motion seeking an order requiring Reliance Standard Life Insurance Company to provide Plaintiff the administrative record and claim file, but denying Plaintiff’s motion seeking an order requiring Reliance Standard to submit initial Rule 26(a) disclosures, and to permit Plaintiff “the full panoply of discovery provided for by the Federal Rules of Civil Procedure” since Plaintiff has not made a showing sufficient to meet the conflict of interest exception to discovery in ERISA cases. [Dragus v. Reliance Standard Life Ins. Co., No. 15-C-09135, 2016 WL 3940106 \(N.D. Ill. July 21, 2016\)](#) (Judge Marvin E. Aspen).

In a long-term disability matter where Plaintiff argued that [Aetna’s](#) vocational consultants failed to provide a labor market survey and that a vocational report’s underlying data did not show available jobs within a reasonable geographical area, the court disagreed with Plaintiff’s assertions and found that Plaintiff failed to show the existence of a specific conflict of interest or instance of misconduct to warrant discovery related to Aetna’s alleged structural conflict of interest. [Schrock v. Aetna Life Insurance Company, No. 15 C 10582, 2016 WL 3693428 \(N.D. Ill. July 12, 2016\)](#) (Magistrate Judge Mary M. Rowland).

Motion to compel discovery responses denied. [Sumpter v. Metropolitan Life Ins. Co., No. 1:13-CV-0347-TWP-DKL, 2016 WL 772552 \(S.D. Ind. Feb. 29, 2016\)](#) (Magistrate Judge Denise K. LaRue). Plaintiff brought suit against MetLife for denying his claim for an early payout of his basic life insurance benefit. His complaint included four causes of action, including a claim for benefits, for breaches of fiduciary duty, and for document penalties for failing to provide the summary of material modification and summary plan description. Plaintiff moved to compel Defendant to respond to interrogatories and produce all documents requested in a subpoena. The court denied the motion, finding that Plaintiff’s claims “appear doomed” and the discovery at issue is not proportional to the needs of the case. The court also found that since MetLife cannot be held liable for failure to provide plan documents, any discovery relating to that issue is not likely to lead to relevant information. Lastly, the court found that discovery relating to alleged failures to follow claims procedures would be unlikely to uncover relevant information and would be disproportionate to the needs of the case since relief for failing to follow claims procedures is deemed exhaustion.

H. Eighth Circuit

In long-term disability matter, granting in part Plaintiff’s motion for additional discovery and permitting only request for production of documents and things related to (1) internal communications from Prudential related to the reason Plaintiff’s particular file was brought up for review; and (2) Standard Operating Procedures (“SOP”) used by Prudential to determine when to review and terminate benefits, including SOP outlining any criteria used for triggering a review. [Johnston v. Commerce Bancshares, Inc., No. 4:15-CV-0852-DGK, 2016 WL 4083492 \(W.D. Mo. Aug. 1, 2016\)](#) (Judge Greg Kays).

Following grant of default judgment against Defendants for delinquent fringe benefit contributions, granting Plaintiffs' motion to compel post-judgment discovery and ordering deposition of representative of judgment debtor pursuant to FRCP 69. [Carpenters' District Council Of St. Louis And Vicinity, et al., v. F.G. Lancia Custom Woodworking, LLC, et al., No. 4:06-CV-1673 CAS, 2016 WL 3903209 \(E.D. Mo. July 19, 2016\)](#) (Judge Charles A. Shaw).

In matter challenging validity of a QDRO, granting surviving spouse's motion to limit discovery related to the separation agreement since the court will not look beyond the Franklin County Circuit Court's March 2015 order to determine whether it is a QDRO. But, if the court later determines that the order is a QDRO, there may be circumstances where the intent of the parties is relevant and the former spouse can seek such discovery at that point. [Anheuser-Busch Companies Pension Plan v. Laenen, et al., 2016 WL 3753702 \(E.D. Mo. July 14, 2016\)](#) (Judge Catherine D. Perry).

I. Ninth Circuit

Motion to compel granted in part; fiduciary exception to attorney-client privilege applies to pre-final denial communications; no waiver of privilege found. [A.F., by & through his parents & guardians, Brenna Legaard & Scott Fournier, et al. v. Providence Health Plan, No. 3:13-CV-00776-SI, 2016 WL 1171022 \(D. Or. Mar. 24, 2016\)](#) (Judge Michael H. Simon). This matter challenges Providence's denial of ABA therapy for plan beneficiaries diagnosed with Autism Spectrum Disorder based on the use of a Developmental Disability Exclusion. Plaintiffs moved to compel pursuant to FRCP 37(a) for Providence to produce: (1) documents listed in an amended privilege log except for those dealing with the lawsuit; (2) documents and communications of any type relating to Providence's conversations with counsel about Providence's use of the Developmental Disability Exclusion not related to litigation; (3) testimony from deponents whom Plaintiffs plan to depose about Providence's conversations with counsel about Providence's use of the Developmental Disability Exclusion not related to litigation; and (4) redacted portions of email strings previously produced by Providence. The court determined that the documents and testimony Plaintiffs seek concern the sincerity of Providence's efforts to understand and perform its responsibilities regarding ABA therapy coverage and its consideration and use of the Developmental Disability Exclusion and the Experimental Exclusion. Therefore, they are relevant to determining whether there is a remediable wrong for which "other appropriate equitable relief" is warranted and, if so, what form that relief should take. With respect to the application of the fiduciary exception to the attorney-client privilege, the court found that Providence acted as a fiduciary with respect to each Plaintiff's Plan when it made its company-wide decisions regarding ABA therapy coverage. The court ordered Providence to produce all requested documents to the extent that they concern plan

administration, such as how the Plan or Plans ought to be interpreted or applied, and do not address any potential or actual civil or criminal liability or were prepared with such liability in mind. The court noted that the interests of the ERISA fiduciary and the beneficiary diverge for purposes of the fiduciary exception after the final administrative appeal, and that the earliest date of the final determination of any Plaintiff's final administrative appeal is April 30, 2013. On the issue of waiver of the attorney-client privilege, the court concluded that because Optum was acting as Providence's agent, Providence did not waive the attorney-client privilege when it forwarded an email from its counsel to Optum. Providence did so in the context of asking Optum to change its language regarding ABA therapy coverage in letters Optum sends to Plan members on Providence's behalf. The court found that Optum had a significant relationship to Providence and Providence's involvement in the transaction that is the subject of legal services, and Optum had a reasonable need to know about the content of the communications.

Court permits Rule 30(b)(6) deposition on conflict of interest and denies other requested discovery. [Sender v. Franklin Res. Inc., No. 11-CV-03828-EMC \(SK\), 2016 WL 814627 \(N.D. Cal. Mar. 2, 2016\)](#) (Magistrate Judge Sallie Kim). Plaintiff sought to depose five individuals "to unpack exactly how and to what extent Franklin's conflict of interest affected that administration," as well as response to ten interrogatories and ten requests for admissions on the subject of Franklin's conflict of interest. The court only permitted Plaintiff the opportunity to conduct a Fed.R.Civ.P. 30(b)(6) deposition of the individual(s) knowledgeable of the following subjects: (1) Steps taken to investigate the subject claim; (2) The factual basis for the denial of the claim; (3) Franklin's information regarding the address of Plaintiff, including record of his address in 1982, information on this subject gained during the administration and investigation of the claim, the removal of termination distribution documentation with the wrong address from the exhibits provided to the administration committee; (4) When the decision to prepare the denial of claim was made and by whom; (5) Evidence that Plaintiff did or did not receive ESOP shares; (6) Procedures in place in 2007-08 to reduce bias in claim administration; (7) Communications between Plaintiff and Defendant's representatives. The court denied Plaintiff's request to depose the five individuals and to propound written discovery.

Several withheld attorney-client privileged communications must be produced as a result of the fiduciary exception to privilege. [Sender v. Franklin Res. Inc., No. 11-CV-03828-EMC \(SK\), 2016 WL 641633 \(N.D. Cal. Feb. 18, 2016\)](#) (Magistrate Judge Sallie Kim). In this matter, Plaintiff alleged that Defendant failed to issue stock to Plaintiff that he earned from his participation in Defendant's ESOP. Plaintiff moved to compel production withheld on the grounds of attorney-client privilege. He sought documents generated before his final administrative appeal was denied on December 5, 2008. The court rejected the argument that there is a bright line rule that until an ERISA administrative benefit claim is finally denied, there can be no attorney-client privilege. Instead, the court found that it is not merely a question of timing in the claim process, but an evaluation of the content of the communication – whether the communication involves administration of the claim or the potential liability of the trustee. The

court performed an *in camera* review of the documents at issue and ordered production of the following: an October 23, 2008 email from outside counsel to the company's Benefits Program Manager, with copies to Senior Association General Counsel for Defendant and other outside counsel, because the communication was not "defensive in nature"; a January 29, 2008 email from outside counsel to the company's Benefits Program Manager which involves issues of plan administration; a February 1, 2008 email from the company's Benefits Program Manager to outside counsel involving plan administration; a February 29, 2008 email from outside counsel to the company's Benefits Program Manager involving plan administration. The court denied the motion with respect to about 15 other communications.

In class action context, court finds fiduciary exception to attorney-client privilege applies to withheld communications. [Wit v. United Behavioral Health, No. 14-CV-02346-JCS, 2016 WL 258604 \(N.D. Cal. Jan. 21, 2016\)](#) (Magistrate Judge Joseph C. Spero). In this putative class action, Plaintiffs allege that their health insurance plans have wrongfully denied insurance coverage for mental health and substance abuse-related residential treatment based on internal guidelines developed by Defendant United Behavioral Health ("UBH"), which administers their insurance plans. Plaintiffs moved to compel Defendants to produce nine categories of documents listed on Defendants' October 30, 2015 privilege log that Defendants allegedly improperly redacted or withheld as privileged. The court engaged in a lengthy analysis of attorney-client privilege and the fiduciary exception to the attorney-client privilege. It found a dearth of cases dealing with the fiduciary exception in the class action context. It concluded that in the class action context, as in cases involving individual claimants, an approach that focuses too heavily on litigation exposure without requiring a showing that advice was actually sought for defensive purposes undermines the principles that the fiduciary exception is designed to protect. To invoke the fiduciary exception, either the context (e.g. actual or imminent litigation on the subject of the communication) or the contents of the communications themselves must reflect that they are defensive in nature and relate to advice sought and obtained to determine how far the trustees are "in peril." Based on this, and after reviewing sample documents offered by Plaintiffs, the court found that Defendants withholding of communications on their privilege log was based on an interpretation of the fiduciary exception more narrowly than the case law supports by relying on the mere possibility of future litigation to withhold communications whose primary purpose was not defensive but rather, for the benefit of the ERISA plan members. The court ordered UBH to produce the sample documents offered by Plaintiff in unredacted form and for UBH to review the remaining documents on its privilege log to determine, whether under the reasoning of the Court's Order, additional communications must be produced.

J. Tenth Circuit

Denying long-term disability claimant's motion to compel Hartford to respond to two interrogatories pertaining to instances in which Hartford has obtained medical opinions through third-party University Disability Consortium ("UDC") and used those medical

opinions as the bases for denial or approval of claims for long-term disability benefits; granting parties' motion for Level 1 Restriction of Exhibits including Hartford internal policy manuals and guidelines and an Independent Medical Consultant Services Agreement between Hartford and UDC. [Rickaby v. Hartford Life and Accident Insurance Company, No. 15-CV-00813-WYD-NYW, 2016 WL 1597589 \(D. Colo. Apr. 21, 2016\)](#) (Judge Nina Y. Wang).

VIII. *Exhaustion of Administrative Remedies*

A. First Circuit

In case brought as a state wage and hour action, finding that the complaint seeks the value of benefits as a dimension to the monetary relief requested for various claims but lacks information about the claim for benefits and insufficiently pleads exhaustion; dismissing each cause of action for plaintiff Kane as relates to fringe benefits. [Hamilton v. Partners Healthcare Sys., Inc., No. CV 09-11725-DPW, F.Supp.3d , 2016 WL 3962813 \(D. Mass. July 21, 2016\)](#) (Judge Douglas P. Woodlock).

B. Second Circuit

Dismissing without prejudice Plaintiff's lawsuit seeking GE's Supplemental Pension Plan ("SPP") benefits for failure to exhaust administrative remedies as set forth in the plan documents even though Plaintiff did not have plan documents at the time he filed the complaint. [Zupa v. Gen. Elec. Co., No. 3:16-CV-00217 \(CSH\), 2016 WL 3976544 \(D. Conn. July 22, 2016\)](#) (Judge Haight).

C. Third Circuit

Failure to make a decision on a disability claim within 45 days renders it deemed exhausted. [Puzzo v. Metro. Life Ins. Co., No. 15-3190 \(FLW\)\(LHG\), 2016 WL 1224029 \(D.N.J. Mar. 29, 2016\)](#) (Judge Wolfson). MetLife moved to dismiss on the basis that Plaintiff failed to exhaust administrative remedies, which the court denied. Defendant acknowledged receipt of Plaintiff's appeal by letter dated October 31, 2014. The disability plan provided that the initial 45-day time period for Defendant's review expired on December 15, 2014. Prior to that date, MetLife did not notify Plaintiff that any additional documentation was required to review Plaintiff's claim under the Plan, or that any extension was necessary due to "special circumstances." As such, the court concluded that Plaintiff is deemed to have exhausted his administrative remedies as of that date. *See* 29 C.F.R. § 2560.503-1(l).

D. Fifth Circuit

Although Plaintiff's amended complaint does not specifically seek a remedy through ERISA, because the health insurance and retirement contribution plan benefits he seeks are ERISA-governed, Plaintiff must exhaust all the administrative remedies required by ERISA. This is even though Plaintiff was never afforded the opportunity to apply for benefits. The court dismissed without prejudice Plaintiff's claims for these benefits.

[England v. Administrators of the Tulane Educ. Fund, No. CV 16-3184, 2016 WL 6520146 \(E.D. La. Nov. 3, 2016\)](#) (Judge Carl Barbier).

Motion for summary judgment on the basis of failure to exhaust is denied where the plan itself does not include a 180-day limit for filing an appeal. The 180-day timeframe set forth in the denial letter cannot become binding policy provisions. Even if the 180-day limitation was included in the Summary Plan Description, the terms of the SPD cannot be enforced under ERISA Section 502(a)(1)(B) as the terms of the plan itself. [Hughes v. Life Ins. Co. of N. Am., No. CV 15-2941, 2016 WL 5231811 \(E.D. La. Sept. 22, 2016\)](#) (Judge Eldon E. Fallon).

District court correctly dismissed lawsuit with prejudice where the claimant did not, and could not, timely submit a written administrative appeal. [Moss v. Unum Grp., No. 15-30341, ___ F.3d ___, 2016 WL 424638 \(5th Cir. Feb. 3, 2016\)](#) (Before STEWART, Chief Judge, and REAVLEY and DAVIS, Circuit Judges). Plaintiff–Appellant alleged that Defendants–Appellees (collectively “Unum”) unlawfully denied his claim for total disability benefits under two ERISA-governed insurance policies. The district court dismissed Plaintiff’s claims with prejudice for failure to exhaust administrative remedies and the Fifth Circuit affirmed. Unum denied Plaintiff’s claim under the policies on June 5, 2009 and gave him 180 days to appeal. On June 30, 2009, Plaintiff’s attorney called a Unum representative and verbally informed him that he disagreed with Unum’s decision. A few weeks later, Plaintiff’s attorney mailed copies of Plaintiff’s paychecks to Unum, but he never filed a formal written appeal. On December 10, 2009, Unum sent Plaintiff another letter reiterating its denial of his claim for benefits and giving him 180 days to file a written administrative appeal. Plaintiff did not file an appeal, but instead, filed a lawsuit against Unum, in which he argued that attempting to exhaust his administrative remedies would be futile. The district court dismissed Plaintiff’s claim without prejudice, at which point Plaintiff asked Unum to allow him to file an administrative appeal. Unum declined to do so because the appeal request was far beyond the 180-day deadline. Plaintiff filed suit again but this time the district court dismissed his case with prejudice since Plaintiff could not demonstrate that he would be able to timely exhaust his administrative remedies in the future. The court rejected Plaintiff’s arguments for why the court should excuse his failure to appeal. First, Plaintiff relied on the following statement from Unum’s December 10, 2009 denial letter: “Unless there are special circumstances, the administrative appeal process must be completed before you begin any legal action regarding your claim.” Plaintiff claimed that Unum’s alleged bad faith in denying his claim for disability benefits constitutes a “special circumstance” that

excuses him from his obligation to file an administrative appeal. And, because the term “special circumstances,” is vague, it should be construed in his favor. The court agreed with the district court that if a claimant could avoid the exhaustion requirement simply by alleging in his complaint that the plan administrator denied his claim in bad faith, then no claimant would ever be required to exhaust administrative remedies before filing suit. Adopting Plaintiff’s interpretation would render the administrative appeal requirement completely toothless. The court held that Plaintiff was required to file a written administrative appeal within 180 days. The court rejected Plaintiff’s next argument that even though he did not file a formal written appeal, he “effectively exhausted” his administrative remedies by taking informal actions that fulfilled “the underlying purpose of the exhaustion requirement.” The court found that informal attempts to substitute the formal claims procedure would frustrate the primary purposes of the exhaustion requirement. Lastly, Plaintiff argued that Louisiana Civil Code art. 3462 tolled the 180–day deadline for filing an administrative appeal when Plaintiff filed his first lawsuit and that it began to run again when the district court dismissed his lawsuit without prejudice. The court found this argument meritless since ERISA requires the claimant to exhaust his administrative remedies within the time period specified in the plan, which in this case was 180 days after denial. At least one other court in this Circuit rejected an identical tolling argument and the court found the reasoning persuasive. Because Plaintiff did not timely file an administrative appeal, the district court correctly dismissed his claim.

Complaint dismissed for failure to exhaust elimination of disability benefits due to offsets for other income. [Thomas v. Metropolitan Life Insurance Company, et al., No. 15-1733, 2016 WL 80634 \(E.D. La. Jan. 7, 2016\)](#). After filing her claim for disability benefits, Plaintiff received a letter informing her that her monthly benefit under the LTD Plan was being reduced as a result of her SSDI award. She later received a letter which informed her that her benefits were being eliminated entirely as a result of her receipt of retirement benefits. Plaintiff did not contest ExxonMobil’s assertion that she failed to file an administrative appeal after receiving these communications. The court granted ExxonMobil’s Rule 12(b)(6) motion because Plaintiff could not prove that (1) the controlling terms of her plan did not impose an administrative appeal requirement or (2) the administrative appeal requirement fails to comply with applicable regulations.

E. Sixth Circuit

In matter where Plaintiffs allege that Defendants did not timely release their benefits under the 401(k) Plan, the issue is contractual in nature—in particular, whether Defendants breached their contractual duty under the Plan to release the funds in a timely manner. As such, the court sees no reason to apply the exhaustion-of-remedies doctrine. [Alexander v. Terry Law Firm, P.C., No. 2:16-CV-91, 2016 WL 6592378 \(E.D. Tenn. Nov. 7, 2016\)](#) (Judge Thomas W. Phillips).

Granting Defendants’ motion to dismiss complaint against a 403(B) DC Plan, where: (1) Plaintiffs did not allege that they exhausted their administrative remedies, nor that exhausting their administrative remedies would be futile; (2) the anti-cutback claim also asks for damages in the amount of lost benefits from a Plan amendment; and (3) the fiduciary-duty count is a repackaging for individual benefits that Plaintiffs were required to administratively exhaust this claim and did not. [Hitchcock, et. al., v. Cumberland University 403\(B\) DC Plan, et. al., No. 3:15-CV-01215, 2016 WL 3197767 \(M.D. Tenn. June 9, 2016\)](#) (Judge Waverly D. Crenshaw, Jr.).

F. Seventh Circuit

In suit challenging Defendants’ refusal to pay for air-ambulance services, denying Defendants’ motion to dismiss on the basis of failure to exhaust administrative remedies, where Plaintiffs allege they administratively challenged the claim denial twice before filing suit, Defendant denied the appeals for being untimely, but then issued a decision on the merits after Plaintiffs already filed suit. [Tolleson v. Kraft Foods Glob., Inc., No. 16-CV-2055, 2016 WL 4439951 \(N.D. Ill. Aug. 23, 2016\)](#) (Judge Sharon Johnson Coleman).

G. Ninth Circuit

In suit seeking payment for two back surgeries, the court concluded that Plaintiff failed to exhaust her administrative remedies, as required by the BCBS plan, and is thus barred from bringing suit in federal court. Here, Plaintiff did not appeal on her own, rather her medical providers initiated the appeal on her behalf. The court found that Plaintiff did not by writing authorize her providers to act on her behalf. [Kojima v. Cross, No. 14-CV-1957-JLS-DHB, 2016 WL 7178852 \(S.D. Cal. Dec. 8, 2016\)](#) (Judge Janis L. Sammartino).

In dispute over retirement health coverage where Plaintiff alleged new matters in the First Amended Complaint that were not raised before or considered by the Claim Appeal Committee, concluding that Plaintiff’s request for benefits should be heard by the Board of Trustees Claim Appeal Committee to consider the facts, argument, and evidence that Plaintiff relies on in his First Amended Complaint and in his Response to Defendants’ Motion for Summary Judgment. [Osires v. Oregon Teamster Employers Trust, No. 3:15-CV-02067-BR, 2016 WL 5844318 \(D. Or. Oct. 4, 2016\)](#) (Judge Anna J. Brown).

Following persuasive authority from the Eleventh, Second, and Seventh Circuits, finding that Plaintiff reasonably interpreted the Plan to not require a second level of appeal, where the Plan terms are ambiguous as to whether Plaintiff was required to pursue a second level of appeal before filing suit. Section XV begins with the language that a plan participant who “wishes” to formally appeal “may do so,” whereas, the first step in the appeal process is described in mandatory terms: “[a] written appeal must be sent” within 180 days after

receipt of notice of an Adverse Benefits Determination. [Lecates v. Blue Cross Of Idaho, No. 3:15-CV-00072-CWD, 2016 WL 4974950 \(D. Idaho Sept. 16, 2016\)](#) (Magistrate Judge Candy W. Dale).

Dismissing lawsuit for pension benefits due to Plaintiff's failure to exhaust administrative remedies, finding that Plaintiff's lack of knowledge about the Plan's review procedures does not negate the exhaustion requirement. [Rodrigues v. Bank of Am., No. C 16-1390 CW, 2016 WL 3566950 \(N.D. Cal. July 1, 2016\)](#) (Judge Claudia Wilken).

H. Eleventh Circuit

State law claims related to long-term disability benefits are preempted by ERISA and subject to dismissal without prejudice for failing to exhaust administrative remedies by submitting an appeal within 180 days of receipt of the denial letter. [Qanadilo v. URS Corp., No. 5:16-CV-635, 2016 WL 5791501 \(N.D. Ala. Oct. 4, 2016\)](#) (Judge C. Lynwood Smith, Jr.).

Concluding that MetLife received Plaintiff's written request for review when MetLife received the Appeal Letter via facsimile on October 28, 2015, even though it did not receive the supporting documents on cd rom until November 4, 2015; finding no substantial compliance with ERISA's deadlines where MetLife did not render a decision on Plaintiff's appeal within 45 days of its receipt of Plaintiff's appeal and it did not seek, in writing or otherwise, an extension of time to review Plaintiff's appeal prior to the 45-day deadline. [Perry v. Metro. Life Ins. Co., No. 4:16-CV-135 \(CDL\), 2016 WL 4536441 \(M.D. Ga. Aug. 30, 2016\)](#) (Judge Clay D. Land).

Suit related to subrogation requirement in health plan is not subject to dismissal for failure to exhaust administrative remedies. [Daily v. The Rawlings Company, LLC, et al., No. 2:15-CV-1138-VEH, 2016 WL 192071 \(N.D. Ala. Jan. 15, 2016\)](#) (Judge Virginia Emerson Hopkins). Plaintiff brought this putative class against The Rawlings Company, LLC and Aetna Life Insurance Company ("Aetna"), alleging an Alabama state law claim for "Interference with Business/Contractual Relations" (Count One), against Rawlings alone, a violation of the Fair Debt Collection Practices Act ("FDCPA"), U.S.C. § 1601, et seq. (Count Two), and an Alabama state law claim for the "Unauthorized Practice of Law" (Count Three). All counts arise out of the settlement of Plaintiff's personal injury claim against a third party, and the attempts by Rawlings and Aetna to enforce Aetna's subrogation interest found in the health insurance policy Aetna administered through Plaintiff's employer. Defendants moved to dismiss for failure to exhaust administrative remedies, arguing that "at the core" Plaintiff's claims in the instant case are about what Defendants are or are not allowed to do under the Plan. The court disagreed. It found that the conduct at issue in this case is not "intertwined with the refusal to pay benefits," and further, the exhaustion requirement defense is only available to Aetna, not Rawlings, who is not a party identified in the Plan and has no role in administering the Plan.

I. D.C. Circuit

Denying Prudential’s Motion to Dismiss Plaintiff’s lawsuit for long-term disability benefits on the ground that Plaintiff failed to exhaust her administrative remedies before filing suit, where Prudential granted itself extensions of time that neither were requested by Plaintiff nor permitted under the applicable ERISA regulations. The 45-day deadline started when Plaintiff submitted her appeal and it did not matter that she continued to supplement her appeal with additional evidence. Prudential did not request a 45-day extension prior to the expiration of the initial 45-day deadline. [Wiley v. Prudential Ins. Co. of Am., No. 16-CV-00391 \(APM\), ___ F.Supp.3d ___, 2016 WL 4468155 \(D.D.C. Aug. 24, 2016\)](#) (Judge Amit P. Mehta).

IX. *Governmental Plans*

A. Sixth Circuit

Affordable Care Act’s Transitional Reinsurance Program applies to group health plans operated by state or local governments and is constitutional. [State of Ohio v. United States, No. 2:15-CV-321, ___ F.Supp.3d ___, 2016 WL 51226 \(S.D. Ohio Jan. 5, 2016\)](#) (Judge Algenon L. Marbley). The Affordable Care Act of 2010 (“the Act”) contains a provision known as the Transitional Reinsurance Program, a feature designed to stabilize prices in the individual insurance market during the first three years of the Act’s guaranteed-issue and community-rating reforms. The State of Ohio challenged the Act’s Transitional Reinsurance Program, arguing that the health plans it provides to its employees are not required to make reinsurance contributions because the plans are not “group health plans” within the meaning of the ACA, and alternatively, requiring its health plans to make these contributions violates the Tenth Amendment and Intergovernmental Tax Immunity Doctrine. The court granted the government’s motion to dismiss and denied the State of Ohio’s motion for summary judgment. First, the court determined that it may entertain the state’s statutory claims because binding precedent establishes jurisdiction over the State’s tax-refund claim and the court may hear the State’s Administrative Procedures Act claim. It found that the text, structure, and purpose of the Act confirms that Congress intended for all group health plans, including those operated by state or local governments, to pay into the Transitional Reinsurance Program. Specifically, the court found that “Non-Federal Governmental Plans” offering qualifying medical care constitute a subset of “Group Health Plans” under the Public Health Service Act, which provides the operative definition for this dispute. Any other interpretation would render many of the Act’s statutory revisions meaningless, yield a null set with respect to the PHSA’s enforcement provisions, and would exempt state and local governmental plans from most of the significant reforms contained in the Act. Further, “Governmental Plans” constitute a type of “Employee

Welfare Benefit Plan” under ERISA, the definitions of which the PHSA incorporates. Any other interpretation would render ERISA’s governmental plan exclusion superfluous. Moreover, Congress and the Department of Health and Human Services did not violate the Constitution when they subjected health plans offered by state and local government employers to the same requirements as those offered by private-sector employers. The court found that it is constitutional under both the Tenth Amendment and the Intergovernmental Tax Immunity Doctrine because the program regulates state and local governments in their capacity as employers, does not commandeer the legislative or executive apparatuses of state or local governments, and does not discriminate against state or local governments in the contributions imposed.

B. Ninth Circuit

No abuse of discretion to deny legal defense fund benefits to Peace Officer terminated for off-duty associations where plan provided coverage only for any act or omission within the scope of employment. Plaintiff waived any objection to court’s consideration of Board’s final decision where he knowingly chose to stay the case pending the Fund’s final determination of the Plaintiff’s claim through the Fund’s administrative claims process. [Cuevas v. Peace Officers Research Ass’n of California Legal Def. Fund, No. 14-CV-02540-BLF, 2016 WL 2754434 \(N.D. Cal. May 12, 2016\)](#) (Judge Beth Labson Freeman).

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

A. First Circuit

Claim for death benefits remanded to Prudential to determine proper beneficiaries; question of whether substantial compliance doctrine applies to ERISA beneficiary designation cases. [Ng v. Prudential Ins. Co. of Am., No. CV 13-11317-TSH, 2016 WL 1170968 \(D. Mass. Mar. 24, 2016\)](#) (Judge Timothy S. Hillman). Plaintiffs assert that they are entitled to death benefits because they were his properly designated beneficiaries by the decedent. They argued that a single-page, unsigned beneficiary form which decedent returned to Prudential complies with the Plan provisions, but in the alternative, the form was sufficient under the federal common law doctrine of “substantial compliance.” Prudential asserted that the Supreme Court in *Kennedy v. Plan Adm. For DuPont Sav. and Invest. Plan*, 555 US. 285, 129 S.Ct. 865 (2009) rejected the application of the substantial compliance doctrine in ERISA cases, and even if it does apply, the submission of a partial, incomplete unsigned form does not constitute “substantial compliance.” The court noted that the First Circuit has not addressed whether post *Kennedy* the court may apply the federal common law substantial compliance doctrine in ERISA beneficiary designation cases; nor has the First Circuit ever addressed

whether the substantial compliance doctrine might apply for purposes of determining who is the proper beneficiary. The court found that even if it conducts a *de novo review* and applies substantial compliance (assuming it survives *Kennedy*), there are material questions of fact which must be resolved. Much of the evidence cited by Plaintiffs was not before Prudential at the time it made its decision. The court determined that Prudential should interpret and determine the eligibility and entitlement of Plaintiffs based on a complete evidentiary record and remanded to Prudential for a renewed evaluation. The court denied Plaintiffs' breach of fiduciary duty claim without prejudice to their renewing motion for summary judgment once Prudential renders a final decision on their benefits claim.

B. Second Circuit

This matter involves a drawn out dispute over life insurance benefits on the life of Judith Thomas, sister of now deceased Raymond Thomas. The day after Mr. Thomas's death, Life Insurance Company of North America paid Plaintiff the \$208,000.00 in benefits demanded in the Second Amended Complaint. Defendant Bank of America as Successor to Countrywide Financial Corporation ("BOA") filed the instant motion for summary judgment, arguing, *inter alia*, that it is not a proper defendant under ERISA § 502(a)(1)(B), that Plaintiff's claims pursuant to ERISA § 502(a)(3) have already been dismissed, and requesting attorney's fees and costs, either as a sanction for refusing to dismiss BOA from the action or pursuant to ERISA § 502(g)(1). The court granted BOA's motion in part, finding that Plaintiff has not introduced any evidence that BOA fit within one of the categories of defendants that can be sued under § 502(a)(1)(B), and even if dismissal of the § 502(a)(3) claims was premature in January 2013, it is clearly appropriate now that Plaintiff has obtained the remedy that he sought to recover under § 502(a)(3). Further, any damage resulting from the delay in payments was not BOA's fault. The court denied BOA's motion for sanctions given the state of the developing law with respect to § 502(a)(3) claims. [Estate of Raymond Thomas v. Cigna Grp. Ins., No. 09CV5029SLTRLM, 2016 WL 7235718 \(E.D.N.Y. Dec. 13, 2016\)](#) (Judge Sandra L. Townes).

Defendants are entitled to review under the arbitrary and capricious standard even though Aetna was late in making a decision, it was otherwise in full conformity with the applicable regulations and the Plan, and Plaintiff did not file suit immediately upon the expiration of the initial ninety day time limit. Aetna did not abuse its discretion in denying accidental death benefits, where the decedent died while extremely intoxicated, driving his motorcycle in excess of 124 miles per hour in a 55 miles per hour zone, at 8:11 p.m. (dusk). Aetna would also prevail if *de novo review* applied. [Wilson v. Aetna Life Ins. Co., No. 815CV752MADCFH, 2016 WL 5717370 \(N.D.N.Y. Sept. 30, 2016\)](#) (Judge Mae A. D'Agostino).

C. Third Circuit

Following the exhaustion of FMLA leave, neither LINA, the Plan, nor WellStar issued a notice of termination of life insurance coverage or a formal conversion notice such that the insured could assume payment of the requisite premiums. LINA paid the insured \$250,000 on his Terminal Illness Benefit claim and suggested in a letter that he continued to have coverage. Because plan benefits are conditioned upon payment of premiums, and premiums were not paid at the time of passing, LINA and the Plan are entitled to judgment as a matter of law on the Section 502(a)(1)(B) claim. However, neither party established entitlement to judgment as a matter of law on whether LINA's letter contained latent misrepresentations/material omissions or as to whether WellStar's actions amount to the requisite notice of conversion rights. [Erwood v. Life Ins. Co. of N. Am., No. CV 14-1284, 2016 WL 4945320 \(W.D. Pa. Sept. 16, 2016\)](#) (Magistrate Judge Maureen P. Kelly).

D. Fourth Circuit

Granting summary judgment in favor of Defendant Unum on supplemental life group life insurance policy denial based on suicide exclusion within the policy, where the decedent, a former Navy SEAL, took his own life, and Unum reasonably determined that he was sane at the time he did so. [Jennifer Mullen Collins v. Unum Life Insurance Company of America, No. 2:15CVL88, ___ F.Supp.3d ___, 2016 WL 2658157 \(E.D. Va. May 6, 2016\)](#).

E. Fifth Circuit

[Briscoe v. Metro. Life Ins. Co., No. 16-30354, ___ F.App'x ___, 2016 WL 7367821 \(5th Cir. Dec. 19, 2016\)](#) (Before WIENER, CLEMENT, and HIGGINSON, Circuit Judges). The court affirmed the district court's determination that MetLife did not abuse its discretion in denying life insurance benefits for an insured who died 34 days after his termination date and the policy provides that benefits would be paid if the insured dies within 31 days after his insurance ends. Plaintiff argued unsuccessfully that the employer's payment of 30.67 hours of accrued but unused vacation time extended the date that his insurance ended by approximately four days.

Granting Lincoln National's Motion to Dismiss the Amended Complaint. Dismissing without prejudice Plaintiff's claim for denial of life insurance benefits and her claims for violation of COBRA for failure to exhaust, and dismissing with prejudice her claims for equitable relief and breach of fiduciary duty. [Swenson v. Eldorado Casino Shreveport Joint Venture, No. 15-CV-2042, 2016 WL 6106483 \(W.D. La. Oct. 19, 2016\)](#) (Judge Elizabeth E. Foote).

In action brought pursuant to Section 1132(a)(1)(B), affirming summary judgment in favor of Prudential and UPS on Plaintiff's denied claim for life insurance benefits based on a policy exclusion for active-duty servicemen, where Plaintiff's husband was an active-duty soldier in the United States Army but was killed in a weekend motorcycle accident while off base and not on duty. Although Plaintiff claimed that exclusion was not listed in the SPD, court noted that relief may be available under Section 1132(a)(3) but Plaintiff did not bring that claim. Plan states that it is governed by Georgia law so court declined to determine whether Louisiana Law (La. Stat. Ann § 22:942(7)) renders the exclusion unenforceable. And, relevant Georgia law (GA. CODE § 33-27-3(a)(7)) is preempted by ERISA. [Singletary v. United Parcel Serv., Inc., No. 15-30762, ___ F.3d ___, 2016 WL 3629029 \(5th Cir. July 6, 2016\)](#) (Before KING, SOUTHWICK, and HAYNES, Circuit Judges).

In interpleader action where marriage settlement agreement required decedent to name his ex-wife as life insurance beneficiary but he later changed the beneficiary to his new wife, finding that as a matter of law the Oklahoma dissolution of marriage decree and settlement agreement is a final judgment, the terms of those documents state that the life insurance policy could not be modified absent the agreement of both parties, the ex-wife never consented to the change in beneficiary, and the Oklahoma judgment must be upheld. [Berry v. Bannerr Life Ins. Co., No. SA-16-CV-52-XR, 2016 WL 3081037 \(W.D. Tex. May 31, 2016\)](#) (Judge Xavier Rodriguez).

Life insurance proceeds, absent beneficiary designation, must be paid to lawful spouse rather than putative spouse. [Myklebust v. McDermott, Inc., et al., No. 4:12-CV-3039, 2016 WL 1258411 \(S.D. Tex. Mar. 31, 2016\)](#) (Judge Kenneth M. Hoyt). In this case the decedent had fraudulently attempted to obtain a legal divorce against his spouse and subsequently remarried. A judgment granting bill of review held the divorce void such that the first spouse remained the decedent's legal spouse and the new spouse considered the putative spouse. The lawful spouse moved for summary judgment on the issue of entitlement to the decedent's ERISA-governed life insurance benefits. The putative spouse argued that the Texas putative spouse doctrine holds that a putative wife is entitled to the same rights in the property acquired during the marital relationship as if she were a lawful wife. The court found that ERISA preempts any state law governing designation of a beneficiary. ERISA requires that an employee benefit plan shall specify the basis on which payments are made to and from the plan and that a plan fiduciary make payments to the beneficiary who is designated by a participant, or by the terms of an employee benefit plan. The court found that a plain reading of the documents at issue in this case, in the absence of a beneficiary designation, requires that the life insurance proceeds be paid to the lawful surviving spouse.

Summary judgment to employer denied on breach of fiduciary duty claim related to life insurance benefit payments. [Evans v. Prudential Ins. Co. of Am., No. 1:14CV169-HSO-RHW, 2016 WL 796128 \(S.D. Miss. Feb. 26, 2016\)](#) (Judge Halil Suleyman Ozerden). Larry McNair

worked for Northrop Grumman Corporation's ("NGC") Pascagoula, Mississippi, shipyard in 1974 and retired in 2004. He participated in the company's group life insurance plan as an employee and retiree of NGC. On October 23, 1990, Mr. McNair completed a paper form for "Life Insurance Beneficiary Change Only" (the "Paper Designation") designating his son, Plaintiff Rynell Roberto Evans, as his life insurance beneficiary with Rynell's mother, Plaintiff Nancy M. Evans, listed as guardian; Rynell was a minor at the time of the designation. In 2010, NGC decided that it would "no longer honor paper beneficiary designation forms" and it announced this change to retirees in an insert to the 2011 Retiree Enrollment Benefits Guide. If a participant did not name a specific beneficiary online, then the life insurance benefit would be paid automatically to a surviving spouse. Mr. McNair did not make an online beneficiary designation and NCG was eventually purchased by Ingalls, which continued the practice of recognizing only online designations. Upon Mr. McNair's passing, Ingalls provided Prudential with beneficiary information required to pay a death benefit under the Plan and informed Prudential that there was no valid beneficiary designation of record at the time of Mr. McNair's death. Ingalls did not provide a copy of Mr. McNair's original Paper Designation to Prudential and so Prudential followed the Plan's default payout procedures and made a \$25,000.00 payment to the highest surviving class of relatives under Plan, Mr. McNair's surviving spouse Vera McNair. Plaintiffs, the paper beneficiaries, submitted a claim several months after Prudential already disbursed the payment. Plaintiffs filed suit and the court granted summary judgment to Plaintiff on the claim for benefits, finding that Prudential was entitled to rely on Ingalls to provide the necessary information for paying claims. On Plaintiffs' breach of fiduciary duty claim against Prudential, the court found that Plaintiffs cited to no legal authority for the proposition that an ERISA fiduciary's duty to investigate claims on a life insurance policy continues after a payment under the Plan has already been distributed. Further, the court found that Prudential appropriately delegated to Ingalls the responsibility to maintain records and deliver documentation, and is not liable for any act or omission of Ingalls in carrying out this responsibility. On Plaintiffs' claims against Ingalls, the court found that Plaintiffs do not lack standing to pursue their ERISA claims against Ingalls since there is no evidence of any affirmative action taken by Mr. McNair to remove Plaintiffs as beneficiaries of his life insurance policy or select a default payout option. The court found that Plaintiffs have sufficiently pled a claim that, but for Ingalls' alleged malfeasance, they would still be considered beneficiaries under the Plan. The court found that Plaintiffs may have an equitable remedy against Ingalls for its alleged failure to fulfill its fiduciary duties and declined to grant summary judgment to Ingalls on this claim. Lastly, the court denied Prudential's request for attorneys' fees, finding that Plaintiffs' assertions are not so obviously without merit and suit was not brought in bad faith.

Life insurance claim properly denied where coverage was terminated ten years earlier and not appealed. [Hawkins v. Aetna Life Insurance Company, No. 14-1944, 2016 WL 236056 \(E.D. La. Jan. 20, 2016\)](#) (Judge Jay C. Zainey). Plaintiffs are descendants of Laura Hawkins, who had an approved Premium Waiver claim for life insurance benefits since she became disabled in 1982. Aetna represented that in 2003 it made two requests for proof of permanent

disability but Ms. Hawkins did not respond. Aetna did not make copies of these requests or have proof that Ms. Hawkins received them. On November 26, 2003, Aetna sent Ms. Hawkins a termination notice, a copy of which it retained, as well as the postal return receipt with Ms. Hawkins' signature. Ms. Hawkins did not appeal Aetna's decision to terminate the permanent and total disability extension and she passed away ten years later in 2013. Plaintiffs sought payment of life insurance benefits, which Aetna denied because Ms. Hawkins was not covered under the policy when she died. The court concluded that under either *de novo* review or review for an abuse of discretion the result of Plaintiffs' challenge to Aetna's decision to deny benefits is the same. The court found that Plaintiffs' claim for benefits is actually an attempt to assert greater rights relative to the Plan than what Ms. Hawkins herself would have been able to do since she did not timely challenge the termination notice or convert her group coverage to an individual policy. Because coverage terminated in 2003, the court found that Aetna is entitled to judgment as a matter of law.

F. Sixth Circuit

Where participant was killed while piloting his private airplane, insurer did not abuse its discretion in denying death benefits based on an exclusion for loss “caused by or resulting from, directly or indirectly, a Primary Insured Person riding as a passenger in, entering, or exiting any aircraft while acting or training as a pilot or crew member.” [Asher v. Battelle Mem'l Inst., No. 2:15-CV-1097, 2016 WL 5661695 \(S.D. Ohio Sept. 30, 2016\)](#) (Judge James L. Graham).

In life insurance dispute, wherein Plaintiff alleges that Defendant failed to properly review relevant information and that Defendant's decision-making process did not provide Plaintiff with a full and fair review, granting Plaintiff's motion to supplement the administrative record with (i) the office of the Medical Examiner Amendment Report and (ii) the final investigative report prepared on behalf of Plaintiff, including witness statements. [Carlson v. Reliance Standard Life Insurance Company, No. 3:15-0200, 2016 WL 4993381 \(M.D. Tenn. Sept. 19, 2016\)](#) (Magistrate Judge Barbara D. Holmes).

Affirming district court's determination that United's interpretation of its plan as requiring Brown II to submit evidence of insurability to be covered was arbitrary and capricious since it was based on an arbitrary modification of the plan term “elect”; reversing district court award of summary judgment to United on Section 502(a)(3) claim because Plaintiff may have another remedy if he has asserted an injury separate and distinct from the denial of benefits—such as an injury from United's acceptance and retention of premiums; affirming award of prejudgment interest awarded under § 502(a)(1) without reliance on § 502(a)(3) for equitable relief; concluding that the district court did not abuse its discretion in finding that the first three factors weighed in favor of awarding attorneys' fees. [Brown, III v. United Of Omaha Life Insurance Company, No. 15-](#)

[4293, ___ F.App'x ___, 2016 WL 4887516 \(6th Cir. Sept. 14, 2016\)](#) (BEFORE: KEITH, COOK, and STRANCH, Circuit Judges).

Because the plan unambiguously requires late entrants to submit evidence of insurability satisfactory to Prudential, and because all relevant forms expressly condition coverage on Prudential's satisfaction, Prudential's denial of voluntary life insurance benefits comports with the unambiguous plan language, and is neither arbitrary nor capricious. Further, because *contra proferentum* does not apply, Prudential's construction is a "reasoned explanation" supported by the record for the denial and the denial is not arbitrary or capricious. [Alquahwagi v. Shelby Enterprises, Inc., No. 14-13691, 2016 WL 4771329 \(E.D. Mich. Sept. 14, 2016\)](#) (Judge Robert H. Cleland).

Concluding that MetLife's decision to deny Plaintiff \$520,000 in supplemental life insurance proceeds based on a "suicide exclusion" was not arbitrary and capricious, where the insured submitted an incomplete insurance enrollment form more than two years prior to the date of suicide, but his enrollment did not take effect until a later date that was not more than two years from his date of suicide. [Hansen v. Metropolitan Life Ins. Co., No. 3:15-CV-00880, 2016 WL 4417292 \(M.D. Tenn. Aug. 19, 2016\)](#) (Magistrate Judge E. Clifton Knowles).

Decree of divorce which provided that:

In order to secure the obligation of the parties to support their child during her minority, [Bruce and Bridget] shall maintain, unencumbered, all employer-provided life insurance, now in existence at a reasonable cost, or later acquired at a reasonable cost, naming their minor child as primary beneficiary during her minority, and the obligation to do so shall continue until she (a) reach(es) the age of eighteen (18) or graduates from high school, whichever occurs last...

substantially complied with 29 U.S.C. § 1056(d)(3)(C), is a QDRO, and is exempt from ERISA's broad preemption provision. Although Bruce never changed the beneficiary for his life insurance benefit from his brother to his daughter, the court determined that the daughter is the proper payee of the life policy proceeds. [Sun Life Assurance Co. of Canada v. Jackson, No. 3:14-CV-41, 2016 WL 4184444 \(S.D. Ohio Aug. 5, 2016\)](#) (Judge Walter H. Rice).

Holding that a change of beneficiary form for life insurance was the product of undue influence, and is null and without effect; awarding previous beneficiaries the life insurance proceeds. [Metro. Life Ins. Co. v. McGhee, No. 15-2467-STA-DKV, 2016 WL 4031347 \(W.D. Tenn. July 26, 2016\)](#) (Judge S. Thomas Anderson).

Denying life insurance beneficiary's motion for judgment on the pleadings in light of plausibility that beneficiary may be disqualified for benefits and the court will need to

resolve significant issues in the litigation, including: (a) whether ERISA applies to preempt Kentucky law; (b) if so, whether federal common law supplies an interstitial slayer's rule; and (c) if not, whether Kentucky has a common law doctrine that could disqualify a beneficiary even absent a criminal conviction. [Unum Life Ins. Co. of Am. v. Lutes, No. 5:15-CV-319-REW, 2016 WL 3964268 \(E.D. Ky. July 21, 2016\)](#) (Judge Robert E. Wier).

Upholding Unum's decision to deny [accidental dismemberment benefits](#) based on a policy exception for dismemberment "caused by, contributed to by, or resulting from...disease of the body," where Unum determined that Plaintiff's below-the-knee amputation, following a slip and fall accident and several operations, was partly necessitated by Plaintiff's diabetes. [Collins v. Unum Life Insurance Company of America, No. 15-CV-2229, 2016 WL 3763097 \(N.D. Ohio July 14, 2016\)](#) (Judge James S. Gwin).

Denying Defendant's Motion for Summary Judgment and giving notice to Mary McGhee that the Court is considering summary judgment in favor of the Jones Defendants on the grounds of (1) undue influence and (2) her otherwise improper procurement of Bernadine McGhee's signature on the beneficiary designation form; giving McGhee thirty days to show why the court should not rule the 2013 beneficiary designation form to be invalid and enforce the December 27, 2006 beneficiary designation form naming the Jones Defendants as the co-primary beneficiaries in equal shares. [Metro. Life Ins. Co. v. McGhee, No. 15-2467-STA-DKV, 2016 WL 2742429 \(W.D. Tenn. May 10, 2016\)](#) (Judge S. Thomas Anderson).

Judgment of Divorce is a QDRO and life insurance benefits payable to former spouse. [Metropolitan Life Ins. Co. v. Blevins, et al., No. 15-CV-11663-DT, 2016 WL 1242434 \(E.D. Mich. Mar. 30, 2016\)](#) (Judge Denise Page Hood). MetLife filed an Interpleader action against Defendant Blevins (decedent's spouse at time of death) and Defendant Leckemby (decedent's former spouse) to determine the proper beneficiary of life insurance proceeds. The relevant facts are as follows: In 1977, the decedent designated Leckemby as a beneficiary to his life insurance proceeds provided by his employer, but they divorced in 1992. The Judgment of Divorce stated that Leckemby must be an irrevocable beneficiary on any life insurance policy until the youngest child reached the age of 19 ½. The Judgment of Divorce was amended in 1995 with no express language governing any life insurance policy, including anything that expressly revokes Leckemby's beneficiary status. Blevins and the decedent were married in 2004 and the decedent died in 2014. The Plan administrator has no record that the 1977 beneficiary designating Leckemby was replaced at any time. The court found that the Judgment of Divorce is a Qualified Domestic Relations Order ("QDRO") even though it did not strictly comply with the technical requirements set forth in 29 U.S.C. Section 1056(d)(3). And, based on these facts, the court found that summary judgment must be entered in Leckemby's favor.

State-law causes of action for life insurance benefits are preempted by ERISA and failure to exhaust defense reserved for summary judgment. [Laitinen v. Sun Life Assurance Co. of](#)

[Canada, No. 2:15-CV-144, 2016 WL 890337 \(W.D. Mich. Mar. 9, 2016\)](#) (Judge Robert Holmes Bell). Plaintiff brought state-law causes of action for Sun Life's failure to pay an additional \$10,000 benefit for accidental death under an ERISA-governed group term insurance policy. Sun Life moved to dismiss on the basis of ERISA preemption and failure to exhaust. The court found that the state law claims raised in Plaintiff's complaint are, in reality, claims arising under ERISA and, thus, are completely preempted. But instead of dismissing Plaintiff's claim, the court granted Plaintiff the right to amend his complaint and expressly assert ERISA claims. The court also found that Defendant's argument that Plaintiff has failed to exhaust administrative remedies may be meritorious on a motion for summary judgment, but it is not properly before the court at this stage since it is an affirmative defense and it is Defendant's burden to establish affirmative defenses. Lastly, the court declined to award Sun Life \$6,000 in attorneys' fees and costs.

Retiree met elements of equitable estoppel on pension benefit claim. [Paul v. Detroit Edison Co. & Michigan Consol. Gas Co. Pension Plan, No. 15-1493, Fed.Appx. ___, 2016 WL 808105 \(6th Cir. Mar. 2, 2016\)](#) (Before Batchelder And Griffin, Circuit Judges; Carr, District Judge*). The Sixth Circuit affirmed the district court's finding that Plaintiff-Appellee proved sufficient facts to support a claim of equitable estoppel. Plaintiff sought relief from the reduction of his benefits two years after his retirement. ERISA equitable estoppel applies to pension plans where a plaintiff can demonstrate extraordinary circumstances in addition to the five traditional estoppel elements. These extraordinary circumstances must include: (1) a written representation; (2) plan provisions which, although unambiguous, did not allow for individual calculation of benefits; and (3) extraordinary circumstances in which the balance of equities strongly favors the application of estoppel. The court found that Plaintiff satisfies both the original five estoppel elements and the additional three elements for the ERISA context.

Plan terms do not permit a cash-out of ex-spouses portion of pension account and no equitable estoppel. [Donati v. Ford Motor Co., Gen. Ret. Plan, Ret. Comm., No. 15-1600, Fed.Appx. ___, 2016 WL 807371 \(6th Cir. Mar. 1, 2016\)](#) (Before BOGGS, GIBBONS, and GRIFFIN, Circuit Judges). In this case, Ford offered to cash out Lydia Donati's retirement benefits for a lump sum, which she accepted, only for a few months later to be told that Ford miscalculated the size of her lump sum by failing to take into consideration her ex-husband's benefits. Donati's daughter subsequently sued the Retirement Committee on behalf of her estate for the money Ford originally promised. The district court granted the Committee judgment on all claims and the Sixth Circuit affirmed. First, court found that the terms of the Plan unambiguously precluded Donati from cashing out the benefits she was deriving from her ex-husband's account under the QDRO. Second, the court determined that under *Rochow*, Plaintiff cannot pursue a claim under Section 1132(a)(3) since she may avail herself of Section 1132's other remedies. The court rejected Plaintiff's argument that she pled her breach of fiduciary duty claim as an alternative to her wrongful denial of benefits claim since the "deciding factor" is not whether a plaintiff *has* recovered under Section 1132(a)(1)(B) successfully, but rather, whether a

plaintiff *may* recover. Lastly, the court concluded that Plaintiff did not meet extraordinary circumstances requirement for her equitable estoppel claim. Since Donati was dying of cancer, the court found that she probably would have elected to cash out her benefits because it was financially advantageous to do so, regardless of the correct sum.

Denial of automobile accident insurance claim is reasonable where substantial evidence supported that the claim came under Plan exclusion. [Garrison v. Union Sec. Ins. Co., No. 2:15-CV-01674, 2016 WL 153031 \(S.D. Ohio Jan. 13, 2016\)](#) (Judge Algenon L. Marbley). In this matter involving benefits denied under an employer-sponsored group automobile accident insurance plan with USIC, the court granted Defendant's Motion for Judgment on the Administrative Record. Under the terms of the Plan, benefits are not payable if the insured died as the direct result of an automobile accident injury while breaking any traffic laws of the jurisdiction in which the automobile was being operated. USIC denied Plaintiff's claim for AA benefits because it found that the insured breaking a traffic law by driving left of center at the time of the accident. The court found that there was substantial evidence—specifically, in the Ohio State Highway Patrol (OSHP) Reconstruction Report—to support a finding that the insured was breaking an Ohio traffic law at the time of the accident, and because that evidence was not clearly contradicted (and in some respects is supported) by the traffic crash reconstruction reports, USIC's denial of benefits was not arbitrary and capricious. Plaintiff had also alleged that USIC breached its fiduciary duty to the Garrisons because it: (1) failed to apply Ohio law; (2) ignored expert reports that contradicted the OSHP's analysis; and (3) had a pecuniary conflict of interest by operating as both the decision-maker and payor of this claim. The court found that none of Plaintiff's allegations of breach of fiduciary duty implicates a different injury than the injury she suffered from the wrongful denial of her benefits. The court found that because Plaintiff makes no argument that she has suffered two distinct injuries, her § 1132(a)(3) claim is duplicative of her § 1132(a)(1)(B) claim and fails under controlling precedent in *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364 (6th Cir. 2015) (en banc).

G. Seventh Circuit

Plaintiff was awarded a judgment in Illinois state court on allegations that his step-mother fraudulently received proceeds from a Lincoln National Life Insurance policy on the life of his late father. In his suit against Lincoln National for violating ERISA when it paid out the policy's proceeds to the step-mother, and for breach of contract, the court found that his breach of contract claim is barred by res judicata, but his ERISA claim was expressly reserved by the state court order; the breach of contract claim is clearly pleaded in the alternative and is not a basis for a preemption finding; and Plaintiff's attempt to win a judgment against Lincoln National in this court does not necessarily raise the specter of a double recovery. [Black v. Lincoln Nat'l Life Ins., No. 16 C 5614, 2016 WL 6582582 \(N.D. Ill. Nov. 7, 2016\)](#) (Judge Thomas M. Durkin).

Where the insured's life insurance policies named his former spouse as beneficiary, but where the actions of the insured's Guardian ad Litem effectively terminated the former spouse's status as beneficiary, such that there were no designated beneficiaries, the benefits are payable to the spouse at the time of death since the policies list the insured's spouse as the first family member to whom payment may be made. [Metro. Life Ins. Co. v. Unger, No. 14 CV 07586, 2016 WL 5477523 \(N.D. Ill. Sept. 29, 2016\)](#) (Judge John J. Tharp).

Finding that pursuant to ERISA and the terms of the supplemental life insurance policy, the designated beneficiary (decedent's sister) is entitled to receive the death benefits for the policy, and rejecting contention by decedent's former spouse that she has a constructive trust of the death benefits since she is currently seeking in state court to have the Judgment of Dissolution of Marriage vacated so that she can assert her interest in the supplemental policy (claiming that she did not know about the supplemental policy at the time of divorce). [Dixneuf v. Wong, No. 15 C 8785, 2016 WL 4366596 \(N.D. Ill. Aug. 16, 2016\)](#) (Judge Samuel Der-Yeghiayan).

On claim for accidental death benefits, granting summary judgment in favor of Zurich, where decedent was electrocuted on the job and showed blood positive for THC at the time of death, and where the policy excludes a loss caused by, contributed to, or resulting from being under the influence of drugs. [Werbianskyj v. Zurich Am. Ins. Co., No. 3:15-CV-104, 2016 WL 4076367 \(N.D. Ind. Aug. 1, 2016\)](#) (Judge William C. Lee).

Deceased life insured breached his divorce judgment by changing the beneficiary designations from his sons to his new wife, but the court cannot determine, without further briefing, the percentage of the benefits payable to the surviving son in light of other son predeceasing insured. [State Farm Life & Accident Assurance Company v. Jeffrey S. Goecks & Donna Goecks, et al., No. 14-CV-885-WMC, 2016 WL 1715205 \(W.D. Wis. Apr. 28, 2016\)](#) (Judge William M. Conley).

AD&D claim denial upheld where administrator reasonably determined that death did not result directly from an accident and independently of all other causes. [Prather v. Sun Life Fin. Distributors, Inc., No. 14-3273, ___ F.Supp.3d ___, 2016 WL 1242093 \(C.D. Ill. Mar. 29, 2016\)](#) (Judge Richard Mills). This case involves a denied claim for accidental death and dismemberment benefits for Plaintiff's deceased husband, who died from deep vein thrombosis and a pulmonary embolism, which Plaintiff alleges was the direct result of an accident-related injury and which Defendant contends developed subsequent to surgical repair of a ruptured Achilles tendon. The decedent ruptured his left Achilles tendon while playing basketball. Plaintiff experienced lower left extremity swelling and he was advised to keep his leg elevated until his surgery one week later. The surgery was without operative complications but decedent passed away three weeks later, minutes after a pulmonary embolism. The policy specifies that the "bodily injuries" must "result directly from an accident and independently of all other

causes” and, further, that Sun Life “will not pay a benefit for any loss that is caused, either directly or indirectly, or contributed to by ... Medical or surgical treatment.” Plaintiff admitted that the decedent died of a known complication of the surgical repair of his ruptured Achilles tendon and, in light of this admission, the court could not conclude that Sun Life’s decision to deny the claim was arbitrary and capricious. The court found that there is no evidence suggesting that Sun Life’s financial conflict of interest affected the denial of benefits. The court granted summary judgment in favor of Defendant.

H. Ninth Circuit

Denying Defendant’s motion to dismiss Plaintiff’s Section 502(a)(3) claim seeking equitable relief for MetLife’s denial of a \$250,000 dependent death benefit where Plaintiff also alleged a Section 502(a)(1)(B) claim; declining to reach the issue of Plaintiff’s surcharge theory or the types of damages that may be awarded at this stage. [Seekatz v. Metropolitan Life Insurance Company, No. 3:15-CV-00017-RRB, 2016 WL 5429647 \(D. Alaska Sept. 26, 2016\)](#) (Judge Ralph R. Beistline).

In dispute over AD&D benefits, denying Defendant’s motion to dismiss and granting Plaintiff’s request for limited discovery on issue as to whether ERISA applies. In this case, Decedent was a member or employee of a labor union that subscribed to the Policy. Plaintiff argues that whether or not the Policy is governed by ERISA would require the Court to engage in a factual inquiry to determine if Decedent’s union promoted, sponsored, endorsed, or supported the Policy. [Wells v. Hartford Life & Accident Ins. Co., No. 2:16-CV-0056-GMN-CWH, 2016 WL 4257769 \(D. Nev. Aug. 10, 2016\)](#) (Judge Gloria M. Navarro).

Plaintiff’s amputation below the knee of his left leg following a severe car accident, but complicated by his diabetes, does not entitle him to benefits under accidental death and dismemberment policy, where the accident was not the “direct and sole cause” of the loss, and because an exclusion for “physical or mental illness” that “caused or contributed to” the loss applies to Plaintiff’s diabetes. [Dowdy v. Metro. Life Ins. Co., No. 15-CV-03764-JST, 2016 WL 1570004 \(N.D. Cal. Apr. 18, 2016\)](#) (Judge Jon S. Tigar).

I. Tenth Circuit

In matter where all ten of Plaintiff’s fingers were at least partially amputated after he suffered severe frostbite while mountain climbing in Nepal, the court granted Zurich’s motion for summary judgment because the partial severance of his fingers is not covered by the unambiguous language of the policy. To be a “covered loss” under the policy, the right index finger and thumb both must be amputated “through or above” the MCP joint and Plaintiff’s right index finger and thumb were not amputated through the MCP joints,

they were both amputated between the MCP joint and fingertip. [Nyberg v. Zurich Am. Ins. Co., No. 15-1359-EFM-JPO, 2016 WL 6778943 \(D. Kan. Nov. 16, 2016\)](#) (Judge Eric F. Melgren).

Granting petition for rehearing and for en banc rehearing to make changes in a revised decision that includes the following footnote: “Forgery can support various causes of action, but is not a freestanding cause of action in Utah. The mother presumably could have used forgery to support a cognizable cause of action, such as fraud. But in both the amended complaint and her supplemental brief, the mother identified her cause of action as one for forgery.” [Woolf v. Shaela K. Wiggington, et al., No. 15-4142, ___ F.App’x ___, 2016 WL 6236319 \(10th Cir. Oct. 25, 2016\)](#) (Before LUCERO, MATHESON, and BACHARACH, Circuit Judges).

Granting Defendant’s motion for judgment on 29 U.S.C. § 1132 (a)(1)(B) claim where insured’s full time date of hire was 12/2/2013, the Plan states “[i]f you are a newly hired full-time employee, coverage begins on the first of the month following 30 days after your date of hire,” and the insured perished on January 20, 2014. However, 29 U.S.C. § 1132(a)(3) claim for estoppel and surcharge may proceed and Plaintiff may conduct limited discovery related to the benefit enrollment and claims handling process and conflict of interest. [Derryberry v. Pharmerica Corp., No. CIV-16-207-C, 2016 WL 5876128 \(W.D. Okla. Oct. 7, 2016\)](#) (Judge Robin J. Cauthron).

Affirming dismissal of dispute over life insurance proceeds brought by decedent’s mother against decedent’s daughter, both of whom were named as co-beneficiaries, based on allegation that the designation was legally invalid. Mother failed to state a valid claim of forgery since Utah does not provide a private cause of action for this claim and she also did not adequately state how the daughter exerted undue influence on the decedent. [Woolf v. Wiggington, No. 15-4142, ___ F.App’x ___, 2016 WL 4576724 \(10th Cir. Aug. 31, 2016\)](#) (Before LUCERO, MATHESON, and BACHARACH, Circuit Judges).

In lawsuit seeking to recover insurance benefits and alleging that Prudential wrongfully turned over his share of his father’s life insurance proceeds to his brother, and that his brother forged the check and converted the proceeds for his own use, affirming district court’s grant of summary judgment in favor of Prudential and denial of Plaintiff’s motions to remand and for additional discovery. [Speer v. Prudential Ins. Co. of Am., No. 15-6183, 2016 WL 1660046 \(10th Cir. Apr. 27, 2016\)](#) (Before KELLY, O'BRIEN, and GORSUCH, Circuit Judges). In this case, Prudential issued two checks made payable to each son of the insured. Both checks were cashed but Speer, one of the beneficiaries, was incarcerated at the time of his father's death and did not learn of the proceeds until much later. Although Prudential attempted to assist the son in filing a fraud claim with the bank where his check was cashed, delays in communicating with the son while he was in prison caused the statute of limitations to

expire on the claim. Speer filed suit against Prudential in state court, which Prudential removed to federal court. The Tenth Circuit affirmed the district court's determination that Speer's claim, seeking to recover ERISA plan benefits, is preempted by ERISA.

Bodily or mental infirmity, illness or disease exclusion under the AD&D Rider is triggered and precludes benefits for insured who died in her home after she attempted to quit drinking alcohol after several years of alcohol abuse, became ill during detoxification, and fell and hit her head before being found dead. [Corey Wagner, Individually & As The Personal Representative of The Estate Of Nancy J. Wagner vs. Minnesota Life Insurance Company, No. CV 15-47-M-DLC, 2016 WL 1644364 \(D. Mont. Apr. 22, 2016\)](#) (Judge Dana L. Christensen).

J. Eleventh Circuit

In matter where Additional Term Insurance expired on September 28, 1995 and the insured died on January 14, 2015, the Section 502(a)(1)(B) claim is barred by the six year statute of limitations. Equitable estoppel does not apply because Plaintiffs do not allege that the Policy is ambiguous or that Defendant made representations to them regarding an ambiguous provision. Because Plaintiffs' Section 502(a)(1)(B) and Section 502(a)(3) claims are supported by the same factual allegations, they cannot bring their claims based on Section 502(a)(3) because they have an adequate remedy available elsewhere in ERISA's statutory framework. [Kirby v. Am. United Life Ins. Co., No. 4:16-CV-776-VEH, 2016 WL 5118265 \(N.D. Ala. Sept. 21, 2016\)](#) (Judge Virginia Emerson Hopkins).

Adopting Magistrate Judge's Report and Recommendation and denying Citigroup, Inc.'s motion to dismiss the claim that it breached a fiduciary duty, under ERISA, by improperly handling Plaintiff's daughter's request to change the daughter's group life insurance policy beneficiary; finding that Plaintiff plead sufficient facts to show that Citigroup acted as a fiduciary when it handled a purported request to change the beneficiary. [McCurry v. Metropolitan Life Insurance Company, et al., No. 5:15-CV-549-OC-32PRL, 2016 WL 4951184 \(M.D. Fla. Sept. 15, 2016\)](#) (Judge Timothy J. Corrigan).

In matter involving contested life insurance benefits, denying Plaintiff's motion to dismiss counterclaim and third party interpleader complaint brought by Prudential, where previous beneficiaries (decedent's children) allege that beneficiary form naming Plaintiff are invalid due to mental incompetency or completed without decedent's consent. [Jacques v. The Prudential Insurance Company Of America, No. 8:16-CV-1297-T-33TGW, 2016 WL 3746538 \(M.D. Fla. July 12, 2016\)](#) (Judge Virginia M. Hernandez Covington).

XI. *Medical Benefit Claims*

A. First Circuit

Plan language did not confer discretionary authority; substance abuse/mental health treatment claim remanded due to procedural violations. [Hatfield v. Blue Cross & Blue Shield of Massachusetts, Inc., No. CV 14-10445-DPW, 2016 WL 552464 \(D. Mass. Feb. 10, 2016\)](#) (Judge Douglas P. Woodlock). Plaintiff brought suit against Defendant for denying health insurance benefits for residential substance abuse and mental health treatment on the basis that the treatment did not meet the medical necessity criteria required for coverage of an inpatient chemical dependency rehabilitation stay in the areas of potential safety risk and relationships. First, the court determined that the following language was not sufficient to overcome the default of *de novo* review: “Blue Cross and Blue Shield decides which covered services are medically necessary and appropriate for you.” The court found that Plaintiff has been denied the procedural protections guaranteed to him by ERISA that would allow him effectively to press his case for coverage. This included Defendant’s failure to give Plaintiff adequate notice of the reasons for denial and failure to gather and request sufficient information. The court found that some prejudice—enough to warrant a remand—resulted from the procedural defects of Blue Cross’s denials. The court remanded the claim to Blue Cross in order to allow for all relevant issues to be raised and all relevant information to be entered into the record, but did not make any substantive determination about Plaintiff’s coverage. The court stated that it would consider an award of reasonable attorneys’ fees in connection with Plaintiff’s partial success on the merits in this litigation.

Medical claims for prematurely born baby denied where participant did not notify employer of son’s birth within 30 days. [Kurma v. Starmark, Inc., No. CV 12-11810-DPW, 2016 WL 526106 \(D. Mass. Feb. 9, 2016\)](#) (Judge Douglas P. Woodlock). Plaintiff was a participant in a health care plan for which the defendant, Starmark, Inc., was the claims processor. Plaintiff’s son was born approximately two months premature and remained in intensive care for over two months. His hospital bills ran in excess of \$667,000. Starmark denied coverage for the hospitalization because the child was not properly enrolled in the health care plan because Plaintiff failed to notify his employer, First Tek Technologies, Inc. of the birth within 30 days as required for coverage by the terms of the health care plan. The court found that it remains undisputed that First Tek was not notified of the birth of Plaintiff’s son within 30 days, and that applying the plain language of the plan, notice to the claims processor does not suffice absent specific notification to the employer. The court granted Starmark’s motion for summary judgment but noted that “[a]s unfortunate as it has turned out to be for a formality to bear such outsized financial consequences, no legal doctrine allows Mr. Kurma to avoid the unambiguous operation of the Plan in this case.”

Denial of coverage for Christian Science care not an abuse of discretion. [Summersgill v. E.I. du Pont de Nemours and Company, et. al., No. 13-CV-10279, 2016 WL 94247 \(D. Mass. Jan. 6, 2016\)](#) (Judge Denise J. Casper). The court granted Defendants’ motion for summary judgment on

Plaintiff's claim that Defendants improperly denied his late mother reimbursement for certain care she received at a Christian Science facility. DuPont ultimately denied claims for Mrs. Summersgill's care at Christian Science care at Chestnut Hill Benevolent Association on the basis that it was custodial, not medically necessary or because insufficient clinical information was provided. The court found that it was not an abuse of the discretion for DuPont to rely on the opinion of a medical professional who used Milliman Care Guidelines in coming to his or her conclusion as there is no language in the Plan suggesting that DuPont must apply Christian Science care guidelines in making a coverage determination.

B. Second Circuit

IBM's Benefits Plan for Retirement Employees requires participants to be enrolled in both Medicare Part A and Part B (unless certain exceptions apply) in order to be eligible to receive retiree health care premium reimbursements. Plaintiff was not enrolled in Medicare Part B and none of the exceptions applies. Therefore, the Plan Administrator's decision denying Plaintiff's claim for reimbursement was based on a correct interpretation of the Plan. Plaintiff further alleged that IBM discriminated against him because it gives people who are enrolled in Medicare Part A and Part B and receive TRICARE or VA coverage a benefit that it does not give to Plaintiff. The court found that the fact that certain retirees may benefit and others may not under the Plan does not state a claim for discrimination under ERISA or any other statute. [Caunitz v. IBM Corp., No. 15 CV 9281 \(VB\), 2016 WL 6956631 \(S.D.N.Y. Nov. 28, 2016\)](#) (Judge Vincent L. Briccetti).

Defendants violated the procedural requirements of the ERISA regulations in a manner which left Plaintiffs believing that they could not pursue further administrative appeal and caused Plaintiffs to suffer harm. Based on this, the court found that Plaintiffs have exhausted administrative remedies and that Defendants are not entitled to summary judgment on that ground. Procedural deficiencies in the claims process means that, under *Halo* and 29 C.F.R. § 2560.503–1(1), the Court must apply a *de novo* standard of review. Because the administrative record does not provide a basis upon which the court could determine whether B.E.'s treatment at Maple Lake was medically necessary, the court remanded the claim to the administrator. [Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Health Plan, No. 514CV1403BKSTWD, ___ F.Supp.3d ___, 2016 WL 6820464 \(N.D.N.Y. Nov. 15, 2016\)](#) (Judge Brenda K. Sannes). In this case, Plaintiff, Jennifer Easter, on behalf of her son, B.E., brought suit against Defendants Cayuga Medical Center at Ithaca Prepaid Health Plan ("Plan"), Cayuga Medical Center ("CMC"), and Excellus Health Plan, Inc. ("Excellus") for violating ERISA by denying their claims for medical benefits and failing to provide requested information. In short, a doctor diagnosed B.E. with conduct disorder; mixed mood and anxiety disorder; a learning disability in language, reading, memory, and sequencing; and antisocial personality disorder. Easter sought residential treatment for B.E. at Maple Lake Academy in Utah, a facility licensed by the State to provide residential treatment, from January 2014 through October 2014.

After numerous attempts to obtain benefit information from Defendants to no avail, Plaintiffs and an Excellus representative discussed issuance of a denial letter so that Plaintiffs could appeal. However, Plaintiffs never received a response from Excellus regarding a written denial or an appeal for any of their benefits claims. Plaintiffs continued to submit claims for payment but only received requests for additional information in response.

Plaintiffs asserted three causes of action: (1) under ERISA § 502(a)(1)(B) to recover full benefits due; (2) under ERISA § 502(a)(3) to remedy alleged breaches of fiduciary duty and claims procedure; and (3) under ERISA § 502(a)(1)(A) for the Plan Administrator's alleged failure to supply plan information within 30 days. On the preliminary issue of whether Plaintiffs have exhausted their administrative remedies, the court found that Excellus did not maintain reasonable procedures governing the filing of benefit claims or follow the regulations' requirements for adverse benefit determinations. The court rejected Excellus's argument that the regulatory timing provisions do not apply because Plaintiffs failed to provide additional information which precluded Excellus from conducting an initial review of the claims and from making an initial determination. This is because ERISA regulations state that adverse benefit determinations must be made "within a reasonable period of time" regardless of whether the claimant has submitted all necessary information. See 29 C.F.R. § 2560.503-1(f)(2)(iii)(B), (f)(4).

Excellus also argued that because it did not technically deny Plaintiffs' claims for benefits, ERISA § 503, which refers specifically to denials, and 29 C.F.R. § 2560.503-1, which "flows from" that statutory section, are inapplicable. The court disagreed. 29 C.F.R. § 2560.503-1(f)(2)(iii)(B) specifically regulates plan procedures in cases where an extension of time to determine a claim is needed due to a failure of the claimant to submit the information necessary. The court found that Defendants violated the procedural requirements of the ERISA regulations as promulgated at 29 C.F.R. § 2560.503-1 and did not meet their burden to show that these procedural failings were "inadvertent and harmless." Plaintiffs attempted to pursue administrative remedies but Excellus did not issue a decision, and because it did not provide Plaintiffs with information regarding the appeals process, it delayed final adjudication of Plaintiffs' claims and prevented further development of the administrative record. Plaintiffs reasonably believed that their only recourse was to file a lawsuit and were unquestionably harmed. As such, the court found that Plaintiffs have exhausted administrative remedies and that Defendants are not entitled to summary judgment on that ground.

On the standard of review, the Plan grants CMC discretionary authority, but the court found that the extent to which Excellus exercises discretion is unclear. Regardless, procedural deficiencies in the claims process mean that, under *Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016) and 29 C.F.R. § 2560.503-1(1), the court must apply a *de novo* standard of review.

In matter where psychiatrists and professional associations allege that health insurers' reimbursement practices discriminate against patients with mental health and substance use disorders in violation of the Mental Health Parity and Addition Equity Act of 2008

(“MHPAEA”), and ERISA, and where the associations brought suit on behalf of their members and their members’ patients, while the psychiatrists brought suit on behalf of themselves and their patients, affirming the district court’s dismissal of the case after concluding that the psychiatrists lacked a cause of action under the statute and the associations lacked constitutional standing to pursue their respective claims. [Am. Psychiatric Ass’n v. Anthem Health Plans, Inc., No. 14-3993-CV, ___ F.3d ___, 2016 WL 2772853 \(2d Cir. May 13, 2016\)](#) (Before: WALKER and RAGGI, Circuit Judges). In this case, psychiatrists and professional associations allege that health insurers’ reimbursement practices discriminate against patients with mental health and substance use disorders in violation of the Mental Health Parity and Addition Equity Act of 2008 and ERISA. The associations brought suit on behalf of their members and their members’ patients, while the psychiatrists brought suit on behalf of themselves and their patients. The Second Circuit affirmed the district court’s dismissal of the case after concluding that the psychiatrists lacked a cause of action under the statute and the associations lacked constitutional standing to pursue their respective claims.

C. Third Circuit

The principles of ERISA contract interpretation favor an interpretation in which C.L. was permitted to assign her husband’s benefits under the Plan, thus, HUMC has set forth enough facts to state a claim to relief that is plausible on its face insofar as HUMC has standing to pursue its claim under ERISA. The court granted HUMC’s cross motion to amend its complaint. [HUMC OPCO LLC v. United Benefit Fund, Aetna Health Inc., No. CV 16-168 \(KM\), 2016 WL 6246352 \(D.N.J. Oct. 25, 2016\)](#) (Magistrate Judge Michael A. Hammer).

Granting summary judgment in favor of Plaintiff and finding that Defendant abused its discretion in denying payment for IVIG maintenance therapy for Plaintiff’s Myasthenia Gravis, where Defendant made a strategic decision to deny coverage for IVIG treatment on the basis of a global policy that disregards the medical circumstances of individual patients; granting Plaintiff’s motion for attorneys’ fees. [Clauss v. Geisinger Health Plan, No. 3:14-CV-00889, 2016 WL 3940714 \(M.D. Pa. July 21, 2016\)](#) (Judge Edwin Kosik).

Granting Plaintiff’s motion for default judgment against plan participants for fraudulently obtained medical benefits under Teamsters health fund, where beneficiary and his spouse were “separated” but did not inform the fund of their status; reserving judgment on the issue of actual damages and interest where the Fund failed to submit any documentation supporting its request for \$192,872.00 in fraudulently obtained medical benefits; and directing Plaintiff to file an affidavit supporting his request for an award of actual damages and interest. [Einhorn v. Connor, No. 15-5910 \(RBK/AMD\), 2016 WL 3919660 \(D.N.J. July 19, 2016\)](#) (Judge Kugler).

Granting Defendants' Motions to Dismiss as they pertain to Count I (Breach of Contract), Count III (Breach of Fiduciary Duty and Co-Fiduciary Duty under 29 U.S.C. § 1132(a)(3), 29 U.S.C. § 1104(a)(1) and 29 U.S.C. § 1105(a)), and Count IV (Failure to Establish/Maintain Reasonable Claim Procedures under 29 C.F.R. 2560.503-1), but denying Motion to Dismiss as to Count II (Failure to Make all Payments Pursuant to Member's Plan under 29 U.S.C. § 1132(a)(1)(B)) without prejudice. [Drzala v. Horizon Blue Cross Blue Shield, No. CV 15-8392, 2016 WL 2932545 \(D.N.J. May 18, 2016\)](#) (Judge John Michael Vazquez).

District Court did not abuse its discretion in denying class certification under Fed.R.Civ.P. 23 on Plaintiffs' claims under ERISA, 29 U.S.C. § 1132(a)(1)(B) and under RICO, 18 U.S.C. § 1962(a) and (d); District Court did not err on the dispositive issue, namely, whether CIGNA's use of Ingenix data to determine UCR violated CIGNA's unambiguous plan terms, resulting in improperly reduced benefits under ERISA; District Court did not erroneously grant CIGNA summary judgment on the issue of whether CIGNA's UCR determinations denied Plaintiffs' benefits under ERISA; District Court did not err in denying Plaintiffs' partial summary judgment that the Ingenix database did not and could not comply with CIGNA's unambiguous plan terms; District Court did not err in granting CIGNA summary judgment on Plaintiffs' RICO claims on the basis that Plaintiffs had to show they suffered a RICO injury demonstrated by out-of-pocket loss such as a payment of a balance bill from their medical provider; District Court did not err in granting CIGNA's motion for summary judgment on the RICO issue of whether the alleged scheme involved any fraud and fraudulent intent by CIGNA; District Court did not err in granting CIGNA's motion to dismiss on the ground that the Nelson Plaintiffs failed to plead RICO standing because they did not allege an out-of-pocket loss in the form of a payment of a balance bill to a provider for ONET service or receipt of such a balance bill from a provider; District Court did not abuse its discretion in granting CIGNA's motion to strike Plaintiffs' supplemental expert reports. [Franco v. Connecticut Gen. Life Ins. Co., No. 14-3395, F.App'x , 2016 WL 1730730 \(3d Cir. May 2, 2016\)](#) (Before RENDELL, HARDIMAN, and VANASKIE, Circuit Judges).

Granting summary judgment in favor of Defendants on benefit claim because care was custodial and excluded under the Plan and on breach of fiduciary duty claim because the Plan is not a proper defendant. [Calabree v. Eaton Medical Plan for Retirees, No. CV 13-828, 2016 WL 1535689 \(E.D. Pa. Apr. 14, 2016\)](#) (Judge C. Darnell Jones II).

Retiree health benefits are not vested. [Grove v. Johnson Controls, Inc., et al., No. 1:12-CV-02622, 2016 WL 1271328 \(M.D. Pa. Mar. 31, 2016\)](#) (Judge Sylvia H. Rambo). In this action brought pursuant to ERISA and the LMRA, Plaintiffs alleged that Defendants violated their rights to retiree health benefits. Following a lengthy analysis, the court concluded that the "clear and express" language requirement in *Int'l Union United Aerospace and Agric. Implement*

Workers of Am., U.A.W. v. Skinner Engine Co., 188 F.3d 130 (3d Cir. 1999) remains binding law in the Third Circuit post-*M & G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 933 (2015). After analyzing the various SPDs and Plan documents as to each Subclass, the court granted summary judgment to Defendant. With respect to Subclass A, Plaintiffs concede that no contract provision in the 1981 CBA clearly and expressly states that retiree benefits are vested and unalterable, and the court cannot conclude that the provision continuing medical benefits after retirement creates an ambiguity. With respect to Subclasses C, D, and E, the court found that the CBAs and Group Insurance Programs have explicit durational clauses providing the exact date and time when those documents ceased to be in effect, as well as additional language contemplating the termination of retiree health benefits. As such, the “until death” language does not constitute clear and express vesting language sufficient to overcome the durational provisions. As to Subclasses B and F, the court found that reservation of rights language is clear and unambiguous, and forecloses any notion of vesting. Further, any testimony regarding the Union’s alleged resistance to the inclusion of the language is irrelevant.

D. Fourth Circuit

In lawsuit where Plaintiff alleges that Aetna engaged in a fraudulent scheme with Optum and other subcontractors, which were employed to process and administer health care claims, whereby insureds were caused to pay the subcontractors’ administrative fees because the Defendants misrepresented such fees as medical expenses, finding that Plaintiff has pleaded a concrete injury sufficient to establish standing to assert the claims in this case; to the extent that the Plaintiff attempts to assert any claims regarding Aetna’s actions with respect to any subcontractors other than Optum, the Plaintiff lacks standing to assert such claims; while recovery under 29 U.S.C. § 1132(a)(2) may benefit the Plaintiff’s plan, that does not preclude the Plaintiff from bringing a claim under that section; allegations that Aetna used plan assets in its own interest to pay the administrative fees that it owed to Optum (for both their benefit) clearly alleges prohibited transactions by Defendants.

[Sandra M. Peters v. Aetna, Inc., No. CV 1:15-CV-00109-MR, 2016 WL 4547151 \(W.D.N.C. Aug. 31, 2016\)](#) (Judge Martin Reidinger).

Retiree health benefits are not vested. [Barton v. Constellium Rolled Products-Ravenswood, LLC, et al., No. 2:13-CV-03127, 2016 WL 51262 \(S.D.W. Va. Jan. 4, 2016\)](#) (Judge Joseph R.

Goodwin). On the parties’ motions for summary judgment, the court was tasked with resolving a single issue: whether the retirees had a vested right to retiree health benefits. The court concluded that retiree health benefits were not vested, finding that Judge Copenhaver’s *Dewhurst* opinion compels the outcome of this case. *See Dewhurst v. Century Aluminum Co.*, No. 2:09-cv-01546, 2015 WL 5304616 (S.D. W. Va. Sept. 9, 2015). Benefits are not vested based on clear and unambiguous language of the collective bargaining agreement at issue. The relevant CBAs include clear and unambiguous durational clauses, which provide that retiree health benefits last

for the term of the operative CBA. The court found that Plaintiffs' extrinsic evidence, including letters concerning retiree health benefits, cannot be considered in the absence of an ambiguity.

E. Fifth Circuit

Concluding that BCBSSC's interpretation of the Plan to exclude the platelet-rich plasma procedure as investigational was legally correct and thus it did not abuse its discretion in denying payment for this treatment of Plaintiff's aseptic necrosis of the femur. [Seymour v. Bluecross Blueshield of S. Carolina, No. CV 15-3829, F.Supp.3d , 2016 WL 4697573 \(E.D. La. Sept. 8, 2016\)](#) (Judge Carl Barbier).

In matter where Defendant Blue Cross Blue Shield of South Carolina ("BCBSSC") denied payment for a core decompression with platelet-rich plasma as an alternative treatment for aseptic necrosis on the basis that it is excluded "investigational/experimental medical treatment," denying Defendant's motion for summary judgment due to genuine issues of material fact, where: (1) Plaintiff's BCBSSC policy contained no reference to "Medical Guidelines," (2) Defendant has not asserted that BCBSSC's "Medical Guidelines" were provided to Plaintiff or that Plaintiff was made aware of such guidelines; and (3) BCBSSC's *ex post facto* determination of whether a procedure is covered or deemed investigational or experimental appears inherently unfair and unreasonable. [Seymour v. Carolina, No. CV 15-3829, 2016 WL 3554727 \(E.D. La. June 30, 2016\)](#) (Judge Carl J. Barbier).

Determining that Defendant Catholic Health Initiative's health plan's exclusion for room and board in a residential mental health treatment facility, which was in effect at the time Plaintiff incurred the room and board charges, is enforceable and does not violate the Interim Final Rules or the Parity Act. Although the Final Rules require such coverage, the rules are not retroactive. [P. v. Catholic Health Initiatives, No. C15-5024 RBL, 2016 WL 3551972 \(W.D. Wash. June 30, 2016\)](#) (Judge Ronald B. Leighton).

No equitable estoppel where no reasonable reliance on representations inconsistent with plain language of certificate of coverage. [Johnson v. United Healthcare of Texas, Inc., No. 7:15-CV-49-DAE, F.Supp.3d , 2016 WL 929324 \(W.D. Tex. Mar. 10, 2016\)](#) (Judge David Alan Ezra). Plaintiffs brought suit against United Health for failing to pay for long term post-acute care, skilled nursing care, rehabilitative therapy and institutional and home-based convalescence, in order to recuperate from two craniotomies. The court found that United Health did not abuse its discretion in denying additional coverage beyond the Certificate's 60-day limits for Plaintiff's post-acute rehabilitation and skilled nursing services. On Plaintiff's equitable estoppel claim, the court found that even assuming the United Health employees misrepresented a material aspect of the Certificate and that Plaintiffs relied on the representation to their detriment, any such reliance was not reasonable since the plain language of the Certificate provides the limits on coverage. The Certificate also provides that no one has the

authority to make any oral changes or amendments to the Policy. As such, the court found that Plaintiffs' ERISA-estoppel argument fails because they cannot establish all elements of the claim.

Motion for reconsideration denied in matter where court found that acceptance of Workplace Injury Settlement Program waived right to sue employer for negligence.

[Castillo v. Tyson Foods, Inc., No. CV H-14-2354, 2016 WL 865358 \(S.D. Tex. Mar. 7, 2016\)](#)

(Judge Lee H. Rosenthal). Plaintiff moved for reconsideration of this court's order granting summary judgment for the defendants, where the court determined that Castillo's choice to participate in the company's Workplace Injury Settlement Program and to accept payment under that program for her workplace injury waived her right to sue Tyson for negligence. The court had found that Tyson showed that the waiver defense applied, and that Plaintiff had not raised a factual dispute material to determining that the waiver was neither procedurally nor substantively unconscionable. On the present motion, Plaintiff argued that the court manifestly erred by preempting her negligence claim under ERISA. Although Plaintiff did not challenge the court's holding that she waived her right to sue under the Texas Worker's Compensation Act, Plaintiff contended that the court manifestly erred in not finding unconscionability under state or federal common law. The court denied Plaintiff's motion for reconsideration. The court explained that it did not find her negligence claim preempted by ERISA, rather, the court had assumed that Plaintiff could pursue the challenge, but found that she had not carried her burden to show that the state-law unconscionability defense applied. Further, the court assumed that the state law on unconscionability governed but found that Plaintiff had not shown that it made her waiver unenforceable. The court concluded that Plaintiff did not show that the Plan or Program terms lacked a legitimate commercial justification or that they were so shocking and devoid of substantial benefit to her to make the entire plan unconscionable and the waiver unenforceable under Texas law.

Humana did not abuse its discretion in denying partial hospitalization treatment. [M. v. Humana Health Plan of Texas, Inc., CV H-14-3206, 2016 WL 690582 \(S.D. Tex., Feb. 19, 2016\)](#)

(Judge Lee H. Rosenthal). In this dispute over the "medically necessary" hospitalization treatment of a young 19-year-old with an eating disorder and depression, the court applied the abuse of discretion standard of review. Humana authorized Plaintiff for partial hospitalization treatment from April 15, 2013 to June 4, 2013, and then denied benefits thereafter. The policy itself uses a set of clinical standards—the "Mihalik criteria"—to assess medical necessity. All 8 of the criteria must be met throughout an episode of care for benefits to continue. Humana cited two medical reviews for their denial, one from their contracted medical reviewer and one from a third-party vendor. Both corroborated a lack of "imminent danger to herself or others", Mihalik criteria #7, and "medical instability", Mihalik criteria #8. Plaintiff appealed and argued that Humana, as an administrator, has a conflict of interest; did not take steps to reduce potential bias; and failed to use a nationally recognized standard of medical practice. Plaintiff further argued that the reviewing physicians were unqualified to review her entitlement to benefits and made

procedural errors, such as allowing, on appeal, deference to the initial adverse benefit determination. The court rejected all of Plaintiff's claims, because Humana has taken steps to reduce conflict of interest and potential bias through a third-party reviewer, and there was no evidence that Humana paid its contracted reviewer more for a denial. She also provided no evidence as to why the Mihalik criteria are not a reliable basis for establishing medically necessary treatment or are otherwise inaccurate. Additionally, there is no evidence that either reviewer is unqualified, as both are board certified psychiatrists and both noted the same deficiencies in Plaintiff's claim. As for the procedural errors, there is no evidence that the second reviewer gave any deference to the first. Ultimately, the court found that Humana did not "reduce" or "terminate" benefits "before the end of such period of time," as per ERISA's procedural regulation, because it only preauthorized hospitalization from April 15 to June 4, which it irrefutably provided to plaintiff. The court granted Humana's motion for summary judgment.

F. Sixth Circuit

[*Soehnlen v. Fleet Owners Insurance Fund, et al.*, No. 16-3124, __F.3d__, 2016 WL 7383993 \(6th Cir. Dec. 21, 2016\)](#) (Before: KEITH, BATCHELDER, and CLAY, Circuit Judges). In putative class action alleging that Defendants failed to comply with the ACA provisions enjoining annual and life-time limitations on benefits, the court affirmed the district court's decision to dismiss the ERISA claims for lack of standing. For the Section 502(a)(1)(B) claim, Plaintiffs did not establish individualized harm by simply claiming that certain members of their class suffer from conditions that have previously required medical expenses in excess of the benefit caps imposed by the Plan and that some of their employees will choose to delay important medical procedures in order to avoid exceeding the cap. Further, Plaintiffs do not state a claim by asserting that they personally suffer a constitutional injury by remitting money towards a non-compliant plan. With respect to Plaintiffs' ERISA Section 502(a)(1)(B) and 502(a)(3) claims for monetary and injunctive relief, the court found that Plaintiffs must still show a constitutional injury in order to proceed. With respect to Plaintiffs' breach of fiduciary duty claims, Plaintiffs claim that the actions of the fiduciaries expose the Plan to prospective liability in the amount of \$15,000,000, but there is no evidence that penalties have been levied, paid, or even contemplated. Thus, Plaintiffs make no showing of actual or imminent injury.

Due to the express terms of the Plan's anti-assignment provision, pro se Plaintiff (medical provider) does not have standing to assert a derivative claim against defendants under ERISA § 502, such that Counts I, II, III and IV are dismissed for lack of standing. The court grants Defendants' motion for judgment on the pleadings. [*Griffin v. Comm. of the UAW Retiree Med. Benefits Trust*, No. 16-12002, 2016 WL 6777854 \(E.D. Mich. Nov. 16, 2016\)](#) (Judge George Caram Steeh).

The court concluded that the CBA at issue is ambiguous concerning the parties' intent to vest lifetime retiree healthcare benefits and extrinsic evidence is necessary to resolve the ambiguities. The court determined that absence of express language promising lifetime retiree healthcare benefits is not dispositive of whether Honeywell must provide lifetime retiree healthcare benefits. [Fletcher v. Honeywell Int'l, Inc., No. 3:16-CV-302, 2016 WL 6780020 \(S.D. Ohio Nov. 15, 2016\)](#) (Judge Walter H. Rice).

Denying Plaintiffs' motion to compel arbitration of collectively-bargained retiree healthcare dispute because it falls outside the scope of the arbitration provision, Honeywell did not agree to arbitrate any disputes with retirees, and the CBA in this case does not specifically authorize arbitration of class-wide disputes. [Fletcher, et al. v. Honeywell International, Inc., No. 3:16-CV-302, 2016 WL 4939561 \(S.D. Ohio Sept. 14, 2016\)](#) (Judge Walter H. Rice).

Fund abused its discretion in denying payment for rehabilitative treatment for stroke patient. [Soehnlen v. Fleet Owners Ins. Fund, No. 1:15 CV 1181, 2016 WL 930983 \(N.D. Ohio Mar. 11, 2016\)](#) (Judge Patricia A. Gaughan). In this case, Plaintiff incurred significant medical expenses as a result of a debilitating stroke. Much of Plaintiff's rehabilitative treatment was with Mentis Ohio, LLC, a neuro rehabilitation facility. The Fund's third-party claims administrator denied payment for many of the services Plaintiff received at Mentis on the basis that maximum benefits were provided for the services. Plaintiff appealed to the Fund's Trustees and they denied the claim for new reasons, including that Mentis is out-of-network and Mentis has engaged in fraudulent billing. Plaintiff filed a second appeal but the Fund did not respond in a timely manner. On Plaintiff's motion for summary judgment, the court found that the Fund's offer of indemnification made during court-ordered mediation did not make the case moot. The court believed that the offer should not have been disclosed because it came about in mediation. Regardless, the court found that the offer did not cover all of the claims at issue in the case. On the standard of review, the court found that SPD does grant discretionary authority to the Trustees so arbitrary and capricious review applies but that it does not apply to questions of law, such as whether the Fund's procedure in denying the claim meets the requirements of ERISA Section 1133. The court also found that Plaintiff did exhaust administrative remedies since the Fund did not respond to Plaintiff's second appeal within sixty days as required by the ERISA regulations and Plaintiff filed suit after the Fund's decision was due. Plaintiff argued that the Fund did not substantially comply with Section 1133 because, at the second-tier review, the Trustees articulated different reasons for denying his claims than the third-party claims administrator articulated at the first-tier review. The court agreed that the Trustee's denial did not substantially comply with the ERISA notice requirements. First, the Trustees offered two rationales for denying Plaintiff's claims but did not cite to any specific plan provision. Second, the Trustees' new rationale and their failure to acknowledge Plaintiff's second appeal request effectively denied Plaintiff an opportunity to respond. The court found that the absence of reasoning in the record to support the Trustees' decision was arbitrary and capricious. The court

ordered a remand to Defendant as the remedy but found that Defendant forfeited its grandfathered status under the ACA and could not rely on its grandfathered status to deny Plaintiff's claim.

Remand to district court to reconsider whether retirees vested in lifetime contribution-free health care without benefit of *Yard-Man* presumption. [Tackett v. M & G Polymers USA, LLC, No. 12-3329, ___ F.3d ___, 2016 WL 240414 \(6th Cir. Jan. 21, 2016\)](#) (Before COLE, Chief Judge; KEITH and MERRITT, Circuit Judges). On the 6th Circuit's third consideration of this matter involving retiree health care benefits, the Court was tasked by the U.S. Supreme Court to construe the parties' agreements using "ordinary principles of contract law" and not apply the *Yard-Man* presumption (which required courts to analyze Collective Bargaining Agreements (CBAs) with a "thumb on the scale" in favor of vesting). From 1991 to 2005, the retirees entered into several CBAs with M & G and its predecessors, which included Pension and Insurance Agreements outlining retiree health care benefits. The Pension and Insurance Agreements provide that the employer will make a full Company contribution towards the cost of health care benefits for certain retirees. In December 2006, M & G announced that retirees would, for the first time, be required to contribute to their health care costs or risk being dropped from the plan. Defendants argued certain side letters or "cap letters" established caps they would pay towards Retirees' cost of benefits. The district court had determined that the cap letters were not part of the Agreements but the 6th Circuit was unclear as to whether the district court and the parties were influenced by the *Yard-Man* inferences during the trial. The court declined Defendants' invitation to reinstate the district court's initial decision dismissing the complaint because that decision had largely relied on the cap letters and did not consider other extrinsic evidence submitted by the retirees. The 6th Circuit remanded the matter to the district court to decide, among other Agreements, whether reference to extrinsic evidence (i.e., the "cap letters") is appropriate; and whether the Agreements, and any extrinsic evidence that may be considered, vests with retirees lifetime contribution-free health care benefits.

G. Seventh Circuit

In action seeking benefits related to Plaintiff's mental health treatment at a residential treatment center, wherein she asserts that her group health plan's exclusion of coverage for residential treatment centers violates the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (which generally requires group health insurance plans to provide parity between mental health benefits and medical/surgical benefits), denying Defendant's motion to dismiss for failure to state a claim. [Natalie V. v. Health Care Serv. Corp., No. 15 C 09174, 2016 WL 4765709 \(N.D. Ill. Sept. 13, 2016\)](#) (Judge Edmond E. Chang).

"Although plaintiff is empowered to sue under § 1132(a)(1)(B) as the assignee of a plan beneficiary, the plan beneficiary who assigned her claim to plaintiff never submitted a

claim for benefits under the plan, did not exhaust her administrative remedies and is not entitled under the plan to the benefits plaintiff is seeking. By obtaining an assignment of its patient's claims under the plan, plaintiff is entitled to raise a claim under § 1132(a)(1)(B), but it is not relieved of any of the prerequisites or limitations on claims generally applicable to the plan's beneficiaries." [University Of Wisconsin Hospitals And Clinics Authority v. Bank Of America Group Benefits Program, Defendant., No. 15-Cv-280-Bbc, 2016 WL 2732201 \(W.D. Wis. May 10, 2016\), Judgment Entered Sub Nom. University Of Wisconsin Hospitals And Clinics Authority, Plaintiff, V. Bank Of America Group Benefits Program , Defendant., No. 15-CV-280-BBC, 2016 WL 2732823 \(W.D. Wis. May 10, 2016\)](#) (Judge Barbara B. Crabb).

H. Eighth Circuit

In suit challenging self-funded medical plan's denial of benefits under the plan's illegal activities exclusion for medical care and expenses incurred for injuries participant sustained in explosion while igniting mortar-style firework, holding that: (1) under the plain statutory language of the ACA, the plan was not a "health plan" required to cover essential health benefits; (2) the plan was not subject to state insurance laws, and thus was not a "health insurance issuer" that was required to provide coverage including the essential health benefits package under the ACA; (3) participant stated claim that at least some of medical services for which coverage was denied were emergency services under the ACA; (4) public policy did not require voiding plan's illegal activities exclusion; (5) as a matter of first impression, participant stated claim that plan was ambiguous as to whether Minnesota, Wisconsin, or Federal law applied to determine what constituted an illegal act under plan's illegal activities exclusion; and (6) participant failed to allege either fraud or mutual mistake, as required to state claim for equitable reformation of plan. [Henrikson v. Choice Prod. USA, LLC, No. 16-CV-1317 \(MJD/LIB\), ___ F.Supp.3d ___, 2016 WL 6143357 \(D. Minn. Oct. 20, 2016\)](#) (Judge Leo I. Brisbois).

Granting summary judgment to Cigna with respect to claim for payment of two medical bills but remanding claim related to a bill for \$5,376.00 from Unruh Chiropractic and Wellness Center because Cigna "ignor[ed] the claim entirely" and then blamed Plaintiff for failing to exhaust administrative remedies; dismissing employer/plan sponsor/Plan administrator from lawsuit because it does not control the administration of the plan and is not a proper party. [Orellana v. Connecticut Gen. Life Ins. Co., No. 5:16-CV-05007, 2016 WL 3982534 \(W.D. Ark. July 22, 2016\)](#) (Judge Timothy L. Brooks).

In matter alleging that Plaintiff's son, a beneficiary under an ERISA-governed health insurance policy, was wrongfully denied coverage for gender reassignment services and surgery, finding that the ACA claim fails because HealthPartners is an improper party to this action and the alleged injury is not traceable to it or redressable by it and Plaintiff lacks statutory standing. [Brittany R. Tovar, Plaintiff, v. Essentia Health, Innovis Health, LLC,](#)

[d/b/a Essentia Health W., & HealthPartners, Inc., Defendants., No. CV 16-100 \(RHK/LIB\), 2016 WL 2745816 \(D. Minn. May 11, 2016\)](#) (Judge Richard H. Kyle).

I. Ninth Circuit

Blue Cross did not abuse its discretion in denying residential treatment for Plaintiff’s anorexia nervosa and related physical conditions because residential treatment was no longer “medically necessary” after she had received sixty days of such treatment at the Monte Nido center in southern California. [Krysten v. Blue Shield of California, No. 15-CV-02421-RS, 2016 WL 5934709 \(N.D. Cal. Oct. 11, 2016\)](#) (Judge Richard Seeborg).

Plaintiffs fail to state a claim for vested lifetime healthcare benefits upon which relief can be granted. In addition, Plaintiffs have failed to allege facts showing a clear and unambiguous promise to vest employees with irrevocable lifetime healthcare benefits, such that they have failed to state a claim for promissory estoppel. Motion to dismiss granted. [Kepner v. Weyerhaeuser Company, No. 6:16-CV-01040-AA, 2016 WL 5939153 \(D. Or. Oct. 10, 2016\)](#) (Judge Ann Aiken).

Finding that the illegal act exclusion in the Plan must be read in light of Idaho law. The exclusion for expenses incurred “for the treatment of injuries sustained while...engaging in an illegal act” is unambiguous, because the phrase “engaging in an illegal act” refers to acts that the Idaho legislature has deemed contrary to law. The blood test results do not meet the legal requirement to support a conclusion of illegal intoxication under Idaho law so Blue Cross abused its discretion in denying LeCates’s claim for medical benefits. [Lecates v. Blue Cross Of Idaho, No. 3:15-CV-00072-CWD, 2016 WL 4974950 \(D. Idaho Sept. 16, 2016\)](#) (Magistrate Judge Candy W. Dale).

Affirming district court’s determination that Providence had abused its discretion in denying preauthorization for additional trauma-related dental services following a seizure-induced fall which fractured Yox’s jaw, since Providence did not follow important procedural requirements, did not adequately assess the substance of her claim (calling it dental rather than medical), and appeared to be affected by its structural conflict of interest; further finding that Yox’s agreement to have her denial reviewed by an Independent Review Organization (IRO) did not constitute an agreement to arbitrate; district court properly held that Yox’s claim does not include the expanded services she requested after starting her internal appeal. [Yox v. Providence Health Plan, No. 14-35127, ___ F.App’x ___, 2016 WL 4709872 \(9th Cir. Sept. 9, 2016\)](#) (Before: PREGERSON, BEA, and OWENS, Circuit Judges).

Dismissing Plaintiffs’ claims for injunctive relief and to clarify their rights to future benefits as moot since Blue Shield of California has amended its Harvoni policy (for

treatment of Hepatitis C) and given notice to its insureds that they can resubmit claims for treatment; but denying dismissal of Plaintiffs' claims for disgorgement of profits because Defendants have not conclusively shown that this is an impermissible legal remedy under Section 502 (a)(3). [Homampour et al. v. Blue Shield Of California Life And Health Insurance Company, et al., No. 15-CV-05003-WHO, 2016 WL 4539480 \(N.D. Cal. Aug. 31, 2016\)](#) (Judge William H. Orrick).

Finding that a group health plan's New York choice-of-law provision means its discretionary clause is not subject to California Insurance Code Section 10110.6, but even if California law applied, Section 10110.6 does not apply to health insurance. [Bain v. United Healthcare Inc., No. 15-CV-03305-EMC, 2016 WL 4529495 \(N.D. Cal. Aug. 30, 2016\)](#) (Judge Edward Chen). A matter seeking reimbursement for healthcare expenses, the court held that California Insurance Code Section 10110.6 does not apply because the Plan is governed by New York law. Applying federal choice of law rules, the court found that the Plan's choice of New York law was not "unreasonable or fundamentally unfair." First, New York has a substantial relationship to the parties and there is a reasonable basis for New York's law to be chosen. Second, New York established an enrollee's right to an external appeal of a final adverse determination by a health care plan. Because New York preserves the independence of decision-makers while affording some protection to enrollees, it was not "fundamentally unfair" to select New York law to govern. Further, the court found that even if California law applied, Section 10110.6 does not apply to health insurance.

On *de novo* review, granting judgment in favor of UBH on Plaintiff's request for reimbursement for residential treatment at Sierra Tucson, where the court found that inpatient treatment was not medically necessary for Plaintiff's depression and eating disorder. [D v. United Healthcare Ins. Co., No. 15CV1012 JM\(BLM\), 2016 WL 4072725 \(S.D. Cal. Aug. 1, 2016\)](#) (Judge Jeffrey T. Miller).

Granting California Department of Managed Health Care's ("DMHC") motion to dismiss complaint brought by three churches that allegedly offer their employees DMHC-regulated health coverage through seven insurers – to whom DMHC wrote requiring them to remove any limitations on or exclusions of abortion services from the health care coverage they offer – claiming that the letters violate their constitutional rights under the First and Fourteenth Amendments. [Foothill Church, Calvary Chapel Chino Hills, & Shepherd Of The Hills Church, v. Michelle Rouillard, in her official capacity as Dir. of the California Dep't of Managed Health Care, No. 215CV02165KJMEFB, 2016 WL 3688422 \(E.D. Cal. July 11, 2016\).](#)

In lawsuit seeking reimbursement for cost of artificial disc replacement procedure, finding that *de novo* review is applicable since Defendant did not meet burden of proving that the "Face Sheet" containing discretionary language is a plan document, but denying motion to

expand the Administrative Record to include medical studies. [Quillan v. Cigna Healthcare of California, Inc., No. 15-CV-00989-EMC, 2016 WL 146149 \(N.D. Cal. Apr. 14, 2016\)](#) (Judge Edward M. Chen).

Artificial disc replacement surgery is “Investigational” under terms of medical plan. [Sammons v. Regence BlueCross BlueShield of Oregon, et al., No. 3:15-CV-01703-SI, 2016 WL 1171019 \(D. Or. Mar. 23, 2016\)](#) (Judge Michael H. Simon). Plaintiff suffers from advanced lumbar disc space narrowing, disc bulging, mild facet arthrosis, and spondylosis. Plaintiff sought a total disc arthroplasty (*i.e.* artificial disc replacement surgery), which Defendants denied under the terms of the Oregon Bakers Union Health and Welfare Trust Fund Plan (the “Plan”). Defendants denied pre-authorization on the basis that the medical procedure was “Investigational,” as defined by the Plan, because the scientific evidence has not yet permitted a conclusion regarding the long-term efficacy and safety of artificial discs, in comparison to recognized alternatives. Defendants also found that the “Alternative Benefits” provision of the Plan had not been triggered and that no waiver has occurred. Following a bench trial on an administrative record, the court concluded that Plaintiff is not entitled to the requested benefits under the Plan. Specifically, the court found that Plaintiff’s artificial disc replacement Surgery is Investigational under the terms of the Plan, and that Plaintiff did not satisfy the requirements for receiving coverage under the “Alternative Benefits” provision of the Plan. Further, the court found that Defendants did not waive their rights to invoke the “Investigational” exclusion and that Plaintiff has not been misled to her prejudice into the honest belief that a waiver was intended or consented to. The court granted Defendants’ motion for judgment on the record.

Health plan cannot charge retirees coinsurance when it serves as secondary payer to Medicare. [Barling v. Uebt Retiree Health Plan, No. 14-CV-04530-VC, 2016 WL 687965 \(N.D. Cal. Feb. 19, 2016\)](#) (Judge Vince Chhabria). Plaintiff’s lawsuit alleges that Defendants violated the terms of the ERISA plan by requiring him, and other similarly situated retirees, to pay deductibles and coinsurance during a time when Medicare served as “primary payer” and the Plan served as “secondary payer.” The court found that Plaintiff is correct that under the plain language of the SPD, the retirees cannot be forced to pay coinsurance when the Plan serves as the secondary payer. Because the language is susceptible to only one meaning (that 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), there’s no need to consider extrinsic evidence. Regardless, the court found that the extra-contractual materials submitted by the parties do not cause the SPD’s clear language to somehow become ambiguous. Plaintiff would prevail under either *de novo* or abuse of discretion review. The court granted summary judgment for Plaintiff on his claim for benefits and denied Defendants’ cross-motion for summary judgment. The court ordered the Plan to refund the deductibles that Plaintiff paid during the relevant time period.

Claim is “incurred” when a service is rendered, not when the Hospital decides to bill for the services. [Perris Valley Cmty. Hosp., LLC v. S. California Pipe Trades Admin. Corp., No.](#)

[14-55408, Fed.Appx. , 2016 WL 492335 \(9th Cir. Feb. 8, 2016\)](#) (Before WARDLAW and HURWITZ, Circuit Judges and RICE, District Judge). Perris Valley Community Hospital LLC is an assignee of a participant in the Southern California Pipe Trades Administrative Corporation and the Southern California Pipe Trades Health and Welfare Fund. Months after the participant reached the Plan's \$500,000 lifetime benefits cap in December 2008, the Fund issued a Supplement to the Plan supplying additional coverage for "claims incurred since January 1, 2009." The Fund paid the Hospital's claims for services rendered to the patient in January 2009, but refused to pay for charges incurred in December 2008 after the lifetime limit had been reached. The Ninth Circuit affirmed the district court's grant of summary judgment in favor of the Fund, finding that it reasonably rejected the Hospital's argument that "claims incurred since January 1, 2009" includes claims for services provided in 2008 but not submitted to the Fund until after January 1, 2009.

Plaintiffs are entitled to reimbursement for out-of-pocket expenses related to ABA therapy; equitable relief claim may also proceed. [A.F., et al. v. Providence Health Plan, No. 3:13-CV-00776-SI, 2016 WL 81796 \(D. Or. Jan. 7, 2016\)](#) (Judge Michael H. Simon). The court previously ruled on cross-motions for summary judgment that Providence's Developmental Disability Exclusion violates the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act and therefore is prohibited under ERISA. On the parties' respective motions on Plaintiffs' second amended class action complaint, the court granted in part and denied in part Plaintiff's motion for summary judgment on their recovery of benefits claim under 29 U.S.C. § 1132(a)(1)(B). The court found that the individual plaintiffs were due reimbursement for out-of-pocket expenses for ABA therapy but denied a portion of one plaintiff's claim because there was no evidence that Providence ever received the claim form. The court denied Providence's motion on Plaintiff's claim for equitable relief under 29 U.S.C. § 1132(a)(3) sufficient to redress Providence's violations of its fiduciary duty, on behalf of all named Plaintiffs. The court found that Plaintiffs have sufficiently pled that reimbursement under Section 1132(a)(1)(B) does not provide them with "adequate relief" to remedy Providence's breach of fiduciary duty. Although Plaintiffs may not simply "repackage" their Section 1132(a)(1)(B) claim and thus obtain duplicative relief, the court cannot conclude at the motion to dismiss stage that the two claims are indeed duplicative. The court rejected Defendant's argument that Plaintiffs are seeking compensatory damages precluded by the Ninth Circuit's ruling in *Bast v. Prudential Insurance Co. of America*, 150 F.3d 1003 (9th Cir. 1998).

J. Tenth Circuit

Health plan administrator's interpretation of "area" to mean "state" is not arbitrary and capricious but residential treatment exclusion violates Parity Act. [F. v. Sinclair Servs. Co., No. 2:14-CV-00505-RJS, 2016 WL 309787 \(D. Utah Jan. 25, 2016\)](#) (Judge Robert J. Shelby). Plaintiffs sued Defendants Sinclair Services Company and Sinclair Services Company Point of Service Basic Plan after Sinclair's Plan Administrator denied Plaintiffs' claim for benefits

relating to long-term residential treatment services rendered to their minor daughter, N.F., for depression in the State of Texas. For claims incurred before January 1, 2013, the Administrator denied the claims on the basis that the Basic Plan does not provide benefits for care or services received from non-network providers. The denial turned on the Administrator's interpretation of the Use of Network Providers During Travel provision. Under that provision, the Plan provides benefits "if a participant travels to obtain care to an area where a network provider is available ... [and] utilizes a network provider For this purpose, the Plan Administrator interprets area to mean a state. The court found that the general term "area" is undefined, ambiguous, and susceptible to two or more reasonable interpretations as used in the Plan. Because the Administrator's interpretation of "area" to mean a state is consistent with a reasonable person's understanding of the term, and even though the Administrator operates under a conflict of interest, the court concluded the Administrator's claim denial based on that interpretation was not arbitrary and capricious. With respect to claims on or after January 1, 2013, the court concluded that the 2013 amendment to the "Plus Plan" excluding benefits for residential treatment violates the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The Plus Plan provides no benefits for services received at a residential treatment facility. Prior to the amendment, residential treatment benefits were available for only mental health conditions. Thus, when it eliminated coverage for residential treatment services, it necessarily imposed a treatment limitation that applies only with respect to mental health conditions. The court found that this violates the plain language of the Parity Act.

K. Eleventh Circuit

On issue of whether an external review precludes Plaintiff from bringing an ERISA action under 29 U.S.C. § 1132(a)(1)(B) in district court to challenge the medical necessity determination of her treatment, finding that: (1) the external review is part of the administrative record; (2) the external review is not binding on the parties in federal court; and (3) the external appeal process is not preempted by ERISA since there is no intrusion on an insured's rights and it does not replace or erase any ERISA remedy. [Alexandra H., Plaintiff - Appellant, v. Oxford Health Insurance Inc. Freedom Access Plan, Defendant, Oxford Health Insurance, Inc., Defendant - Appellee., No. 15-11513, ___ F.3d ___, 2016 WL 4361936 \(11th Cir. Aug. 16, 2016\)](#) (Before HULL, JULIE CARNES, and CLEVENGER,* Circuit Judges).

XII. *Pension Benefit Claims*

A. First Circuit

In "highly sympathetic case" of a retiree who died one week before his official retirement date, but after his final day of work, affirming the district court's grant of judgment under

ERISA Section 502(a)(1)(B) in favor of UPS on beneficiaries' claim to the 10-year guaranteed benefits payments since the retiree did not live after his Annuity Starting Date as required by the express plan terms; further affirming dismissal of the equitable relief claim since any equitable claim based on alleged misrepresentations made to the retiree when he selected his retirement benefits was released when he signed a release agreement. [O'Shea, et al. v. UPS Retirement Plan, et al., No. 15-1923, ___ F.3d ___, 2016 WL 4750214 \(1st Cir. Sept. 13, 2016\)](#) (Before Thompson, Circuit Judge, Souter,* Associate Justice, and Barron, Circuit Judge).

B. Second Circuit

In this lawsuit for unpaid SERP benefits, the court concluded that state and federal law do not permit YAI to withhold Plaintiff's SERP benefits simply because YAI and its agents have determined them to be excessive or unreasonable. YAI forfeited its public policy defense argument that New York's Office for People with Developmental Disabilities ("OPWDD") concluded that Plaintiff's SERP benefits were excessive because it did not raise this argument in the partial summary judgment motion. But, even if YAI did not forfeit this argument, YAI did not produce evidence that OPWDD ever formally found that Plaintiff's compensation violated NY law. Plaintiff agreed to a reduction of his SERP benefits in 2008 and that amendment is valid. [Levy v. Young Adult Inst., Inc., No. 13-CV-2861 \(JPO\)\(SN\), 2016 WL 6092705 \(S.D.N.Y. Oct. 18, 2016\)](#) (Judge J. Paul Oetken).

Former spouse's execution of a separate renunciation of benefits (waiver) did not alter the plan administrator's obligation to distribute benefits to deceased participant's former spouse in compliance with the plan documents based on rule articulated in *Kennedy v. Plan Administrator for DuPont Savings and Investment Plan*, 555 U.S. 285 (2009); Plaintiff cannot circumvent the plan documents rule by repackaging his claim for wrongful denial of benefits under Section 502(a)(1) as claims for breaches of fiduciary duties under Section 502(a)(3), where Section 502(a)(3) does not permit claims seeking monetary damages from a plan administrator payable to the claimant. [Irvins v. Metropolitan Museum of Art, No. 15-CV-5180 \(RJS\), 2016 WL 4508364 \(S.D.N.Y. Aug. 26, 2016\)](#) (Judge Richard J. Sullivan).

Affirming grant of summary judgment in favor of defendant-appellee PepsiCo Hourly Employees Retirement Plan in this action challenging the denial of Plaintiff's application for pension benefits (where he sought benefits more than six months after his entitlement to LTD benefits), and the district court's subsequent order denying reconsideration of that decision. [Preville v. PepsiCo Hourly Employees Ret. Plan, No. 15-2553, ___ F.App'x ___, 2016 WL 2942612 \(2d Cir. May 20, 2016\)](#) (Present JOSÉ A. CABRANES, CHESTER J. STRAUB, RAYMOND J. LOHIER, JR., Circuit Judges).

Entering judgment in favor of Plaintiff in his 29 U.S.C. § 1132(a)(1)(B) claim that the Committee was arbitrary and capricious in denying his benefits under the Supplemental Retirement Plan by unreasonably interpreting “total compensation” in Appendix D-1 of the Pension Plan to exclude Option Proceeds; entering judgment in favor of the Committee on Plaintiff’s Benefit Equalization Plan-related claims and on his claims that the ERISA’s anti-cutback provision, 29 U.S.C. § 1054(g)(1) as well as ERISA’s notice provision, 29 U.S.C. § 1054(h) were violated by the Committee; denying attorney’s fees to Plaintiff. [Kelly v. Retirement Plan Committee, No. 3:11-CV-01890 \(WGY\), 2016 WL 2963417 \(D. Conn. May 20, 2016\)](#) (Judge William G. Young).

Pension plan amendment does not violate ERISA Section 204(g). [Morrone v. The Pension Fund of Local No. 1, I.A.T.S.E., No. 14 CIV. 8197 \(PAC\), 2016 WL 554844 \(S.D.N.Y. Feb. 10, 2016\)](#) (Judge Paul A. Crotty). Plaintiff, a participant in the pension plan of The Pension Fund of Local No. 1, I.A.T.S.E. (the “Plan”), brought suit against Defendant alleging that subjecting him to a parity rule is an impermissible reduction of accrued benefits. Here, Plaintiff accrued pension credits under the Plan from 1970 to 1996; went on a hiatus from 1997 to 2011; and resumed accruing credits from 2012 to 2014. The Plan’s Board of Trustees found that he is subject to the Plan’s current parity rule for calculation of pension accrual rates rather than the prior five-year rule, which was added to the Plan by amendment in 1994 and removed in 1999. Plaintiff argued that this violates ERISA Section 204(g). Section 204(g), commonly referred to as the anti-cutback rule, provides that the accrued benefits of a participant under a plan may not be decreased by an amendment of the plan. Further, the rule also provides that a plan amendment which has the effect of eliminating or reducing a retirement-type subsidy with respect to benefits attributable to service before the amendment shall be treated as reducing accrued benefits. The court granted summary judgment in favor of the Plan. It found that the 1999 amendment affected benefits attributable to service after the 1999 amendment and the amendment did not decrease an accrued benefit because it only modified the conditions under which Plaintiff could accrue additional benefits in the future.

Claims related to Xerox retirement plan’s “phantom account” are released and time-barred. [Clouthier v. Becker, No. 08-CV-6441L, 2016 WL 245157 \(W.D.N.Y. Jan. 21, 2016\)](#) (Judge David G. Larimer). This case is one of several cases relating generally to the calculation and payment of retirement benefits for participants of the Xerox Corporation Retirement Income Guarantee Plan who left Xerox’s employ at some point, took a lump-sum distribution of accrued pension benefits, and later returned to Xerox for a second period of employment. *See Frommert v. Conkright*, 738 F.3d 522 (2d Cir. 2013). Defendants moved for summary judgment on two grounds: first, that Plaintiff has released Defendants from all the claims presented in this suit, and second, that his claim is time-barred. Plaintiff argued that a release he signed in 1999 does not bar his claims, because at the time he signed the release, he was unaware that Xerox would later determine that he was not entitled to pension benefits, based on the phantom account method. In other words, there was no existing controversy or dispute at the time he executed the

release so it is ineffective as to his claims here. The court rejected this argument because when Plaintiff signed the release in 1999, he did so with full notice of the phantom account's existence. He also agreed to release all claims "known or unknown" and he signed the release knowingly and voluntarily. With respect to the limitations period, the court concluded that even if it were to apply a six-year limitations period (rather than a one-year contractual limitations period advanced by Defendants), Plaintiff's claims are time-barred because the limitations period in this case began to run when Plaintiff was first apprised of the phantom account offset, by means of the 1998 SPD. Plaintiff did not file suit until 2008. For these reasons, the court agreed with Defendants on both grounds and granted their motion for summary judgment.

C. Third Circuit

In this case, Plaintiff contends that a 2005 Settlement Agreement required the Fund to credit her with service time dating back to March 26, 2002, when she was first hired, rather than September 26, 2005, when her position was restored. Had the Fund recognized her pre-2005 service, she would be entitled to an immediate early retirement benefit. The court found that because the Settlement Agreement provided Plaintiff with no back pay, she is not entitled to claim any additional hours of creditable service based on that settlement. Additionally, the court found that Plaintiff's claim must also be dismissed for failing to exhaust administrative remedies. The court dismissed the lawsuit with prejudice. [Dooley v. US Steel Workers of Am. PIUMPF, No. 16CV0402, 2016 WL 7178778 \(W.D. Pa. Dec. 9, 2016\)](#) (Judge Arthur J. Schwab).

Under the 2004 National Memorandum of Understanding (the "MOU"), which requires Alcatel to provide certain benefits to former occupational employees through 2019, Alcatel must fund the 401(h) account in accordance with Section 6.E, but need not use excess pension assets to do so. Thus, the court found that Plaintiffs have not adequately pleaded that the transfers of these excess assets out of the Lucent Technologies Pension Plan breached the MOU. Individual Plaintiffs do not have Article III standing because they have not shown individualized injury and the Union Plaintiffs lack associational standing under ERISA to bring the ERISA claim. [Commc'ns Workers of Am. v. Alcatel-Lucent USA Inc., No. 15-CV-8143, 2016 WL 7013463 \(D.N.J. Nov. 30, 2016\)](#) (Judge Claire C. Cecchi).

Allstate's 1991 amendments of the Plan phasing out an early retirement subsidy and 1993 amendments excluding "exclusive agent independent contractors" ("EA") from earning "service" toward eligibility for the subsidy does not violate ERISA's anti-cutback provision. However, factual issues remain on Plaintiffs' "Beef-Up claim" (based on 1989 Plan early retirement subsidy) and, to the extent unidentified Plaintiffs claim they should receive credit for service as an employee regardless of their forced conversion to an EA contract, those Plaintiffs may proceed to an eventual individual resolution. [Romero v.](#)

[Allstate Ins. Co., No. CV 01-3894, 2016 WL 6876307 \(E.D. Pa. Nov. 22, 2016\)](#) (Judge Kearney).

The application of the Taft Hartley Act does not render Plaintiff legally incapable of having been a participant in the Pension Plan and therefore lacking a colorable claim to benefits under ERISA. However, Plaintiff failed to prove her participant status on the basis of the undisputed facts and is not entitled to benefits as a matter of law. Although the issue of Plaintiff's statutory standing to bring § 1132 and § 1104 claims remains unresolved, the applicable statutes of limitations bar Plaintiff's claims, regardless of her participant status. [Fiorentino v. Bricklayers & Allied Craftworkers Local 4 Pension Plan & the Bd. of Trustees of the Bricklayers & Allied Craftworkers Local 4 Pension Plan, No. CV1502065FLWLHG, 2016 WL 5723660 \(D.N.J. Sept. 30, 2016\)](#) (Judge Freda L. Wolfson).

Denying Plaintiff's motion for reconsideration of court's previous determination that the mandatory arbitration provision in the 401(a) Plan is enforceable and dismissing the relevant claims with prejudice; rejecting Plaintiff's argument that the 401(a) Plan's arbitration provision is unenforceable as a matter of law because its cost-splitting provision unduly inhibits and hampers the initiation and processing of claims for benefits in violation of ERISA. [Luciano v. Teachers Ins. & Annuity Ass'n of Am. - Coll. Ret. Equities Fund \(TIAA-CREF\), No. CV156726MASDEA, 2016 WL 4728105 \(D.N.J. Sept. 9, 2016\)](#) (Judge Shipp).

Defendant abused its discretion in determining that Plaintiff became eligible for disability retirement benefits as of the date his SSDI benefits became payable, rather than as of his date of disability, where the court found that Defendant's interpretation of the Plan completely disregards and renders superfluous a provision of the Plan which governs the "commencement" of benefits upon retirement. [Marino v. Joint Bd. of Admin. Trustees, No. CV 15-6933 \(JLL\), 2016 WL 4620371 \(D.N.J. Sept. 6, 2016\)](#) (Judge Jose L. Linares).

Affirming district court's grant of summary judgment to GM and determining that QDRO obtained after former spouse's death could not be qualified in order to alienate a post-retirement survivor annuity, which vested upon the spouse's death. [Marva Jane Richardson-Roy v. Abigail Johnson, et al., No. 15-1914, F.App'x , 2016 WL 4088732 \(3d Cir. Aug. 2, 2016\)](#) (Before: GREENAWAY, JR., GARTH and RENDELL, Circuit Judges).

Former spouse has separate interest in 50% of decedent's pension and a valid QDRO but administrator must determine whether separate interest was extinguished upon death. [Einhorn v. McCafferty, et al., No. 5:14-CV-06924, 2016 WL 1273937 \(E.D. Pa. Mar. 31, 2016\)](#) (Judge Joseph F. Leeson). In this case, a deceased Teamsters Pension Plan participant was married to his former spouse, Deborah, for 22 years. As part of their divorce proceedings they agreed that Deborah is "entitled to half of his work pension." The participant subsequently married but then passed away after being married for less than a year. At the time of death, the participant had not yet reached the minimum age to begin receiving benefits. The surviving

spouse, Susan, began receiving pre-retirement surviving spouse benefits, which she is entitled to for only sixty monthly payments due to the length of the marriage. On the question of Deborah's entitlement to benefits, the court concluded that Deborah has an enforceable, separate interest in fifty percent of the decedent's pension, and a valid QDRO under ERISA to enforce that interest, provided that the terms of the Plan did not extinguish that interest upon his death. If Deborah's interest was extinguished, her only resort would be to seek to be treated as his surviving spouse so that she could collect the Plan's qualified preretirement survivor annuity. But, the original divorce decree did not explicitly mention surviving spouse rights, which means it is not sufficient under ERISA to secure her those rights, and it cannot be amended now. The court found that Deborah lost her chance to be treated as the decedent's surviving spouse and her ability to obtain any benefits from the pension depends upon whether her separate interest survived the death. The court determined that the Plan administrator must make that initial determination at first instance. However, the court found that Deborah cannot obtain an interest in the survivor annuity that Susan is currently receiving, which means that if Deborah's separate interest was extinguished by the participant's death, she is not entitled to any benefits.

State law claims against fund preempted by ERISA and plaintiff fails to state an ERISA claim because no standing as a plan participant. [Giuffrida v. New Jersey Builders Statewide Benefits Fund, et al., No. CV 14-7059 \(CCC\), 2016 WL 1223324 \(D.N.J. Mar. 29, 2016\)](#) (Judge Claire C. Cecchi). Plaintiff brought state law claims alleging two alternative theories of liability: (1) the Union either failed to ensure Plaintiff worked for employers that had signed collective bargaining agreements with the Union and, as a result, Plaintiff was not entitled to a pension; or (2) the Fund lost Plaintiff's employment records, which could have revealed Plaintiff was entitled to a pension because he had in fact worked for collectively bargained employers. The court granted Defendant's motion to dismiss because it found that federal law preempts Plaintiff's state law claims. Here, Plaintiff's negligence, common-law fraud, and breach of fiduciary duty claims are expressly preempted by ERISA § 514 since those claims arise from Plaintiff's allegations that the Fund mismanaged plan assets and failed to transfer or maintain records of the Plaintiff's employment, thereby preventing him from collecting a pension through the plan. The court also found that Plaintiff fails to state a claim under ERISA because Plaintiff is not an ERISA plan participant and therefore lacks standing to bring claims against the Fund under ERISA.

No equitable estoppel claim where the plaintiff could not show reasonable reliance on alleged misrepresentation of pension benefit amount. [O'Blenis v. Nat'l Elevator Indus. Pension Plan, No. 15-3209, Fed.Appx., 2016 WL 1169129 \(3d Cir. Mar. 25, 2016\)](#) (Before: JORDAN, BARRY and VAN ANTWERPEN, Circuit Judges). The Third Circuit found that the district court appropriately awarded summary judgment on Plaintiff's equitable estoppel claims under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). In this Circuit, a plaintiff seeking equitable relief in an ERISA case must establish: (1) a material misrepresentation or fraudulent concealment; (2) reasonable and detrimental reliance upon the misrepresentation or concealment;

and (3) extraordinary circumstances. Here, Plaintiff alleged that the Local One's secretary/treasurer made a material misrepresentation to Plaintiff regarding what the amount of his pension would be, but the court found that Plaintiff could not show reasonable reliance on that misrepresentation. This is because Plaintiff had no reason to believe that the secretary/treasurer had the authority to bind the pension plan, especially when the secretary/treasurer gave Plaintiff the phone number to call the pension plan, implying that Plaintiff needed to contact someone else. Additionally, the plan sent Plaintiff two "calculation/option" sheets reflecting that Plaintiff would receive a reduced pension; followed by a third document that showed the exact amount that Plaintiff would receive monthly.

Pension plan administrator did not abuse its discretion in calculating pension benefit based on "deemed compensation" earned while participant was receiving long-term disability benefits. [Dowling v. Pension Plan for Salaried Employees of Union Pac., No. 14-CV-3926, 2016 WL 1169565 \(E.D. Pa. Mar. 24, 2016\)](#) (Judge William Ditter). Plaintiff filed an action under ERISA Section 502(a)(1)(B), alleging that provisions of benefit plans sponsored by his former employer require that incentive pay awards be included in the calculation of his pension benefit. It is undisputed that the plan administrator in this case was granted the discretion and authority to determine eligibility and interpret the plan terms. The parties also agree that the terms of the plan are unambiguous, but disagree as to the method used to calculate Plaintiff's Final Average Compensation, as defined by the plan, and whether it was a reasonable application of the plan. Plaintiff ceased to be employed when he retired and became a pensioner in 2012. While he was a disabled participant, he was deemed to have been paid his base salary of \$208,000 for each of the ten years prior to 2012 and his pension is based upon that salary. Plaintiff contended that the final average compensation should have been calculated on his actual compensation during the 120-month period immediately preceding his disability, even though his time on long-term disability was added to his years of credited service. The court concluded that it was not an abuse of discretion for the administrator to base the calculation on "deemed compensation" earned in the 120-month period during which Plaintiff was on long-term disability. Under the terms of the plan, there is a general rule that years of service end when employment ends and a participant's pension is based upon pay received during the ten years that end when employment ends. For disabled participants, the applicable sections of the plan create an exception to the general rule, such that when their employment ends when they are no longer a disabled participant, a pension is based upon their deemed pay during the prior ten years.

D. Fourth Circuit

In suit challenging suspension of pension plan benefits, the court found that the Trustees did not abuse its discretion when it found that (1) Plaintiff did not "retire" under the terms of the Plan because his work as an estimator was within the "jurisdiction of the Plan" and he can only be considered retired if he has been withdrawn from work in the jurisdiction of

the Plan for a period of 30 days or more; and (2) Plaintiff's work as an Operations Manager is "work in the jurisdiction of the Plan" subject to a suspension of benefits.

[Maltese v. Nat'l Roofing Indus., No. 5:16CV11, 2016 WL 7191798 \(N.D.W. Va. Dec. 12, 2016\)](#) (Judge Frederick P. Stamp).

Concluding that the Plan Administrator's decision to disburse Plaintiff's money from the 401(k) Plan to his mother was reasonable and not a breach of fiduciary duty where Plaintiff was a minor and his mother was providing for his care; South Carolina Probate Code § 62-5-433 does not apply to the distribution of a 401(k) plan, thus the court need not decide whether it is preempted by ERISA. [Robert C. Stills, Plaintiff, v. Janney Montgomery Scott LLC, Prudential Ret. Ins. & Annuity Co., & Ansaldo STS USA, Inc., Defendants. Janney Montgomery Scott LLC, Third Party Plaintiff, v. Amy Stills, Third Party Defendant, No. 3:15-3699-JFA, 2016 WL 4247744 \(D.S.C. Aug. 11, 2016\)](#) (Judge Joseph F. Anderson, Jr.).

Domestic relations order conferring interest in ERISA-qualified TIAA-CREF account is excluded from bankruptcy estate. [In re Chilson, No. 1:15-CV-00020-MR, 2016 WL 1079149 \(W.D.N.C. Mar. 18, 2016\)](#) (Judge Martin Reidinger). In this matter involving a Chapter 7 Petition, the Trustee argued that the Debtor has no ownership interest in her former spouse's TIAA-CREF account and instead merely has a right to payment that is subject to turnover because no qualified domestic relations order ("QDRO") was entered transferring ownership of the funds to the Debtor. The court found that is not disputed that the divorce decree constitutes a "domestic relations order" within the meaning of ERISA. A domestic relations order must create or recognize the existence of an alternate payee's right to receive all or a portion of the benefits payable with respect to a participant under a plan. (29 U.S.C. § 1056(d)(3)(B)(i)). But, to qualify as a QDRO, the domestic relations order must comply with certain technical requirements, including setting forth: (1) the name and mailing address of both the participant and the alternate payees, (2) the amount or percentage of the participant's benefits to be paid to each alternate payee, (3) the number of payments to which the order applies, and (4) the plan to which the order applies. (29 U.S.C. § 1056(d)(3)(C)). Although noncompliance with the technical shortcomings may preclude the plan administrator from paying such benefits, they have no effect on the validity of the domestic relations order which created the ownership interest in the account in the first place. In this case the Debtor and her former spouse entered into a separation agreement with the intent to give the Debtor an interest in the TIAA-CREF account as of the date of their divorce. The state court entered a domestic relations order incorporating the agreement and awarding the Debtor a portion of that account. The court concluded that even though there is no "qualified" domestic relations order, the Debtor obtained a legal and equitable ownership interest in the ERISA-qualified TIAA-CREF account as of the date of her divorce, and because it is ERISA-qualified, the Debtor's interest in that account is, by its nature, excluded from the bankruptcy estate and thereby not subject to turnover. The court concluded that the Bankruptcy Court's Order denying turnover was correct.

Despite alleged agreement by employer to vest participant in the pension plan, Plan Administrator reasonably denied benefits based on explicit Plan terms. [Ritter v. IBM Corp. Pension Plan Adm'r, No. CV DKC 14-2126, 2016 WL 160264 \(D. Md. Jan. 14, 2016\)](#) (Judge Deborah K. Chasanow). The court granted summary judgment in favor of IBM on Plaintiff's claim for additional pension benefits. Plaintiff alleged that, as a condition of her agreeing to reemployment with IBM, the company agreed to vest her in their Employee Retirement Plan immediately upon her return to employment on February 1, 1994. According to Plaintiff, IBM accomplished this by changing her "service computation date" and changed her records to indicate that she had been working continuously at IBM for nine years since January 1985, rather than for a nine year period from 1966 to 1975. She further claimed that before she accepted a buyout in 1994, she was assured that her benefits were vested, and she had received a "vested rights estimate" that indicated she would receive \$1,952.16 annually upon retirement (that utilized the aforementioned revised employment records per her agreement). When Plaintiff did not receive benefits based on her understanding of the agreement, she submitted a claim, which the Plan Administrator denied and upheld on administrative appeal. First the court found that Plaintiff's lawsuit was timely because, applying Maryland's three-year statute of limitations for breach of contract, the lawsuit was brought within three years of the final denial of her claim. The court rejected that the statute should start accruing when Plaintiff received notice that her benefits were less than she expected. With respect to the merits of the claim, the court found that the denial of benefits was reasonable because it is based on an explicit provision of the Plan that governs creditable years of service when there has been a break in service of more than five years. The court found that there is no evidence raising a concern that a potential conflict improperly influenced the decision and the Plan Administrator did not abuse its discretion.

E. Fifth Circuit

The Western & Southern Agency Group Long Term Incentive and Retirement Plan is a "top-hat" plan and Defendants were not required to provide a summary plan description to Plaintiffs; the plan administrator's finding that becoming licensed to sell insurance for another company constitutes engaging in competing business is a reasonable interpretation of the Plan and it did not abuse its discretion in denying Plaintiffs' claims for benefits. [Owens v. The W. & S. Life Ins. Co., No. CV 13-4782, 2016 WL 4718185 \(E.D. La. Sept. 8, 2016\)](#) (Judge Mary Ann Vial Lemmon).

In matter where decedent named his son from a prior marriage as beneficiary of his 401(k) plan, concluding that the surviving spouse did not waive her right to the surviving spouse annuity by entering into a separate property agreement which does not meet the section 1055(c) surviving spouse standard. [Callegari v. Scottrade, Inc., No. CV 16-1750, 2016 WL 4210841 \(E.D. La. Aug. 10, 2016\)](#) (Judge Carl J. Barbier).

Pension benefits rolled over to an IRA are not an offset against disability benefits based on language in SPD. [Thomason v. Metro. Life Ins. Co., No. 3:14-CV-0086-P, F.Supp.3d , 2016 WL 791044 \(N.D. Tex. Feb. 25, 2016\)](#) (Judge Jorge A. Solis). The issue in this case is whether pension benefits from the policyholder’s pension plan, which was rolled over to an IRA, is an offset properly taken against monthly long-term disability benefits. The long-term disability plan SPD provides that certain benefits are offset from the LTD benefit amount, including “[p]ension benefits from a Verizon pension plan, if you elect to receive them.” The SPD is incorporated into the Plan by reference. Plaintiff contended that he did not “receive” the pension benefits because he rolled his lump-sum pension payment into an IRA. Defendant contended that the money was received when MetLife delivered the lump-sum payment. The court, following Fifth Circuit precedent, determined that the rule of *contra proferentum* applies to the interpretation of SPDs when the language is ambiguous. The court found that both of the requested interpretations are reasonable so that a conflicting inference exists, justifying the application of *contra proferentem*. Applying *contra proferentem*, the court construed the term “receives” to mean possession through actual receipt of funds, rather than through a trustee-to-trustee transfer under the tax code. The court concluded that the administrator’s interpretation is incorrect and granted Plaintiff’s motion for summary judgment as to this issue. The court also found that two of the three abuse-of-discretion factors fall in favor of Plaintiff and granted summary judgment to Plaintiff as to the abuse-of-discretion prong. Plaintiff also asserted a claim under 29 U.S.C. § 1132(c) for the Committee’s failure to provide the pension-plan document and the trust agreement in response to his requests in violation of 29 U.S.C. § 1024(b)(4). Because Plaintiff did not allege or show prejudice from the delay in receiving these documents, the court denied his motion for summary judgment on this claim. Lastly, the court granted Plaintiff summary judgment on his claim under 29 U.S.C. § 1132(a)(3), where he asserted that the pension offset provision in the summary plan description is in violation of 29 U.S.C. § 1022(a) because it is not written in a manner calculated to be understood by the average plan participant and sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the Plan.

F. Sixth Circuit

In dispute over funds held in a 401(k) account, the court found that the divorce decree designated no “alternate payee” to receive “all or a portion of the benefits” such that it does not constitute a QDRO, and denied Executor’s motion for summary judgment. The Plan Administrator erred in relying on the divorce decree to determine the rightful beneficiary and should have distributed the funds to the beneficiary on the designation of beneficiary form, the deceased’s ex-wife. The court declined to decide whether to impose a constructive trust on Betty for the benefit of the estate based on its argument that claiming the 401(k) fund is a violation of the divorce decree and breach of the agreement.

[Cunningham v. Hebert, No. 14 C 9292, 2016 WL 6442180 \(N.D. Ill. Nov. 1, 2016\)](#) (Judge Joan H. Lefkow).

Plaintiff sufficiently alleged that 29 U.S.C. § 1132(a)(3) claim is more than a mere “re-packaging” of denial of pension benefits claim, where Plaintiff alleges a course of conduct by Defendants, by which they provided Plaintiff with confusing and inconsistent information in response to his written benefits inquiries; alleges that Defendants failed to furnish full copies of plan documents from which he could ascertain his rights; and alleges that Defendants failed to offer a full and fair claims process. [Bulger v. Eaton Corp., No. 1:16CV405, 2016 WL 5807111 \(N.D. Ohio Oct. 5, 2016\)](#) (Judge Christopher A. Boyko).

Although there was a material misrepresentation when Chebowski received benefit statements and communications from the Plan Administrator stating that his monthly retirement benefit was \$183.86 and that his benefit was 100% vested; and (2) that the Plan Administrator was aware of the true facts and had all of the information needed to determine Chebowski’s vesting and retirement benefit — Chebowski has not sufficiently alleged the remaining elements of equitable estoppel and those claims are dismissed. [Chebowski v. Kelsey-Hayes Salaried Pension Plan, No. 15-13092, 2016 WL 5477335 \(E.D. Mich. Sept. 29, 2016\)](#) (Judge Denise Page Hood).

Affirming the grant of summary judgment in Plaintiff’s favor on his equitable estoppel, breach of fiduciary duty, and anti-cutback claims, where the gist of the claims is that Plaintiff was denied pension credit for ten years of employment in Canada after the management team promised Plaintiff that he would get the credit, he received various written materials confirming the same, and he turned down employment opportunities from a competitor at a higher salary. [Deschamps v. Bridgestone Americas, Inc. Salaried Employees Retirement Plan, et al, No. 15-6112, 2016 WL 4728029 \(6th Cir. Sept. 12, 2016\)](#) (BEFORE: SILER, GIBBONS, and COOK; Circuit Judges).

In matter where Salary Continuation Agreement (“SCA”) provided that all rights under the agreement terminate if employment ends for reasons other than total disability or the sale of the company to a third party, finding that a 1999 change of ownership and Plaintiff’s termination in 2014 are not causally linked under the circumstances presented, and as a matter of law, Plaintiff is not entitled to benefits under the SCA. [Smith v. Integral Structures, Inc., No. 3:14-CV-00419-GNS-DW, 2016 WL 4581414 \(W.D. Ky. Sept. 1, 2016\)](#) (Judge Greg N. Stivers).

Adopting Magistrate Judge’s report and recommendation over Defendants’ objections about the consideration of extrinsic evidence in interpreting QDRO; finding that consideration of the express terms of the Divorce Judgment shows the “unmistakeable” intent of Richard and Margaret “at the time of their divorce was for Margaret Trapp to receive 50% of the benefits accrued through the time of their divorce;” granting

Defendants' motion for leave to file a cross claim against Margaret for portions of the surviving spouse pension benefit that should have been paid by the Plan to Plaintiff (surviving spouse). [Trapp v. Ford Motor Co. Gen. Ret. Plan, No. 15-10742, 2016 WL 4204131 \(E.D. Mich. Aug. 10, 2016\)](#) (Judge Sean F. Cox).

In putative class action challenging Defendant's new method of retirement benefit calculation for employees that were transferred from Dow to DuPont Dow Elastomers and then back to Dow, granting Defendant's motion for judgment on the administrative record, dismissing complaint with prejudice, and denying motion for class certification as moot. [Johnston v. Dow Employees' Pension Plan, No. 14-CV-10427, 2016 WL 4158379 \(E.D. Mich. Aug. 5, 2016\)](#) (Judge Thomas L. Ludington).

Granting in part and denying in part government's motion for an order directing payments from the defendant's pension plan, finding that although section 3613 of the MVRA supersedes ERISA's anti-alienation provision, this right does not always guarantee that the government will be able to cash out the defendant's retirement plan unilaterally and Thyseen has not shown that participant has a current, unilateral right to his benefits under the pension plan. [United States v. Ibianski, No. 07-20632, 2016 WL 3995939 \(E.D. Mich. July 26, 2016\)](#) (Judge David M. Lawson).

Denial of lump sum benefit not arbitrary and capricious where pension plan participant died prior to commencement of his assigned Lump Sum Window Election Period, he never became eligible to elect a lump sum distribution, and thus had no vested interest in the lump sum opportunity. Prior to Lump Sum Window Election Period, Plaintiff made four phone calls to the Plan requesting the paperwork to make the election in light of her husband's serious illness and husband stated in a letter that he was hospitalized, death may be imminent, and he desired to election the lump sum option. [Strang v. Ford Motor Co., No. 14-CV-14410, 2016 WL 3625601 \(E.D. Mich. July 7, 2016\)](#) (Judge Bernard A. Friedman).

Application of pension plan amendment violates anti-cutback rule. [Carter v. Arkema, Inc. & Arkema Inc. Retirement Benefits Plan, No. 3:13CV-01241-JHM, 2016 WL 1274594 \(W.D. Ky. Mar. 31, 2016\)](#) (Judge Joseph H. McKinley, Jr.). Plaintiffs allege that the Arkema Inc. Retirement Benefits Plan ("Arkema plan"), along with the other plans, have been subjected to unilateral changes imposed by the employer or the administrator, or both, which have reduced the participants' credit years of service and deprived plan participants of vested rights in contravention of ERISA. Plaintiffs were former employees of M&T Chemicals before it was sold to Arkema's corporate predecessor. Plaintiffs were participants in the M&T Chemicals pension plan and then became participants in the Arkema plan. The question before the court is whether Arkema's use of the adjusted service date under its Primary Method of calculating Plaintiffs' retirement pension benefits pursuant to the 1997 Plan Amendment deprived Plaintiffs of accrued benefits under the 1994 Plan and violated the anti-cutback rule. The court found that

Plaintiffs have shown that their accrued benefits decreased because of the 1997 Plan Amendment as interpreted by Defendants. The court further found that the 1994 Plan clearly and unambiguously provides that a former participant under the M&T Chemical Pension Plan shall receive an Accrued Benefit under the Plan equal to the benefit to which a participant would be entitled under the 1994 Plan based on all of the participant's service with the Company. But, Defendants application of the 1997 Amendment does not consider all of the participants' service with the Company. The court found that Plaintiffs are entitled to accrued benefits equal to the benefits to which the Plaintiffs would be entitled to under the Arkema Plan based on all of the Plaintiffs' service with M&T Chemicals and Arkema. Plaintiffs also alleged that the Arkema Plan, and any other plans in which the individual Plaintiffs were participating, revoked the 85-year rule, depriving Plaintiffs of the option of early retirement without penalty. The court found that the Rule of 85 applies only to the years of service before the amendment and granted in part Plaintiffs' motion for partial summary judgment on the Rule 85 claim. However, the court found that two of the plaintiffs did not qualify for the plant closing early retirement benefit under the M&T Combined Plan. While they may "grow into" eligibility for an early retirement-type subsidy or benefits under the anti-cutback rule, these Plaintiffs did not satisfy all of the eligibility requirements of the pre-amendment early retirement benefit. The court also found that these Plaintiffs are not entitled to Arkema's retirement medical coverage.

Court grants summary judgment against claimant who failed to exhaust administrative remedies and attorneys' fees awarded to defendant insurer. [Spath v. Standard Ins. Co., No. 15-CV-6128-SJ-DGK, F.Supp.3d](#), 2016 WL 772690 (W.D. Mo. Feb. 29, 2016) (Judge Greg Kays). In this case involving a denial of long-term disability benefits, the court granted summary judgment to Standard, finding that "no reasonable jury could find that Standard was unreasonable to conclude that Spath had not exhausted her administrative remedies." Standard sent Plaintiff a claim termination letter and informed her that she must send a written request for Standard to review the claim decision within 180 days. Plaintiff's attorney mailed Standard a letter within the 180-day timeframe, but the letter did not specifically request a "review" or "appeal." Instead, the letter requested medical opinions, which the court found that a reasonable mind could interpret to mean that Plaintiff was assessing the strength of her case, and not necessarily appealing the decision yet. Further, following receipt of the attorney's letter, Standard informed Plaintiff that it did not consider the letter to be a request for review. However, Plaintiff never responded to the letter although more than three months remained for Plaintiff to do so. Standard requested that the court award \$1,000 in attorneys' fees and costs. The court awarded Standard only \$500 in fees after consideration of the five *Martin* factors. The court found that Plaintiff did not act in bad faith and that she did not have the ability to pay \$1,000. However, the court found that a fee award would have some positive deterrent effect; including that plan participants would be incentivized to undertake an investigation as to the likelihood of success of certain arguments. Additionally, this lawsuit does not involve any significant question about ERISA since courts have consistently affirmed a plan participant's

obligation to exhaust administrative remedies before filing suit. Lastly, Plaintiff's position was relatively much weaker than Standard's position.

Nunc pro tunc order granting right to ex-spouse's pension is an enforceable domestic relations order. [Patterson v. Chrysler Grp., LLC, No. 15-10563, 2016 WL 627886 \(E.D. Mich. Feb. 17, 2016\)](#) (Judge Arthur J. Tarnow). Plaintiff was once married to an employee of Defendant FCA US LLC (Chrysler), which is the sponsor of Defendant FCA US LLC—UAW Pension Plan, an ERISA plan under which Plaintiff's ex-husband accumulated benefits. A 1993 divorce judgment awarded her half of her ex-husband's pension benefits accumulated under the plan during their marriage. Defendants twice denied Plaintiff's claim for benefits under the divorce judgment. Plaintiff hired new counsel who obtained a new order recognizing her right to benefits awarded in the divorce judgment and purporting, under the nunc pro tunc doctrine, to date back to September 1993. However, Defendants continued to deny Plaintiff's claim. The court granted summary judgment in favor of Plaintiff and awarded the benefits provided to her under the terms of the Nunc Pro Tunc Order. The court found that Plaintiff's claim was not time-barred because it was filed within one year of the Nunc Pro Tunc Order. On the merits, the court determined that the Nunc Pro Tunc Order is qualified only if it is considered to date back to the 1993 divorce judgment. If so, then at the time the plan started paying the benefits to the ex-husband, it was already required to pay some of them to Plaintiff instead. Paying that share now is not an increase in benefits as contemplated by 29 U.S.C. § 1056(d)(3)(D)(ii). Further, the order would predate the "benefit commencement date," and therefore could not violate the plan's prohibition on a change in the form of benefits after the benefit commencement date.

Pre-employment promise of extra years of service is not enforceable and claim waived by release agreement. [Pearson v. Firstenergy Corp., No. 5:14-CV-634, 2016 WL 471859 \(N.D. Ohio Feb. 8, 2016\)](#) (Judge Sara Lioi). In this case, Plaintiff alleged that he was promised a special retirement program when he accepted employment with Duquesne Light Company. The special arrangement was that he would be given 10 years of service after 5 years of employment. Duquesne was subsequently required by FirstEnergy Corp. ("FE"). Plaintiff was later laid off and signed a release of claims in exchange for a severance payment. Close to his benefit commencement date, Plaintiff received a benefit statement and then disputed the projected calculation with the FE Pension Plan Administrator. The Plan Administrator denied Plaintiff's request to be credited with additional service. Plaintiff brought suit alleging both a claim for benefits under 29 U.S.C. § 1132 and for breach of fiduciary duty. The court granted Defendants' motion for summary judgment and dismissed the first amended complaint with prejudice. The court found that the application of the "two-for-one" arrangement with Duquesne would not be permitted under FE's qualified ERISA plan. With respect to the breach of fiduciary duty claim, the court found that Plaintiff was merely a "potential employee" at the time he negotiated the terms of employment. Because he was not yet a participant in the FE Pension Plan, Defendants owed no fiduciary duty to him, and, as a result, the pre-employment representations, both oral and in writing, are legally insufficient to support his ERISA breach of fiduciary claim. The court

further concluded that Plaintiff's breach claim is time-barred. Even under Plaintiff's more generous "discovery rule," instead of § 413's more restrictive "time of the breach" rule, the action was still not filed within the six-year limitations period. Lastly, the court found that the release agreement Plaintiff signed contains a waiver that validly releases the ERISA claims contained in the first amended complaint. When Plaintiff signed the release he knew he was not receiving the benefit of the "two-for-one" agreement.

G. Seventh Circuit

In dispute over pension death benefits, the court found that the Appeals Committee's decision to deny Plaintiff's appeal is arbitrary and capricious because the Committee failed to respond to Plaintiff's arguments that the decedent substantially complied, as defined by federal law, with the Iron Workers' Union 63 change of beneficiary requirements, and that sufficient evidence has been presented to invoke a presumption of receipt. The court remanded the claim to the plan administrator for reconsideration. [Muff v. Iron Workers' Mid-Am., Pension & Supplemental Monthly Annuity Fund, No. 16 C 655, 2016 WL 6948383 \(N.D. Ill. Nov. 28, 2016\)](#) (Judge Charles P. Kocoras).

Affirming the district court's decision and finding not arbitrary and capricious the Plan's determination that Plaintiff's \$2,500 quarterly payments for Board service are not considered as part of Plaintiff's salary for purposes of calculating his pension benefit. [Rabinak v. United Bhd. of Carpenters Pension Fund, No. 15-1717, ___ F.3d ___, 2016 WL 4248377 \(7th Cir. Aug. 10, 2016\)](#) (Before WOOD, Chief Judge, and BAUER and WILLIAMS, Circuit Judges). The Seventh Circuit Court of Appeals affirmed the district court's judgment in favor of the defendant Fund on the issue of how it calculated Rabinak's pension benefit. Rabinak served on his organization's Executive Board and received quarterly payments of \$2,500 for his service. These payments were made separate from his regular salary payments but were reported as wages on his Form W-2s. The Fund would not take into consideration the additional \$10,000 in annual compensation that Rabinak received for purposes of calculating his pension benefit. The specific reason given was that "[t]he stipends received from the Regional Council of Carpenters for being on the Executive Committee are not included as Compensation for purposes of calculating Final Compensation." The plan defines "Compensation" as "all salary" but does not include "overtime, or fees or expenses paid or reimbursed" or "the value of employee benefits or other non-wage payments, even if such payments are considered income for tax purposes."

The court concluded that the Fund's decision was not arbitrary and capricious given that the \$2,500 quarterly payments were coded differently than salary and were not paid with his weekly salary payments. The court also found that the fact that the president of Plaintiff's former employer is on the Plan's Board of Trustees did not create a conflict of interest since the Fund's benefit appeals are decided by a subcommittee of the Board of Trustees of which the president was not a member. And in any event, the presence of a conflict will "act as a tiebreaker when the other factors are closely balanced." The court rejected Rabinak's argument

that the determination was arbitrary and capricious for failure to provide specific reasons for its exclusion of the quarterly payments. The court explained that a decision must give “specific reasons” for the denial (29 U.S.C. § 1133(1)), but “that is not the same thing as the reasoning behind the reasons” or “the interpretive process that generated the reason for the denial.”

From the plaintiff’s perspective, the idea that Section 1133 does not require “reasoning behind the reasons” puts claimants appealing a claim denial at a significant disadvantage. According to Merriam-Webster dictionary, “reason” means “a statement or fact that explains why something is the way it is, why someone does, thinks, or says something, or why someone behaves a certain way.” The Fund’s stated “reason” in *Rabinak* hardly provides an explanation for how and why the Fund interpreted the Plan the way that it did. This doesn’t make any sense.

The Mandatory Victims Restitution Act of 199 supersedes ERISA’s anti-alienation provision. [United States v. Sayyed, No. 11 CR 625-1, 2016 WL 2622307 \(N.D. Ill. May 9, 2016\)](#) (Judge Gary Scott Feinerman).

Amount of early retirement benefit is proper offset under retirement plan. [Cocker v. Terminal R.R. Ass’n of St. Louis Pension Plan For Nonschedule Employees, No. 15-2690, ___ F.3d ___, 2016 WL 1055839 \(7th Cir. Mar. 16, 2016\)](#) (Before POSNER, FLAUM, and EASTERBROOK, Circuit Judges). At issue in this case is the proper benefit payable under a retirement plan, which provides that “the retirement income benefit payable under this Plan shall be offset by the amount of retirement income payable under any other defined benefit plan ... to the extent that the benefit under such other plan or plans is based on Benefit Service taken into account in determining benefits under this Plan.” The Plan further provides that if “the benefit under such another plan is paid in a form other than the form of payment under this Plan, including without limitation a single lump sum cash payment made prior to retirement, the amount of such offset shall be the dollar amount per month of the benefit that would have been payable under such other plan in the form of a Single Life Annuity commencing on the Participant’s Normal Retirement Date.” The parties dispute the meaning of “payable,” since Plaintiff took an early retirement from the Union Pacific Plan and received a monthly benefit of \$1,022.94 rather than the \$2,311.73 that he would have received had he waited until normal retirement age to retire. The district court found in favor of Plaintiff in that the Plan should have reduced his benefit by the lower amount that he received. The Seventh Circuit found that the two dollar figures are actuarially identical, in the sense that the present value of the two streams of money is the same because the smaller monthly benefit is received for 111 months longer than the larger one. The monthly offset required by the Plan is the amount payable under the prior employer’s plan and \$2,311.73 was the maximum amount payable to Plaintiff per month under the Union Pacific Plan. Further, Plaintiff lost nothing by choosing to receive only \$1,022.94. The court reversed the judgment with instructions to dismiss the suit with prejudice.

H. Ninth Circuit

In matter seeking unpaid SERP benefits, the court denied the motions for summary judgment on the ERISA claim for benefits pursuant to an executive retirement plan, equitable estoppel, and contract reformation. The court found that nothing in the Plan language prohibits an agreement to release claims that encompass claims for SERP benefits and Plaintiff did not show as a matter of law that the Committee abused its discretion in denying his claim for SERP benefits. [Buster v. Comp. Comm. of the Bd. of Directors of Mechanics Bank, No. C 16-01146 WHA, 2016 WL 6804581 \(N.D. Cal. Nov. 17, 2016\)](#) (Judge William Alsup).

In action challenging the administrator’s refusal to actuarially increase the amount of accrued benefit that Allbaugh had earned at normal retirement age for each month that his benefits were withheld as a result his employment beyond normal retirement age, denying Allbaugh’s motion for reconsideration of the class certification order and motion for summary judgment, and granting Defendants’ motion for summary judgment in part. [Allbaugh v. California Field Ironworkers Pension Trust, et al., No. 212CV00561JADGWF, 2016 WL 6138244 \(D. Nev. Oct. 19, 2016\)](#) (Judge Jennifer A. Dorsey).

Denying petition for panel rehearing and rehearing en banc of holding that where a participant has made a prima facie case that he is entitled to pension benefits under the plan but lacks access to information needed to substantiate claim and the defendant controls such information, the burden shifts to the defendant to produce this information. In the dissenting opinion, Judge Smith laments that the majority “invents an unprecedented burden-of-proof standard that only it seems to have had the foresight to impose on plan administrators. ... Why have the Supreme Court and our circuit mandate standards of review if judges can ignore them at any time they are so inclined? Our circuit has inexplicably turned its back on the principle of stare decisis in this case. From this time forward, can each panel decide the law on its own, provided enough active judges are willing to live with it?” [Estate of Barton v. ADT Sec. Servs. Pension Plan, No. 13-56379, ___ F.3d ___, 2016 WL 5030341 \(9th Cir. Sept. 20, 2016\)](#) (Before Kozinski, Ikuta, and Owens).

Committee did not violate ERISA in denying Plaintiff’s appeal to have his pre-1999 service credited under the Boeing Company Employee Retirement Plan, where it had been properly transferred to the Boeing Company Pension Value Plan when he became a salaried, non-union employee. [Wortman v. The Boeing Company, No. 3:15-CV-01735-AC, 2016 WL 4625836 \(D. Or. Sept. 6, 2016\)](#) (Judge John V. Acosta).

In lawsuit involving denied claim for Supplemental Executive Retirement Plan (“SERP”) benefits, denying Defendants’ motion to dismiss claims for relief for equitable estoppel, and reformation; finding a strong showing that Mechanics Bank cheated Plaintiff out of his

SERP benefits by telling him the release would not affect his pension yet changed its position after he signed the release; holding that “appropriate equitable relief” under ERISA Section 502(a)(3) may extend to remedy inequitable conduct pertaining to a supposed waiver of plan rights; further holding that consistent with the uniform trend of decisions addressing Section 502(a)(3) in the context of a top-hat plan, that equitable remedies thereunder are available for a breach of the general good faith standard of contract law by the plan administrator. [Buster v. Comp. Comm. of the Bd. of Directors of Mechanics Bank, No. C 16-01146 WHA, 2016 WL 4492577 \(N.D. Cal. Aug. 26, 2016\)](#) (Judge William Alsup).

In action alleging improper handling and distribution of Plaintiff’s share in a profit sharing plan and after granting in part Plaintiff’s motion for summary judgment, finding that the Plan’s valuation of Plaintiff’s distribution was proper where it valued the share as of the date of distribution. [Feikes v. Cardiovascular Surgery Associates Profit Sharing Plan, Trust, et al., No. 2:04-CV-1724-LDG-GWF, 2016 WL 3566985 \(D. Nev. June 29, 2016\)](#) (Judge Lloyd D. George).

In putative class action lawsuit brought by Plan participants against a retirement benefit plan, plan administrator, and employer for their alleged violations of ERISA, in which participants sought payment of benefits under plan or, in alternative, equitable relief, holding that: (1) Plaintiffs failed to establish existence of any structural conflict of interest on part of administrator of ERISA employee retirement plan, that was so serious as to warrant *de novo* review of the plan administrator’s denial of benefits; (2) the plan administrator reasonably interpreted plan terms defining accrued retirement benefits when it denied claims that calculation of their benefits should have included Plaintiffs’ past service with company whose assets were acquired by employer; (3) Plaintiffs could simultaneously pursue, as alternate remedies under ERISA, both a claim for benefits and equitable claim for surcharge, estoppel, and restitution; (4) Plaintiffs were not entitled to reformation of plan on fraud theory; and (5) district court did not abuse its discretion in certifying plaintiff class. Affirmed in part, reversed in part, and remanded. [Moyle v. Liberty Mut. Ret. Ben. Plan, No. 13-56330, ___ F.3d ___, 2016 WL 2946271 \(9th Cir. May 20, 2016\)](#) (Before: HARRY PREGERSON and CONSUELO M. CALLAHAN, Circuit Judges and STANLEY ALLEN BASTIAN,* District Judge). Moyle involves a claim by former Golden Eagle employees against Liberty Mutual for past service credit they alleged Liberty Mutual promised them when Liberty Mutual purchased Golden Eagle through a conservatorship sale and they became employees of Liberty Mutual. The former Golden Eagle employees brought four claims against Liberty Mutual, including a claim for entitlement to past service credit under the terms of the retirement plan under 29 U.S.C. § 1132(a)(1)(B) and a claim for equitable relief under 29 U.S.C. § 1132(a)(3) seeking reformation and surcharge.

The district court found that the terms of the retirement plan did not provide the benefits Appellants are seeking. The Ninth Circuit agreed that Liberty Mutual's reading of the retirement plan was reasonable and Appellants' do not prevail on the claim for benefits under § 1132(a)(1)(B). The district court dismissed the equitable relief claim, which the Ninth Circuit reversed, holding that Appellants may pursue simultaneous claims under 29 U.S.C. § 1132(a)(3) and 29 U.S.C. § 1132(a)(1)(B) in light of *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011). In *Amara*, the Supreme Court held that § 1132(a)(3) authorized equitable relief in the form of plan reformation, even though plaintiffs also claimed relief under § 1132(a)(1)(B). "While *Amara* did not explicitly state that litigants may seek equitable remedies under § 1132(a)(3) if § 1132(a)(1)(B) provides adequate relief, *Amara*'s holding in effect does precisely that." Further, *Amara*'s conclusion that a plaintiff may seek relief under both § 1132(a)(1)(B) and § 1132(a)(3) does not contravene the ruling in *Varity*, where the key holding was that § 1132(a)(3) extends to other sections of the statute, even when § 1132 does not expressly provide a remedy for those sections. The Ninth Circuit explained that *Varity* did not explicitly prohibit a plaintiff from pursuing simultaneous claims under § 1132(a)(1)(B) and § 1132(a)(3). This approach also comports with the Federal Rules of Civil Procedure, which requires that "[a] pleading that states a claim for relief must contain ... a demand for the relief sought, which may include relief in the alternative or different types of relief." Fed.R.Civ.P. 8(a)(3). And to top it off, allowing plaintiffs to seek relief under both § 1132(a)(1)(B) and § 1132(a)(3) is consistent with ERISA's intended purpose of protecting participants' and beneficiaries' interests.

The takeaway: Plaintiffs are allowed to plead alternate theories of relief without obtaining double recoveries.

Reversing district court's judgment concluding that Defendant did not abuse its discretion in denying Plaintiff's claim for pension benefits and holding that where a participant has made a prima facie case that he is entitled to pension benefits, but lacks access to information needed to substantiate the claim and defendant controls such information, the burden shifts to the defendant to produce this information. [Estate of Barton v. ADT Sec. Servs. Pension Plan, No. 13-56379, ___ F.3d ___, 2016 WL 1612755 \(9th Cir. Apr. 21, 2016\)](#)

(Before: ALEX KOZINSKI, SANDRA S. IKUTA, and JOHN B. OWENS, Circuit Judges). In this case, the pension plan administrator denied Bruce Barton's request for pension benefits because it determined that Barton did not prove he was entitled to a pension because he could not document that he worked 1000 hours or more for each of the nearly twenty years he was employed by ADT and its affiliates, or that his employers participated in the Plans. After a bench trial, the district court determined that the administrator did not abuse its discretion in denying Barton pension benefits. It also declined to award Barton statutory penalties for the administrator's failure to comply with ERISA's disclosure obligations since he lacked standing to assert a disclosure violation as he had no colorable claim to pension benefits. The Ninth Circuit Court of Appeals reversed the district court's judgment. The Court held that the district court incorrectly placed the burden of proof on Barton for matters within Defendants' control. The court explained that Defendants are in a far better position to ascertain whether an entity was

a participating employer. Instead, if Barton has made a prima facie case that he is entitled to pension benefits, it is properly Defendants' burden to clarify what entities are covered under the Plans in the first instance. The court remanded the claim to the district court to determine in the first instance whether Barton established a prima facie case and the court may consider the evidence available at trial, including Barton's Social Security records, W-2 statements, pay stubs with the pension box marked, and a letter thanking him for ten years of service. The court also reversed the district court's judgment for Defendants on Plaintiff's statutory penalties claim. Although a plaintiff pursuing such claim must qualify as a plan participant, this issue turns on the ultimate merit of Barton's claim for pension benefits. The court's conclusion aptly sums up the importance of this case:

“This case ultimately is about burdens—to qualify for his pension, must a former employee who quit working for the company more than twenty-five years ago decipher the corporate structure of his former employer from documents that were not disclosed to him? Should he have saved all of his pay stubs in the off chance that his employer would demand proof that he met the hours requirement for obtaining a pension? Or should the corporate defendant bear this load? ERISA, our precedent, and common sense dictate that the corporate defendant should not lay that arduous task at the feet of former employees. To hold otherwise would essentially reward Lucy for pulling the football away from Charlie Brown, something that we do not believe Congress intended when it enacted ERISA.”

In putative class action to recover withheld pension benefit contributions, denying Defendants' motion to dismiss and finding Plaintiff has made a colorable claim that he is a Plan participant, sufficiently alleged a constitutional injury, and alleged facts sufficient to plausibly support an inference that he exhausted his administrative remedies. [Norris v. Mazzola, No. 15-CV-04962-JSC, 2016 WL 1588345 \(N.D. Cal. Apr. 20, 2016\)](#) (Magistrate Judge Jacqueline Scott Corley).

Telephone calls changing legal beneficiary in the absence of written confirmation do not constitute a strict or substantial compliance with governing plan documents. [Becker v. Carmen Stephanie Mays-Williams, No. C11-5830 BHS, 2016 WL 878492 \(W.D. Wash. Mar. 8, 2016\)](#) (Judge Benjamin H. Settle). The issue in this case is who is the legal beneficiary to Asa Sr.'s Xerox Retirement Income Guarantee Plan (“RIGP”) and the Xerox Savings Plan (“Savings Plan”) benefits. Plaintiff, the fiduciary of the Plans, initiated an interpleader action to resolve a dispute between Asa Jr. (the son), and Carmen (the former wife). A Ninth Circuit panel remanded for the court to determine whether Asa Sr. “strictly or substantially complied with the governing plan documents” by telephoning his beneficiary change. The court found that the Plans fail to provide any mechanism for how a beneficiary change may or should be made, but the problem with Asa Jr.'s position is not the type of communication, but rather the *lack* of any clear and unequivocal communication. First, Asa Jr. failed to establish that Asa Sr. was the individual who called Xerox to change the beneficiary designation and it is reasonable for Xerox to require written verification of the designation change to avoid fraudulent transactions.

Second, after each of the three phone calls, Xerox sent Asa Sr. an authorization form, asking Asa Sr. to “validate” the beneficiary change requested in the phone call but he did not do so. There was no evidence presented as to why Asa Sr. failed to comply with the plan administrator’s directives when he did not die for more than three months after he was reminded by Xerox what he must do to effectuate the beneficiary change. Third, the court found that there was substantial and credible evidence showing that Asa Sr. would not have made the alleged change of removing Carmen in favor of Asa Jr. Although Asa Sr. and Carmen were divorced, in the years following the divorce they had an ongoing positive relationship. The court concluded that Asa Jr. failed to meet his burden of proving that Asa Sr. strictly or substantially complied with the governing plan documents in order to change the beneficiary of the Plans, failed to prove that Asa Sr. unequivocally manifested an intent to change his beneficiary, and failed to prove that Asa Sr. did all that was reasonably possible to do to effectuate a change. Therefore, the court found that the designation naming Carmen controls and she is entitled to be paid the benefits.

Denial of pension benefits an abuse of discretion where administrator did not adequately investigate claim. [Gurasich v. IBM Ret. Plan, No. 14-CV-02911-DMR, 2016 WL 362399 \(N.D. Cal. Jan. 29, 2016\)](#) (Magistrate Judge Donna M. Ryu). The parties’ central disagreement is whether Plaintiff’s right to pension benefits terminated when she stopped working for IBM. Defendants took the position that her pension rights terminated because she transferred employment from IBM to another company as a result of the sale of the IBM business unit where she had been working. Defendants contend that Plaintiff’s IBM Plan assets were transferred to her subsequent employer’s benefit plan as part of that transaction. On the contrary, Plaintiff’s position is that she did not end her employment with IBM as part of an IBM asset sale; instead, she voluntarily quit IBM to take a job with Siemens, which happened to be the same company that eventually ended up purchasing her former IBM business unit. Plaintiff contended that if the IBM Plan transferred her pension assets to another employer, it had no right to do so, and she is entitled to pension benefits as evidenced in the many notices she received over the years until she made a claim for benefits. The court granted each parties motion in part. On the benefits claim, the court found that the Plan Administrator abused its discretion by denying Plaintiff’s claim based on an inference drawn from another employer’s records, rather than reviewing records within its own control. In reaching this conclusion, the court gave some weight to the structural conflict, as the Plan Administrator failed to adequately investigate the claim even though Plaintiff brought concrete and undisputed factual discrepancies to its attention. The court rejected Defendants’ argument that the Plan Administrator had no affirmative duty to investigate a plaintiff’s claim for benefits under the Plan. On Plaintiff’s second claim for breach of fiduciary duties and her third claim for equitable relief, Plaintiff conceded that because the court has awarded her benefits under the IBM Plan in her first cause of action, she is not entitled to further relief under her second and third claims. As such, the court did not reach these issues.

I. Tenth Circuit

It was not arbitrary or capricious for the Trust to honor the notices of levy and send Plaintiffs' benefits to the IRS. Additionally, the Trust's application of the sixty-day deadline to Plaintiffs' appeals of the decision regarding the notices of levy was not arbitrary or capricious. [Amador v. Boilermaker-Blacksmith National Pension Trust, No. 16-3090, F.App'x](#), 2016 WL 7321200 (10th Cir. Dec. 16, 2016) (Before TYMKOVICH, Chief Judge, PHILLIPS and McHUGH, Circuit Judges).

J. Eleventh Circuit

In per curiam opinion, finding that the Committee's decision to apply the Social Security benefit offset provided in Plan § 1.27 was not *de novo* wrong, where the plain language of this section provides for an offset based on a conditionally available Social Security benefit, "whether or not payment is delayed, suspended or forfeited because of failure to apply, other work, or any other reason." Plaintiff had a Social Security benefit that had been "delayed, suspended or forfeited" due to his incarceration, but the court found that there is nothing in the Plan language that suggests that Plaintiff must be "legally eligible" for a Social Security benefit before the offset applies. [Slakman v. Administrative Committee of Delta Air Lines, Inc., No. 16-10572, F.App'x](#), 2016 WL 4978353 (11th Cir. Sept. 19, 2016) (Before MARCUS, WILLIAM PRYOR and FAY, Circuit Judges).

K. D.C. Circuit

Request for lump-sum retirement benefits payment made before notice of intent to terminate the plan remanded to PBGC for reconsideration. [Fisher v. Pension Benefit Guar. Corp., No. CV 14-1275 \(RDM\), F.Supp.3d](#), 2016 WL 755607 (D.D.C. Feb. 25, 2016) (Judge Randolph D. Moss). Plaintiff requested a lump-sum retirement benefits payment several months before the plan administrator submitted formal notice of its intent to terminate the plan. The administrator denied the request on the ground that applicable law prohibits the payment of lump sum distributions in anticipation of the termination of the Plan. When Plaintiff's claim was denied the plan administrator had not yet submitted formal notice. The Pension Benefit Guaranty Corporation ("PBGC") took over as trustee of the Plan after it was terminated and denied Plaintiff's request for a lump-sum benefits payment. Plaintiff brought this action against the PBGC. That PBGC relied on its policy to not accept a plan application to pay a benefit in a lump sum received by the plan administrator before the date the plan is terminated—even if it was received before the date of the Notice of Intent to Terminate. The court determined that Section 1341(c) cannot be read to permit the pre-notice denial of a pre-notice request. The PBGC provided no explanation which reconciled the Appeals Board's conclusion and the text of

Section 1341(c). Further, the PBGC did not address Plaintiff's other argument that 29 C.F.R. § 4044.4, which prohibits the distribution of assets "in anticipation of plan termination" in a manner not consistent with ERISA, did not bar a lump-sum payment because the regulation was *ultra vires* and, in any event, inapplicable under the circumstances. The court determined that the Court cannot evaluate the potential impact of § 4044.4(b) on Plaintiff's claim in the absence of the agency's considered opinion on the matter. On the parties' cross-motions for summary judgment, the court concluded that the PBGC Appeals Board failed to justify its decision not to honor Plaintiff's request for a lump-sum payment and remanded the matter to the agency for further proceedings.

L. U.S. Tax Court

Petitioner did not apply the correct method to reduce the maximum benefits under section 415(b)(2)(C) for a retirement age before to age 62, where the plan does not provide for forfeiture of the participant's benefits at death. Petitioner is liable for excise taxes under section 4972 for nondeductible contributions made to the plan for calendar years 2002 through 2006 because the contributions were in excess of the limitations imposed by section 404. Petitioner is liable for additions to tax pursuant to section 6651(a)(1) and (2) for failure to timely file Forms 5330, Return of Excise Taxes Related to Employee Benefit Plans, and failure to timely pay the excise taxes for calendar years 2002 through 2006. The statute of limitations does not bar the assessment and collection of excise taxes pursuant to section 4972 for nondeductible contributions to the plan for calendar years 2002 through 2006. [Pizza Pro Equipment Leasing, Inc., v. Commissioner of Internal Revenue, No. 13149-15., 2016 WL 6804474 \(T.C. Nov. 17, 2016\)](#) (Judge Laro).

XIII. *Plan Status*

A. First Circuit

The Fraser Papers Guidelines does not constitute an ERISA severance plan, where the Guidelines establishes that the Guidelines contemplated a lump sum payment based on a defined computation, and Defendant did not have ongoing management and administrative burdens in connection with the payment of severance because under the terms of the Guidelines, Defendant was not required to manage a designated severance fund, and Defendant was not required to provide benefits on an ongoing basis. [Gehrman v. Twin Rivers Paper Co., No. 1:14-CV-00341-JCN, 2016 WL 5816988 \(D. Me. Oct. 5, 2016\)](#) (Magistrate Judge John C. Nivison).

Determining that severance benefits offered by AstraZeneca AB is an ERISA plan, where the severance payment is only available to "eligible" employees, and one of the criteria for

eligibility is that the employee cannot have been terminated “for cause;” the Plan grants discretion to the administrator to construe its terms, including the definition of “notice of termination,” which was the purported basis for AstraZeneca’s denial of benefits in this case; other benefits under the Plan—post-termination medical, dental, life insurance, and employee assistance—are the types of ongoing benefit payments that constitute a typical ERISA plan. [Gordon v. AstraZeneca AB, No. 4:16-CV-40042-TSH, 2016 WL 4212250 \(D. Mass. Aug. 9, 2016\)](#) (Judge Hillman).

B. Second Circuit

Severance benefit plan is not an ERISA plan where no discretion is required under the Plan as to the amount of severance, the timing of the payouts, or the form of the severance; no reasonable employee would perceive an ongoing commitment by Defendants to provide employee benefits under the structure of the Plan; the “good reason” determination requires minimal separate analysis by the employer; and very few of the “usual earmarks” of an ERISA plan are present. Motion to remand to state court granted. [Hall v. Lsref4 Lighthouse Corp. Acquisitions, LLC, No. 6:16-CV-06461 EAW, 2016 WL 6651389 \(W.D.N.Y. Nov. 10, 2016\)](#) (Judge Elizabeth A. Wolford).

C. Third Circuit

In matter where the insured was on disability leave at the time he enrolled in life insurance plan that had an active service requirement, but passed away before receiving notice of such requirement, vacating the district court’s grant of summary judgment to Defendant and remanding for application of the correct standard as to the existence and terms of the life insurance plan at the time that Plaintiff’s benefits, if any, vested; district court applied the incorrect standard to determine that the disclosures and representations made to employees could not constitute an ERISA plan and the district court erred in then resorting to a document that was not even in Defendant’s possession until well after the insured’s death. [Woerner v. Fram Group Operations, LLC, No. 15-2813, ___ F.App’x ___, 2016 WL 4410066 \(3d Cir. Aug. 19, 2016\)](#) (Before: CHAGARES, KRAUSE, SCIRICA, Circuit Judges).

Finding that Defendant has met its burden of proving that the Safe Harbor provision of ERISA does not apply to Plaintiff’s various long-term disability policies and that the Policies satisfy the five factors for ERISA application; Plaintiff’s employer “contributed” to the Policies by getting a discount through participation in the Unum FlexBill program and by making some of the payments for Plaintiff’s premiums over the years. [D’elia v. Unum Life Ins. Co. of Am., No. CV 15-3040, 2016 WL 4366979 \(E.D. Pa. Aug. 15, 2016\)](#) (Judge Cynthia Rufe).

Employment agreement providing for severance benefits creates an ERISA plan. [Zgrablich v. Cardone Industries, Inc., No. CV 15-4665, 2016 WL 427360 \(E.D. Pa. Feb. 3, 2016\)](#) (Judge R. Barclay Surrick). The court found that an employment agreement providing for severance benefits is governed by ERISA. The court found that Plaintiff's eligibility to collect the severance benefits as set forth in the Agreement turns on whether he was terminated with or without cause—a standard requiring the exercise of judgment on a case-by-case basis. Standing alone, the court found this fact strong proof that the plan at issue involves a separate determination of each individual's eligibility for benefits and is therefore governed by ERISA. In addition, the Agreement has language demonstrating the ongoing need for administration of the plan. For example, Cardone Industries is not obligated to provide Plaintiff with medical coverage if he obtains comparable substitute coverage from another employer. And, all severance and medical benefits provided by the Agreement terminate in the event that Plaintiff breaches any of the restrictions or provisions in the Agreement's "Non-Compete; Non-Solicitation clause." The court found that the Agreement creates an ERISA benefits plan even through it is a "one-person employment agreement" since the Agreement itself recognizes that other senior company executives made similar agreements.

D. Fourth Circuit

The STD plan is not a welfare benefit program and is not covered under ERISA because the STD plan meets the criteria of a payroll practice in that payments under the program are a substitute for the covered employee's wages and are paid out of BIPI's general assets. Because there is no privity between Plaintiff and Aetna, the court grants Aetna's motion to dismiss Plaintiff's breach of contract claim against it. [Nardello v. Boehringer Ingelheim USA Corp., No. CV JKB-15-3792, 2016 WL 5940844 \(D. Md. Oct. 13, 2016\)](#) (Judge James K. Bredar).

Pursuant to Rule 42(a), consolidating two Church Plan cases: *Hodges v. Bon Secours Health System, Inc. et al.*, RDB-16-1079 and *Miller v. Bon Secours Health System, Inc. et al.*, RDN-16-1150; appointing Cohen Milstein Sellers & Toll as sole lead interim class counsel. [Hodges v. Bon Secours Health Sys., Inc., No. CV RDB-16-1079, 2016 WL 4447047 \(D. Md. Aug. 24, 2016\)](#) (Judge Richard D. Bennett).

In matter where the court found that the Alpha Natural Resources Inc. and Subsidiaries Deferred Compensation Plan was not subject to the substantive requirements of ERISA, and concluding that the Debtors did have the right (i) to reject the ANR Employee Plan under §§ 363 and 365 of the Bankruptcy Code, (ii) to terminate the rabbi trusts in accordance with the Trust agreements, and (iii) to recover the funds held by the Trustee for the benefit of the creditors of the bankruptcy estate, denying motion to reconsider the Termination Order under Rules 9023 and 9024 because the Motion to Terminate was properly brought before the Court as a contested matter and an adversary proceeding was

not required. [In re Alpha Nat. Res., Inc., No. 15-33896-KRH, ___ B.R. ___, 2016 WL 4202927 \(Bankr. E.D. Va. Aug. 5, 2016\)](#) (Bankruptcy Judge Kevin R. Huennekens).

Superior’s holiday pay policy is not an ERISA plan where it provides for payment of ordinary wages on five of the six most commonly observed holidays (omitting only New Year’s Day), as though an employee had worked a shift even if he got the day off; where there is no evidence that the policy is funded by a separately administered fund, nor is there any reason to believe that the policy was contingent upon anything beyond the occurrence of a specified holiday during an employee’s tenure. [Joshua Hatfield v. Superior Coal Services, L.L.C., No. CV 15-14997, 2016 WL 2643029 \(S.D.W. Va. May 6, 2016\)](#) (Judge John T. Copenhaver, Jr.).

E. Fifth Circuit

Denying motion for new trial seeking to vacate the court’s conclusion that judicial estoppel applied to prevent Plaintiffs from taking the inconsistent position that the Plan is not a “top-hat” plan because Plaintiffs have not presented any new evidence, demonstrated that there was a manifest error of fact or law or shown a change in the law that would justify the extraordinary remedy of reconsidering a final judgment. [Owens v. W. & S. Life Ins. Co., No. CV 13-4782, 2016 WL 6679848 \(E.D. La. Nov. 10, 2016\)](#) (Judge Mary Ann Vial Lemmon).

A Bonus Agreement, offered by employer Trend Personnel Services, Inc. to six key employees for whom it purchased life insurance policies and paid annual premiums, does not qualify it as an ERISA employee welfare benefit plan. [Sarah Mozingo Martin v. Trend Personnel Services, No. 15-11263, ___ F.App’x ___, 2016 WL 4547225 \(5th Cir. Aug. 31, 2016\)](#) (Before STEWART, Chief Judge, and CLEMENT and HAYNES, Circuit Judges).

Occupational Accident Benefit Plan (the Plan) is an ERISA plan where: (1) ERISA’s safe harbor provisions do not apply because the employer’s role was not limited to collecting premiums and remitting them to an insurer; (2) employer was the Policyholder under the Plan, designated its agent as the claims administrator, had the right to terminate the Plan, calculated Plaintiff’s monthly premiums, paid such premiums in a timely fashion, and maintained a policy that covered whole classes of employees; and (3) the Plan was established with the intent to benefit employees. State-law claims preempted by ERISA. [Roberts v. Reynolds & Reynolds Trucking, Inc., No. 3:15-CV-3662-B, 2016 WL 3570652 \(N.D. Tex. July 1, 2016\)](#) (Judge Jane J. Boyle).

F. Sixth Circuit

The court affirmed the district court’s judgment dismissing Plaintiff’s complaint for lack of subject matter jurisdiction. The City of Livonia is a political subdivision of the State of Michigan, making the pension plan at issue a governmental plan excluded from the scope of ERISA. [Halttunen v. City of Livonia, No. 16-1190, ___ F.App’x ___, 2016 WL 6832971 \(6th Cir. Nov. 21, 2016\)](#) (BEFORE: CLAY, KETHLEDGE, and DONALD, Circuit Judges).

Death benefit plan is an ERISA plan. [Wolf v. Causley Trucking, Inc., No. 15-CV-12530, 2016 WL 454442 \(E.D. Mich. Feb. 5, 2016\)](#) (Judge Thomas L. Ludington). This matter involves a dispute over death benefits, which Plaintiff sought to remand to state court on the basis that the plan which provides the benefits is not an ERISA plan. The court disagreed, finding that the plan at issue is an ERISA plan and thus, Plaintiff’s state law claims are preempted. Causley Trucking adopted a resolution authorizing the Causley Trucking’s Death Benefit Only Plan “to provide death benefits to the beneficiaries of the Corporation’s eligible employees, if death occurs while the employee remains in the employment of the Corporation or has retired from employment after attaining age 65 with a minimum of 20 years of service.” The Death Plan authorized Causley Trucking to purchase principal life insurance policies to fund the plan as follows:

In order to assure that the Corporation will have sufficient assets to meet its obligation to pay the death benefits provided for under this Plan, the Corporation may wish to purchase life insurance policies from Principal National Life Insurance Company or Principal Life Insurance Company, Des Moines, Iowa. The Secretary shall, as directed by the Board of Directors, apply for insurance policies on the lives of Participants. The Corporation shall be designated as owner and the beneficiary of any such policies purchased and all rights and benefits accruing from such policies shall belong solely to the Corporation. The Participant shall have no rights or interest in such policies.

Defendant Causley, the company’s owner and president, was named as the Death Benefit Plan’s fiduciary and plan administrator. The decedent entered into an agreement under the plan that same day. Pursuant to the agreement, if a participant dies while employed by Causley Trucking, the Corporation shall, beginning on the month following the participant’s death, make payments in the amount of no less than the cash value of the policy in equal installments over 10 years to the participant’s surviving spouse while living. The court rejected the contention that the Death Benefits Plan is ephemeral, contingent, or wholly discretionary. Instead, the court determined that the Plan was an ongoing, non-contingent plan established to pay death benefits in the amount of at least the minimum cash value of the policy. The Death Benefits Plan establishes both the nature of the benefits (death benefits) and the amount of the benefits (at least the cash value of the policy), such that there is no danger that the court would need to fashion any details of the plan or determine what benefits would go to which employees or retirees. Because a

reasonable person can ascertain the intended benefits, the court determined that the Death Benefits Plan is an employee benefit plan within the meaning of ERISA, and thus any claims related to the plan are subject to ERISA preemption.

G. Seventh Circuit

United’s Early Out Benefit Plan for Certain Association of Flight Attendant-Represented Employees is an ERISA plan. [Scarber v. United Airlines, Inc., No. 15 C 9147, 2016 WL 362377 \(N.D. Ill. Jan. 29, 2016\)](#) (Judge Harry D. Leinenweber). The court denied Plaintiff’s motion to remand his lawsuit seeking benefits under United’s Early Out Benefit Plan for Certain Association of Flight Attendant-Represented Employees. The Plan enabled certain flight attendants to receive lump sum payments of up to \$100,000 upon their separation from the airline. Plaintiff challenged Defendants’ claim that the Plan was an ERISA plan such that his lawsuit is preempted. The court agreed with Defendants that the Plan at issue here is different than the Plan discussed in the Supreme Court’s decision in *Fort Halifax*. First, the Plan includes administrative procedures to determine claimant eligibility and vests the plan administrator with discretion to “limit participation and determine exit dates.” Second, the Plan provides a review procedure in the event a claimant is denied benefits. Third, a payment amount cannot be calculated until a claimant’s exit date is determined. Finally, the Plan provides for additional benefits beyond the lump sum payment, including continued health benefits and travel passes. The court found that these features taken together require ongoing administration and is an employee benefit plan subject to ERISA.

H. Eighth Circuit

Denying motion to remand breach of contract action in state court because the benefits plan at issue is governed by ERISA. There is no evidence that Saint Louis University or SLU hospital is controlled by the Catholic Church, so the plan at issue cannot be considered a church plan under 29 U.S.C.A. § 1002(33)(A). Applying the three-factor test from *Chronister*, the plan at issue is not a church plan. There is no evidence that SLU or its hospital receives financial support from the Catholic Church, or that the Catholic Church governs or approves board members for SLU or the hospital. Additionally, there is a denominational requirement for SLU and the hospital. [Walsh v. Mutual of Omaha Ins. Co., No. 4:16 CV 800 RWS, 2016 WL 5076197 \(E.D. Mo. Sept. 20, 2016\)](#) (Judge Rodney W. Sippel).

I. Ninth Circuit

Defendant’s Equity Growth Plan (“EGP”) is not subject to ERISA because its primary purpose is not to provide deferred compensation, and its terms do not include a “policy or

method of funding” or an “ongoing administrative scheme.” *Donovan* “surrounding circumstances” inquiry does not apply since the EGP has a written plan document. [Miller v. Eric Olsen, et al., No. 3:15-CV-00571-AC, 2016 WL 4154936 \(D. Or. Aug. 4, 2016\)](#) (Magistrate Judge John V. Acosta).

Affirming the district court’s partial summary judgment determination that Dignity Health’s pension plan did not qualify for ERISA’s church-plan exemption because it was not established by a church, or by a convention or association of churches. ERISA defines the term “church plan” as a plan that is established *and* maintained by a church. The court need not defer to the view expressed by the IRS that a plan qualifies as a church plan if it is maintained by a principal-purpose organization. The court’s decision does not conflict with the Establishment and Free Exercise Clauses. [Rollins v. Dignity Health, No. 15-15351, F.3d , 2016 WL 3997259 \(9th Cir. July 26, 2016\)](#) (Before: A. Wallace Tashima and William A. Fletcher, Circuit Judges and Robert W. Gettleman, Senior District Judge).

The Benefits Plan of the Presbyterian Church is an ERISA-exempt church plan governed by Pennsylvania trust law. [MacNeill v. Benefits Plan of the Presbyterian Church \(U.S.A.\), No. C16-189RSL, 2016 WL 3017711 \(W.D. Wash. May 26, 2016\)](#) (Judge Robert S. Lasnik).

Noting that what qualifies under 29 U.S.C. § 1002(2)(A) is matter of first impression in this circuit, and agreeing with sister circuits that have determined that the paramount consideration is whether the primary purpose of the plan is to provide deferred compensation or other retirement benefits. Here, the Stock Rights Plan’s main purpose was not to provide retirement or systematically deferred income and, thus, is not covered by ERISA. [Rich v. Shrader, No. 14-55484, F.3d , 2016 WL 2994736 \(9th Cir. May 24, 2016\)](#) (Before: Richard R. Clifton and Sandra S. Ikuta, Circuit Judges, and Frederic Block, District Judge).

Severance plan meets the requirements of an ERISA-governed employee welfare benefit plan. [Ditchey v. Mechanics Bank, No. 15-CV-04103-JSC, 2016 WL 730290 \(N.D. Cal. Feb. 24, 2016\)](#) (Magistrate Judge Jacqueline Scott Corley). Plaintiff brought suit under ERISA § 502(a)(1)(B) for reimbursement of her reasonable legal fees and expenses incurred as a result of the Bank’s dispute of her right to benefits under the Mechanics Bank Change in Control Plan. The first issue the court determined is whether the Plan is an ERISA plan. ERISA applies to employee welfare benefits plans which may include a severance plan. The determinative question is whether the benefit package implicates an ongoing administrative scheme. The court found the facts of this case similar to the Ninth Circuit’s decision in *Bogue v. Ampex Corp.*, 976 F.2d 1319 (9th Cir. 1992), which held that ERISA governed a severance plan which provided benefits to certain executives if the company/employer was sold and neither the employer nor the buyer offered the executive substantially equivalent employment and the executive’s employment was terminated. Here, the Plan requires the Bank to determine whether an

executive has been involuntarily terminated because she has experienced a material diminution in the scope of her responsibilities, duties or authority or any material change in her title, position or reporting relationship, or a material reduction in the executive's base compensation, or a material breach by the Bank of the executive's employment agreement, among other triggering conditions. The court found that the Bank's obligation requires more than an unthinking, one-time, nondiscretionary application. Thus, the Plan is governed by ERISA.

J. Eleventh Circuit

Plaintiff plausibly alleged that an Executive Plan is not a Top Hat Plan and he is entitled to vested retirement benefits. [Magasrevy v. Retirement Committee, Plan Administrator of Executive Retirement Plan of Thermal Ceramics Latin America, No. 15-62143-CIV, 2016 WL 1321406 \(S.D. Fla. Apr. 5, 2016\)](#). Counts II and II of Plaintiff's complaint seek clarification that the Executive Plan is not a Top Hat Plan, and based on that finding, to recover vested retirement benefits under the Plan. ERISA exempts certain employee benefit plans—known as Top Hat Plans—from many of the law's substantive provisions. A Top Hat Plan is a plan which is unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees. Defendants moved to dismiss these claims, arguing that the Executive Plan is a Top Hat Plan as a matter of law. The question is whether the Executive Plan is “unfunded” within the meaning of ERISA. Here, the Executive Plan provides that a Trustee “shall establish a trust Fund in connection with the Plan for the purpose of receiving the contributions and paying the benefits provided by the Plan.” Further, the Plan envisions that the “contributions” to the fund will be made by the companies “whose employees may be eligible for participation in the Plan.” In a letter to Plaintiff, the company stated that: “This [Executive] Plan is completely funded by the Company. You are not required to contribute to the Plan.” The Executive Plan describes its “Provision of Benefits” as follows:

All benefits under the Plan will be paid out of the Fund and any Member or other person having any claim under the Plan must look solely to the assets of the Fund for such benefits. No person shall have any right to, or interest in, any part of the assets of the Fund except as and to the extent provided from time to time under the Plan and the Trust Agreement. Under no circumstances shall any liability attach to any Participating Company, or any officer, shareholder, director or employee of any Participating Company for payment of any benefits or claims hereunder.

The court found that Plaintiff has plausibly alleged that the Executive Plan is not a Top Hat Plan and he is entitled to vested retirement benefits owed to him under the Plan.

K. D.C. Circuit

In dispute under Voluntary Employee Beneficiary Association Trust (the “Trust”), which was created to provide supplemental unemployment benefits to teachers in the District of Columbia Public Schools (“DCPS”) who met certain conditions, finding that, despite the language of the Trust’s founding documents, the Trust is a government plan established by DCPS and is exempted from the provisions of ERISA. [Saunders v. Davis, No. 15-CV-2026 \(RC\), 2016 WL 4921418 \(D.D.C. Sept. 15, 2016\)](#) (Judge Rudolph Contreras).

L. Tax Court

No abuse of discretion in respondent’s determination that ESOP was not qualified under section 401(a) for its 2010 plan year and its subsequent plan years and that the related trust was not exempt under section 501(a). [Family Chiropractic Sports Injury & Rehab Clinic, Inc. v. Comm’r of Internal Revenue, T.C.M. \(RIA\) 2016-010 \(T.C. 2016\)](#) (Judge Dawson). In this declaratory judgment proceeding under section 74761, petitioner challenges respondent’s September 16, 2013, final revocation letter determining that for its plan year ending June 30, 2003, and its subsequent plan years, the Family Chiropractic Sports Injury & Rehab Clinic, Inc. Employee Stock Ownership Plan (ESOP) was not qualified under section 401(a) and that the related trust was not exempt from taxation under section 501(a). The court concluded that it was not an abuse of discretion for respondent to determine that the ESOP: (1) failed in operation to satisfy the anti-alienation requirements of section 401(a)(13) and section 1.401(a)-[*3] 13(b), Income Tax Regs. (when it transferred a participant’s fully vested plan benefits) and (2) failed to follow its plan document in operation as required by section 1.401-1(a)(2) and (b)(3), Income Tax Regs. (when it transferred a participant’s fully vested plan benefits).

XIV. *Pleading Issues & Procedure*

A. First Circuit

Plan language setting forth BCBCRI’s “power to decide” does not bestow discretionary authority; *de novo* review will apply to BCBCRI’s decision to deny payment for two periods of in-patient treatment for patient with severe mental illness. [Doe v. Blue Cross & Blue Shield of Rhode Island, No. 15-CV-41-M-LDA, 2016 WL 4223331 \(D.R.I. Aug. 9, 2016\)](#) (Judge John J. McConnell, Jr.).

In matter where Plaintiffs assert that two violations of ERISA arise out of Defendants’ alleged underpayment of compensation under the FLSA, dismissing the ERISA claims where Plaintiffs failed to plead sufficient facts to allege a plausible cause of action under

the FLSA, but even if they did, the complaint does not support a plausible claim under ERISA because Plaintiffs do not indicate who their employer is, what plan they participated in, the fiduciary for any such plan, or the terms of the pension plan. [Hamilton v. Partners Healthcare Sys., Inc., No. CV 09-11461-DPW, F.Supp.3d , 2016 WL 3962810 \(D. Mass. July 21, 2016\)](#) (Judge Douglas P. Woodlock).

Former employee required to arbitrate profit sharing plan claims based on terms of settlement agreement. [Fusco v. Plastic Surgery Ctr., P.A., No. 2:15-CV-460-DBH, 2016 WL 845263 \(D. Me. Mar. 4, 2016\)](#) (Judge D. Brock Hornby). The court granted Defendants’ motion to stay and compel arbitration of Plaintiff’s claims for profit sharing plan benefits and attorneys’ fees. Plaintiff had entered into a settlement agreement which required that any dispute involving any aspect of Plaintiff’s employment relationship with her former employer be subject to binding arbitration if requested by either party. The settlement agreement did not release Plaintiff’s claim for profit sharing plan benefits. The court noted that Circuit precedents overwhelmingly support the conclusion that ERISA rights can, by agreement, be subjected to arbitration. Although Plaintiff did not settle her ERISA claims in the settlement agreement, the court found that she agreed to submit them to arbitration. At the very least, the scope of her settlement agreement is ambiguous and the arbitrator gets to decide the scope of the arbitration clause.

Federal district court is proper forum for breach of fiduciary duty claim notwithstanding bankruptcy court proceedings. [Perez v. Badillo, No. CV 15-1541 \(FAB\), 2016 WL 798385 \(D.P.R. Mar. 1, 2016\)](#) (Judge Besosa). Plaintiff Secretary of Labor filed this action against defendants Atilano Cordero–Badillo (“Cordero”) and the Empresas A. Cordero Badillo Retirement Plan (“the Plan”) alleging that Cordero breached his fiduciary duty as trustee of the Plan, which caused the Plan to exist without a named fiduciary or with assets not held in trust in violation of ERISA sections 402–403, 29 U.S.C. §§ 1102–1103. Defendants moved to dismiss, arguing that this court is not the proper forum because administration of the Plan by the chapter 7 bankruptcy trustee should be monitored by the bankruptcy court, and that Cordero is not the proper defendant because, at the time the complaint was filed, the chapter 7 bankruptcy trustee was the administrator for the Plan. The court denied Defendants’ motion to dismiss. It found that removal for breach of a fiduciary duty is a remedy that is created by ERISA law, 29 U.S.C. § 1109(a), and typically arises outside of bankruptcy proceedings. Thus, the court lacks “arising in” and “arising under” jurisdiction. Additionally, the only monetary relief that plaintiff Secretary seeks is payment of expenses incurred in appointing a new fiduciary for the plan and payment of losses to the plan from Cordero’s alleged fiduciary breach. These expenses are to be made by Cordero and Cordero is not the party in bankruptcy. As such, any monetary award will not impact the bankruptcy estate. Accordingly, the bankruptcy court lacks “related to” jurisdiction. On the second issue, the court found that the Secretary’s claims against Cordero are proper because he remained a trustee of the Plan after the chapter 7 bankruptcy trustee was appointed.

Power to “decide” claims is not sufficient to alter the standard of review from *de novo*.

[Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc., No. 15-1531, F.3d , 2016 WL 629058 \(1st Cir. Feb. 17, 2016\)](#) (Before LYNCH, SELYA and KAYATTA, Circuit Judges). In this case, the Plaintiff/Appellant challenged BCBS’s decision to partially deny her claim for benefits for the treatment of her minor son at a residential/educational mental healthcare facility. The district court held that BCBS had discretionary authority to make benefit determinations under the plan and it did not abuse that discretion in partially denying Plaintiff’s claim for benefits. The First Circuit found that Plaintiff received the full and fair internal review that 29 U.S.C. § 1133 prescribes, including that she received a sufficiently definite explanation of the reason for the denial of benefits and received a sufficient explanation of the internal appeal procedures. However, with respect to the standard of review, the First Circuit found that *de novo* review applies because language contained in the Certificate of Coverage did not unambiguously grant discretion to BCBS. It only provides that BCBS “decides which health care services and supplies that you receive (or you are planning to receive) are medically necessary and appropriate for coverage.” The court found that this language is not sufficiently clear to give notice to either a plan participant or covered beneficiary that the claims administrator enjoys discretion in interpreting and applying plan provisions. Further, the premium account agreement (the PAA), which defines the relationship between participating employers and BCBS, does contain an unambiguous grant of discretionary authority, but the court declined to find the PAA controlling where it was not ever disclosed to Plaintiff when coverage attached. Because the district court employed the wrong standard of review, the First Circuit vacated that portion of its judgment and remanded for reconsideration.

Court has personal jurisdiction over third-party complainant with no connection to the forum state due to ERISA’s nationwide service of process. [Ng v. Prudential Insurance Company of America, No. CV 13-11317-TSH, 2016 WL 424956 \(D. Mass. Feb. 3, 2016\)](#) (Judge Timothy S. Hillman). The court denied the third-party complainant’s motion to dismiss for lack of personal jurisdiction. The movant was married to the decedent at the time of his death and was originally named the decedent’s beneficiary under a life insurance plan insured by Prudential. The decedent’s children brought suit against Prudential over the life insurance proceeds. Prudential determined that the movant is the proper beneficiary. The movant has lived in New York her entire life. From 2010 through 2013, the movant, who suffers from mental health issues, lived in several different psychiatric facilities in New York. There was a time when her location was unknown to family and friends and she was ultimately located and hospitalized at a psychiatric hospital in Brentwood, New York. From there she was moved to an outpatient facility for several months until March 11, 2013, when she was placed in the mental health group home where she currently resides. The court found that ERISA provides for nationwide service of process so that as long as the movant has the requisite “minimum contacts” with the United States, the court has personal jurisdiction over her. The court did note that there is an element of unfairness where an individual has no contacts with the forum state relating to

the lawsuit but that the court did not expect the movant would have to travel from New York to Massachusetts either for pre-trial discovery, or to attend a trial, should it prove necessary.

B. Second Circuit

Plaintiff sufficiently demonstrated his standing to bring an ERISA claim as a plan participant, where he alleges that he was denied compensation for sick days and unused vacation days, that he had joined the Union in 1994 and, therefore, earned a pension until he was terminated in 2015. Plaintiff may not recover \$1,000,000 in compensatory damages for “prejudices, damage caused to my person in 20 years.” DDS, the third-party administrator of his dental benefits, is not a proper defendant in this action. [Romero v. Local Union 272, No. 1:15-CV-7583-GHW, 2016 WL 5376210 \(S.D.N.Y. Sept. 26, 2016\)](#) (Judge Gregory H. Woods).

Court is bound by Second Circuit precedent holding that suits to recover benefits under Section 1132(a)(1)(B) are equitable in nature and there is no right to a jury trial in a suit brought to recover ERISA benefits. [Pravda v. Prudential Ins. Co. of Am., No. 16-CV-2750 \(AJN\), 2016 WL 3842741 \(S.D.N.Y. July 12, 2016\)](#) (Judge Alison J. Nathan).

Because Plaintiff’s proposed ERISA breach of fiduciary duty claim is based on information that Plaintiff knew, or should have known, in advance of the scheduling order’s deadline to amend the complaint, Plaintiff has failed to show “good cause” under Rule 16(b). [Motorola Sols., Inc. v. Xerox Bus. Servs., LLC, No. 14CIV206LTSHBP, 2016 WL 2889057 \(S.D.N.Y. May 17, 2016\)](#) (Magistrate Judge Henry Pitman).

A plan’s failure to comply with DOL regulation, 29 C.F.R. § 2560.503–1, will result in *de novo* review, unless the plan has otherwise established procedures in full conformity with the regulation and failure to comply was inadvertent and harmless; civil penalties are not available for a plan’s failure to comply with the claims-procedure regulation; and a plan’s failure to comply with the regulation may, in the district court’s discretion, constitute good cause to consider additional evidence outside the administrative record. [Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ., No. 14-4055, ___ F.3d ___, 2016 WL 1426291 \(2d Cir. Apr. 12, 2016\)](#) (Before: KATZMANN, Chief Judge, LYNCH, Circuit Judge, and ARTERTON, District Judge).

Participant lacks constitutional standing for breach of fiduciary duty claim against brokers who profited from trades made on behalf of ERISA retirement plans. [Fletcher v. Convergenx Grp. LLC, No. 13CIV. 9150\(LLS\), 2016 WL 690889 \(S.D.N.Y. Feb. 17, 2016\)](#) (Judge Louis L. Stanton). Plaintiff is a participant in a retirement plan. Defendants are a group of related brokers whose customers include asset managers who manage funds on behalf of ERISA retirement plans, including Plaintiff’s retirement plan. Plaintiff claims that, from 2006 to 2011, Defendants

breached their fiduciary duties under ERISA by adding unauthorized and undisclosed markups and markdowns to the trades they executed on behalf of their customers. Defendants moved to dismiss based on the argument that Plaintiff does not have standing. The court agreed and concluded that Plaintiff has not established constitutional standing to sue for the incremental loss he, as a plan participant, suffered from Defendants' overcharges to the plan. Here, Defendants allegedly misappropriated \$1,577.93 from a pension plan that was underfunded by more than \$16 billion. "The extent to which that enhanced the plan's existing prospect of default is so minute as to be imaginary and inconsequential rather than 'an injury in fact' and 'actual or imminent' as required for constitutional standing."

Complaint alleging that employer reduced employee's hours for the purpose of disqualifying her for medical coverage adequately alleges Section 510 violation. [Marin v. Dave & Buster's, Inc., No. 15 CIV. 3608 \(AKH\), F.Supp.3d , 2016 WL 526542 \(S.D.N.Y. Feb. 9, 2016\)](#) (Judge Alvin K. Hellerstein). Plaintiff alleged that her former employer, Dave & Busters ("D & B"), violated section 510 of ERISA by reducing her hours from full-time to part-time in order to disqualify her for health benefits. According to Plaintiff, in June of 2013, in response to the enactment of the ACA in March of 2010, the D & B Times Square store managers told employees that compliance with the ACA, after its effective date of January 1, 2015, would cost as much as two million dollars, and that to avoid the costs, the location planned to reduce its full-time employees at the Times Square store from more than 100 to approximately 40. As a result of D & B's reduction of her hours after June 1, 2013, Plaintiff lost eligibility for medical and vision benefits. Defendants moved to dismiss the complaint, arguing that Plaintiff's theory of liability fails as a matter of law under Section 510. The statute provides that: "It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan ... or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan ..." The court found that Plaintiff alleged a legally sufficient claim for relief that Defendants' curtailment of her hours discriminated against her "for the purpose of interfering with the attainment" of a right to which Plaintiff "may become entitled" under the employee benefit plan of which she was a participant. Specifically, Plaintiff alleges that Defendants intentionally interfered with her current health-care coverage, motivated by Defendants' concern about future costs that would become associated with the plan's health-care coverage. The court found that Plaintiff put forward factual allegations supporting her claim that the employer had the specific intent to interfere with her right to health insurance. Defendants argued that an employee has no entitlement, and thus no legally sufficient claim, to benefits not yet accrued, and that a plaintiff must show more than lost opportunity to accrue additional benefits to sustain a § 510 claim. The court rejected this argument, finding that Plaintiff alleges that Defendants' discrimination affected her current benefits, in addition to interfering with her ability to attain future benefit rights. This claim arises from the employer's unlawful motivation, acting to interfere with either the exercise or the

accrual of benefits to which Plaintiff may become entitled. The court denied Defendants' motion to dismiss.

Counterclaims may not be dismissed for lack of subject matter jurisdiction. [Wilhelm v. Beasley, No. 15-CV-4029 \(LAK\), 2016 WL 94254 \(S.D.N.Y. Jan. 7, 2016\)](#) (Judge Lewis A. Kaplan). This matter is one of several actions relating to the decision of the National Retirement Fund to expel the Caesars Employers from the Legacy Plan of the Fund. The Defendants are the Fund itself and the trustees who voted for the expulsion. The court sustained Defendants' objections to the R&R's recommendation that counterclaim Counts 1, 2 and 4 be dismissed for lack of subject matter jurisdiction. The court did not find that litigation of the remaining part of the counterclaim, which may well be susceptible to disposition either by deciding the merits of the Rule 12(b)(6) motion already made or on summary judgment and seems to raise relatively finite issues, would be terribly burdensome to the court or the parties. The court explained that the vitality of the prudential element of the ripeness analysis recently has been questioned by the Supreme Court, which has observed that it is in some tension with the principle that a federal court's obligation to hear and decide cases within its jurisdiction is virtually unflagging. The court remanded the matter to the magistrate judge for further proceedings with respect to the motion to dismiss Counts 1, 2 and 4 on the ground that they fail to state a claim upon which relief may be granted.

C. Third Circuit

In matter by medical provider against twenty-six named defendants, the court granted Plaintiff's motion to remand due to procedural defects in the removal process. The court explained that the rule of unanimity is strictly enforced and applied regardless of the number of defendants in the case. Attempts to amend or later justify non-joinder of defendants are rejected. Because at least one defendant did not timely join in the notice of removal, the case is remanded. [Brain v. Aetna Life Ins. Co., No. CV 16-1797 \(WJM\), 2016 WL 6892076 \(D.N.J. Nov. 22, 2016\)](#) (Magistrate Judge Falk).

Granting motion to dismiss since the District Court's order remanding this matter to the ERISA plan administrator for further proceedings is not a final order; denying an award of fees against Appellant, but granting costs. [Morrison v. Liberty Life Assurance Company of Boston, et al., No. 15-2095, ___ F.App'x ___, 2016 WL 5682554 \(3d Cir. Oct. 3, 2016\)](#) (Before: CHAGARES, GREENAWAY, JR., and RESTREPO, Circuit Judges).

Denying motion to disqualify law firm of Proskauer Rose LLP brought by Steelworkers Pension Trust (the "SPT"), a multi-employer pension plan making a withdrawal liability claim against Defendants. Although SPT is not a current or former client of Proskauer, it has standing to bring the motion to disqualify, but the court found that SPT has not met its burden and identified any lawsuit that Proskauer is presently handling in which its clients'

interests would be adversely affected if Defendant Renco prevailed on its argument as to the effect of the filing of a proof of claim or an “evade or avoid” theory in this case’s particular circumstance. [Steelworkers Pension Trust By Daniel A. Bosh, Chairman v. The Renco Group, Inc., Ilshar Capital Llc, Blue Turtles, Inc., Unarco Material Handling, Inc., Iteva Products LLC, The Doe Run Resources Corporation, & Us magnesium LLC, No. 16-190, 2016 WL 3633079 \(W.D. Pa. July 7, 2016\)](#) (Judge Robert C. Mitchell).

Affirming district court’s decision that there is no private right of action under § 503 of ERISA and finding no § 503 claim where Plaintiff alleges that he was denied an opportunity to review the plan itself but did not file a claim and so no decision was ever rendered denying any claim. Finding that district court correctly dismissed Plaintiff’s § 502(a)(1)(B) claim where Plaintiff did not provide any details concerning his standing to sue as a beneficiary, the plan, or any provision showing that he is entitled to retirement benefits. [Piscopo v. Public Service Electric and Gas Company, No. 15-2819, ___ F.App’x ___, 2016 WL 3000342 \(3d Cir. May 25, 2016\)](#) (Before: FISHER, RENDELL and BARRY, Circuit Judges).

Court orders restitution to 401(k) plan where fiduciary failed to deposit withheld contributions to the plan. [Perez v. Kwasny, No. CV 14-4286, 2016 WL 492433 \(E.D. Pa. Feb. 9, 2016\)](#) (Judge Eduardo C. Robreno). The Secretary brought this action to restore \$40,416.30 in losses (plus prejudgment interest) sustained by the Kwasny and Reilly, P.C., 401(k) Profit Sharing Plan and to obtain other injunctive relief. Kwasny, a managing partner of the law firm of Kwasny & Reilly, P.C. and a trustee and fiduciary of the Plan, withdrew contributions from his employees’ paychecks but purposefully failed to deposit those contributions into the Plan in a timely manner. Further, Kwasny directed that the withheld contributions be commingled with the general assets of the Firm and be used for the benefit of the Firm. The court granted the Secretary’s motion for summary judgment and denied Kwasny’s cross-motion for summary judgment where he raised four defenses. First, Kwasny claimed that the action was barred by the three-year statute of limitations. The court concluded that receiving calls in 2006 and 2010 of possible ERISA violations regarding an unidentified plan did not provide the Secretary with actual notice of Kwasny’s fiduciary duty violations. The Secretary received actual notice when he received evidence documenting the breaches and that occurred within the applicable statute of limitations. Second, the Secretary’s suit is not barred by the doctrine of claim preclusion based on a private suit brought by an employee where the Bucks County Court of Common Pleas awarded punitive damages against Kwasny in the amount of \$32,677.15 to be awarded to Haft. Because the actual judgment in the case was based solely on the punitive damages order, the court found no need to offset that award against the funds sought in this case as Haft was not awarded judgment on his underlying claims regarding his withheld Plan contributions. Third, Kwasny’s law partner is not an indispensable party requiring dismissal of the suit since ERISA fiduciaries may be held jointly and severally liable. Lastly, the United States is not subject to the defense of laches in enforcing its rights.

Court has personal jurisdiction over defendant due to ERISA’s nationwide service of process. [Rafferty v. Metro. Life Ins. Co., No. 15-CV-206 ERIE, 2016 WL 153225 \(W.D. Pa. Jan. 13, 2016\)](#) (Judge Barbara Jacobs Rothstein). Here, life insurance proceeds are in dispute between the insured’s ex-wife and wife at time of death. In response to the lawsuit by the wife against MetLife and the ex-wife, the ex-wife moved to dismiss for lack of personal jurisdiction and/or under the Declaratory Judgment Act. She also moved to dismiss MetLife’s cross-claim for Interpleader. The court denied all motions. It found that although the ex-wife’s minimal contacts would not be sufficient to subject her to personal jurisdiction under Pennsylvania’s long-arm statute, this lawsuit was brought pursuant to ERISA, which provides for nationwide service of process. Because the ex-wife has sufficient contacts with the United States, the court may exercise personal jurisdiction over her. The court found that it would not be unfair or unjust to require her to litigate the ERISA claim in this district as she is represented by counsel and this is a declaratory action that should be able to be resolved without a trial. The court found that the factors it must consider in determining whether to exercise its jurisdiction under the Declaratory Judgment Act weigh in favor of exercising its jurisdiction under the Act. First, there is no pending related state court action. Second, the ex-wife failed to articulate a reason why this court should decline to exercise its jurisdiction under the Declaratory Judgment Act in favor of another district court. Lastly, the instant lawsuit was filed before the ex-wife filed her state court lawsuit in Missouri and under the first-to-file rule, the matter should proceed in this court.

D. Fourth Circuit

In putative class action alleging improper calculation of vesting and eligibility service under the terms of a pension plan, because Plaintiffs present a plausible argument supported by factual allegations that an exception to the exhaustion requirement should apply and it is not apparent that “all facts necessary to the affirmative defense [of exhaustion] clearly appear on the face of the complaint,” the court finds that it is premature to dismiss Plaintiffs’ wrongful denial of benefits claim based on Defendants’ failure to exhaust arguments. [West v. Cont’l Auto., Inc., No. 316CV00502FDWDSC, 2016 WL 6543128 \(W.D.N.C. Nov. 2, 2016\)](#) (Judge Frank D. Whitney).

In matter arising out of the decision by NationsBank, a company that subsequently merged with Bank of America, to allow its employees to transfer their 401(k) assets to a cash balance defined benefit plan, denying Defendants’ Motion in Limine to Exclude Expert Testimony of Clark L. Maxam and Lawrence Deutsch. [Pender v. Bank of Am. Corp., No. 3:05-CV-00238-GCM, 2016 WL 6133850 \(W.D.N.C. Oct. 20, 2016\)](#) (Judge Graham Mullen).

In matter involving removed “bad faith insurance claim” against Cigna brought by a surgery center, granting Cigna’s motion to transfer case to the District of Colorado pursuant to the first-to-file rule, which provides that when multiple suits are filed in different federal courts involving the same factual issues, courts usually permit the first-

filed action to proceed to the exclusion of the subsequently filed suit. [Westminster Surgery Ctr., LLC v. Cigna Health & Life Ins. Co., No. CV GLR-15-3576, 2016 WL 4083355 \(D. Md. Aug. 1, 2016\)](#) (Judge George L. Russell, III).

In interpleader action to determine rightful beneficiary of Salaried Savings Plan, finding that doctrine of collateral estoppel does not apply in this case where the Virginia Court of Appeals directed the Circuit Court to enter what the Court of Appeals deemed a QDRO, where the supposed QDRO said that, after entry of the order, Dominion would decide whether it is a QDRO, and where a new issue not resolved in the state court proceedings is whether Dominion properly deems the DRO to be a QDRO. [Dominion Res. Inc. v. Estate of David Griffin, No. 3:15-CV-407, 2016 WL 4071969 \(E.D. Va. July 29, 2016\)](#) (Judge John A. Gibney, Jr.).

In breach of fiduciary duty action brought by the Secretary of the DOL, granting the Secretary's two procedural motions: (1) the Secretary's Motion to Strike AmeriGuard's Demand for a Jury Trial filed pursuant to Rule 12(f) of the Federal Rules of Civil Procedure; and (2) AmeriGuard's Motion to Strike Silva's Answer on Behalf of Other Defendants, also filed pursuant to Rule 12(f). [Perez v. Silva, No. JKB-15-3484, 2016 WL 2625261 \(D. Md. May 9, 2016\)](#) (Judge James K. Bredar).

Court empanels advisory jury in dispute over ERISA-governed life insurance proceeds. [American United Life Insurance Company v. Arthur, et al., No. 3:14-CV-00586-GCM, 2016 WL 165034 \(W.D.N.C. Jan. 14, 2016\)](#) (Judge Graham C. Mullen). In this action in interpleader involving a group life insurance policy, one of the defendants challenged the validity of the change in beneficiary form executed shortly before the insured's death. Although the court acknowledged that the Fourth Circuit has explained that no jury trial is available under 29 U.S.C. § 1132(a)(1)(B) in an effort to preserve ERISA's high degree of deference to Plan administrators; here, the defendant does not challenge the authority of the Plan Administrator, but disputes the validity of the operative Plan document. The court found that the question of whether the defendant is entitled to a jury trial on claims that question the validity of ERISA Plan documents is entirely unsettled. Further, the defendant's original claims are highly fact intensive and turn primarily on credibility determinations, the types of claims for which a jury tends to be most appropriate. For these reasons, the court proceeded as though the jury's verdict in this case is advisory and issued findings of fact and conclusions of law consistent with the verdict. The court found that the decedent signed a change in beneficiary form and was not operating undue influence at the time that he signed the form. As such, the court directed judgment in favor of the named beneficiary on the designation form.

Claim related to cancellation of health insurance benefits is inadequately pled under Rule 12(b)(6). [Jassie v. Mariner, No. CV DKC 15-1682, 2016 WL 67257 \(D. Md. Jan. 6, 2016\)](#) (Judge Deborah K. Chasanow). Defendant moved to dismiss Plaintiff's claim for wrongful cancellation

of health insurance – interpreted as a breach of contract claim – due to ERISA preemption and Defendant is not a proper ERISA defendant. Here, Plaintiff alleges that he was entitled to health insurance benefits that he did not receive but the court found that the amended complaint is vague and the court cannot determine whether Plaintiff’s wrongful cancellation claim is covered by ERISA. If Plaintiff is asserting a claim that the employer breached the terms of his employment contract, part of which entailed an obligation to provide benefits during the course of employment, such a claim would not be preempted by ERISA. The court found unclear from the amended complaint whether Plaintiff’s insurance coverage was cancelled prematurely or at the time Plaintiff’s employment was terminated since Plaintiff does not provide precise dates for either the cancellation of his insurance coverage or the termination of his employment. Any converted ERISA claim cannot be sustained because Plaintiff did not bring suit against the plan, the plan administrator, or a plan fiduciary. In addition, the amended complaint does not contain plausible allegations that Defendant breached contractual duties owed to Plaintiff as Plaintiff’s employment contract appears to be with his employer, rather than Defendant, a regional human resources manager. For these reasons, the court found that the amended complaint cannot withstand Rule 12(b)(6) scrutiny and dismissed Plaintiff’s claim.

E. Fifth Circuit

The court denied Plaintiff’s motion to file her first amended complaint to assert her proposed § 1132(c) claim against Central Bank for untimely production of the SPD. The court rejected Plaintiff’s claim that Central Bank led her into believing that MetLife, the claim administrator, was responsible for the drafting and publication of the SPD. The court found that Plaintiff knew, before filing her Original Complaint, that Central Bank—not MetLife—was the Plan Administrator; knew that she had submitted a written request for plan documents to Central Bank; and knew that the documents she received in response to that request did not include a document titled “SPD.” The court also found that Plaintiff failed to demonstrate that the proposed claim would not be futile, or that allowing the proposed amendment at this late date would not unduly prejudice Defendants. [Keith v. Metro. Life Ins. Co., No. CV H-15-1030, 2016 WL 7017421 \(S.D. Tex. Nov. 30, 2016\)](#) (Judge Sim Lake).

In this matter, Plaintiff originally filed her petition against Cigna and L-3 Communication, Inc. in Nueces County, Texas regarding a dispute over employee disability benefits provided to Plaintiff as a result of her prior employment with L-3 Communications Vertex Aerospace, LLC, pursuant to a disability insurance policy underwritten and offered by Cigna. In Nueces County Court, Plaintiff requested and received a default judgment against L-3 Communication. The court granted Plaintiff’s Agreed Motion to Set Aside Default Judgment, finding that setting aside the state court default judgment against L-3 Communication is justified under Rule 60(b)(1). [Garza v. Cigna Life Ins. Co. of N.Y., No. 2:16-CV-182, 2016 WL 6947992 \(S.D. Tex. Nov. 28, 2016\)](#) (Judge Hilda Tagle).

Based on the Fifth Circuit’s reasoning in *Musmeci v. Schwegmann Giant Super Markets, Inc.*, Plaintiff failed to allege sufficient facts that Shell Oil is a proper party defendant because it is the plan administrator. The court dismissed with prejudice Plaintiff’s claims against Shell Oil under 29 U.S.C. § 1001, *et seq.* [McNealy v. Becnel, No. CV 14-2181, 2016 WL 6070073 \(E.D. La. Oct. 17, 2016\)](#) (Judge Susie Morgan).

In long-term disability matter where Plaintiff seeks benefits under Section 502(a)(1)(B) and also alleges that Liberty Life committed various procedural infractions during the claims process, denying Liberty Life’s motion for partial dismissal of Plaintiff’s equitable relief claim under Section 502(a)(3). Though Plaintiff may not succeed on claims for both legal and equitable relief, he “may state as many separate claims or defenses as [he] has, regardless of consistency.” [FED. R. CIV. P. 8\(d\)\(3\)](#). [Peterson v. Liberty Life Assurance Company of Boston, No. 1:15-CV-00204-SA-DAS, 2016 WL 3849693 \(N.D. Miss. July 13, 2016\)](#) (Judge Sharion Aycock).

Finding that Assurance, a third-party administrator, is a proper party defendant to ERISA Section 502(a) action, but Companion, a company alleged to be an underwriter of the Plan and employer’s indemnitor, is not a proper party. [Roberts v. Reynolds & Reynolds Trucking, Inc., No. 3:15-CV-3662-B, 2016 WL 3570652 \(N.D. Tex. July 1, 2016\)](#) (Judge Jane J. Boyle).

In *pro se* action seeking disgorgement of retirement funds, denying Plaintiff’s motion to disqualify defense counsel and granting Defendant’s motion to dismiss for lack of subject matter jurisdiction where Plaintiff failed to demonstrate his standing as a beneficiary under ERISA. [Feingerts v. Sandra Mills Feingerts, No. 15CV2895NGGJCW, 2016 WL 2744812 \(E.D. La. May 10, 2016\)](#) (Judge Nicholas G. Garaufis).

Removal was untimely where pre-suit notice put Defendant on notice of basis for removal. [Decatur Hosp. Auth. v. Aetna Health Inc., No. 4:15-CV-922-A, 2016 WL 722155 \(N.D. Tex. Feb. 19, 2016\)](#) (Judge John McBryde). Plaintiff initiated this action on June 24, 2015, by filing an original petition in a Texas state court. On December 4, 2015, Defendant removed this action alleging that this court has subject matter jurisdiction by reason of federal question under 28 U.S.C. § 1331, including on the basis of ERISA preemption and by virtue of the Federal Employee Health Benefits Act and the Federal Officer Removal Statute. The court declined to reach the arguments on subject matter jurisdiction since it concluded that Defendant did not timely remove the action under 28 U.S.C. Section 1446(b). This Section requires that notice of removal shall be filed within 30 days after the receipt by the defendant of a copy of the initial pleading setting forth the claims for relief upon which the action is based, or where removal is not proper based on the initial pleading but the action later becomes removable, a notice of removal may be filed within 30 days after receipt by the defendant of a copy of an amended pleading, motion, order or other paper from which it may first be ascertained that the case is one

which is or has become removable. Here, Defendant, which was served with Plaintiff's state court pleading on June 30, 2015, argues that it is within the thirty-day time period for removal because Plaintiff first put it on notice of the facts that it contends caused this action to be removable through answers to interrogatories, which confirmed for the first time that the claims forming the basis of this action included claims based on ERISA and FEHBA. The court disagreed, finding that a May 27, 2015 pre-suit notice to Defendant regarding the claims at issue in this action provided a detailed list of claims at issue and put Defendant on notice that the claims may deal with a payment arrangement that included ERISA and FEHBA. Because Defendant failed to establish that this action was timely removed, the court granted Plaintiff's motion to remand.

ESOP has standing to sue for breach of fiduciary duty. [HC4, Inc. Employee Stock Ownership Plan v. HC4, Inc., et al., No. H-15-0872, 2016 WL 109880 \(S.D. Tex. Jan. 11, 2016\)](#) (Judge Melinda Harmon). Defendant moved to dismiss the ESOP's claim against it for breach of fiduciary duty, arguing that the ESOP does not have standing to sue because it is not a participant, beneficiary, or fiduciary. The court denied the motion and found that under *Louisiana Bricklayers & Trowel Trades Pension Fund & Welfare Fund v. Alfred Miller General Masonry Contracting Co.*, 157 F.3d 404 (5th Cir. 1998) and ERISA § 515, the ESOP has standing to sue for diminishment of the stock plan's assets over which it had authority and control to administer the investment of the Plan's assets under the terms of the Plan. With respect to Defendant HC4's motion to sever, to which the ESOP did not respond, the court granted the motion. The claims against HC4 included breach of fiduciary duty arising from an alleged failure to adequately investigate the financial situation of a company with which HC4 is merging but the claims against Defendant Travelers included breach of the insurance agreement and violations of the Insurance Code and the Deceptive Trade Practices Act arising from an alleged failure to pay a covered claim under an insurance policy. Although the court has only supplemental jurisdiction over the claims against Travelers, it found that remand was not permissible under the circumstances.

F. Sixth Circuit

Rule 55(a) provides that a default may only be entered if the defendant has failed to answer or otherwise defend. When Versa filed its answer on August 30, 2016, it frustrated Plaintiffs' ability to seek an entry of default in the future. The court denied the motion for default. [Bachel v. Republic Storage Sys., LLC, No. 5:16-CV-1403, 2016 WL 7115947 \(N.D. Ohio Dec. 7, 2016\)](#) (Judge Sara Lioi).

In lawsuit alleging wrongful denial of insurance coverage for prescription drugs and medical treatment, the court denied Plaintiff's motion to remand because, notwithstanding the label of the claims, clearly the essence of the claims are for the recovery of ERISA plan benefits. Additionally, the Complaint alleges a violation of federal anti-trust law which

would justify removal on that basis alone. [Roll v. Med. Mut. of Ohio, No. 1:16 CV 2487, 2016 WL 7097630 \(N.D. Ohio Dec. 6, 2016\)](#) (Judge Patricia A. Gaughan).

In this matter where there are two insurance contracts that cover different injuries (i.e., Plaintiff's personal bodily injuries and her alleged resulting disability) that arise out of the same automobile accident, the court has supplemental jurisdiction over Plaintiff's state law claims. The court found that Defendant UniCare's removal of this case without the consent of its co-defendant, Metropolitan Property and Casualty Insurance Company, was improper. [Askew v. Metro. Prop. & Cas. Ins. Co., No. 16-CV-12130, F.Supp.3d , 2016 WL 6776286 \(E.D. Mich. Nov. 15, 2016\)](#) (Judge Gerald E. Rosen).

In putative class action alleging that Defendant Blue Cross Blue Shield of Michigan breached its fiduciary duty as a third-party administrator by charging Plaintiffs' respective ERISA healthcare plans "hidden" fees, the court dismissed the Fourth Amended Complaint with prejudice because: (1) Plaintiffs lack constitutional standing to pursue "other appropriate equitable relief" under 29 U.S. C. § 1132(a)(3)(B) because they failed to allege that they suffered any particularized or concrete injury; and (2) Plaintiffs lack constitutional standing to pursue injunctive relief under 29 U.S. C. § 1132(a)(3)(A) because they failed to allege any likelihood of repeated injury or future harm. [Cox v. Blue Cross Blue Shield of Michigan, No. 14-CV-13556, F.Supp.3d , 2016 WL 6395587 \(E.D. Mich. Oct. 28, 2016\)](#) (Judge Mark A. Goldsmith).

Union with appointing authority has standing as a fiduciary to bring an ERISA claim. [Stockwell v. Hamilton, No. CV 15-11609, 2016 WL 612757 \(E.D. Mich. Feb. 16, 2016\)](#) (Judge Linda V. Parker). The court held that an entity with authority to appoint and replace trustees has standing as a fiduciary to bring an ERISA claim as one method of fulfilling the duty to take action upon discovery that an appointed fiduciary failed to perform properly. In other words, the court held that if an entity is a fiduciary when named as a defendant for failing to fulfill its duties to monitor appointed trustees and to take action upon discovery that an appointed trustee is not performing properly, the same entity is a fiduciary to the extent it is bringing an ERISA claim alleging improper performance by an appointed trustee. The court concluded that the Union has ERISA standing to bring breach of fiduciary duty claims under ERISA Sections 404 and 406.

LTD claim transferred to forum where Plaintiff resides. [Perry v. Hartford Life & Accident Ins. Co., No. 3:14-CV-00737-CRS, 2016 WL 552594 \(W.D. Ky. Feb. 10, 2016\)](#) (Judge Charles R. Simpson III). The court granted Defendant's motion to transfer this long-term disability matter to the Western District of Tennessee. Plaintiff resides within the Western District of Tennessee and her treating physicians are located in Tennessee. Plaintiff's employer, which entered into the ERISA plan, is headquartered in Kansas, although Plaintiff worked in Lexington, Tennessee. The only alleged factual connection to Kentucky is that Defendant uses a third party vendor to manage a mail drop facility in the Commonwealth. However, Defendant has no employees at this facility. The only other connection to the Commonwealth is that Plaintiff's

attorney resides there, but the court found that this is insufficient to make Kentucky the more convenient forum. Because Plaintiff does reside in the Western District of Tennessee and relevant events underlying the claim occurred in that district, the court transferred this action there.

Michigan ban on discretionary clauses does not apply to LTD policy not issued or delivered to a person in Michigan. [Mellian v. Hartford Life and Accident Insurance Company, No. 14-10867, 2016 WL 552723 \(E.D. Mich. Feb. 12, 2016\)](#) (Judge Gerald E. Rosen). In 2007, Michigan adopted an insurance regulation stating that “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.” Mich. Admin. Code R. 500.2202(c). Where it applies, operates to override a clause in an insurance policy that otherwise would confer discretionary authority on an ERISA plan administrator and thereby trigger arbitrary and capricious review. In this case, Plaintiff argued that this regulation required *de novo* review of her long-term disability claim, but the court agreed with Hartford that this state insurance rule is not applicable here. The court explained that Rule 500.2202(c) applies only to a “policy, contract, rider, indorsement, certificate, or similar [insurance] contract document” that is “issued or delivered to” a person in Michigan. Mich. Admin. Code R. 500.2202(c). The LTD Policy in this case expressly states that it was issued by Defendant to Plaintiff’s employer, Atkore International, and that a copy of the Policy is available for review in Atkore’s office located in Harvey, Illinois. Because of this, the court found that the Policy was not issued in Michigan, nor is there any evidence that it was delivered to any individual in Michigan.

G. Seventh Circuit

Quad’s challenge to the 2012 withdrawal liability assessment does not present a live case or controversy. Although Quad’s challenge to the request for information does present a live case or controversy, that challenge is the mirror image of the GCIU-Employer Retirement Fund’s action to enforce the request for information, which is pending in the Central District of California. Granting motion to dismiss and declining to hear request for declaratory relief when there is a mirror-image claim for “coercive” relief pending. [Quad/Graphics, Inc., V. GCIU-Employer Retirement Fund, No. 16-C-0033, 2016 WL 5121758 \(E.D. Wis. Sept. 20, 2016\)](#) (Judge Lynn Adelman).

In ERISA and negligence suit brought by 401(k) Plan against its former trustee and other defendants, granting motion to dismiss because the Plan, by filing this suit, improperly split claims that it could and should have brought in a closely related case, Weir v. Elmhurst Lincoln-Mercury, Inc., No. 13 C 2694 (N.D. Ill. filed Apr. 10, 2013). [Elmhurst Lincoln-Mercury, Inc. Employees 401\(K\) Profit Sharing Plan & Trust v. David G. Mears, Elmhurst Lincoln-Mercury, Inc., Universal Underwriters Insurance Company, & James F. Best, P.C., No. 16 C 2390, 2016 WL 4505171 \(N.D. Ill. Aug. 29, 2016\)](#) (Judge Gary Feinerman).

In matter alleging breach of fiduciary duty by Defendants with respect to Plaintiffs' Anthme 401(k) Plan, concluding that Plaintiffs are not entitled to a jury demand under ERISA Section 502(a)(2) and granting Defendants' motion to strike the jury demand. [Bell v. Pension Comm. of Ath Holding Co., LLC, No. 115CV02062TWMPMB, 2016 WL 4088737 \(S.D. Ind. Aug. 1, 2016\)](#) (Judge Tanya Malton Pratt).

In action seeking to recover medical benefits under the Liebovich Bros. Inc, Plan, dismissing defendant Northern Illinois Health Plan ("NIHP") for failing to be a proper defendant. Plaintiff alleged that NIHP is the Claims Administrator "having the authority to apply the terms of the Plan in order to make an initial determination of eligibility for benefits and to administer the Plan in accordance with its terms." The court found that NIHP does not have an obligation to pay Plaintiff any benefits and it does not have discretion to decide whether Plaintiff is entitled to benefits. [Kunz v. Liebovich Bros., No. 15 C 50279, 2016 WL 3093045 \(N.D. Ill. May 31, 2016\)](#) (Judge Frederick J. Kapala).

Denying motion to remand ERISA lawsuit brought by home health care services provider against City of Hammond and claim's management service company, finding that court has no discretion to remand a case presenting an issue of federal law and removal statute permits removal of a suit that includes both a federal law claim and an otherwise non-removable one. [Anchor Health Sys., Inc. v. Radowski, No. 2:16-CV-65-RLM-PRC, 2016 WL 1593231 \(N.D. Ind. Apr. 21, 2016\)](#) (Judge Robert L. Miller, Jr.)

ERISA Section 502(a)(3) claim dismissed as duplicative of ERISA Section 502(a)(1)(B) claim. [Craft et al. v. Health Care Service Corporation, No. 14 C 5853, 2016 WL 1270433 \(N.D. Ill. Mar. 31, 2016\)](#) (Judge Virginia M. Kendall). In their claim under ERISA Section 502(a)(1)(B), Plaintiffs seek money benefits owed and a declaratory judgment that blanket exclusions of coverage for residential treatment for mental illness are void under the Parity Act. The court found that Plaintiffs' claim under ERISA Section 502(a)(3)—repackaged as a claim seeking an injunction requiring Defendants to reprocess all claims for RTC denied within the statute of limitations—seeks essentially the same relief and is based on the same underlying conduct. The court noted that the Seventh Circuit has yet to decide whether a claim for benefits under Section 502(a)(1)(B) bars a Section 502(a)(3) claim for equitable relief under *Varity Corp. v. Howe*, but it has recognized that "a majority of the circuits" have interpreted *Varity* to mean that "if relief is available to a plan participant under subsection (a)(1)(B), then that relief is un available under subsection (a)(3)." The court found that certain Plaintiffs' claims for relief under subsection (a)(3) are dismissed as duplicative of the identical claims brought under subsection (a)(1)(B). The court found that the relief sought pursuant to the former section would be available under the latter, such that Plaintiffs would be fully compensated if they prevail under the latter section.

H. Eighth Circuit

To seek judicial review of an arbitrator's decision under the MPPAA, a party must bring an action in court, commenced by filing a complaint. The Pension Fund's "Petition to Vacate" was not styled a "complaint," but the court will construe it as a complaint and subject to Rule 4(m)'s time frame for service of process. Given the lack of guidance from courts on the proper procedure for seeking judicial review of an arbitrator's decision under the MPPAA, there is good cause to extend the time frame for service of process under Rule 4(m). [In the Matter of the Arbitration Between Genz-Ryan Plumbing & Heating Co. v. Sheet Metal Workers' Local 10, Pension Fund, No. CV 16-280 \(DWF/SER\), 2016 WL 5107074 \(D. Minn. Sept. 19, 2016\)](#) (Judge Donovan W. Frank).

Finding that Plaintiffs have not pled administrative exhaustion as required for ERISA claims in this circuit and granting Defendant's motion to dismiss, but giving Plaintiffs leave to replead and allege in their amended complaint any facts they believe to be relevant to the administrative exhaustion requirement. [Lacy v. Valmont Indus., Inc., No. 8:15-CV-3070, 2016 WL 3014656 \(D. Neb. May 24, 2016\)](#) (Judge John M. Gerrard).

Plaintiff lacks statutory standing to assert ERISA claim for benefits or equitable relief. [Hart v. Nationwide Mutual Ins. Co., No. 4:14 CV 1299 CDP, 2016 WL 1161594 \(E.D. Mo. Mar. 23, 2016\)](#) (Judge Catherine D. Perry). In this case, Plaintiff received long-term disability benefits from Nationwide until she reached age 65 and then sought pension benefits under the Nationwide Retirement Plan. She was initially given an estimate of pension benefits, but was then told that she was not eligible to receive them. She filed suit against Nationwide under ERISA seeking either unpaid benefits or equitable relief. The court granted summary judgment in Nationwide's favor on the ground that Plaintiff was not a Plan participant and lacks standing to bring an ERISA action. Plaintiff's job classification excluded her from the Plan such that she is not an employee in, or reasonably expected to be in, currently covered employment, or a former employee who has a reasonable expectation of returning to covered employment or who has a colorable claim to vested benefits. This case does not fit the narrow exception to the standing requirement in cases where but for the employer's conduct alleged to be in violation of ERISA, the employee or former employee would be a plan participant. The court determined that any alleged misrepresentations to Plaintiff regarding her participation in the Plan through receipt of Plan documents and a pension packet do not change her undisputed job classification and corresponding exclusion from the Plan.

No jury trial for breach of fiduciary duty claim. [Wengert v. Rajendran, No. 8:15CV366, 2016 WL 827754 \(D. Neb. Mar. 2, 2016\)](#) (Judge Thomas D. Thalken). The court granted the ESOP Committee's motion to strike Plaintiff's jury demand. The court found that Plaintiff's breach of fiduciary duty claim is a claim for failure to pay benefits under the terms of an ERISA-governed plan. Although Plaintiff styled her claim as one for breach of fiduciary duty, in

essence she is seeking to recover benefits due to her under the terms of the plan, which is a claim under 29 U.S.C. § 1132(a)(1)(B). “When any monetary relief turns on a determination of entitlement to benefits, such relief is an integral part of an equitable action for which the Seventh Amendment provides no right to a jury.” The court determined that Plaintiff is not entitled to a jury trial on that claim. Moreover, Plaintiff’s breach of fiduciary duty claim arises under 29 U.S.C. § 1132(a)(3), which by its own terms pertains to claims for equitable relief for which there is no right to a jury. The court concluded that the remedy sought by Plaintiff against the ESOP Committee for its alleged breach of fiduciary duty arising under ERISA is equitable in nature. For these reasons, the court struck the jury demand on Plaintiff’s claim for breach of fiduciary duty against the ESOP Committee.

Court grants leave to amend complaint to add Aon Hewitt as defendant in lawsuit alleging violations of ERISA and COBRA. [Borovac v. Nat’l R.R. Passenger Corp., No. 8:15CV196, 2016 WL 697101 \(D. Neb. Feb. 19, 2016\)](#) (Judge Cheryl R. Zwart). Plaintiff filed a complaint against Aon Hewitt, LLC (“Aon Hewitt”) and Amtrak on November 19, 2014, alleging violations of ERISA and COBRA. The case was dismissed without prejudice and Plaintiff refiled the lawsuit naming Amtrak and Conexis as Defendants. Plaintiff moved to amend his complaint to add Aon Hewitt, LLC as an additional party and add pertinent provisions, factual statements, and causes of action. Amtrak objected to Plaintiff’s motion to amend, stating Aon Hewitt is not a proper party to this action, and any claims against him would be futile and frivolous. The court granted the motion and explained that the language of ERISA provides the means for identifying a plan administrator, and in some situations, the proper defendants may include the party who controls administration of the plan. Here, neither party provided the court with the plan instrument which may designate who the administrator is in this case. But, in Plaintiff’s proposed amended complaint he states “Defendant Aon Hewitt was contracted by Defendant Amtrak as a plan administrator to contract health benefits with Conexis” and “Aon Hewitt is and was at all times material an ‘administrator’ within the meaning of ERISA and COBRA.” In Amtrak’s answer, it twice referred to Aon Hewitt as its administrator. The court could not conclude that the additions within Plaintiff’s complaint would be futile. Further, the court found that Plaintiff has alleged sufficient facts to support a claim under 29 U.S.C. § 1166 against Aon Hewitt.

Plaintiff released and could no longer accrue ERISA claims in connection with deferred equity compensation upon execution of release agreement. [Manuel vs. Aventine Renewable Energy Holdings, Inc., et al., No. 8:15CV188, 2016 WL 54201 \(D. Neb. Jan. 4, 2016\)](#) (Judge Laurie Smith Camp). Plaintiff brought suit alleging that Aventine failed to comply with the terms of the Equity Plan, through which he received awards of deferred equity compensation including stock options. Plaintiff signed a release of claims when his employment ended and had agreed that all outstanding equity awards granted to him were fully vested and exercisable. Defendants moved to dismiss Plaintiff’s ERISA claim, arguing that the Equity Plan and Restricted Stock Unit Agreement did not create an ERISA plan, but regardless, he waived any claims and limited his

remedies to those for breach of contract. The court did not decide whether portions of the equity awards constituted, or were distributed pursuant to, an ERISA-governed benefits plan because Plaintiff waived all ERISA claims by agreeing to the Release, and he cannot accrue new claims subsequent to its signing. Plaintiff argued that his release of his ERISA claims only applied to claims that had accrued up to or before the signing the Release, and that any claims that arose subsequent to the signing could not have been knowingly and voluntarily released. The court found that he is only half-correct: after Plaintiff released his rights, he could no longer accrue claims under ERISA. The court explained that an alternate conclusion would render Plaintiff's promise to bring all subsequent claims as a breach of the Release devoid of meaning. Accordingly, the court dismissed the ERISA claims.

I. Ninth Circuit

In suit brought by third party administrator against a former client, granting former client's motion to realign (i.e., switching who is the plaintiff and defendant), where the court remanded the state law claims and cross-complaints and the only remaining claims are the federal ERISA cross-complaints. [FCE Benefits Administrators, Inc. v. Training, Rehab. & Dev. Inst., Inc., No. 15-CV-01160-JST, 2016 WL 4426897 \(N.D. Cal. Aug. 22, 2016\)](#) (Judge Jon S. Tigar).

In matter involving judgment against Debtor for self-dealing, prohibited transactions and breaches of fiduciary duty under ERISA related to the Harris Realty Pension Plan, denying Debtor's claim of exemption under [Cal. Code of Civil Procedure Section 708.550](#) and ordering that 100% of any distributions made to Michael F. Harris from the Rita Harris Trust, the Gilbert Harris Bypass Trust and/or the Michael Harris Discretionary Trust shall be assigned to Plaintiffs in partial satisfaction of Debtor's outstanding judgment. [Cavellini v. Harris, No. 93-CV-00057-SBA\(KAW\), 2016 WL 3648927 \(N.D. Cal. July 8, 2016\)](#) (Magistrate Kandis A. Westmore).

Striking demand for jury trial for ERISA breach of fiduciary duty claim, finding that Ninth Circuit law holds that jury trials are not required for ERISA claims. [Rodrigues v. Bank of Am., No. C 16-1390 CW, 2016 WL 3566950 \(N.D. Cal. July 1, 2016\)](#) (Judge Claudia Wilken).

In matter seeking to enjoin the Internal Revenue Service from levying against the pension plan pursuant to ERISA section 502(a)(3), denying Plaintiff's motion for a temporary restraining order because: (1) Plaintiff has not established that the court has subject matter jurisdiction over this action; (2) Plaintiff has not established that the Anti-Injunction Act, 26 U.S.C. § 7421, does not bar this action; and (3) Plaintiff has not satisfied the Federal Rule 65(b) standard applicable to unnoticed TROs. [Nemlowill v. United States,](#)

[No. 16CV1642-MMA \(WVG\), 2016 WL 3552070 \(S.D. Cal. June 29, 2016\)](#) (Judge Michael M. Anello).

In matter involving a single claim for relief related to the calculation of retirement benefits, Plaintiff's motion for an enlargement of time is denied where Plaintiff failed to carry his burden under Rule 16(b)(4) and LR 16-3(a) to show that the court should modify the court's prior scheduling order. Plaintiff delayed too long seeking to amend his complaint and that delay, combined with the passage of the discovery close date and the summary judgment deadline, results in significant prejudice to the Defendant such that Plaintiff is denied leave to amend complaint. [Wortman v. The Boeing Company, No. 3:15-CV-1735-AC, 2016 WL 2869060 \(D. Or. May 16, 2016\)](#) (Judge John V. Acosta).

Failure to arbitrate results in waiver of right to contest withdrawal liability. [Dairy Employees Union Local No. 17 v. Dairy, No. 13-57143, Fed.Appx. , 2016 WL 851624 \(9th Cir. Mar. 4, 2016\)](#) (Before CALLAHAN and N.R. SMITH, Circuit Judges, and RAKOFF,*Senior District Judge). The court affirmed the district court's grant of summary judgment determining that Dairy owed withdrawal liability to Dairy Employees Union Local No. 17 Christian Labor Association of the United States of America Pension Trust. The court found that Appellant waived its right to contest withdrawal liability in federal court by failing to arbitrate.

AD&D claim subject to abuse of discretion review; Washington ban on discretion does not apply. [Osborn by & through Petit v. Metro. Life Ins. Co., No. 3:15-CV-00605-MO, F.Supp.3d , 2016 WL 589863 \(D. Or. Feb. 11, 2016\)](#) (Judge Mosman). In this case, Plaintiff claims that MetLife wrongfully denied her claim for \$1.25 million in accidental death and dismemberment ("AD & D") benefits under the Providence Health & Services Welfare Benefit Plan (the Program). The parties filed motions for partial summary judgment on the standard of review. Plaintiff asserted three reasons why the standard of review should be *de novo* in this case: 1) the relevant plan documents do not contain the unambiguous grant of discretionary authority required to overcome the *de novo* presumption; 2) there is a conflict between the Certificate of Insurance and the Program and therefore the terms of the Certificate of Insurance, which does not contain an unambiguous grant of discretion, controls; and 3) any conveyance of discretionary authority is void under Washington law. The court rejected each of these arguments and held that MetLife's denial of benefits will be reviewed for abuse of discretion. First, although the Program does not grant MetLife discretion to interpret the terms of the plan, it did grant MetLife discretion to determine eligibility for benefits. The court found that *Firestone's* use of the disjunctive "or" compels it to hold that either the discretion to determine eligibility for benefits *or* the discretion to interpret the terms of the plan are sufficient grants of discretionary authority. Second, although the Certificate of Insurance does not contain a discretionary clause (is silent as to this), it does not conflict with the provision in the Program granting MetLife discretion. Third, WAC 284-44-015 clearly prohibits discretionary clauses in

the health care services context, but it does not ban discretionary clauses in all insurance related contracts. Further, WAC 284-96-012 applies to employee benefit plans (not just insurance policies), but the Program is a life insurance policy, not “disability insurance”. Although WAC 284-96-012 is not preempted by ERISA, it does not apply to the Program since its dominant purpose is to protect against the loss of life.

Substantial attorneys’ fees and costs awarded to ERISA plaintiff whose attorneys achieved “enviable success” on claim for denied medical treatment. [Dragu v. Motion Picture Indus. Health Plan for Active Participants, No. 14-CV-04268-RS, F.Supp.3d , 2016 WL 454066 \(N.D. Cal. Feb. 5, 2016\)](#) (Judge Richard Seeborg). In this matter, the court previously granted summary judgment in favor of Plaintiff on her claim for denied medical treatment for injuries she sustained to her jaw, mouth, teeth, and gums. On Plaintiff’s motion for attorneys’ fees, wherein the court noted that “Dragu’s attorney, James Keenley, helped his client significantly... and achieved enviable success”, the court ordered the defendant plan to pay Dragu \$114,570 in attorneys’ fees and \$666.39 in costs and expenses. Keenley and members of his firm devoted 215.91 hours to this case and sought to recover for 199.65 hours of work. The court found that a rate of \$600/hour is reasonable and within market range for attorneys of Keenley’s caliber. The rate was supported by local ERISA practitioners: Jeffrey Lewis, Daniel Feinberg, Glenn R. Kantor, Terrance Coleman, and Michelle Roberts. The court only minimally reduced the time sought by Plaintiff, including: 1.45 hours spent mooting and preparing for the hearing for summary judgment; 5.35 hours to account for some inefficiency in reviewing various documents; 1 hour for some inefficiency for reviewing notice and preparing some documents; and .9 hours spent consulting with colleagues on some issues. Notably, the court declined to reduce time spent on alleged “clerical or administrative tasks” such as reviewing notices from the court, preparing documents for service, and revising an opposition brief. The court also awarded time spent consulting with his colleagues and devoting large chunks of time to a single task, which the Plan unsuccessfully argued was “block billing.” The court rejected the Plan’s argument that the fee request should be reduced because the requested fees are not proportional to the total amount at issue, approximately \$25,288. The court noted that ERISA does not require attorneys’ fees to be proportional to the total recovery and courts routinely award fees in excess of the ERISA plaintiff’s total recovery.

District court lacks jurisdiction to consider renewed fee motion where party had filed a notice of appeal of previously denied fee motion. [Cox v. Allin Corporation Plan & Unum Life Insurance Company of America, No. C 12-5880 SBA, 2016 WL 270955 \(N.D. Cal. Jan. 22, 2016\)](#) (Judge Sandra Brown Armstrong). Plaintiff previously filed a notice of appeal of the district court’s denial his motion for attorneys’ fees following the court’s remand of his long-term disability claim to Unum for further consideration. Plaintiff then voluntarily dismissed his appeal and subsequently filed a motion for the district court to amend its previous judgment and award attorneys’ fees. The court ruled that Plaintiff’s renewed fee motion is not properly before the court because at the time he filed the instant motion, Plaintiff’s appeal of the court’s prior

order denying his motion for attorneys' fees remained pending. As a hornbook rule of law, once a notice of appeal is filed, the district court is divested of jurisdiction over the matters being appealed. The court found that his current fee motion seeks essentially the same relief and is predicated on the same grounds as the prior motion from which he appealed. Although Plaintiff voluntarily dismissed his appeal, the appeal remained pending at the time the motion for attorneys' fees was filed, rendering Plaintiff's fee motion "a nullity." Jurisdictional issues aside, the court found that Plaintiff's renewed fee motion is misplaced and denied it.

Assignee's claims are properly removed and the court has supplemental jurisdiction over state law claims. [Hackert v. Cigna Health and Life Insurance Company, et al., No. 215CV1248KJMCKDPS, 2016 WL 121786 \(E.D. Cal. Jan. 12, 2016\)](#). The court adopted the Magistrate Judge's report and recommendation denying a medical provider's motion to remand and motion to dismiss the insurance company's counterclaims. The court just addressed the provider's objections to the report and recommendation. The court found that removal was proper because Cigna carried its burden to show that the provider submitted claims as his patients' assignee and would have standing to bring an ERISA action. The provider objected the Magistrate Judge tacitly and improperly lumped together (1) the claims Cigna argues were preempted by ERISA and (2) other claims involving a Health Maintenance Organization (HMO), for which he claims an independent California statutory remedy exists. The court assumed without deciding that the court would lack independent subject matter jurisdiction over these HMO-related claims, but because all the claims arise within the same factual circumstances, the court has supplemental jurisdiction over them. *See* 28 U.S.C. § 1367(a).

29 U.S.C. § 1132(a)(3) fiduciary misconduct claim is not clearly duplicative of § 1132(a)(1)(B) claim for wrongfully denied benefits. [Mullin v. Scottsdale Healthcare Corp. Long Term Disability Plan, No. CV-15-01547-PHX-DLR, 2016 WL 107838 \(D. Ariz. Jan. 11, 2016\)](#) (Judge Douglas L. Rayes). The court denied Omaha Life Insurance Company's motion to dismiss Plaintiff's breach of fiduciary duty claim under § 1132(a)(3), which she brought in connection with her claim for long-term disability benefits under § 1132(a)(1)(B). With respect to the § 1132(a)(3) claim, Plaintiff alleged that Omaha's arbitrary and capricious claims handling generally constitutes a breach of fiduciary duty, because Omaha's claims handling was discharged imprudently, it instructs and/or incentivizes certain employee(s) to terminate fully insured LTD claims and appeals based on bias, it wrongfully withheld Plaintiff's benefits for its own profit, sought an independent medical examination on appeal and used the IME as a justification for tolling deadlines under ERISA, Omaha did not even attempt to complete a timely review within 45 days, Omaha acted with malice and in bad faith which constitutes a violation of its fiduciary duty. The court concluded that Plaintiff's § 1132(a)(3) fiduciary misconduct claim is based on the same injury as her § 1132(a)(1)(B) claim for wrongfully denied benefits, but the equitable relief she seeks is distinct from past due benefits, and she alleges that the available legal remedies are inadequate to make her whole. Accordingly, the court permitted Plaintiff to pursue both claims, keeping in mind that she is not entitled to relief where ERISA

elsewhere provides an adequate remedy. Specifically, Plaintiff must prove that Omaha engaged in fiduciary misconduct, that she is entitled to LTD benefits, those benefits, attorneys' fees, and any appropriate prejudgment interest are inadequate to make her whole, and her requested equitable relief is appropriate. At this stage, the court found that Plaintiff adequately pled a § 1132(a)(3) fiduciary misconduct claim that is not clearly duplicative of her § 1132(a)(1)(B) claim for wrongfully denied benefits.

J. Tenth Circuit

Because the ERISA-related counts 6-10 (theft from an ERISA plan; willful violation of ERISA) are not properly joined with Counts 1-5 (bank fraud) and 11-26 (bank fraud, wire fraud, aggravated identity theft, check kiting and committing a felony while on release), the court grants the motion to sever Counts 6-10. [United States v. Wood, No. 14-20065-01-JAR-JPO, 2016 WL 6680956 \(D. Kan. Nov. 14, 2016\)](#) (Judge Julie A. Robinson).

In action brought by Savings Plan participant alleging breach of fiduciary duty and prohibited transaction claim, granting Motion to Restrict Public Access filed by Defendant Great-West Life & Annuity Insurance Company related to Plaintiff's Motion for Class Certification and related filings. [Teets v. Great-West Life & Annuity Insurance Company, No. 14-CV-02330-WJM-NYW, 2016 WL 1586418 \(D. Colo. Apr. 20, 2016\)](#) (Magistrate Judge Nina Y. Wang).

Denying motion to dismiss cross-claim interpleading insurance proceeds based on named life beneficiary committing a disqualifying homicide under Utah Probate Code. [Life Insurance Company Of North America v. Janet Wagner And Conrad Truman, No. 2:15-CV-00505-DS, 2016 WL 1494711 \(D. Utah Apr. 14, 2016\)](#) (Judge David Sam).

Granting LINA's motion for leave to deposit life insurance proceeds into the Registry of the Court, for discharge and dismissal with prejudice, and for attorney fees and costs. [Life Insurance Company Of North America v. Janet Wagner And Conrad Truman, No. 2:15-CV-00505-DS, 2016 WL 1494711 \(D. Utah Apr. 14, 2016\)](#) (Judge David Sam).

Allegations of fraud depriving plaintiff of status as a plan participant or beneficiary does not create ERISA standing. [Yarbary v. Martin, No. 15-3224, F.App'x , 2016 WL 1273027 \(10th Cir. Apr. 1, 2016\)](#) (Before HOLMES, MATHESON, and PHILLIPS, Circuit Judges). Plaintiff appealed from the district court's order dismissing his complaint for lack of subject-matter jurisdiction and from a separate order denying his motion for relief from judgment, wherein he sought declaratory and injunctive relief as well as punitive damages related to the beneficiary designation of a life insurance policy governed by ERISA. The Tenth Circuit affirmed. On the issue of subject-matter jurisdiction, the court found that it is beyond peradventure that Plaintiff was not a participant or a beneficiary of the decedent's policy at the

time he filed his complaint. Therefore, he lacked standing under ERISA. The court found that Plaintiff's allegations of fraud in the change of his beneficiary status does not alter the standing calculus since ERISA standing may not be based on the notion that, but for the wrongful behavior, the plaintiff would have been a participant or beneficiary under the plan.

Denial of motion for reconsideration under FRCP60(b) affirmed. [Lebahn v. Owens, No. 14-3244, ___ F.3d ___, 2016 WL 683828 \(10th Cir. Feb. 19, 2016\)](#) (Before GORSUCH, MURPHY, and McHUGH, Circuit Judges). In this case, Plaintiff sued his employee pension plan consultant for negligently misrepresenting the amount of his monthly retirement benefits, causing him to rely on the misrepresentation and retire early. Defendant moved to dismiss the complaint on the basis of ERISA preemption. The district court ruled in Defendant's favor, finding that but for the Plan, plaintiff would have no claim—making the Plan itself a critical factor in the case. Plaintiff filed a Motion for Reconsideration under FRCP 59(e), arguing for the first time that ERISA preemption does not apply because Defendant is not a fiduciary of the Plan, just a third party consultant. The district court found Plaintiff's motion untimely, past the 28-day deadline by 3 days, and instead treated it as a motion under Rule 60(b). The district court denied the motion because it determined that Plaintiff failed to demonstrate "exceptional circumstances" since his argument was "raised too late," and a Rule 60(b) motion was not the proper time to raise an argument for the first time. Plaintiff appealed. The Tenth Circuit found that it lacks jurisdiction to consider any challenges to the district court's order granting Defendant's motion to dismiss since he did not timely file a notice of appeal. With respect to the court's review of the Rule 60(b) decision, Plaintiff argued that the court need not give deference to the district court's decision and may directly consider his mistake-of-law challenge to the district court's underlying judgment. The court determined that this argument is without merit because appeal from the denial of the motion raises for review only the district court's order of denial and not the underlying judgment itself. The court ruled that the district court did not abuse its discretion in denying Plaintiff's Rule 60(b) motion because Plaintiff's fiduciary claim was not mistakenly "overlooked," it was not timely raised and was therefore not a proper basis on which to grant Rule 60(b) relief. The Tenth Circuit affirmed the district court.

K. Eleventh Circuit

In matter where Plaintiffs challenge a plan administrator's determination their decedent father never designated beneficiaries for a life insurance policy, the court granted Defendants' Motion to Strike Plaintiffs' Jury Demand. [Taylor v. Prudential Ins. Co. of Am., No. CV 516-009, 2016 WL 6892083 \(S.D. Ga. Nov. 21, 2016\)](#) (Magistrate Judge Brian K. Epps).

Where plan documents make clear that AT&T is the plan sponsor, but that AT&T Services, Inc., is the plan administrator, AT&T is due to be dismissed as a named defendant in this action since it is not the party that controls the administration of the plan.

[Johnson v. AT&T, Inc., et al., No. 2:15-CV-01074-HGD, 2016 WL 6661164 \(N.D. Ala. Nov. 10, 2016\)](#) (Magistrate Judge Harwell G. Davis).

In a long-term disability dispute where Plaintiff seeks a court order requiring a pre-exhaustion neuropsychological IME to be videotaped, the court denied without prejudice Plaintiff's Motion to Perpetuate Evidence, filed pursuant to Federal Rule of Civil Procedure 27, because the record does not indicate that Prudential has been served and Prudential has not responded to the Motion. [Stratigos v. Prudential Ins. Co. of Am., No. 8:16-CV-2780-T-27JSS, 2016 WL 6138662 \(M.D. Fla. Oct. 21, 2016\)](#) (Magistrate Judge Julie S. Sneed).

In putative class action seeking preliminary injunction for Allstate to continue life insurance benefits for retirees, finding that Plaintiffs have established a substantial likelihood that they can succeed on the merits of their § 502(a)(3) claim; Plaintiffs have demonstrated a substantial likelihood that their claim is not barred by § 1113; Plaintiffs have demonstrated a likelihood that irreparable harm will result if their Allstate-provided retiree group life insurance policies are allowed to lapse during the course of this litigation, and the relative harms to the parties and the balancing of equities favor issuance of the injunction. Public policy favors the injunction as it will not undermine the public's interest in allowing employers flexibility if they choose to exercise it within the requirements of their fiduciary duties. [Turner v. Allstate Insurance Company, No. 2:13-CV-685-WKW, 2016 WL 5422071 \(M.D. Ala. Sept. 27, 2016\)](#) (Judge W. Keith Watkins).

In matter relating to a bankruptcy petition where Blue Cross filed a Motion to Withdraw Reference based on its position that ERISA must be "interpreted" for its subrogation claim, finding that withdrawal is not mandatory because no significant interpretation of a non-title 11 federal law is required. [Victor, No. 2:15-MC-2198-VEH, 2016 WL 3997235 \(N.D. Ala. July 26, 2016\)](#) (Judge Virginia Emerson Hopkins).

Where Amended Complaint has alleged that MetLife denied payment of the life insurance benefit because the policy had lapsed due to lack of premium payments, and that International Paper had a duty to fund the policy through a plan, which it failed to do, or had a fiduciary duty pursuant to 29 U.S.C. § 1132 to pay the premiums, Plaintiff is permitted to plead claims in the alternative under Rule 8. [Vinson v. Metropolitan Life Insurance Co., et al., No. 2:15CV885-WHA, 2016 WL 3156065 \(M.D. Ala. June 3, 2016\)](#) (Judge W. Harold Albritton Sr.).

In *pro se* action asserting claims of medical malpractice and violations of various federal statutes including ERISA and HIPAA against numerous defendants, affirming district court's dismissal of the action because Plaintiffs violated a previously entered permanent injunction requiring leave of court before filing a new civil action. [Duwell v. Atlanta Med. Ctr., No. 15-14510, F.App'x , 2016 WL 2640575 \(11th Cir. May 10, 2016\)](#) (Before HULL, WILSON and ROSENBAUM, Circuit Judges).

Affirming district court’s denial of Plaintiff’s Rule 59(e) motion related to long-term disability benefit claim and her request for an extension of time to reply to Defendant’s response to that motion, but reversing order granting Defendant’s motion for costs and remand for further proceedings. [Emery v. Am. Airlines, Inc., No. 15-10100, F.App’x, 2016 WL 1425939 \(11th Cir. Apr. 12, 2016\)](#) (Before JULIE CARNES, JILL PRYOR and ANDERSON, Circuit Judges).

Accommodation for nonprofit organizations implementing the ACA’s contraceptive mandate does not violate the constitution. [Eternal Word Television Network, Inc. v. Sec’y of U.S. Dep’t Health & Human Servs., No. 14-12696, F.3d, 2016 WL 659222 \(11th Cir. Feb. 18, 2016\)](#) (Before TJOFLAT, JILL PRYOR and ANDERSON, Circuit Judges). The Eleventh Circuit determined that the regulations implementing what is known as the “contraceptive mandate” of the Affordable Care Act (“ACA”)—the requirement that employers provide health insurance coverage for preventive care (including contraception) to women –does not violate the Religious Freedom Restoration Act (“RFRA”), 42 U.S.C. § 2000bb, et seq. In these consolidated appeals, Plaintiffs claim that the regulations’ accommodation for nonprofit organizations substantially burdens their religious exercise in violation of RFRA by forcing them to take actions that cause their health plan administrators to provide contraceptive coverage and to maintain a health plan that serves as a conduit for contraceptive coverage. The court concluded that the regulations do not substantially burden their religious exercise and, alternatively, because (1) the government has compelling interests to justify the accommodation, and (2) the accommodation is the least restrictive means of furthering those interests. Additionally, the court determined that the accommodation is a neutral, generally applicable law that does not discriminate based on religious denomination in violation of the Establishment and Free Exercise Clauses. Lastly, the court determined that the regulations do not violate the Free Speech Clause because any speech restrictions that may flow from the accommodation are justified by a compelling governmental interest and are thus constitutional.

ERISA claims dismissed where laboratories lack standing to assert claims under self-funded Cigna plans and failed to exhaust administrative remedies. [Biohealth Medical Laboratory, Inc., et al. v. Connecticut General Life Insurance Company, et al., No. 1:15-CV-23075-KMM, 2016 WL 375012 \(S.D. Fla. Feb. 1, 2016\)](#) (Judge K. Michael Moore). This matter involves a dispute arising out of Cigna’s denial of claims for toxicology testing performed by the plaintiff Laboratories. Cigna is a global health service company that serves as the claims administrator for various employer-sponsored health and welfare benefit plans. The Laboratories are out-of-network healthcare providers that routinely receive requests for testing services from Cigna’s insureds. Cigna moved to dismiss the ERISA and state law claims on several grounds. Cigna contended that the Laboratories lack broad derivative standing and are barred from bringing fiduciary duty claims and claims related to self-funded plans under the express language

of the Assignment. The court found that the Laboratories' standing by assignment theory for self-funded plans does not survive the express language of the Assignment. The Laboratories have standing to assert claims for breach of fiduciary duty but lack standing to assert claims under the self-funded Cigna plans and the court dismissed those claims without prejudice. Cigna also asserted that the Laboratories have failed to exhaust their administrative remedies. The court found that in the Complaint and the parties' arguments that the Laboratories have not alleged the exhaustion of administrative remedies. Instead, they allege that Cigna ignored their payment demands and failed to provide them with an adequate administrative remedy. The court found that the Laboratories' "bald assertions" of futility undercut the exacting requirement to exhaust administrative remedies. Because the Laboratories failed to make a "clear and positive showing" that proper assertion of their claims would be futile or offer more than "naked assertions devoid of further factual enhancement" that the Laboratories were denied meaningful access to administrative review of their claims, the court dismissed the ERISA benefit claims without prejudice so that the Laboratories may pursue their administrative remedies.

L. D.C. Circuit

Complaint fails to state a plausible claim for relief under *Dudenhoeffer*. [Coburn v. Evercore Trust Co., N.A., No. CV 15-49 \(RBW\), F.Supp.3d , 2016 WL 632180 \(D.D.C. Feb. 17, 2016\)](#) (Judge Reggie B. Walton). This matter involves a putative class action which alleges that Defendant, in its capacity as the plan fiduciary of an ESOP, breached its duty of prudence by failing to prevent plan participants from purchasing or holding J.C. Penney Corporation stock in their retirement plans once it allegedly became clear that J.C. Penney's transformation strategy was doomed to fail. Defendant moved to dismiss and the court granted its motion. The court found that the complaint's exclusive reliance on public information as the basis for the allegation that Defendant should have known that continued investment in J.C. Penney stock was imprudent, is indistinguishable from the types of allegations that the *Dudenhoeffer* Court held are implausible as a general rule. The court also found that Plaintiff's decision not to plead special circumstances is fatal to her claim that Defendant should have known, solely from public information, that continued investment in J.C. Penney stock was imprudent. Lastly, the court found that the Supreme Court's decision in *Tibble* does nothing to alter its conclusion because that case did not involve claims based on a drop in an employer's stock price.

XV. ***Preemption***

A. U.S. Supreme Court

Vermont law requiring reporting by health insurers is preempted as it relates to ERISA plans. [Gobeille v. Liberty Mut. Ins. Co., No. 14-181, S.Ct. , 2016 WL 782861 \(U.S. Mar.](#)

[1, 2016](#)). The Court affirmed the Second Circuit's decision finding that ERISA preempts Vermont law which requires certain entities, including health insurers, to report payments relating to health care claims and other information relating to health care services to a state agency for compilation in an all-inclusive health care database. The Court explained that ERISA seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures, and those systems and procedures are intended to be uniform. As part of the uniform plan administration system, ERISA mandates extensive reporting, disclosure, and recordkeeping requirements. Vermont's law and regulation also govern plan reporting, disclosure, and recordkeeping. The Court found that Respondent need not show that Vermont's regime has caused it to suffer economic costs. Further, Vermont's regime cannot be saved by invoking the State's traditional power to regulate in the area of public health. The Court also found that ERISA's pre-existing reporting, disclosure, and recordkeeping provisions maintain their preemptive force regardless of whether the new Patient Protection and Affordable Care Act's reporting obligations also preempt state law.

B. First Circuit

C. Second Circuit

In lawsuit alleging state law claims for medical malpractice, lack of informed consent, wrongful death, and loss of services, it is undisputed that decedent received treatment from an authorized provider under his ERISA plan. The question presented is whether JP Morgan and the Center are vicariously liable for the alleged malpractice of the treating doctor and nurse under state law. The court found that it would not need to interpret the terms of the ERISA plan to answer these questions, and as such, Plaintiffs' claims are not preempted by ERISA. [Walsh v. Pisano, No. 16-CV-4589 \(LAK\), 2016 WL 7046823 \(S.D.N.Y. Dec. 2, 2016\)](#) (Judge Lewis A. Kaplan).

In matter where Plaintiff brought state law claims against Defendant for improperly honoring a fraudulent change-of-beneficiary form submitted by an executor of Decedent's estate, the court found that Plaintiff's claims are preempted by ERISA, and he lacks standing to bring an ERISA action because Plaintiff is neither a participant, nor a fiduciary, nor a beneficiary. [Massimino v. Fid. Workplace Servs., LLC, No. 1:15-CV-01046\(MAT\), 2016 WL 6893609 \(W.D.N.Y. Nov. 23, 2016\)](#) (Judge Michael A. Telesca).

Claims for common law damages related to life insurance conversion are preempted by ERISA. [Varela v. Barnum Fin. Grp., No. 15-2876-CV, Fed.Appx. , 2016 WL 1105154 \(2d Cir. Mar. 22, 2016\)](#) (DENNIS JACOBS, PETER W. HALL, Circuit Judges and JANE A. RESTANI, CIT Judge). The Second Circuit affirmed the district court's dismissal of Plaintiff-Appellant's claims for common law damages against Defendant based on purported oral

misrepresentations concerning the process for converting a group life insurance policy. In this case, Plaintiff is the beneficiary of a life insurance policy that her now deceased spouse had failed to convert within a 31-day period. Shortly after the expiration of the time to convert, the spouse died of cancer. The court found that ERISA preempts Plaintiff's claims since Plaintiff is a beneficiary of the ERISA Plan and her claims arise out of purported oral misrepresentations by MetLife d/b/a Barnum and a Barnum employee about the process for converting a group life insurance policy under the Plan. The alleged breach here concerns the Plan itself and not an agreement separate and independent from the Plan.

D. Third Circuit

The court found that neither 29 U.S.C. § 185 nor 29 U.S.C. § 1132 supply the subject matter jurisdiction necessary to confirm the Committee's arbitration award so the court denied Plaintiffs' request for the entry of a default judgment against Hiester. The court explained that whether ERISA may ultimately preempt the Committee's attempt to enforce its arbitration award in state court is an issue for that court to address. [Apprentice v. Hiester, No. 5:16-CV-04306, 2016 WL 6948162 \(E.D. Pa. Nov. 28, 2016\)](#) (Judge Joseph F. Leeson, Jr.).

To settle a dispute alleging an improper denial of claims under a health plan, the insurer offered to freeze premiums for a substantial period of time, and then allegedly reneged on its commitment. The plan sponsor sued to enforce the agreement and alleged state law claims. The court found that the subsidiary dispute over enforcement of the agreement is preempted by ERISA and denied Plaintiff's Motion to Remand. [Shore v. Independence Blue Cross & Independence Health Group, No. CV 16-5224, 2016 WL 6821944 \(E.D. Pa. Nov. 18, 2016\)](#) (Judge Gerald Austin McHugh).

In suit seeking to enforce promises made in an employment offer letter, including that Plaintiff would be credited for years of service at an acquired company, the court found that Plaintiff's state law claims arise from legal duties independent from the ERISA plans and seek to recover damages in the form of severance pay or lost opportunities, not ERISA benefits *per se*. Since the claims will involve a cursory examination of the benefit plans and will not require the Court to interpret the plans, the claims are not preempted. [Lapham v. Accenture, LLP, No. 16-1394 \(RMB/JS\), 2016 WL 6609177 \(D.N.J. Nov. 8, 2016\)](#) (Judge Renee Marie Bumb). This case involves pre-employment promises of group benefits in the context of corporate merger. Plaintiff was employed by NaviSys Holdings, Inc. and participated in several of its group benefit plans. NaviSys was acquired by Accenture. Plaintiff asserted that Accenture had recruited him to remain employed by newly-merged venture. Accenture's promises included access to certain group benefits. By agreeing to stay aboard as an employee, Plaintiff gave up a cash severance benefit. Years later, the plan administrators of Accenture's group benefit plans denied Plaintiff's request for benefits, asserting that the terms of the plans do not provide the

benefits sought by Plaintiff. The plans at issue are retiree medical, pension, and 401(k). With respect to each plan, Plaintiff exhausted his pre-litigation claim and appeal remedies. He placed the matter into suit in the Camden Division, U.S. District Court, District of New Jersey, and Accenture filed its motion to dismiss. U.S. District Judge Renee Marie Bumb ruled in Lapham's favor, holding that the claims for fraud, breach of contract, and breach of covenant of good faith and fair dealing "do not require the Court to analyze or interpret the ERISA plans' terms." The District Court noted that Plaintiff "seeks damages in the form of lost severance pay and lost opportunities -- not ERISA benefits." Plaintiff is represented by Lisa Marone, Esq. in Cherry Hill and Matt Vance, Esq. in Montclair.

Holding that the District Court erred in concluding that the City acts as a market participant when it enforces Section 304 of Jersey City's Municipal Code with respect to Tax Abated Projects, where tax benefits are conditioned on the developers' entry into agreements with labor unions that bind the developers to specified labor practices. The court did not decide whether the challenged Ordinance is in fact preempted by the NLRA or ERISA, or whether it runs afoul of the dormant Commerce Clause. [Associated Builders And Contractors Inc. New Jersey Chapter et al. v. City Of Jersey City, New Jersey, et al, No. 15-3166, ___ F.3d ___, 2016 WL 4728006 \(3d Cir. Sept. 12, 2016\)](#) (Before: CHAGARES, KRAUSE, and SCIRICA, Circuit Judges).

Breach of contract and fiduciary duty claims contending that Defendants failed to adhere to their contractual notice obligations, thereby causing the denial of \$115,000 in life insurance benefits, is completely preempted by ERISA. No breach of fiduciary duty claim under ERISA where SPD provided to insured described conversion option. [Haymaker v. Reliance Standard Life Ins. Co., No. CV 15-06306, 2016 WL 1696851 \(E.D. Pa. Apr. 27, 2016\)](#) (Judge Pappert).

Granting Defendant's motion to dismiss and finding preempted Plaintiff's claims arising out of the purported failure by Guardian to pay Plaintiff's disability benefits; further finding no "independent legal duties" created by New Jersey Consumer Fraud Act. [Khan v. Guardian Life Ins. Co. of Am., No. CV 16-253, 2016 WL 1574611 \(D.N.J. Apr. 19, 2016\)](#) (Judge John Michael Vazquez).

LTD policy qualifies as an employee welfare benefit plan not subject to ERISA safe harbor provision. [Arsdel v. Liberty Life Assurance Co. of Boston, No. CV 14-2579, 2016 WL 1237317 \(E.D. Pa. Mar. 29, 2016\)](#) (Judge Edward G. Smith). In this case involving long-term disability benefits, the court found that the Pratt Disability Policy qualifies as an employee welfare benefit plan under ERISA because it is (1) a plan, fund, or program; (2) that is established or maintained; (3) by Pratt; (4) for the purpose of providing benefits; (5) to its participants or beneficiaries. The court also found that the Pratt Disability Policy does not fall under the safe harbor provision because an objectively reasonable employee would conclude on the basis of Pratt's actions that Pratt had not merely facilitated the policy's availability but had

exercised control over it or made it appear to be part and parcel of its own benefit package. Because the court concluded that the Pratt Disability Policy is an ERISA plan and the plaintiff's state-law claims for breach of contract and bad faith under 42 Pa. C.S. § 8371 are related to his claim under the policy, ERISA preempts those claims.

Claims under NJ Administrative Code Section 42.10 are conflict preempted by ERISA § 502(a) as claims for benefits due, but Section 42.10 itself is saved from preemption under ERISA § 514(b)(2)(A) as a law regulating insurance. [Roche v. Aetna, Inc., No. 13-1377 \(NLH/KMW\), 2016 WL 797553 \(D.N.J. Mar. 1, 2016\)](#) (Judge Hillman). Plaintiffs complain on behalf of themselves and a putative class of persons similarly situated that recovery actions taken by Defendants violate New Jersey's anti-subrogation laws as well as the New Jersey Consumer Fraud Act, and other common law torts. Plaintiffs argued that their claims under the applicable New Jersey Administrative Code section, Section 42.10, are saved from preemption under ERISA § 5147. Defendants argued that Section 42.10 is completely preempted by ERISA § 502, which renders any saving under ERISA § 514(b)(2)(A) irrelevant. The court found that the claims under Section 42.10 are conflict preempted by ERISA § 502(a) as claims for benefits due, but Section 42.10 itself is saved from preemption under ERISA § 514(b)(2)(A) as a law regulating insurance, and so provides the relevant rule of decision for determining what benefits are due under a claim properly pleaded under ERISA § 502(a). The court explained that if Plaintiff decides to replead these claims, Section 42.10 may supply the relevant rule of decision for the ERISA § 502(a) claim as it has been saved from express preemption under ERISA § 514(b)(2)(A), but the New Jersey Collateral Source Statute may not, as it has been ruled to be expressly preempted by ERISA § 514. The court also found preempted Plaintiff's other state law claims for (1) violation of the NJCFA and misrepresentation; (2) claims for breach of contract and breaches of various duties related to entering into contracts; and (3) claims for theft or attempted theft as well as conversion and unjust enrichment.

Negligence and/or breach of contract lawsuit related to processing of coverage is not preempted by ERISA. [Fitzsimmons v. Aetna, Inc., No. CV 15-3297, 2016 WL 98123 \(E.D. Pa. Jan. 7, 2016\)](#) (Judge R. Barclay Surrick). Plaintiffs are a married couple who had attempted to consolidate their healthcare by enrolling in the husband's health plan. The wife allegedly informed her employer to remove her from its health plan, which is administered by Aetna. Plaintiffs filed suit after the husband's health plan did not cover bills for the wife's medical services related to the birth of their child. Plaintiffs filed suit against various defendants in state court alleging that Defendants violated a legal duty owed to them which resulted in losses in the form of unpaid medical bills, denial of coverage, bad credit, and related damages. One set of defendants removed the matter contending that the lawsuit was preempted by ERISA. Plaintiffs sought a remand, which the court granted. The court found that Plaintiffs' claims are not preempted because they are not directly challenging coverage denials or seeking to clarify Plan benefits. Instead, they contend that payment should not have been made under the wife's health plan because she had removed herself as a beneficiary. The court concluded that this is a

negligence and/or third-party beneficiary breach of contract lawsuit that touches ERISA only insofar as Defendants allegedly caused Plaintiffs' damages in the form of medical expenses when they failed to terminate the wife's plan coverage. The court also found that Aetna did not file a consent to remove or explicitly join in the Removal Petition so removal is improper.

E. Fourth Circuit

The court found that state-law claims that seek damages for the post-termination denial of healthcare benefits are dismissed with prejudice because they are preempted by ERISA and cannot be reframed as a claim under the statute's civil-enforcement provision. But, the wrongful-discharge claim, for which Plaintiff seeks restoration of his healthcare benefits, can proceed as an ERISA claim. [Crosson v. Seneca One Fin., Inc., No. PWG-16-449, 2016 WL 6462039 \(D. Md. Nov. 1, 2016\)](#) (Judge Paul W. Grimm).

Plaintiffs' claims, which allege that Defendants breached the terms of the National Bituminous Coal Wage Agreements by improperly siphoning assets from Mystic, LLC, leaving the company unable to satisfy its obligation to provide retirement healthcare benefits, "relate" to an employee benefit plan within the meaning of Section 514. But even if they did not, the claims nonetheless conflict with the exclusive remedies available under ERISA, as set forth in Section 502(a)(1)(B). [Int'l Union v. Mystic, LLC, No. 5:16-CV-02030, 2016 WL 4596353 \(S.D.W. Va. Sept. 2, 2016\)](#) (Judge Irene C. Berger).

Granting summary judgment in favor of Defendant and finding that Plaintiff's claims are preempted by ERISA, and that Plaintiff was reasonably denied a claim under a group policy that her employer terminated more than two years prior to the onset of her disability. [Breit v. Am. Heritage Life Ins. Co., No. JKB-15-2483, 2016 WL 3162814 \(D. Md. June 6, 2016\)](#) (Judge James K. Bredar).

In matter where Defendants' removed Plaintiff's state court action alleging disability discrimination and wrongful discharge in violation of the West Virginia Human Rights Act and public policy, granting Plaintiff's motion to remand where Defendants merely cited to Section 502 and stated that Plaintiff's action appears to relate to ERISA because it alleges a loss of income and benefits. [Moreland v. Bali Surgical Practice, PLLC, No. 2:16-CV-03666, 2016 WL 3024162 \(S.D.W. Va. May 25, 2016\)](#) (Judge Joseph R. Goodwin).

Salary Continuation Agreement is an ERISA-governed plan. [Shepherd v. Cmty. First Bank, No. 8:15-CV-4337-MGL, 2016 WL 865334 \(D.S.C. Mar. 7, 2016\)](#) (Judge Mary G. Lewis). The issue in this case is whether a "Salary Continuation Agreement," which was "maintained primarily to provide supplemental retirement benefits" to Plaintiff, including the provision of an annual payment of \$210,000.00 in monthly installments to commence after Plaintiff's 71st birthday and to continue for 20 years, is an ERISA-governed plan. The court concluded that it is. Although, the plan at issue here makes no reference whatsoever to either § 415 or its substantive

provisions, it does include the following language: “This Salary Continuation Agreement...is entered into... to encourage the Executive [the Plaintiff] to remain an employee of the Bank.” And, it provides Plaintiff the “right to bring a civil action under ERISA section 502 (a) following an adverse benefit determination.” The court concluded that the Plan is not “an excess benefit plan” enacted solely to avoid the contribution limits of § 415 but rather a benefit plan for a high value employee—a bank President and CEO—created as a means to entice the individual to remain in his post and subject to ERISA’s enforcement provisions. Based on this, the court denied Plaintiff’s motion to remand and for attorneys’ fees because his state law claims are completely preempted.

F. Fifth Circuit

Granting MetLife’s motion for reconsideration and finding that Plaintiff’s remaining state law claims – breach of contract, detrimental reliance, Louisiana Revised Statutes sections 22:655; 22:1269; 22:1892; and 22:1973 – are conflict preempted under ERISA Section 514. [McNealy v. Becnel, No. CV 14-2181, 2016 WL 6807395 \(E.D. La. Nov. 17, 2016\)](#) (Judge Susie Morgan).

In dispute over payment of medical expenses, the court determined that the plan is an ERISA-governed MEWA plan and Plaintiff’s state law claims are preempted. [Walker v. Regence Blue Cross Blue Shield of Oregon, No. CV G-15-064, 2016 WL 6747285 \(S.D. Tex. Nov. 14, 2016\)](#) (Magistrate Judge John R. Froeschner)

ERISA preempts Plaintiff’s state-law tort claims related to Blue Cross and Blue Shield of Texas’s denial of prescription medication, Remicade, which allegedly resulted in Plaintiff’s spouse’s death from diabetic ketoacidosis. The preemption issue is dispositive and requires dismissal of Plaintiff’s claims with prejudice because Plaintiff did not request leave to amend to attempt to assert a non-preempted claim. [Milton v. Blue Cross Blue Shield Of Texas, Inc., No. CV 16-458, 2016 WL 2926846 \(E.D. La. May 19, 2016\)](#) (Judge Lance M. Africk).

Texas Prompt Pay Act does not apply to self-funded ERISA plans. [Aetna Life Ins. Co. v. Methodist Hosps. of Dallas, No. 15-10210, Fed.Appx. , 2016 WL 683112 \(5th Cir. Feb. 18, 2016\)](#) (Before SMITH, WIENER, and GRAVES, Circuit Judges). Plaintiff–Appellant Aetna Life Insurance Company appealed the district court’s judgment, which held that (1) Texas Insurance Code, Chapter 1301 applies to Aetna Life as the administrator of self-funded employer plans, and (2) the ERISA does not preempt such application. Chapter 1301 applies to “each preferred provider benefit plan in which an insurer provides, through the insurer’s health insurance policy,” payment to preferred providers at discounted rates. Chapter 1301 also applies to entities with which insurers contract to perform particular administrative functions. It imposes a range of penalties for late payments. After Aetna Life filed its federal declaratory judgment

action, the Providers filed two lawsuits against Aetna Health in Texas state court—one in Tarrant County and the other in Dallas County—seeking penalties for late payments. The Tarrant County court denied Aetna Health’s motion for summary judgment, holding, without explanation, that the Texas Prompt Pay Act (TPPA) “applies to Aetna with respect to claims administered by Aetna for self-funded plans. The federal district court exercised jurisdiction over the action and granted the Providers’ motion for summary judgment. In so doing, it deferred to the Texas state trial court’s “non-final interpretation of state law” on the issue of the TPPA’s applicability to administrators of self-funded plans and held that ERISA does not preempt such application. The Fifth Circuit determined that the district court erred when it deferred to the Texas court’s non-final interpretation of law on the question of the TPPA’s applicability. Because the district court did in fact exercise jurisdiction over the action, it should have made an *Erie* guess as to how the Texas Supreme Court would decide whether Chapter 1301 applies to Aetna Life’s activities in this case. The court also held that self-funded ERISA plans are not “insurers” under Chapter 1301 such that the Chapter cannot apply to Aetna Life’s administration of the self-funded ERISA plans. The court reversed, vacated, and remanded for entry of judgment in favor of Aetna Life.

Claim for reimbursement under stop-loss policy is not preempted by ERISA. [Candies Shipbuilders, LLC v. Westport Ins. Corp., No. CV 15-1798, 2016 WL 614694 \(E.D. La. Feb. 16, 2016\)](#) (Judge Joseph C. Wilkinson). The court determined the question of whether ERISA preempts claims for damages, penalties and attorneys’ fees under Louisiana state law brought by an insured, plaintiff, Candies Shipbuilders, LLC, against its insurer, defendant Westport Insurance Corporation. In this case, Candies seeks reimbursement under a stop-loss policy of amounts that Candies paid to cover the medical expenses of a beneficiary under its self-insured employee benefit plan. The court determined that Plaintiff’s claims for damages, penalties and attorneys’ fees under La. Rev. Stat. § 22:1821 are not preempted by ERISA. First, Westport presented no evidence that Candies is suing Westport as a fiduciary under the Plan. Rather, Candies is suing as an insured for damages under the Policy. Second, Plaintiff’s claims arise out of Westport’s independent legal duty contained in the Policy. Lastly, the court determined that Westport did not carry its burden to show that Plaintiff’s state law claims under La. Rev. Stat. § 22:1821 “relate to” an employee benefit plan as required by Section 1144(a) for conflict preemption.

Claims by hospital against ERISA health plan administrators not preempted by ERISA. [Post Acute Specialty Hosp. of Corpus Christi v. Baker Benefits Administrators, Inc., No. 2:15-CV-494, 2016 WL 525481 \(S.D. Tex. Feb. 8, 2016\)](#) (Judge Nelva Gonzales Ramos). The Plaintiff Hospital filed suit in state court against Defendant payment negotiators and administrators for charges incurred over several months in the treatment of a patient who had been injured in a motor vehicle accident. The Hospital alleged that Defendants affirmatively represented that the charges would be paid and even entered into a contract for prompt payment in exchange for a reduction in the amount of the bill. But then, Defendants issued Explanations

of Benefits (EOBs) denying coverage under the patient's ERISA Plan and subsequently refused to pay. Some of the EOBs specifically stated that coverage was denied because the injuries were related to substance abuse and were therefore excluded from insurance coverage. Defendants also relied on a felony exclusion. The court granted the Hospital's motion to remand, finding that the lawsuit was not preempted by ERISA. On the face of the complaint, the Hospital is not suing a Plan Administrator under the patient's assignment of benefits for Plan benefits. Rather, the Hospital sues as an independent victim of Defendants' alleged commercial misrepresentations, without reliance on any status as assignee of the patient's rights. Further, the Hospital does not seek Plan benefits but only seeks to recover against an entity other than the Plan for misrepresenting a payable amount that may or may not be measured by available Plan benefits. The court found that this is a non-derivative action stating state law claims independent of actual Plan coverage and that ERISA does not govern this relationship between healthcare providers and the insurance companies that supply ERISA plan benefits.

G. Sixth Circuit

[*Milby v. MCMC LLC*, No. 16-5483, __F.3d __, 2016 WL 7404753 \(6th Cir. Dec. 22, 2016\)](#) (Before: BATCHELDER, STRANCH, and DONALD, Circuit Judges). Following denial of her ERISA-governed long-term disability benefit claim, Plaintiff filed this lawsuit in state court alleging a state-law claim of negligence per se against MCMC (the third-party vendor that provided a medical review for the disability plan administrator) for practicing medicine in Kentucky without the appropriate licenses. The court affirmed the district court's denial of Plaintiff's motion to remand the case to state court on the basis of complete preemption. The court found that the first prong of *Davila* is satisfied since Plaintiff's claim arises from the denial of ERISA benefits, even though MCMC is not a proper defendant for an ERISA action. Under the second prong, the medical reviewers did not owe Plaintiff an independent duty under Ky. Rev. Stat. Section 311.560, which prohibits the practice of medicine without a license, since medical professionals reviewing documents without making determinations regarding medical necessity are not practicing medicine within the meaning of the Kentucky licensing law.

In dispute over AD&D benefits, the court denied Plaintiff's motion to amend the Complaint because Plaintiff's proposed Kentucky Unfair Claims Settlement Practices Act claims are preempted by the civil enforcement mechanism in 29 U.S.C. § 1132(a) of ERISA. The court rejected Plaintiff's argument that ERISA's "savings clause" captures his KUCSPA claims. [*Everett v. Metro. Life Ins. Co.*, No. 3:16-CV-00074-GNS, 2016 WL 7209678 \(W.D. Ky. Dec. 12, 2016\)](#) (Magistrate Judge Dave Whalin).

The court affirmed the district court's dismissal of Plaintiffs' Michigan's Elliott-Larsen Civil Rights Act age discrimination claim. The court held that ERISA preempts Plaintiffs' age-discrimination claim because it is untimely under the ADEA and preemption of Michigan's statute of limitations neither impairs nor modifies federal law. [*Loffredo v.*](#)

[Daimler AG, No. 15-1443, ___ F.App'x ___, 2016 WL 6595962 \(6th Cir. Nov. 8, 2016\)](#) (BEFORE: MOORE, SUTTON, and STRANCH, Circuit Judges).

The Responsible Bidder Ordinance (“RBO”) is not narrowly tailored to address proprietary concerns of the City, and thus, the City was not acting as a market participant when it enacted the RBO. ERISA preempts Section 320-5 of the RBO, which requires bidders and the bidders’ subcontractors to participate in an apprenticeship program for the primary apprenticeable occupation on the project that has graduated at least one apprentice from the apprenticeship program for each of the past five years. Section 320-5 impermissibly impacts the uniformity of the structure and administrative practice for ERISA plans. [Allied Constr. Indus. v. City of Cincinnati, No. 1:14CV450, 2016 WL 5661674 \(S.D. Ohio Sept. 30, 2016\)](#) (Judge Michael R. Barrett).

Action asserting state-law claims of breach of contract, promissory estoppel, fraudulent misrepresentation, and innocent misrepresentation arising from Defendants’ failure to make the monthly payments allegedly promised to Plaintiff in connection with the parties’ settlement of Plaintiff’s workers’ compensation claim are not completely preempted by ERISA. [Roback v. United Parcel Serv., Inc., No. 15-14331, 2016 WL 4761804 \(E.D. Mich. Sept. 13, 2016\)](#) (Judge Gerald E. Rosen).

Finding that Plaintiff’s claim alleging that his employer and third-party administrator, Matrix Absence Management, Inc., were fraudulently “acting in concert” to keep his hours below 30-per-week and thus, ineligible for long-term disability benefits, is preempted by ERISA. [Watkins v. Matrix Absence Mgmt. Grp., No. 3:16-CV-130-TBR, 2016 WL 4392819 \(W.D. Ky. Aug. 15, 2016\)](#) (Judge Thomas B. Russell).

In action by organization representing sponsors and administrators of self-funded employee benefit plans against Michigan state officials, alleging that ERISA preempted provision of Michigan’s Health Insurance Claims Assessment Act imposing tax on paid claims by carriers or third-party administrators to health care providers for services rendered in Michigan for Michigan residents, holding that there is no ERISA preemption where: (1) the Michigan law did not impose administrative burdens in addition to those prescribed by ERISA or interfere with uniform plan administration; (2) the Michigan law did not alter the relationship between ERISA plan administrators and plan beneficiaries; and (3) the Michigan law did not force carriers or third-party administrators to collect the tax from the ERISA-covered entities. [Self-Ins. Inst. of Am., Inc. v. Snyder, No. 12-2264, 2016 WL 3606849 \(6th Cir. July 1, 2016\)](#) (Before: BOGGS and MOORE, Circuit Judges; BARRETT, District Judge).

In matter where disability claimant brought Kentucky state-court action against two nurses who worked for ERISA plan administrator and provided their opinions regarding

claimant’s eligibility, alleging negligence per se by giving medical advice without being licensed under state’s medical-licensure laws, holding that: (1) negligence per se claims fell within ERISA’s complete preemption provision; (2) nurses were not proper defendants after recasting claim as ERISA claim to recover benefits; (3) allegations merely recited ERISA statutory language barring “interference” with obtaining benefits; and (4) imposing appellate sanctions against claimant’s counsel based on frivolousness was unwarranted. [Hogan v. Jacobson, No. 15-5572, ___ F.3d ___, 2016 WL 2957153 \(6th Cir. May 23, 2016\)](#) (Before MOORE, GIBBONS, and DAVIS, Circuit Judges).

Various state law claims brought by tribal government to recover funds Blue Cross illegally billed and retained in violation of its third-party administrator (TPA) agreements are preempted by ERISA. [Band v. Blue Cross Blue Shield of Michigan, No. 15-13708, ___ F.Supp.3d ___, 2016 WL 1665157 \(E.D. Mich. Apr. 27, 2016\)](#) (Judge David M. Lawson).

Claim for a declaratory judgment to determine hire date for purposes of pension benefits is preempted by ERISA. And, claim dismissed because Plaintiff failed to exhaust his administrative remedies. [Doran v. Joy Glob., Inc., No. 2:15-CV-243, 2016 WL 1633307 \(E.D. Tenn. Apr. 22, 2016\)](#) (Judge J. Ronnie Greer).

State law claims against peer reviewer company related to ERISA benefits claim is preempted. [Milby v. MCMC LLC, No. 3:15-CV-00814-CRS, 2016 WL 552595 \(W.D. Ky. Feb. 10, 2016\)](#) (Judge Charles R. Simpson III). Plaintiff asserted state law claims against MCMC LLC alleging it issued a medical opinion about her without a license to practice medicine in the Commonwealth as required under KRS § 311.560. MCMC rendered the medical opinion in reviewing Plaintiff’s claim for disability benefits provided under an ERISA-governed plan. Plaintiff alleges that the medical opinion led to the denial of her claim. MCMC removed the action to federal court and Plaintiff sought a remand and attorneys’ fees and costs. The court denied Plaintiff’s motion, finding that her lawsuit is preempted by ERISA. Specifically, the court found that in seeking damages related to a medical professional’s medical review for an ERISA plan benefit determination, a plaintiff must seek damages under ERISA. Otherwise, a state enforcement mechanism supplants Congress’ uniform enforcement system. In this case, Plaintiff already has a pending suit against the insurer for wrongful denial of benefits. Because Plaintiff’s suit against MCMC arises only because of her ERISA benefit claim review, Plaintiff does not allege a violation of any legal duty beyond the scope of the ERISA plan and the review of her benefit claim.

H. Seventh Circuit

Granting Defendant’s motion dismiss without prejudice because the Life Policy, as pled, is governed by ERISA and Count II, alleging bad faith under § 155 of the Illinois Insurance Act, is pre-empted by ERISA; noting Circuit courts are split on the issue of the conversion

of insurance from a plan covered by ERISA to an individual plan. [Frankenthal v. Connecticut Gen. Life Ins. Co., No. 15-CV-10307, 2016 WL 4720030 \(N.D. Ill. Sept. 8, 2016\)](#) (Judge John W. Darrah).

Fraud and unjust enrichment claims for recovery of the value of employee benefits are preempted by ERISA. [Cox v. Gannett Company, Inc., et al., No. 1:15-cv-02075-JMS-DKL, 2016 WL 1425525 \(S.D. Ind. Apr. 12, 2016\)](#) (Judge Jane Magnus-Stinson).

USERRA related state law claims preempted by ERISA. [Duffer v. United Cont'l Holdings, Inc., No. 13 C 3756, 2016 WL 1213668 \(N.D. Ill. Mar. 29, 2016\)](#) (Judge John Robert Blakey). In this case, Plaintiff alleges that Defendants violated USERRA and related state laws by underpaying him during military leave periods. The court found that USERRA does not create a joint state and federal enforcement scheme, like Title VII, that is saved under ERISA § 514(d). As such, the court found that ERISA § 502(a) preempts Plaintiff's California Military and Veterans Code § 394 and negligence claims to the extent they regard the ERISA-governed money purchase defined contribution pension plan known as the Continental Pilots Defined Contribution Plan.

I. Eighth Circuit

The court granted Plaintiffs' motion to remand its lawsuit alleging underpayment by ERISA-governed benefit plans for medical services provided to plan beneficiaries. The court explained that where medical providers sue payers and/or network operators for payments at the rates set out in network agreements, courts routinely find that neither prong of the *Davila* test is satisfied, and remand the case. Additionally, the medical providers could not bring their rate-of-payment claims under ERISA's civil enforcement provision, and that there is a duty of payer network participants to honor their network agreements, independent of ERISA. [KDCO, Inc. v. Healthlink, Inc., No. 1:16CV00212 AGF, 2016 WL 6995873 \(E.D. Mo. Nov. 30, 2016\)](#) (Judge Audrey G. Fleissig).

The court found that the JATC's apprenticeship program is an ERISA plan, not an unfunded scholarship program nor a qualified on-the-job training program, but the scholarship loan agreements that might have been to facilitate participation in an ERISA plan do not "relate to" the plan such that they fall within the scope of ERISA preemption. The scholarship loan agreements provide that Plaintiffs would distribute certain benefits to defendant and, if defendant did not meet certain obligations, he would need to repay to Plaintiffs the value of the benefits distributed to him. These agreements do not concern the distribution of benefits, but rather the post-administration liability of defendant should he not meet certain obligations. Thus, Plaintiffs' breach of contract claim is not preempted by ERISA and the action is remanded to the Circuit Court of the City of St. Louis. [Joint Apprenticeship And Training Committee Of Local Union No. 36, affiliated with International](#)

[Association Of Sheet Metal, Air, Rail And Transportation Workers & International Training Institute For The Sheet Metal And Air Conditioning Industry v. Weddle, No. 4:16 CV 1371 DDN, 2016 WL 6441601 \(E.D. Mo. Nov. 1, 2016\)](#) (Magistrate Judge David D. Nocel).

Granting Plaintiff's motion to remand since looking only to the face of the complaint, Plaintiff's only claim is for violations of the MHRA and there are no allegations that Defendants violated any provision of the collective bargaining agreement, there are no references to the agreement in his complaint, there are no claims that Defendants violated ERISA, and there are no claims for recovery of severance pay under Defendant's health insurance plan. [McBrien v. Ruan Transp. Mgmt. Sys., Inc., No. 16-CV-6058-FJG, 2016 WL 6080818 \(W.D. Mo. Oct. 17, 2016\)](#) (Judge Fernando J. Gaitan, Jr.).

Denying motion to remand Plaintiff's complaint that St. Anthony's Medical Center deprived her of benefits under her health insurance plan by refusing to submit its charges for the allegedly covered services to her plan and instead seeking payment from a third-party liability insurer. Since Plaintiff can only prevail on her claims if she was entitled to benefits under her health insurance plan in the first instance, and the court will have to make that determination based on the terms of Plaintiff's plan, the claims fall within the scope of § 502(a) and are completely preempted. [Hern v. St. Anthony's Medical Center, No. 4:16-CV-1296 JAR, 2016 WL 6031911 \(E.D. Mo. Oct. 14, 2016\)](#) (Judge John A. Ross).

On Plaintiff's claim for severance benefits and a retention bonus, finding that Plaintiff's claim seeks benefits under an independent contract (not a plan governed by ERISA), and granting Plaintiff's motion to remand. [Arvind Thapar v. Moody's Analytics Solutions, Llc, And Moody's Analytics, Inc., No. 8:15CV324, 2016 WL 1755817 \(D. Neb. May 3, 2016\)](#) (Judge Joseph F. Bataillon).

State law claims related to failure to change beneficiary designation are preempted by ERISA. [Estate of Dean Disabato v. National Automatic Sprinkler Industry Welfare Fund, et al., No. 4:15-CV-828 JAR, 2016 WL 1182637 \(E.D. Mo. Mar. 28, 2016\)](#) (Judge John A. Ross). In this case, the decedent attempted to change his beneficiary designation under the Defendant Plans after his divorce. The employer only made the change to the medical/health insurance portion of the Welfare Fund, and not the designation on the Pension Plan, Supplemental Pension Plan, and life insurance portion of the Welfare Fund. As such, benefits were paid to the decedent's former spouse. The Plaintiff Estate filed suit in the Circuit Court of St. Louis County against the Defendant Plans, asserting state common law claims for negligence, tortious interference with expectancy, fraud in the inducement, and negligent misrepresentation related to the employer's failure to change the decedent's beneficiary designation on all Plan documents. Defendants moved to dismiss on the basis of ERISA preemption. The court found that it is clear that Plaintiff is essentially challenging the distribution of benefits under the Plans and seeking to recover benefits it believes are due the Estate. Since the essence of Plaintiff's claims, however characterized, is a denial of benefits, the court found that they "relate to" the Plans and are

preempted by ERISA. The court found that it is unclear how Plaintiff's complaint would be amended to state a claim for relief under ERISA, so it dismissed the action without prejudice.

J. Ninth Circuit

Because KFHP's interpretation of its plans and administration and payment of members' claims bears directly on the letters KFHP sent its members (containing allegedly defamatory statements about HLF), the court held that to the extent HLF's Counterclaim is based on those communications, it is preempted. The court also found that HLF has failed to sufficiently plead the elements of an unfair competition claim arising from KFHP's communications with hospitals. [Sidlo v. Kaiser Permanente Ins. Co., No. CV 16-00073 ACK-KSC, 2016 WL 6818942 \(D. Haw. Nov. 17, 2016\)](#) (Judge Alan C. Kay, Sr.).

In lawsuit where Plaintiff alleges state law claims arising out of his provision of surgical assistant services to 28 patients insured by employer self-funded health insurance plans administered by defendants, the court found that Plaintiff's state law claims are preempted under ERISA. The court recommended that defendant's motion for summary judgment be granted. [Hackert v. Cigna Health & Life Ins. Co., No. 215CV1248KJMCKDPS, 2016 WL 6611594 \(E.D. Cal. Nov. 9, 2016\)](#) (Magistrate Judge Carolyn K. Delaney).

In disability benefit lawsuit brought by a law firm partner, denying Plaintiff's motion to remand and finding that contemporaneous documents that relate to Plaintiff's IDI policy show that this policy was issued pursuant to her employer's Supplemental Disability Plan. Unum met its burden of showing that Plaintiff's IDI policy was part of a plan covered by ERISA and that her state law claims are preempted. [Bender v. Unum Grp., No. 16-CV-03990-PJH, 2016 WL 5420156 \(N.D. Cal. Sept. 28, 2016\)](#) (Judge Phyllis J. Hamilton).

Plaintiff's IIED claim, based on the termination of Plaintiff's long-term disability benefits, is preempted by ERISA. [Johnson, III v. Lucent Technologies Inc., No. 14-56542, ___ F.App'x ___, 2016 WL 5390352 \(9th Cir. Sept. 27, 2016\)](#) (Before: TASHIMA, WARDLAW, and BYBEE, Circuit Judges).

In suit by out-of-network provider against Cigna for failing to pay for the medical care provided to Defendant's insureds after the provider sought verbal pre-confirmation, finding that the lawsuit is not preempted by ERISA, since under *Marin General Hospital v. Modesto & Empire Traction Company*, 581 F.3d 941 (9th Cir. 2009), a claim is not preempted when a healthcare provider asserts a right to relief under an oral contract and disclaims reliance on the terms of any ERISA-governed plans. [N. Va. Operating Co., LLC v. CIGNA Healthcare of Ca., Inc., No. CV 16-5168 PA \(AFMX\), 2016 WL 4770021 \(C.D. Cal. Sept. 12, 2016\)](#) (Judge Percy Anderson).

Ordering that Plaintiff may be able to proceed on his UCL claim to the extent it is based on his ERISA claims, which Groceryworks did not challenge in its present motion. [Cleveland v. Groceryworks.com, LLC, No. 14-CV-00231-JCS, 2016 WL 4140504 \(N.D. Cal. Aug. 4, 2016\)](#) (Magistrate Judge Joseph Spero).

State-court action to determine the validity of Hawaii Management Alliance Association's lien against a \$1.5 million third-party tort settlement for \$400,779.70 of medical expenses paid pursuant to an ERISA-governed medical benefit plan is completely preempted by ERISA because: (1) Plaintiff could have brought his claim under ERISA Section 502(a)(1)(B) and, (2) Plaintiff's petition is dependent on ERISA because he would have no claim in the absence of an ERISA plan. [Rudel v. Hawaii Mgmt. All. Ass'n, No. CV 15-00539 JMS-RLP, 2016 WL 4083320 \(D. Haw. Aug. 1, 2016\)](#) (Judge J. Michael Seabright).

In putative class action against Defendants related to Anthem data breach, denying Defendants' motion to dismiss some claims brought by certain Plaintiffs on the basis of ERISA preemption, and finding that "(1) Defendants are precluded from asserting an ERISA preemption defense as to Plaintiffs' UCL claims, (2) the presumption against preemption applies, (3) Defendants' privacy obligations are not 'benefits' for purposes of ERISA express or complete preemption, and (4) even if Defendants' privacy obligations were considered 'benefits,' there is a genuine dispute concerning whether Plaintiffs' ERISA employee benefit plan incorporated these obligations." [In re Anthem, Inc. Data Breach Litig., No. 15-MD-02617-LHK, 2016 WL 3029783 \(N.D. Cal. May 27, 2016\)](#) (Judge Lucy H. Koh).

GHC has demonstrated that complete preemption of Plaintiffs' state-law Washington's Consumer Protection Act claims, as they apply to GHC's administration of ERISA plans, is warranted because both prongs of the *Davila* test are met. [Hansen v. Grp. Health Coop., No. C15-1436RAJ, 2016 WL 2930442 \(W.D. Wash. May 19, 2016\)](#) (Judge Richard A. Jones).

Rejecting argument that Plaintiff's claims – (4) violation of CFRA for retaliation in the form of termination of paid health insurance benefits on behalf of Reynolds against Entity Defendants, and (7) intentional infliction of emotional distress on behalf of Reynolds against Defendants – are preempted by ERISA; granting motion to remand. [Reynolds v. Diamond Pet Food Processors of California, LLC, No. 2:15-CV-02118-JAM-AC, 2016 WL 1711671 \(E.D. Cal. Apr. 29, 2016\)](#) (Judge John A. Mendez).

Claim seeking determination that ERISA plan is not entitled to reimbursement out of health plan participant's settlement reached with third-party tortfeasor under Haw. Rev. Stat. § 663-10 is completely preempted under the test in *Davila*. [Noetzel v. Hawaii Medical Service Association, No. CV 15-00310 SOM/KJM, 2016 WL 1698264 \(D. Haw. Apr. 27, 2016\)](#) (Judge Susan Oki Mollway).

In suit by medical provider against insurer of ERISA health plan, the court denied insurer's motion to dismiss breach of written contract, breach of oral contract, and breach of implied-in-fact contract claims, but granted motion as to *quantum meruit* claim because provider did not allege that any defendant ever requested the services rendered. [Health v. Usable Mut. Ins. Co., No. C 15-05730 WHA, 2016 WL 1598729 \(N.D. Cal. Apr. 21, 2016\)](#) (Judge William Alsup).

IIED claim related to MetLife's conduct during the processing of disability claim is not preempted by ERISA. [Kresich v. Metro. Life Ins. Co., No. 15-CV-05801-MEJ, 2016 WL 1298970 \(N.D. Cal. Apr. 4, 2016\)](#) (Magistrate Judge Maria-Elena James). Plaintiff asserted a claim for intentional infliction of emotional distress ("IIED") arising from Defendant Metropolitan Life Insurance Company's conduct during the processing of his claim for long-term disability benefits. Specifically, Plaintiff alleged that MetLife ignored his correspondence, demanded time extensions, intimidated him into attending multiple IMEs and often delaying them, accused him of lying about and exaggerating his disability, and purposely misstated and misrepresented statements made by Plaintiff and his treating physicians. He further alleged that MetLife knew of his physical disabilities and weak emotional state, yet it prolonged review of his claim to force him to drop his disability claim, return to work in pain, and/or accept a smaller settlement than he is rightly entitled under the Plan. Defendant moved for judgment on the pleadings pursuant to Federal Rule of Civil Procedure 12(b)(6), arguing that Plaintiff's Complaint is preempted under section 514(a) of ERISA. The court denied MetLife's motion, finding that Plaintiff's claim is not preempted by ERISA. First, the fact that the alleged conduct occurred in the course of administering an ERISA plan does not automatically result in preemption. No allegation in Plaintiff's Complaint references whether or not his benefits were granted or denied and the lawsuit is not based on the processing of his claim. The court found that Plaintiff's allegations of harassing and oppressive conduct are independent of the duties of administering an ERISA plan. "If such claims were held to be preempted by ERISA, Plaintiff would be subject to such treatment with no available recourse, and a plan administrator could investigate a claim in all manner of tortious ways with impunity." The court further found that Plaintiff's IIED claim appears to be only tangentially related to the administration of the Plan.

Claim brought pursuant to Hawaii law concerning validity of health insurance plan lien is not preempted by ERISA. [Rudel vs. Hawaii Management Alliance Association, No. 15-00539 JMS-BMK, 2016 WL 1271465 \(D. Haw. Mar. 31, 2016\)](#) (Judge Barry M. Kurren). Defendant HMAA is the health insurance company that paid over \$600,000 in medical expenses following Plaintiff's catastrophic motor vehicle accident. Allstate Insurance offered to pay Plaintiff the policy limits of the driver's insurance coverage in the amount of \$1,500,000, which Plaintiff accepted. HMAA then placed a lien on Plaintiff's settlement in the amount of \$400,779.70 that it claimed it was entitled to be reimbursed. Plaintiff filed a Petition for Determination of Validity of Claim of Lien of Defendant HMAA in state court. The Petition was brought pursuant

to Haw. Rev. Stat. § 431:13-103(a)(10) and § 663-10 and seeks a determination of the validity of HMAA's claim of lien against the settlement. Defendant removed to federal court and Plaintiff moved to remand. The court found that Plaintiff does not seek to recover benefits from HMAA under the terms of his plan, nor is he attempting to enforce or clarify his rights under the terms of the plan. He also does not allege that HMAA violated ERISA, is not seeking to enjoin actions that violate ERISA, and does not seek equitable relief relating to violations of ERISA. Rather, the court found that he seeks protection from Hawaii state insurance law that limits the amount of a valid lien to the amount of the corresponding special damages recovered by the settlement. *See* Haw. Rev. Stat. § 663-10(a). Since Plaintiff's claim could not have been brought under ERISA § 502(a)(1) or (3), the court found that it was not preempted and granted Plaintiff's motion.

Claim by healthcare provider against insurer is not completely preempted by ERISA.

[Healthcare Ally Mgmt. of California, LLC v. US Airways, Inc., No. CV 16-1411 PA \(JCX\), 2016 WL 1069944 \(C.D. Cal. Mar. 17, 2016\)](#) (Judge Percy Anderson). Defendant US Airways Inc. filed a notice of removal based on its assertion that Plaintiff's claims are subject to ERISA preemption. Defendant argued that any right to payment that La Peer, or Plaintiff as its assignee, may have for the services provided to the ERISA plan participant are dependent on the terms of that plan and any right to payment is derivative of the patient's right as an ERISA plan participant to benefits under the plan. Further, it argued that any alleged promise of payment could only have been based on the plan's terms. The court disagreed and relied on the Ninth Circuit decision in *Marin General Hospital v. Modesto & Empire Traction Company*, 581 F.3d 941 (9th Cir. 2009), which held that a provider's claims are not completely preempted by ERISA where the provider is seeking payment based upon a separate agreement between it and the insurer. The court found that because Plaintiff has alleged only claims based on implied rights and an oral contract, but has not alleged rights specifically growing out of assignments of ERISA beneficiaries, the court cannot conclude that there is no other independent legal duty upon which Plaintiff's claims are based. The court concluded that the notice of removal is inadequately pled, the court lacks subject matter jurisdiction, and the matter is remanded to Los Angeles County Superior Court.

Claim for unpaid wages is not preempted by ERISA. [Bergen v. Tualatin Hills Swim Club, Inc., No. 3:16-CV-00052-HZ, 2016 WL 1064488 \(D. Or. Mar. 16, 2016\)](#) (Judge Hernandez).

Plaintiff alleged that Defendant violated Oregon law when it failed to pay him "all wages due and owing" by the end of the first business day after his discharge. Plaintiff's representative "sent a written demand for payment of outstanding wages in accordance with ORS 652.150," and included as "wages" unpaid retirement benefits for 2013 and 2014. Although Plaintiff's attorney referred to ERISA-governed benefits to which Plaintiff was entitled in the written demand letter in order to articulate and quantify damages, the court found that this is an insufficient basis upon which to find complete preemption. Nowhere in the Complaint did Plaintiff state a claim for retirement benefits. The court concluded that nothing in the record suggests that Plaintiff could

have proceeded under ERISA or that an ERISA-governed plan may grant what Plaintiff is asking for—past wages due and penalty wages, pursuant to Oregon state law obligations.

Unlawful deduction claim and related UCL claim not preempted by ERISA. [Mendoza v. Aramark Servs., Inc., No. 15-CV-05142-JSC, 2016 WL 614713 \(N.D. Cal. Feb. 16, 2016\)](#) (Judge Jacqueline Scott Corley). Plaintiff, individually and on behalf of all others similarly situated, sued his former employer, Defendant Aramark Services, Inc., in the Superior Court for the County of Alameda for various violations of California law. Aramark subsequently removed the action to this court alleging federal subject matter jurisdiction pursuant to ERISA complete preemption of Plaintiff's first cause of action for illegally withholding, deducting, and diverting wages and Plaintiff's sixth cause of action for violation of California's Unfair Competition Law ("UCL") in relation to the unlawful deduction claim. Defendant argued that Plaintiff could have brought his claims for unlawful deductions under Section 502(a): (1) under Section 702 through the enforcement mechanism provided in Section 502(a)(3); (2) under Section 404 through the enforcement mechanism provided in Section 502(a)(3); or (3) under Section 502(a)(1)(B). The court determined that Plaintiff could not have brought his claims under ERISA Section 502(a)(3) or Section 502(a)(1)(B). The court granted Plaintiff's motion to remand.

Promissory estoppel claim for pension benefits is preempted by ERISA. [Yaralian v. Fastovsky, No. CV 15-8989-GHK \(EX\), 2016 WL 552675 \(C.D. Cal. Feb. 10, 2016\)](#) (Judge George H. King). Plaintiff brought a number of state law causes of action against his former employer's named partner related to the failure to pay Plaintiff his full accrued benefit from the firm's defined benefit pension plan. Defendant removed the action arguing that Plaintiff's promissory estoppel claim is completely preempted by ERISA. Plaintiff filed a motion to remand as well as a first amended complaint which included expanded allegations with respect to the promissory estoppel claim. The court denied Plaintiff's motion, finding that both prongs of the *Davila* test are satisfied. First, Plaintiff could have brought his claim under ERISA § 502(a)(1)(B) because, in essence, his claim is nothing but a request for accrued benefits under an ERISA plan. Second, Plaintiff's claim is not independent of ERISA because the claim merely duplicates the claim he could have brought under ERISA and derives from defined benefit plan benefits allegedly withheld from him. The fact that the Plan no longer exists does not appear to prevent a suit under ERISA. The court dismissed the promissory estoppel claim as completely preempted, but granted Plaintiff leave to replead this claim to assert an appropriate claim under ERISA.

In matter involving cyberattackers and personal health information, court denies reconsideration of decision denying motion to remand. [In re Anthem, Inc. Data Breach Litig., No. 15-CV-04739-LHK, 2016 WL 324386 \(N.D. Cal. Jan. 27, 2016\)](#) (Judge Lucy H. Koh). In this putative class action against Defendants related to cyberattackers unauthorized access to Anthem's data systems and Plaintiffs' personal health information, the court had previously denied Plaintiffs' motion to remand, finding that Plaintiffs' claims were subject to ERISA complete preemption. Plaintiff's moved for leave to file a motion for reconsideration,

which the court denied. Plaintiffs contend that the court's decision denying remand was grounded on the mistaken predicate that Plaintiffs have not challenged the documentation submitted by Defendants showing that Plaintiffs received health benefits during the relevant time period as dependent beneficiaries of employer sponsored ERISA plans. And, based on this mistaken finding, the court erroneously concluded that Plaintiffs could have brought their claims under ERISA § 502(a), 29 U.S.C. § 1132(a). The court rejected Plaintiffs' arguments. First, Plaintiffs conceded that they received benefits under an ERISA plan and that they had standing to bring their claims under ERISA § 502(a). Second, Plaintiffs' challenges to some of the documents submitted by Defendants do not clear the bar necessary for leave to file a motion for reconsideration since Plaintiffs do not challenge the fact that Plaintiffs were enrolled in an ERISA plan. The court found that Defendants sufficiently demonstrated that Plaintiffs were covered under an ERISA plan during the relevant time period and Plaintiffs have not shown a manifest failure by the court to consider material facts or dispositive legal arguments.

Proposed amended complaint alleging misrepresentation about participation in employee benefit plans is not preempted by ERISA. [Roberts v. Daymon Worldwide Inc., No. 15-CV-00774-WHO, 2016 WL 301997 \(N.D. Cal. Jan. 25, 2016\)](#) (Judge William H. Orrick). Plaintiff moved to amend his complaint, which arises from his termination by Defendants, to add two causes of action for intentional and negligent misrepresentation related to statements Defendants made to him about his participation in the 401(k) plan and Employee Stock Ownership Plan (ESOP). Defendants opposed the motion, in part arguing that the amendment would be futile because Plaintiff's proposed new claims are preempted by ERISA Section 514(a). The court disagreed and permitted Plaintiff to amend his complaint. In finding that Plaintiff's claims are not preempted by ERISA, the court reasoned that ERISA does not purport to regulate the broad spectrum of unlawful employment practices that may be committed by employers. Further, Plaintiff's claims do not concern the need for unifying plan administration or standardizing the regulations applicable to all plan beneficiaries; nor do they arise out of Defendants' administration of the 401(k) Plan or the ESOP. Instead, Plaintiff alleges that Defendants made false statements about the compensation Plaintiff could expect as a result of the sale of Omni Pacific. As such, the allegations are based on a common law duty to refrain from providing false statements, a duty that arises independently from any obligation ERISA may impose on Defendants. They also do not duplicate, supplement, or supplant the ERISA civil enforcement remedy.

NIED and IIED claims are remanded to state court for federal court's lack of subject matter jurisdiction. [Ernsting v. Pacific Bell Telephone Company, et al., No. SACV1501682CJCKESX, 2016 WL 184417 \(C.D. Cal. Jan. 15, 2016\)](#) (Judge Cormac J. Carney). Plaintiff brought NIED and IIED claims against Defendants for conduct which appears to be related to the administration of her disability claim. Plaintiff alleged that Defendants have "harass[ed]" and "threaten[ed]" her by, among other things, "keeping her under surveillance." The court reiterated its previous decision that that Plaintiff's NIED and IIED claims are not

necessarily preempted. For purposes of this motion, the court found no reason for it to sort out which Defendants, exactly, those non-preempted claims are being asserted against, because that determination has no bearing on subject matter jurisdiction. Plaintiff represented to the court that she is seeking traditional tort recovery, not ERISA benefits under the guise of a state law cause of action. The court declined to “manage the pleadings,” and remanded the case to state court under 28 U.S.C. § 1447(c) for lack of subject matter jurisdiction.

K. Tenth Circuit

Plaintiff’s state court action seeking a declaratory judgment that she is not obligated to pay EagleMed the full amount of the helicopter transportation bill, and also requesting a declaratory judgment as to the “reasonable value of the services rendered” by EagleMed, is preempted by ERISA; Plaintiff could have brought this case as a claim against her insurer and the court will necessarily need to consider the terms of the health plan to determine the amount of Plaintiff’s outstanding obligation to EagleMed. [Garrett v. Eaglemed, LLC, No. 16-CV-0377-CVE-FHM, 2016 WL 4718017 \(N.D. Okla. Sept. 8, 2016\)](#) (Judge Claire V. Eagan).

L. Eleventh Circuit

The court denied Plaintiff’s motion to remand his lawsuit for life insurance benefits, where the Complaint exhibits are policy documents reflecting on their face that the subject policy is a group insurance contract between Prudential and “NEA Members Insurance Trust,” and the SPD references compliance with ERISA. The court found that there are numerous indications in the documents that the plan was conceived and established as an ERISA plan. As such, the claims are completely preempted by ERISA. [McIntosh v. Prudential Ins. Co., No. CV 16-0523-WS-C, 2016 WL 6832639 \(S.D. Ala. Nov. 18, 2016\)](#) (Judge William H. Steele).

Death benefit policy is an ERISA-covered plan and Plaintiffs’ breach of contract claim is preempted by ERISA and therefore subject to dismissal. [Boone v. Life Ins. Co. of N. Am., No. 2:16-CV-646-FTM-99CM, 2016 WL 5943596 \(M.D. Fla. Oct. 13, 2016\)](#) (Judge Sheri Polster Chappell).

XVI. *Provider Claims*

A. Second Circuit

In lawsuit by medical provider against benefit fund, the court granted Defendant’s motion to dismiss. It found that only Patient AM, not plaintiffs POA and Dr. Cohen, can maintain

a cause of action under ERISA Sections 502(a)(1)(B) and 502(c)(1)(B). Patient AM did not assign his/her rights as a beneficiary under the Plan to the other plaintiffs. But, Patient AM has failed to state a claim on both causes of action and failed to exhaust his/her administrative remedies. [Prof'l Orthopaedic Associates, PA v. 1199 Nat'l Benefit Fund, No. 16-CV-4838 \(KBF\), 2016 WL 6900686 \(S.D.N.Y. Nov. 22, 2016\)](#) (Judge Katherine B. Forrest).

Granting Plaintiff's motion for reconsideration and reinstating claims against Suffolk based on the determination that ERISA regulation C.F.R. 2560.503-1 applies to government-sponsored health plans governed by the Patient Protection and Affordable Care Act. [Semente v. Empire Healthchoice Assurance, Inc., No. 14CV5823DRHSIL, 2016 WL 4621076 \(E.D.N.Y. Sept. 6, 2016\)](#) (Judge Hurley).

Concluding allegations are sufficient at this early pleading stage to establish an effective assignment that permits Plaintiffs to proceed on ERISA causes of action for payment of medical services, although to ultimately prevail Plaintiffs will have to set forth actual proof that patients in fact signed such assignments in exchange for provided health services; rejecting United's argument that no private right of action exists under ERISA Section 502(a)(3) for violations of ERISA Section 503, but penalties under ERISA Section 502(c) are not available for violations of the claims-procedure regulation. [Mbody Minimally Invasive Surgery, P.C. v. United Healthcare Ins. Co., No. 14 CIV. 2495 \(ER\), 2016 WL 4382709 \(S.D.N.Y. Aug. 16, 2016\)](#) (Judge Ramos).

Plaintiffs do not have ERISA standing to pursue claims governed by Plans with anti-assignment provisions, where the anti-assignment provisions in the governing Plans unambiguously prohibit assignment. Plaintiffs do not allege any extraordinary circumstances that warrant the application of estoppel and the parties have already litigated whether direct payments to the plaintiffs waived the anti-assignment provisions (and the court held that the argument had no merit). The anti-assignment provisions also preclude Plaintiffs' pursuit of the ERISA claims as their patients' "authorized representatives" under 29 C.F.R. § 2560.503-1(b)(4). [Mbody Minimally Invasive Surgery, P.C. v. Empire Healthchoice Hmo, Inc., No. 13CV6551 \(DLC\), 2016 WL 2939164 \(S.D.N.Y. May 19, 2016\)](#) (Judge Denise Cote).

Plaintiff chiropractors' ERISA claims against claims administrator dismissed for lack of standing due to valid anti-assignment provisions. [Merrick v. UnitedHealth Grp. Inc., No. 14 CIV. 8071 \(ER\), 2016 WL 1229616 \(S.D.N.Y. Mar. 25, 2016\)](#) (Judge Ramos). In this putative class action brought by four chiropractors for purported violations of the ERISA claims regulation, United moved to dismiss three of the four Plaintiffs on the basis that they lack standing. Here, the relevant ERISA-governed healthcare plans contain anti-assignment provisions. The court found that the three Plaintiffs do not have statutory standing to bring an ERISA Section 502(a) claim simply because they have a right to payment under the plan. The

court noted that the Second Circuit has not yet spoken on the effect of assignments made in violation of anti-assignment provisions in ERISA plans but other Circuit Courts have concluded that where an ERISA-governed plan contains an unambiguous anti-assignment provision, assignments under that plan are invalid. Further district courts in the Second Circuit have followed this reasoning and, applying federal common law, have found that where plan language unambiguously prohibits assignment, an attempted assignment will be ineffectual and a healthcare provider who has attempted to obtain an assignment in contravention of a plan's terms is not entitled to recover under ERISA. Lastly, United did not waive the anti-assignment provision by providing direct payment to Plaintiffs. Nor did it waive the provision by failing to reference it in its communications with Plaintiffs. United requested documentation to support its previous payments and ultimately recouped payments from Plaintiffs for their failure to comply, but the court found that nothing about these requests suggest that Plaintiffs were being treated as assignees of their patients' benefits rather than as providers United has the discretion to pay directly. The court granted United's motion to dismiss with prejudice since United did not waive, nor is estopped from relying on the anti-assignment provision, which is valid and enforceable.

Panel denies rehearing in matter where it determined that divorce settlement agreement does not constitute a QDRO. [Yale-New Haven Hosp. v. Nicholls, No. 13-4725, F.3d](#), [2016 WL 279354 \(2d Cir. Jan. 22, 2016\)](#) (Before: KEARSE, STRAUB, and WESLEY, Circuit Judges). In *Yale-New Haven Hosp. v. Nicholls*, 788 F.3d 79 (2d Cir. 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. Nicholls petitioned for a panel rehearing which the panel denied over a dissent by Circuit Judge Wesley. Judge Wesley explained that shortly before its decision, the Supreme Court of Virginia decided substantially the issue presented in this case. In opposing a writ of certiorari in the U.S. Supreme Court, the appellee opposed principally on the ground that the posthumous qualified domestic relations order there assigned to an alternate payee payable *lump-sum* benefits, as opposed to *annuity* benefits, and thus no conflict existed between the decision of Supreme Court of Virginia and those of other state supreme courts or federal courts of appeals. Judge Wesley did not comment on the merits of the distinction but noted that *Nicholls* squarely presents this important ERISA question in the context of annuity benefits.

B. Third Circuit

Finding that Plaintiff has adequately pled that he has standing to pursue this action as an assignee of the Participant's rights and benefits under her ERISA plan even assuming that Plaintiff obtained the assignment of benefits from the Participant after the administrative appeals process concluded; *Varity* does not create a bright-line rule precluding the assertion of alternative claims under Sections 502(a)(1)(B) and 502(a)(3) at the motion to dismiss stage; dismissing claim alleging a failure to establish and maintain reasonable claims procedures under 29 C.F.R. § 2560.503-1, because this regulation does not create a private right of action. [Rahul Shah, M.D. v. Horizon Blue Cross Blue Shield, No. 15-8590 \(RMB/KMW\), 2016 WL 4499551 \(D.N.J. Aug. 25, 2016\)](#) (Judge Renee Marie Bumb).

Following the Eighth Circuit in holding that, in the absence of any other formal plan document, the SPD is the formal plan document, and granting in part Defendants' motion for partial summary judgment as to 24 plans in dispute where the governing SPD excludes coverage of facility fees for single-room, unlicensed outpatient surgical facilities. [Montvale Surgical Ctr., LLC v. Connecticut Gen. Life Ins. Co., No. CV 12-5257 \(SRC\), 2016 WL 4204548 \(D.N.J. Aug. 8, 2016\)](#) (Judge Stanley R. Chesler).

Dismissing complaint for failing to set forth facts showing that anti-assignment provisions in self-funded health plan are unenforceable and finding that Plaintiff lacks derivative standing to collect payment as its patient's assignee; rejecting Plaintiff's argument that the anti-assignment provisions are unenforceable because: (1) the anti-assignment provisions violate New Jersey law and "federal public policy"; (2) Defendants waived the anti-assignment provisions; and (3) Defendants are estopped from enforcing the anti-assignment provisions. [Kaul v. Horizon Blue Cross Blue Shield, No. CV 15-8268, 2016 WL 4071953 \(D.N.J. July 29, 2016\)](#) (Judge Claire C. Cecchi).

Provider has standing to sue for benefits regardless of whether patient remains financially responsible under terms of assignment. [Zapiach v. Horizon Blue Cross Blue Shield of New Jersey, No. 15-CV-5333 \(KM\), 2016 WL 796891 \(D.N.J. Feb. 29, 2016\)](#) (Judge Kevin Mcnulty).

Plaintiff is a physician who brought suit as an assignee of his patient to recover reimbursement from Horizon Blue Cross Blue Shield of New Jersey on an out of network claim. Horizon moved to dismiss, which the court granted in part. On the state law contract claim, Plaintiff conceded that it is preempted by ERISA and consented to dismissal. However, on the ERISA claim, the court found that Plaintiff has standing to sue as an assignee of his patient. In light of recent decisions in *N.J. Brain & Spine Ctr. v. Aetna, Inc.*, 801 F.3d 369, 372 (3d Cir. 2015) and *American Chiropractic Ass'n v. American Specialty Health Inc.*, 625 F. App'x 169, 175 (3d Cir. 2015), the court concluded that the doctor/assignee's standing to sue did not depend on whether the patient remained financially responsible under the terms of the assignment. The court found

that the following assignment language confers standing on Plaintiff to pursue a claim for benefits: “I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me, including but not limited to all of my rights under ‘ERISA’” applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeal conducted pursuant to ‘ERISA’.”

Assignment of benefits sufficient to confer standing notwithstanding patients’ ultimate responsibility to pay. [Garden State Pain and Radiology, P.C. v. Horizon Healthcare Services, Inc., et al., No. 15-2878 \(KSH\)\(CLW\), 2016 WL 347315 \(D.N.J. Jan. 28, 2016\)](#) (Judge Katharine S. Hayden). Garden State has its patients sign the following Assignment of Benefits (AOB):

For the professional or healthcare expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

The court found the above AOB sufficient to confer derivative standing under § 502(a). The court found that patients’ ultimate responsibility to pay the balance of the charges to the medical providers does not undercut the validity of the assignment. The court denied Horizon’s motion to dismiss as to Garden State but granted it with prejudice as to Mann Anesthesia because it did not provide the court with a copy of the AOB it required patients to sign.

C. Fourth Circuit

In suit by dermatologist against health plan for underpayment of surgeries, dismissing case under the doctrine of res judicata since the Northern District of Georgia has already dismissed the same exact case. [W.A. GRIFFIN, M.D. v. SEVATEC, INC., No. 1:16-CV-630, 2016 WL 4527357 \(E.D. Va. Aug. 29, 2016\)](#) (Judge Liam O’Grady).

Finding action to be clearly barred by *res judicata*; where Plaintiff Griffin has a demonstrated history of filing numerous duplicative claims in other courts and against

similarly-situated defendants, granting Areva’s motion to dismiss and denying its request for a pre-filing injunction; ordering Plaintiff to show cause why she should not be sanctioned—either in the form of attorneys’ fees or otherwise—for bad faith and baseless litigation. [Griffin v. Areva, Inc., No. 6:16-CV-00029, 2016 WL 4250494 \(W.D. Va. Aug. 10, 2016\)](#) (Judge Norman K. Moon).

In consolidated actions brought by Bethesda Surgery against United for denying coverage or underpaying for services for insureds with out-of-network benefits, granting motion to remand and finding that motion was timely since it was filed within 30 days of Plaintiff’s provision of information necessary to identify the policies that applied to each patient. The court rejected Plaintiff’s contention that pre-litigation communications put Defendant on notice of the basis of removal. The statutory language of 29 U.S.C. § 1446(b)(3) makes plain that the meaning of the term “other paper” in that provision refers to documents exchanged after the case has been initiated. [Bethesda Chevy Chase Surgery Ctr., LLC v. Unitedhealthcare Ins. Co., No. GJH-15-3496, 2016 WL 3042957 \(D. Md. May 27, 2016\)](#) (Judge George J. Hazel).

D. Fifth Circuit

The *Connecticut General Life Insurance Co., et al. v. Humble Surgical Hosp., LLC*, C.A. No. 4:13-cv-3291, 2016 WL 3077405 (S.D. Tex. Jun. 1, 2016) decision has preclusive effect on the issue of legal correctness: Cigna’s interpretation of the plan stating that “payment for the following is specifically excluded:...charges for which you [patients] are not obligated to pay or for which you are not billed” to mean that patients had no insurance coverage for medical procedures for which the patient was not billed, was legally incorrect. Cigna abused its discretion where there is strong evidence in the record that Cigna acted in bad faith, including by deliberately targeting North Cypress with its Fee-Forgiving Protocol in order to pressure it to negotiate an in-network contract. Cigna is thus entitled to summary judgment on North Cypress’s § 502(a)(3) claim because North Cypress may not seek identical relief via an allegation of breach of fiduciary duty under § 502(a)(3). Cigna waived the affirmative defense of recoupment by failing to plead it. [N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare, No. 4:09-CV-2556, 2016 WL 5408994 \(S.D. Tex. Sept. 28, 2016\)](#) (Judge Keith P. Ellison).

In suit brought by surgeons who perform post-mastectomy breast reconstruction medical services and a hospital where the physicians are affiliated, finding that certain of the surgeons’ ERISA benefits claims are barred by anti-assignment clauses but Defendants fail to establish as a matter of law that certain of the hospital’s ERISA benefits claims are barred by anti-assignment clauses; dismissing with prejudice claims for which appeals were untimely or no appeal was filed and the applicable time limit has passed. [Ctr. for](#)

[Restorative Breast Surgery, L.L.C. v. Blue Cross Blue Shield of Louisiana, No. CV 11-806, 2016 WL 4208479 \(E.D. La. Aug. 10, 2016\)](#) (Judge Susie Morgan).

In matter where Plaintiffs allege that Defendants paid the charges for its patients' medical care at significantly reduced rates, well below the amount billed and also below the reasonable and customary rate, finding that: (1) the allegations adequately state a promissory estoppel claim under Texas law and a promissory estoppel claim can be asserted in a lawsuit by a healthcare provider for payments from an ERISA plan; (2) dismissal of the ERISA Section 502(a)(1)(B) claim is not warranted where the plan documents are not before the court and it cannot be determined whether the plan requires payment at the reasonable and customary rate or, instead, provides for reimbursement at a different rate; (3) dismissal of ERISA Section 503 claim for failure to provide a full and fair review is warranted where neither defendant is an ERISA plan. [Allied Ctr. for Special Surgery v. Unitedhealthcare Ins. Co., No. CV H-16-1273, 2016 WL 4192059 \(S.D. Tex. Aug. 9, 2016\)](#) (Judge Nancy F. Atlas).

In matter brought by Cigna against a hospital to recover alleged overpayments made for out-of-network healthcare services, determining that Cigna's claim(s) for reimbursement of overpayments made pursuant to ERISA and/or common law fail, as a matter of law, and granting hospital's Rule 52 motion for judgment; concluding that Cigna's defenses to hospital's ERISA claims fail and hospital is entitled to recover damages under § 502(a)(1)(B) and penalties under § 502(c)(1)(B). [Connecticut Gen. Life Ins. Co. v. Humble Surgical Hosp., LLC, No. 4:13-CV-3291, 2016 WL 3077405 \(S.D. Tex. June 1, 2016\)](#) (Judge Kenneth M. Hoyt).

E. Sixth Circuit

Relying on Plaintiff's admission in its original Complaint that it was an in-network provider subject to BCBST's Provider Agreement, pursuant to *Brown v. BlueCross BlueShield of Tennessee, Inc.*, 827 F.3d 543 (6th Cir. 2016), Plaintiff lacked standing to bring its ERISA claims. Since Plaintiff is bound by the terms of the Provider Agreement, it is prohibited from passing the cost of BCBST's recoupments back on its patients, and because the present suit to enjoin Blue Cross's recoupments is not a suit that Blue Cross members could have brought, Plaintiff's claims do not fall within the scope of its derivative ERISA standing. Claims dismissed for lack of subject matter jurisdiction. [Apple Corp. Wellness, Inc v. Bluecross Blueshield of Tennessee, Inc., No. 1:15-CV-324, 2016 WL 5390878 \(E.D. Tenn. Sept. 27, 2016\)](#) (Judge Harry S. Mattice).

F. Seventh Circuit

Provider lacks standing under ERISA where health plan did not give written consent to provider's assignment as required by the plan. [University of Wisconsin Hospitals and Clinics Authority v. Aetna Life Insurance Company, et al., No. 14-CV-779-WMC, 2016 WL 305062 \(W.D. Wis. Jan. 25, 2016\)](#) (Judge Williams M. Conley). Plaintiff UWHCA operates a hospital in Dane County and is the putative assignee of its patient, Buckingham, who received medical treatment for complications arising from a surgery for which she had only been discharged less than a week before. UWHCA attempted to precertify the follow-up treatment with Aetna, the claims administrator for Buckingham's health plan. Aetna denied Plaintiff's request for precertification and then issued a notice indicating that it was denying payment on UWHCA's claim for "failure to follow contractual notification requirements." UWHCA appealed multiple times from the denial of benefits but Aetna ultimately upheld its original decision denying benefits. On summary judgment, the court found it undisputed that Aetna did not give written consent to Plaintiff's assignment as required by the Plan. Accordingly, Plaintiff does not have standing under ERISA despite that the Plan allows for direct payment to medical providers. The court distinguished *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698 (7th Cir. 1991) as merely recognizing that the possibility of direct payment may be enough to make a claim colorable for the purpose of establishing subject matter jurisdiction at the motion to dismiss stage. The court found that *Kennedy* does not hold out the possibility of direct payment overriding an otherwise valid and unambiguous anti-assignment clause and, in fact, instructs the court to strictly enforce the terms of ERISA plans. The court concluded that since Plaintiff makes no other argument challenging the validity of the anti-assignment clause or Aetna's ability to enforce that clause, the court cannot reach the merits of Plaintiff's claims for coverage. The court granted summary judgment in favor of Defendants but denied Defendants attorneys' fees.

Provider presents colorable claim for benefits where health plan contemplated assignment with consent of administrator and allows direct payment to medical care provider. [Univ. of Wisconsin Hosps. & Clinics Auth. v. Aetna Health & Life Ins. Co., No. 15-CV-286-WMC, 2016 WL 305063 \(W.D. Wis. Jan. 25, 2016\)](#) (Judge William M. Conley). Defendants moved to dismiss Plaintiff's ERISA claim on the basis that the Plan's restrictions on assignments prohibit Plaintiff from pursuing these claims. Defendants characterize the restriction as an "anti-assignment" but the court found that the relevant assignment provision does not prohibit assignments. In another case involving the same parties and same claims, where the court granted Defendants' motion to dismiss, the plan expressly provided that "coverage and your rights under this Aetna medical benefits plan may not be assigned." Here, an assignment is actually contemplated, albeit only with the consent of Aetna. The court found that the assignment provision, coupled with the provision allowing direct payment to the medical care provider, presents a "colorable claim" for benefits that is sufficient to satisfy subject matter jurisdiction. Whether Aetna withheld consent (and whether that withholding was proper) is a

merits issue, which the court cannot decide on the pleadings alone. The court denied Defendants' motion to dismiss but cautioned Plaintiff to consider whether it has a viable claim in light of court's concurrent decision on a motion for summary judgment in *University of Wisconsin Hospitals and Clinics Authority v. Aetna Life Insurance Company, et al.*, No. 14-CV-779-WMC, 2016 WL 305062 (W.D. Wis. Jan. 25, 2016), at least without Aetna's consent or an amendment substituting the true plaintiff in interest.

G. Eighth Circuit

In lawsuit alleging various state law claims brought by a medical provider against Aetna for payment of surgical procedures for which the provider obtained preauthorization, granting Aetna's motion for summary judgment on the basis of ERISA preemption; denying Plaintiff's motion for leave to amend the complaint to allege ERISA claims since Plaintiff did not identify any basis for finding that it acted diligently and satisfied the good cause standard to amend a pleading after the deadline. [Chesterfield Spine Center, LLC v. Aetna Life Insurance Company, No. 4:15-CV-133 \(CEJ\), 2016 WL 4124115 \(E.D. Mo. Aug. 3, 2016\)](#) (Judge Carol E. Jackson).

Provider adequately alleged exhaustion of administrative remedies to survive motion to dismiss. [Chesterfield Spine Center, Llc, v. Healthlink Hmo, Inc., No. 4:15 CV 1169 RWS, 2016 WL 2594069 \(E.D. Mo. May 5, 2016\)](#) (Judge Rodney W. Sippel).

ERISA plans only prohibited assignment of right to benefits, not assignment of legal claims, but dismissal due to failure to exhaust. [Podiatric OR of Midtown Manhattan, P.C. v. UnitedHealth Grp., Inc., United HealthCare Servs., Inc., et al., No. CV 15-3234\(DSD/HB\), 2016 WL 126362 \(D. Minn. Jan. 11, 2016\)](#) (Judge David S. Doty). United adopted a policy of not paying for office-based surgery (OBS) facility fees" that it applied to Plaintiff as a non-participating out-of-network physician office with an OBS accreditation, but without a license to operate as an Ambulatory Surgery Center. Podiatric submitted claims on behalf of two patients who underwent surgeries at its OBS facility and United informed Podiatric facility fees would not be paid and provided instructions about how to appeal the decision. Podiatric filed a putative class action complaint, seeking benefits under 29 U.S.C. § 1132(a)(1)(B), and injunctive relief under § 1132(a)(1)(B) or, alternatively, § 1132(a)(3). United moved to dismiss, which the court granted. On the issue of standing, the court found that Plans contain non-assignment clauses which prohibit Podiatric from obtaining the rights to the insureds' benefits. Further, even if waiver of a Plan provision could be asserted in an ERISA case, a point the court does not decide, United did nothing to evince an intent to waive the non-assignment clauses. However, the court agreed with Podiatric that the clauses prevent the assignment of benefits, but not the assignment of a cause of action. As such, the court found that Podiatric obtained valid assignments of the right to pursue a cause of action, and has standing to bring the instant claims. But because

Podiatric did not exhaust administrative remedies and failed to establish that pursuing administrative remedies would be futile, the court granted the motion to dismiss without prejudice.

District court did not abuse its discretion in denying the preliminary injunction, and pharmacies were not “beneficiaries” entitled to bring an ERISA action on their own behalf. [Grasso Enterprises, LLC v. Express Scripts, Inc., No. 15-1578, ___ F.3d ___, 2016 WL 104494 \(8th Cir. Jan. 11, 2016\)](#) (Before LOKEN, BEAM, and SHEPHERD, Circuit Judges). Plaintiffs, compounding pharmacies that prepare and sell customized compound drugs made in accordance with doctors’ prescriptions, brought suit against Express Scripts, Inc. (“ESI”), a pharmacy benefits manager that contracts with health plan sponsors and administrators to administer the pharmacy benefits provided in their group health plans, for allegedly systematically denying payment of compound drug claims without adhering to the procedural requirements of ERISA’s “Claims Regulation,” 29 C.F.R. § 2560.503–1. Plaintiffs sought a preliminary injunction declaring that ESI must pay all claims for compound medications until it is in compliance with the Claims Regulation, but the district court denied the requested preliminary injunction on numerous grounds. Plaintiffs appealed and the Eighth Circuit affirmed the district court’s decision, concluding that Plaintiffs failed to meet the well-established standards for preliminary injunctive relief. The basis of injunctive relief in the federal courts has always been irreparable harm and inadequacy of legal remedies. Here, the court found that the plan beneficiaries have an adequate remedy at law, a suit under § 502(a)(1)(B) that will overturn the initial denial of a compound drug pharmacy benefit if that medication was in fact covered under the plan. As such, the court found that there is no need for injunctive relief under § 502(a)(3), or for equitable relief to enforce or clarify the beneficiary’s rights under the plan under § 502(a)(1)(B). The court reasoned that the grant of equitable relief declaring what procedures are needed to substantially comply with the Claims Regulation would disrupt efficient plan administration and in some cases would conflict with the ERISA policy that reviewing courts should review final decisions to deny claims for benefits, rather than the initial denials. The court also affirmed the district court’s decision that Pharmacies do not have standing under ERISA to assert harm to themselves because they are not ERISA beneficiaries and that Plaintiffs may only seek injunctive relief under § 502(a)(1)(B) or (a)(3) as assignees of ERISA plan beneficiaries.

H. Ninth Circuit

An ASSIGNMENT OF BENEFITS form which states: I hereby authorize and request that payment of authorized insurance company benefits be made on my behalf directly to DUAL DIAGNOSIS ... for the amount due to me for any medical or psychological/psychiatric treatment or services that are rendered to me by DUAL DIAGNOSIS ... does not permit Plaintiffs to sue for fiduciary breach for their patients.

The court declined to dismiss Plaintiffs' ERISA Section 502(a)(1)(B) claim, where they alleged that they provided medical services to their patients which were covered by each patient's ERISA plan, received an assignment of ERISA benefits from each patient, submitted a claim for those benefits, which they were entitled to receive by virtue of the assignments, but that the Blue Cross Defendants refused to pay. The court found that neither a denial nor adverse benefits determination occurred when the Defendants paid the patients, so the court dismissed Plaintiffs' claims for breach of fiduciary duty without prejudice. [Dual Diagnosis Treatment Ctr., Inc. v. Blue Cross of California, No. SACV150736DOCDFMX, 2016 WL 6892140 \(C.D. Cal. Nov. 22, 2016\)](#) (Judge David O. Carter).

The court found that as a matter of law that members may assign their rights under the health plans to their medical providers without violating the plans' anti-assignment provision. The court granted summary judgment to that limited extent in favor of Hawaii Life Flight Corporation and Air Medical Resource Group, Inc. [Sidlo v. Kaiser Permanente Ins. Co., No. 16-00073 ACK-KSC, 2016 WL 6821787 \(D. Haw. Nov. 17, 2016\)](#) (Judge Alan C. Kay, Sr.).

In matter involving challenge to health plan's lien provision on tort settlement, denying motion for reconsideration of court's denial of Plaintiff's motion to remand, finding that: (1) Plaintiff was not entitled to reconsideration of its decision that the first and second prongs of *Davila* were met; (2) Plaintiff was not entitled to reconsideration of the court's "observation" that Plaintiff was attempting to save her claim from ERISA preemption under the Savings Clause in ERISA § 514(b)(2)(A) by characterizing Haw. Rev. Stat. § 431:13-103(a)(10) as a state law regulating insurance; (3) Plaintiff is not entitled to reconsideration of the court's determination that there is no private right of action under Haw. Rev. Stat. § 431:13-103(a)(10)(A). [Noetzel v. Hawaii Med. Serv. Ass'n, No. CV 15-00310 SOM-KJM, 2016 WL 4033099 \(D. Haw. July 27, 2016\)](#) (Judge Susan Oki Mollway).

In a matter brought by a hospital against administrators of self-insured medical plan for additional payment for medical services the hospital provided to medical plan participants, granting Defendant's motion to provide a more definite statement of its claims in accordance with Rule 12(e), where Plaintiff did not allege basic facts concerning the claimed representations and how they support the assertion of either breach of an oral or implied-in-fact contract. [Lodi Mem'l Hosp. Ass'n v. Tiger Lines, LLC, No. 215CV00319MCEKJN, 2016 WL 2855187 \(E.D. Cal. May 16, 2016\)](#) (Judge Morrison C. England, Jr.).

In matter brought by surgery centers against hundreds of defendants for stopping payment for lap-band surgeries, dismissing the action with prejudice under Rule 41(b) for Plaintiff's failure to retain new lawyers, where previous lawyers withdrew for non-payment of

attorneys' fees. Rule 41(b) provides that involuntary dismissals are on the merits, absent exceptions not applicable here. [Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc., No. CV1402139MWFVBKX, 2016 WL 2851298 \(C.D. Cal. May 13, 2016\)](#) (Judge Michael W. Fitzgerald).

I. Eleventh Circuit

Lockheed was not the proper party defendant to the cause of action for unpaid benefits and provider lacked standing based on patient assignment to bring breach of fiduciary duty and breach of contract claims. [Griffin v. Lockheed Martin Corp., No. 15-13515, ___ F.App'x ___, 2016 WL 1397707 \(11th Cir. Apr. 11, 2016\)](#) (Before: WILLIAM PRYOR, JILL PRYOR and FAY, Circuit Judges).

Dismissal of *pro se* provider's complaint seeking unpaid benefits affirmed. [Griffin v. Habitat for Humanity Int'l, Inc., No. 15-13516, ___ Fed.Appx. ___, 2016 WL 385893 \(11th Cir. Feb. 2, 2016\)](#) (Before HULL, MARCUS and JILL PRYOR, Circuit Judges). The court affirmed the dismissal of the *pro se* Appellant's complaint seeking approximately \$928 in unpaid benefits, at least \$64,000 in penalties, and declaratory relief related to treatment she provided as an out-of-network provider for a participant in Defendant's health plan. The court concluded that even though the insured assigned Plan benefits to Appellant, the assignment is void under the Plan's anti-assignment provision. The court found that the anti-assignment provision applied even though BCBSGA failed to notify Appellant of the provision after she asked whether the Plan contained such a term. The court disagreed that BCBSGA is equitably estopped from relying on the anti-assignment term or has waived it.

XVII. *Remedies*

A. Second Circuit

Granting in part and denying in part Plaintiffs' motion for prejudgment interest. Defendants must pay prejudgment interest to each plaintiff who has taken a distribution of benefits under the Plan, who received less than would have been due under the court's new-hire remedy imposed on January 5, 2016. Prejudgment interest shall be calculated using the prime interest rate, as published by the Federal Reserve, as to each plaintiff, calculated from the date of the plaintiff's distribution up to January 5, 2016. [Frommert v. Becker, No. 00-CV-6311L, ___ F.Supp.3d ___, 2016 WL 6524250 \(W.D.N.Y. Nov. 3, 2016\)](#) (Judge David G. Larimer).

Equitable remedy of contract reformation is appropriate to redress violation of ERISA's notice requirements. [Frommert v. Becker, No. 00-CR-6311L, ___ F.Supp.3d ___, 2016 WL 64678](#)

[\(W.D.N.Y. Jan. 5, 2016\)](#) (Judge David G. Larimer). On remand from the Second Circuit Court of Appeals, the district court was tasked with determining the form of remedy Plaintiffs are entitled to as a result of Xerox's failure to give adequate notice of the circumstances that would result in an offset or reduction of pension benefits to former employees who took a lump-sum payment of a prior distribution before starting a second term of employment at Xerox. It is now undisputed that Defendants' application of the "phantom account" violated Plaintiffs' rights under ERISA, and that Plaintiffs are entitled to relief for that violation. The court determined that Defendants' notice violations justify the imposition of an equitable remedy, and as such, the court need not analyze and consider Xerox's latest interpretation of the Plan with respect to how benefits should be calculated. The court found that a "new hire" remedy is an appropriate equitable remedy: Plaintiffs will receive whatever benefits they are due for their second period of employment, the same as if they were new hires. The court found that this remedy will fully compensate Plaintiffs for all their years of service. Plaintiffs' prior lump-sum distribution will have no effect on the employee's subsequent benefits. The court applied a remedy of contract reformation. Under principles of long standing, a contract may be reformed due to the mutual mistake of both parties, or where one party is mistaken and the other commits fraud or engages in inequitable conduct. The court found that equitable fraud does not require a showing of intent to deceive or defraud. Inequitable conduct - deception or even mere awareness of the other party's mistake combined with superior knowledge of the subject of that mistake - is enough to support reformation when combined with the plaintiff's mistake. The court found that Xerox's failure to disclose the operation of the phantom account, combined with its intransigence in defending the use of the phantom account, produced an inequitable result, the kind of harm that the concept of equitable fraud was designed to remedy. In fashioning this remedy, the court found irrelevant how the individual plaintiffs actually disposed of their initial lump-sum payments (i.e., whether they had spent it all or made money from investment). The court rejected Defendants' argument that Plaintiffs are not entitled to this relief because this remedial theory was not sought in the complaint.

B. Third Circuit

Equitable considerations result in denial of prejudgment interest to successful counterclaim plaintiff. [Regional Employers' Assurance Leagues Voluntary Employees' Beneficiary Association Trust v. Gretchen Hutto Castellano, No. CV 03-6903, 2016 WL 540817 \(E.D. Pa. Feb. 10, 2016\)](#) (Judge Elizabeth T. Hey). Following a twelve-year court battle, a court awarded the Counterclaim Plaintiff Castellano summary judgment on her claim for VEBA life insurance benefits, which totaled \$750,000. Castellano then moved for prejudgment interest on that amount. The court denied the motion. Based on the court's review of caselaw from the Third Circuit, it found that although there is a presumption in favor of an award of prejudgment interest to fully compensate an aggrieved party in the ERISA context, equitable considerations can overcome that presumption. In this case, the court was moved by the economic reality that other

Trust beneficiaries will bear the cost of every dollar that is given to Castellano in prejudgment interest. Specifically, other victims of the “Koresko scheme” will not be in the same position to recover benefits as a result of a shortfall of over \$19 million due to the malfeasance of the Koresko Entities. The court concluded that the equities weigh heavily against an award of prejudgment interest and it exercised its discretion to deny such award. However, in a separate opinion, 2016 WL 540794, the court did award attorneys’ fees in the amount of \$567,400.26 to be paid from the funds in the SEWBPT and REAL VEBA Trust, to be restored by the Koresko Defendants.

C. Fourth Circuit

Anti-cutback claim permitted to proceed but claims for equitable relief under Section 502(a)(3) dismissed because adequate remedy available under Section 502(a)(1). [Wood v. Gen. Dynamics Corp., No. 1:15CV45, F.Supp.3d , 2016 WL 258620 \(M.D.N.C. Jan. 19, 2016\)](#) (Judge Thomas D. Schroeder). Plaintiff worked for General Dynamics Advanced Technology Systems, Inc. (“ATS”) for twenty-one years before taking an early retirement at the age of forty-six. At the time of her initial retirement, ATS pension plan documents stated that Plaintiff’s benefits would be recalculated to account for additional benefits and service in the event she ultimately returned to work. Plaintiff believed that this language meant that future retirement benefits would be based on her age at the time of her second retirement, discounted to compensate for the payments she had already received. Plaintiff later returned to ATS and worked for an additional six years, during which period of time her pension benefits were suspended. ATS amended its pension plan documents to explicitly state that, in the event of a second retirement, an employee’s benefits would be calculated based on her “adjusted” age, defined as her age at initial retirement, adjusted upward to compensate for the period of time in which her benefits were suspended due to reemployment. Plaintiff brought a number of claims against ATS, its pension plans, and a number of ATS subsidiaries. On Defendants’ motion to dismiss, the court declined to dismiss Plaintiff’s anti-cutback claim at this juncture, finding that it applied to Plaintiff’s claim that the amendment resulted in a lower monthly pension payment than she would have received under the original plan. The court also found that a settlement agreement that Plaintiff signed in 2010 did not necessarily waive any anti-cutback claim since General Dynamics modified its retirement plans both in 2009 and 2011, before and after the agreement was signed, and in any event, it is questionable whether Plaintiff could effectively waive her ERISA claims if Defendants actively concealed information from her. Because the settlement agreement was not mentioned in or included with the complaint, the court did not consider it. The court also declined to decide at this stage whether the anti-cutback claim is distinct from, or merely duplicative of, Plaintiff’s denial of benefits claim. The court did, however, dismiss Plaintiff’s breach of fiduciary duty claims, variously styled as claims for “misrepresentation,” “failure to follow plan documents,” “omission,” “equitable estoppel,” and “surcharge,” because under Fourth Circuit precedent, a plaintiff may not plead a claim for

equitable relief under Section 1132(a)(3) when a denial of benefits claim under Section 1132(a)(1) could provide adequate remedies for the injury alleged. The court also dismissed Plaintiff's declaratory judgment claim, finding that it would serve no useful purpose in this matter and dismissed all of the named defendants except for General Dynamics, the ATS Pension Plan, and the Life Insurance Plan – the entities with authority to provide the relief Plaintiff seeks. Lastly, the court granted Defendants' motion to strike the jury demand.

D. Sixth Circuit

In complaint for long-term disability benefits, under “Claims,” Plaintiff asserts that “29 U.S.C. §§ 1132(a)(1)(B) and (a)(3) are the enforcement mechanisms permitting [him] to enforce the contractual terms of the insurance policies, to obtain past benefits, to obtain reinstatement of future disability benefits, to obtain declaratory relief, and to obtain other appropriate equitable relief including, but not limited to, surcharge.” Because Plaintiff failed to alleged an injury separate and distinct from the denial of benefits or show why the remedy afforded by Congress under § 1132(a)(1)(B) is inadequate, the court dismissed his § 1132(a)(3) claim. [Quarles v. Hartford Life & Accident Insurance Company, No. 3:15-CV-372-DJH, 2016 WL 2903284 \(W.D. Ky. May 18, 2016\)](#) (Judge David J. Hale).

Where Plaintiff could have brought suit under § 502(a)(1)(B), he is precluded from proceeding under § 502(a)(3). Further, Plaintiff's requested relief under § 502(a)(3) is not “appropriate equitable relief,” where Plaintiff seeks to recover the funds that Central States promised to pay his medical providers in settling the subrogation lien on his tort judgment, where Central States fulfilled its promised (albeit in an untimely fashion), and any sums awarded to Plaintiff for the stress he suffered and the negative impact on his credit profile would be compensatory, and therefore legal, in nature. [Harrison v. Teamcare—A Cent. States Health Plan, et al., No. CV 15-60-DLB-CJS, 2016 WL 2858520 \(E.D. Ky. May 13, 2016\)](#) (Judge David L. Bunning).

E. Eighth Circuit

Affirming district court's award of equitable relief under ERISA Section 502(a)(3) to Plaintiff for Defendants' violations of ERISA, including amount of premium payments Plaintiff made for health insurance coverage that was not properly continued under COBRA and amount of 401(k) deposits and contributions that were not deposited. [Smith v. Health Res. of Arkansas, Inc.; Alternative Opportunities, Inc., No. 16-1066, F.App'x , 2016 WL 4010516 \(8th Cir. July 27, 2016\)](#) (RILEY, Chief Judge, BOWMAN and BEAM, Circuit Judges).

XVIII. *Retaliation/Discrimination Claims*

A. First Circuit

The plaintiff alleged enough facts to state an ERISA interference claim. [Rachael K. Brown v. HCA Health Servs. of New Hampshire, Inc., No. 15-CV-323-AJ, 2016 WL 141672 \(D.N.H. Jan. 12, 2016\)](#) (Magistrate Judge Andrea K. Johnstone). The court denied the employer's motion to dismiss Plaintiff's ERISA interference claim. The court found that at this early stage, Plaintiff has alleged enough facts to state an ERISA interference claim. First, the complaint attaches two exhibits demonstrating that the plaintiff was a member of an ERISA plan. Second, the complaint alleges that she was qualified for her position based on multiple positive performance reviews. Lastly, the complaint alleges that circumstances that give rise to an inference of discrimination occurred when, just before she applied for FMLA leave, she was notified that her employment was terminated. Whether Plaintiff's notice was proper or if there is any plausible basis that the employer intended to interfere with her ERISA benefits should be resolved on a properly developed summary judgment record, rather than at this early stage in the proceedings.

B. Second Circuit

Granting summary judgment in favor of MetLife on Plaintiff's ERISA Section 510 claim where Plaintiff failed to put forward any evidence that MetLife acted with the specific intent to interfere with his benefits when it terminated his employment, and even if he did, MetLife put forward a legitimate nondiscriminatory reason for Plaintiff's termination, and Plaintiff did not put forward facts upon which a reasonable jury could find that MetLife was motivated by a desire to deprive him of his benefits. [Ghorpade v. MetLife, Inc., No. 14-CV-4379 \(JPO\), 2016 WL 3951183 \(S.D.N.Y. July 20, 2016\)](#) (Judge J. Paul Oetken).

Denying motion for reconsideration of court's decision to dismiss Plaintiff's Amended Complaint and to deny leave to amend his claim for wrongful termination brought under ERISA Section 510, but reserving decision on Plaintiff's request for leave to amend his claim for unpaid benefits under ERISA Section 502(a)(1)(B). [Abe v. New York Univ., No. 14-CV-9323 \(RJS\), 2016 WL 2757761 \(S.D.N.Y. May 11, 2016\)](#) (Judge Richard J. Sullivan).

C. Third Circuit

In consolidated action by terminated Allstate agents against Allstate Insurance Company, finding that the agents may proceed on retaliation claims under the ADEA and ERISA based on Allstate's counterclaims since the agents plead facts from which one can reasonably infer Allstate's counterclaims are objectively baseless, made in bad faith, and brought with a retaliatory motive. [Romero, et al. v. Allstate Insurance Company, et al., No. 01-3894, 2016 WL 3654265 \(E.D. Pa. July 6, 2016\)](#) (Judge Andrews).

In matter where Plaintiff alleges that he was discriminatorily discharged from his employment in violation of ERISA, and where Defendant filed a motion to dismiss on the basis that Plaintiff failed to plausibly plead an employer-employee relationship between Integrative Staffing and himself, denying the motion because it is premature at this stage to determine the employer-employee relationship as a matter of law, and the applicable law appears to weigh in favor of finding that Integrative Staffing and Allegheny Plywood were joint employers. [Dunkel v. Integrative Staffing Grp., No. 15-1632, 2016 WL 2958269 \(W.D. Pa. May 23, 2016\)](#) (Judge Maurice B. Cohill, Jr.).

D. Fifth Circuit

Dismissing ERISA § 510 claim based on Prudential’s alleged threats to initiate legal action in an attempt to dissuade Plaintiff from seeking further benefits because controlling jurisprudence from the Fifth Circuit clearly states that a valid § 510 claim requires an employment relationship, and there was no such relationship between Prudential and Plaintiff. [Manuel v. Turner Indus. Grp., LLC, No. CV 14-599-SDD-RLB, 2016 WL 5349446 \(M.D. La. Sept. 23, 2016\)](#) (Judge Shelly D. Dick).

Dismissing Plaintiff’s ERISA interference claim because although Plaintiff can establish a prima facie case of ERISA retaliation in light of the close proximity between his inquiry regarding short term disability benefits and his termination, he cannot overcome Defendant’s legitimate, non-discriminatory reason for his termination—a reduction in force. [Crain v. Schlumberger Technology Co., No. CV 15-1777, 2016 WL 2942417 \(E.D. La. May 20, 2016\)](#) (Judge Jane Triche Milazzo).

Plaintiff “failed to present any evidence from which a reasonable fact finder could conclude that CCCHC’s stated, legitimate, nondiscriminatory reasons for discharging her were not true but, were instead, pretexts for discrimination based on a specific intent to retaliate against her for having enrolled in an ERISA plan, or to prevent her from attaining ERISA benefits.” [Francis v. S. Cent. Houston Action Council Inc., No. CV H-14-1277, 2016 WL 1650790 \(S.D. Tex. Apr. 25, 2016\)](#) (Judge Sim Lake).

E. Seventh Circuit

In suit alleging wrongful termination brought by the former Administrator of the ABA employee pension plan, concluding that Plaintiff cannot bring an ERISA Section 510 claim because he is a former fiduciary, not a current one, and he is bringing the lawsuit solely in his own interests as a former employee. [Trujillo v. Am. Bar Ass’n, No. 13-CV-8541, 2016 WL 4678301 \(N.D. Ill. Sept. 7, 2016\)](#) (Judge Robert M. Dow).

Interference claim not subject to dismissal. [Gipson v. Four Cty. Comprehensive Mental Health Ctr., Inc., No. 3:15CV360-PPS/CAN, 2016 WL 1059355 \(N.D. Ind. Mar. 16, 2016\)](#) (Judge Philip P. Simon). Plaintiff filed a complaint alleging that her termination was an act of age discrimination, disability discrimination and interference with her rights under the Center's health insurance plan. Plaintiff was terminated after her disabled son visited her at her workplace carrying a gun that he was licensed to carry. Defendant claimed that Plaintiff violated the No Weapon Policy by failing to report her son's visit but Defendant did not terminate other employees who also did not report the incident. Plaintiff contended that she instructed her son to leave the building and did not violate the policy but also that her son has Crohn's Disease, is a covered dependent under her employer-provided healthcare insurance, and requires costly medical care. Plaintiff's supervisor was aware of these facts. The court found that Plaintiff's complaint contains sufficient plainly-stated facts to support plausible claims that her termination was unlawfully based on her age, her son's disability, and/or an effort to interfere with her continued coverage under the Center's ERISA health insurance plan. The court held that the complaint is not subject to dismissal for failure to state claims upon which relief could be granted.

F. Eighth Circuit

Assuming without deciding, that Section 510 of ERISA provides a claim for retaliation based on Plaintiff's informal complaints and protests, Defendants articulated legitimate nondiscriminatory reasons for Plaintiff's termination, including that Plaintiff sent numerous emails from her work account disparaging her bosses at the company, failed to cooperate fully in providing her boss with customer information, and acting disrespectfully to them in front of customers. [Graham v. Hubbs Mach. & Mfg., Inc., No. 4:14-CV-419 \(CEJ\), 2016 WL 2910209 \(E.D. Mo. May 19, 2016\)](#) (Judge Carol E. Jackson).

G. Ninth Circuit

Jury's determination of Plaintiff's entitlement to front pay as a remedy for his state law claims foreclosed the district court from granting front pay on Plaintiff's ERISA Section 510 claim. [Teutscher v. Riverside Sheriffs' Association, et al., No. 13-56411, ___ F.3d ___, 2016 WL 4488008 \(Circuit Judges\), 9th Cir. Aug. 26, 2016\)](#) (Before: Milan D. Smith, Jr., Paul J. Watford, and Michelle T. Friedland,

H. Eleventh Circuit

Plaintiff adequately pled Section 510 claim that he was terminated to interfere with his right to future retirement benefits. [Magasrevy v. Retirement Committee, Plan Administrator of Executive Retirement Plan of Thermal Ceramics Latin America, No. 15-62143-CIV, 2016](#)

[WL 1321406 \(S.D. Fla. Apr. 5, 2016\)](#). Here, Plaintiff claimed that Defendant TCI interfered with his potential rights under the Executive Plan by terminating his employment to prevent him from obtaining early or normal retirement benefits. Defendant TCI moved to dismiss on the basis that Plaintiff has not pleaded facts showing that Defendants terminated him to avoid paying benefits, including that Plaintiff has not demonstrated “close temporal proximity” between his termination date and his eligibility for retirement benefits. The court found that aside from the timing of his discharge, Plaintiff has pleaded more than enough facts to state a plausible claim under § 510. He alleged that, on multiple occasions, TCI management expressed concerns about having to pay Executive Plan benefits. He also alleged that in 2006, TCI’s Director of Compensation and Benefits said that something had to be done about the Executive Plan before the “first executive reaches age 65 and claims his non-existent pension!” In the year before TCI discharged Plaintiff—without cause and despite his strong job performance—his supervisor asked him to provide a detailed analysis of the value of his early and normal retirement benefits under the Executive Plan, and to provide an explanation of his understanding regarding the Company’s obligation with regard to such benefits.. The court found that these and other facts plausibly allege that TCI had the specific intent to interfere with Plaintiff’s ERISA rights.

XIX. *Retiree Medical*

A. Second Circuit

Court reaffirms summary judgment in favor of retirees on post-*Tackett* reconsideration. [United Steel v. Kelsey-hayes Co., No. 4:11-CV-15497, 2016 WL 337467 \(E.D. Mich. Jan. 28, 2016\)](#) (Judge Gershwin A. Drain). In this matter involving a class of retirees affected by Defendants’ decision to discontinue group coverage insurance for eligible retirees and spouses, age 65 and older, and replace it with health reimbursement accounts, the court previously granted Plaintiffs’ Motion for Summary Judgment and denied Defendants’ Motion for Summary Judgment. One year later, the Sixth Circuit affirmed the court’s judgment but then vacated its opinion and remanded the case back to district court for reconsideration in light of the Supreme Court’s decision in *M & G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926 (2015). Defendants filed a Renewed Motion for Summary Judgment and Plaintiffs filed a Brief in Support of Reaffirmation of Summary Judgment and Permanent Injunction. The court reaffirmed its prior award of summary judgment to Plaintiffs. Although Defendants argued that vesting must now be established by unequivocal, explicit language within the CBA, the court found that the Supreme Court did not adopt this standard in *Tackett*. Relying on the ordinary principles of contract interpretation to determine whether the contracts in question created vested rights, the court concluded that the parties’ contracts unambiguously demonstrated intent to provide for vested healthcare benefits for retirees, beyond the duration of the CBAs, and the court need not consider extrinsic evidence. The court declined to address Plaintiffs’ preclusion arguments, because doing so to these pre-*Tackett* decisions may run the risk of perpetuating the now invalid

Yard-Man inference. Similarly, the court declined to apply the *Carbon Fuel* doctrine (which stands for the proposition that judicial interpretations of CBA terms become part of those terms in later CBAs, if not altered by the parties' agreement), since prior cases may have been tainted by the *Yard-Man* inference.

XX. *Severance Benefit Plans*

A. Third Circuit

Finding that denial of severance benefits available to employees of Sunoco whose employment is terminated in connection with Sunoco's idling of the main processing units at its Marcus Hook Refinery was not an abuse of discretion where Plaintiffs' salary and benefits were largely unaffected by their becoming permanent employees of Philadelphia Energy Solutions LLC, Plaintiffs experienced no period of unemployment, and their responsibilities and place of work remained the same. [Felker v. USW Local 10-901, No. CV 13-7101, 2016 WL 3198615 \(E.D. Pa. June 9, 2016\)](#) (Judge J. Slomsky).

LTD claimant not eligible for severance; late decision on appeal does not change standard of review to de novo where Plan confers discretion. [Becknell v. Severance Pay Plan of Johnson & Johnson & U.S. Affiliated Companies, No. 15-2660, Fed.Appx., 2016 WL 1085527 \(3d Cir. Mar. 21, 2016\)](#) (Before CHAGARES, RESTREPO and VAN ANTWERPEN, Circuit Judges). Plaintiff-Appellant appealed the final decision of the district court in favor of Appellee Severance Pay Plan of Johnson & Johnson and Affiliated U.S. Companies ("J & J"). More than three years after exhausting his long-term disability benefits, Plaintiff sent a letter to J & J requesting an application for severance benefits. Manager of Global Benefits for J & J responded to Plaintiff's request in a February 4, 2013 letter which indicated that Becknell did not qualify for severance benefits because his termination did not result from one of the "Severance Events" enumerated in the Severance Pay Plan. Moreover, the letter explained that Plaintiff ceased to be eligible for benefits on April 15, 2008 when he began receiving long-term disability benefits because he was unable to work, with or without reasonable accommodation. After exhausting administrative remedies, Plaintiff filed suit and J & J moved to dismiss on the basis that Plaintiff did not file his claim for severance benefits within 180 days as required by the Plan. The district court found that a reason for denial not raised by J&J in its denial letters could not be asserted as a defense in the litigation. Appellee's challenged that determination but the Third Circuit did not explicitly address it. The court found that abuse of discretion review applies even though J & J did not render a timely decision on Plaintiff's appeal. Contrary to Plaintiff's argument that de novo applies because J & J did not exercise discretion, the court found that J & J did exercise discretion because it decided Plaintiff's initial claim and its late decision is only one factor for the court to consider in whether the administrator abused its discretion. A late decision on appeal, however, cannot strip an administrator of deference. The court found that

under the terms of the Plan, Plaintiff was not eligible for severance benefits since he was LTD-eligible and did not meet one of the Plan’s “Severance Events.”

Financially conflicted administrative committee’s decision to deny severance plan benefits constituted a reasonable interpretation of plan terms. [Feeko v. Pfizer, Inc., No. 14-4752, Fed.Appx. , 2016 WL 66535 \(3d Cir. Jan. 6, 2016\)](#) (Before AMBRO (dissenting), HARDIMAN and SLOVITER Circuit Judges). The majority affirmed the district court’s grant of judgment on the administrative record in favor of Pfizer on the Plaintiffs’ claim for severance benefits. Plaintiffs were employed by Wyeth, a pharmaceutical company, which had adopted the Special Transaction Severance Plan (“the Plan”) in anticipation of a corporate takeover bid by Pfizer, Inc. An employee was eligible to receive severance benefits under the Plan if “following a Change in Control, the Employee has either (i) experienced an Involuntary Termination of Employment or (ii) resigned for Good Reason.” Excluded from the definition of “Termination of Employment” was any change in employment constituting a “transfer of employment to any successor company of the Company or (any of its affiliates).” The Plan documents do not define the phrase “successor company of the Company.” Pfizer completed its purchase of Wyeth and assumed responsibility over the Plan as its sponsor. Pfizer transferred Plaintiffs employment to Benchmark, a separate company that provided credit services to Wyeth. The terms of employment remained the same except that Benchmark did not continue their “Rule of 70” benefits or contribute to their pension plans as Wyeth (and then Pfizer) had done. Plaintiffs applied for benefits under the Plan on the basis that Benchmark was not a successor company. The Committee that made the decision determined that Benchmark was a successor company insofar as Plaintiffs’ employment was concerned and denied benefits. Although the majority recognized that there were several inherent conflicts of interest because the Committee was comprised of senior-level Pfizer employees who had financial incentives to deny benefit claims and reduce company expenses, it found that the Committee’s interpretation of the Plan itself was reasonable. Judge Ambro dissented, finding that Benchmark may be the successor *employer* but it does not make Benchmark a successor *company* to Pfizer. Judge Ambro also believed that the Committee’s significant incentive to deny claims should have been given determinative effect here.

B. Fifth Circuit

In lawsuit for severance benefits, affirming the district court’s grant of summary judgment in favor of the employer and holding that: (1) severance agreement was an “employee benefit plan” subject to [ERISA](#); (2) employee failed to exhaust administrative remedies on claim that employer’s property did not include electronic property; and (3) severance agreement permitted employer to require employees to return company property prior to receiving benefits. [Gomez v. Ericsson, Inc., No. 15-41479, F.3d , 2016 WL 3669965 \(5th Cir. July 8, 2016\)](#) (Before SMITH, BARKSDALE, and COSTA, Circuit Judges).

C. Seventh Circuit

[Carlson v. Northrop Grumman Corp., No. 13-cv- 2635, 2016 U.S. Dist. LEXIS 89083 \(N.D. Ill. July 11, 2016\)](#), involves a putative class of former employees laid off from Northrop Grumman Corporation. Northrop Grumman allegedly changed how it interprets and applies the terms of the plan to make a new condition to receiving benefits after a “harmonization,” which resulted in a change in application of the terms of the plan to make receipt of a memorandum of eligibility required to receive benefits, but the plan terms did not actually change. As they say, “that was yesterday.” The plan states an employee working in the United States who is laid off, worked at least 20 hours per week, and worked in the United States is entitled to severance, and the employee must receive a memorandum signed by a vice president advising the laid off employee of eligibility. All of the plaintiffs worked over 20 hours per week in the United States and were laid off, but they did not receive the memorandum of eligibility. Plaintiffs alleged the memorandum serves as a vehicle to notify participants they satisfied eligibility criteria, rather than representing a discretionary decision to include or exclude a given employee. In addition, they alleged Northrop Grumman violated ERISA § 510 by withholding the memorandum to interfere with plaintiffs’ attainment of the benefits, and breach of fiduciary duty for failing to disclose a change in application to the terms of the plan. The court denied Northrop Grumman’s motion to dismiss the amended complaint. Because plaintiffs alleged that Northrop Grumman changed its interpretation and application of identical plan terms to make receipt of the memorandum a condition in 2001, without changing any plan terms, the court reasoned “[i]nterpretation of the same plan term in different ways is ‘paradigmatically arbitrary and capricious.’” Next the court rejected the notion that there must be an adverse employment action to constitute a § 510 violation and that withholding the memorandum in order to prevent a laid off employee from receiving severance can constitute unlawful benefit interference under the text of § 510. Finally, the court held plaintiffs properly sought reformation of the severance plan to modify any changed terms regarding interpretation to reflect that the application of the terms had not changed since Northrop Grumman never disclosed to employees it would begin treating the memorandum as a condition to receiving benefits.

D. Eight Circuit

Denial of severance benefits not an abuse of discretion or breach of fiduciary duty. [Boyd v. Conagra Foods, Inc., No. 4:14-CV-1435-JAR, 2016 WL 759326 \(E.D. Mo. Feb. 26, 2016\)](#) (Judge John A. Ross). Under the deferential standard of review, the court concluded that substantial evidence supports ConAgra Food’s denial of Plaintiff’s severance benefits on the basis that he failed to terminate his employment within the 90-day window following the initial existence of “Good Reason,” and notwithstanding his untimely self-termination, Plaintiff did not have “Good Reason” because he did not incur a material reduction in his position, duties or responsibilities or a material adverse change in his reporting relationships. Plaintiff believed he had “Good Reason” to terminate his employment when he received the offer to continue working for ConAgra Foods as Vice President of Manufacturing. He had been working as Vice President of Operations for Ralcorp. Plaintiff alleged there were “material differences” between the jobs,

including that two plants were added to his workload, his authority over hiring had decreased, his reporting relationships had changed, and his compensation and benefits had been altered. The court rejected Plaintiff's argument that his exclusion from a few meetings amounted to "Good Reason" under the Severance Plan. With respect to Plaintiff's breach of fiduciary duty claim, the court found that ConAgra Foods did not breach its fiduciary duty in failing to provide Plaintiff clarification concerning the definition of Good Reason or what ConAgra Foods considered to be material. "Fiduciaries are not required to anticipate every possible application of a plan to the plan participant." The court further found that even if a statement made to Plaintiff was material and misled Plaintiff, it was unreasonable for Plaintiff to rely on the statement when he had easy access to convenient ways of ascertaining the truth. The court granted ConAgra Foods' motion for summary judgment.

E. Ninth Circuit

Motion to dismiss claim for severance benefits denied where Defendants failed to establish that the claimant was "terminated" as defined in the Plan. [Ditchey v. Mechanics Bank, No. 15-CV-04103-JSC, 2016 WL 80560 \(N.D. Cal. Jan. 7, 2016\)](#) (Magistrate Judge Jacqueline Scott Corley). Plaintiff submitted a claim to Mechanics Bank seeking severance benefits under the Mechanics Bank Change in Control Plan because there had been a material diminution in the scope of her responsibilities, duties or authority following the "Change in Control" which resulted in her Involuntary Termination. Defendants did not respond within the 30-day response period so Plaintiff filed suit alleging a Section 502(a)(1)(B) claim. Defendants moved to dismiss on the basis that Plaintiff did not satisfy a condition precedent to receiving benefits – that she sign a release agreement within 30 days of her Termination. Defendants also argued that Plaintiff lacked standing. The court denied Defendants' motion because Defendants did not establish as a matter of law that Plaintiff incurred a "Termination" within the meaning of the Plan. The court rejected Defendants' related argument that Plaintiff lacks standing to bring suit because she is not an eligible Plan participant as she has not submitted the release. For standing purposes, all Plaintiff needs to show is that she has suffered an injury in fact, that the injury is traceable to the challenged action of the defendant, and that the injury can be redressed by a favorable decision.

XXI. *State Bans on Discretionary Clauses*

A. Sixth Circuit

Despite the Texas Insurance Code's prohibition on discretionary clauses contained in insurance policies, a long-term disability plan document's discretionary language adequately confers discretion necessary to justify an arbitrary and capricious review

standard. [Littleton v. Liberty Life Assurance Company of Boston, No. CV 6:15-187-KKC, 2016 WL 3093887 \(E.D. Ky. June 1, 2016\)](#) (Judge Karen K. Caldwell). In Littleton, Liberty Life administered the long-term disability claim in dispute. The Plan documents issued by Plaintiff's employer delegated discretionary authority to Liberty Life for administration of the claims made under the Plan. The insurance policy documents do not confer discretion and the parties agreed that any such provision would be prohibited by Texas Insurance Code Section 1701.062. The court found that the Texas law did not ban discretionary clauses in Plan documents, only documents issued or delivered by an insurer. Since the Plan documents were issued and delivered by Plaintiff's employer, they do not fall within the scope of the Texas law. As such, the court found that abuse of discretion review applies to Liberty Life's claim decision. The court explained that, "[f]f the Texas Legislature sought to indirectly limit the terms a benefit plan might include in its plan documents, they could have limited insurers' ability to enter into any contract that would permit them to exercise discretion in administering a policy they underwrote."

XXII. *Statute of Limitations*

A. First Circuit

A plan administrator's failure to inform a claimant of the time limit for filing suit renders the contractual limitations period inapplicable. [Santana-Diaz v. Metro. Life Ins. Co., No. 15-1273, ___ F.3d ___, 2016 WL 963830 \(1st Cir. Mar. 14, 2016\)](#) (Before THOMPSON, HAWKINS,* and BARRON, Circuit Judges). Plaintiff-Appellant challenged the district court's dismissal of his suit for long-term disability benefits as time-barred, because the plan administrator, Appellee Metropolitan Life Insurance Company ("MetLife"), failed to include the time period for filing suit in its denial of benefits letter. The Plan contained a three-year limitations period that provided, in relevant part, that "[n]o legal action of any kind may be filed ... more than three years after proof of Disability must be filed." Under this provision, Plaintiff's proof of disability had been February 17, 2009, and according to MetLife, the time period for filing suit expired three years thereafter. MetLife terminated Plaintiff's claim on November 24, 2010 and issued a final denial on August 19, 2011. Neither letter informed Plaintiff of the time limit for filing suit; Plaintiff filed suit on August 18, 2013. The First Circuit held that ERISA's regulation, 29 C.F.R. § 2560.503-1(g)(1)(iv), requires a plan administrator in its denial of benefits letter to inform a claimant of not only his or her right to bring a civil action, but also the plan-imposed time limit for doing so. The plan administrator's failure to do so is *per se* prejudicial to the claimant. The court found that because MetLife violated this requirement, the limitations period in this case was rendered inapplicable, and Plaintiff's suit was therefore timely filed. Because the court found that MetLife violated the regulation, it did not decide when the limitations period would have begun to run (i.e., February 17, 2009 versus November 24, 2010 versus August 19, 2011). The court reversed and remanded the decision of the district court.

Section 204(h) and 402 claims not time-barred at motion to dismiss stage. [White v. Jerome A. Chase, Jr., No. CV 15-40013-TSH, 2016 WL 347040 \(D. Mass. Jan. 27, 2016\)](#) (Judge Timothy S. Hillman). The court considered Defendant’s objections to the Magistrate Judge’s report and recommendation denying Defendant’s motion to dismiss as to the following counts in Plaintiffs’ First Amended Class Action Complaint: (1) Improper, Untimely and Inadequate Notice under ERISA Section 204(h), 29 U.S.C. § 1054(h) (“Section 1054(h)”) (Count I), as the result of the Defendant terminating/amendment of the Plan without proper notice; and (2) violation of ERISA Section 402, 29 U.S.C. § 1102 (“Section 1102”), as the result of Defendant implementing the Plan termination “without written Plan Document.” The court found that the Amended Complaint cannot fairly be read to assert claims for benefits under Counts I and II, and it declined to adopt the reasoning of the Magistrate Judge in finding that those claims are timely. But, since the Amended Complaint alleges that Plaintiffs never received notice of the 2007 Plan amendment, they never received copies of the Summary Plan Description, and the amendments were implemented without written “Plan Document,” the court cannot find at this stage of the proceedings that the claims are time barred, regardless of what limitations period applies. Instead, the court will reconsider this issue on summary judgment on a more factually developed record. For these reasons, the court denied Defendant’s motion to dismiss these two counts.

B. Second Circuit

In putative class action alleging mismanagement of a 401(k) Plan, the court found that dismissal under Rule 12(b)(6) based on ERISA’s three-year statute of limitation is denied because Defendants have not shown that it is clear from the face of the Complaint or any judicially noticed court filings that Plaintiffs actually knew of the fee or performance data for the comparable alternative funds more than three years before the commencement of this suit. Dismissal based on ERISA’s six-year statute of limitation is also denied where the Complaint sufficiently alleges that monthly payments to fund advisors were prohibited transactions and statute does not run from the initial decision to include the proprietary funds in the Plan. [Moreno, et al. v. Deutsche Bank Americas Holding Corp., et al., No. 15 CIV. 9936 \(LGS\), 2016 WL 5957307 \(S.D.N.Y. Oct. 13, 2016\)](#) (Judge Lorna G. Schofield).

Finding that Plaintiff cannot avail herself of the exceptional remedy of equitable tolling of claims for benefits and breach of fiduciary duty, where there was no tolling agreement and Plaintiff relied on a good faith belief that an on-the-record understanding had been reached to dismiss the prior federal case without prejudice, appeal the state court decision, and if the appeal was successful, re-file in federal court. [Guo v. IBM 401\(k\) Plus Plan, No. 13-CV-8223 \(KMK\), 2016 WL 4991666 \(S.D.N.Y. Sept. 15, 2016\)](#) (Judge Kenneth M. Karas).

In lawsuit by *pro se* plaintiff seeking pension and ESOP benefits denied him for being improperly classified, finding that these claims are time barred since Plaintiff did not bring this action until approximately 25 years after he was first classified as an independent

contractor and 19 years after he was first classified as a leased employee. [Reches v. Morgan Stanley and Company, No. 16CIV1663BMCSMG, 2016 WL 4530460 \(E.D.N.Y. Aug. 29, 2016\)](#) (Judge Brian M. Cogan).

Affirming the district court’s determination that Appellants’ action is barred by the three-year statute of limitations because they had “actual knowledge” of a breach before December 2008, where Appellants repeatedly alleged in their complaint that, prior to December 2008, there were widely publicized warnings about Citigroup’s exposure to subprime mortgages. (Per 29 U.S.C. § 1113(2), ERISA claims alleging a breach of fiduciary duty must be brought within three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation). [Muehlgay v. Citigroup Inc., No. 15-2461-CV, ___ F.App’x ___, 2016 WL 2956958 \(2d Cir. May 23, 2016\)](#) (Present RALPH K. WINTER, PETER W. HALL and CHRISTOPHER F. DRONEY, Circuit Judges).

Life waiver of premium claim barred by contractual limitations period and no equitable tolling applies. [Soares v. United of Omaha Life Insurance Company, No. 3:14CV968 \(DJS\), 2016 WL 158495 \(D. Conn. Jan. 13, 2016\)](#) (Judge Dominic J. Squatrito). This matter involves a denial of a claim for waiver of premium benefits based on disability. The court granted United of Omaha’s motion for summary judgment. The court found that the lawsuit was time-barred under the limitations period set forth in the Plan and even if it were assumed that the limitations period was extended by virtue of the opportunity to submit additional information provided by United of Omaha in its initial denial of Plaintiffs’ claim for waiver of premium benefits, this action would still be untimely. The court rejected Plaintiff’s contention that the limitations period should not have begun until United of Omaha denied her appeal on June 2, 2011. The court found that this argument is contrary to the express language of the Plan, which may be enforced even if the administrative exhaustion requirement will, in practice, shorten the contractual limitations period. The court also rejected Plaintiff’s contention that the limitations period specified in the Plan should not be enforced because the notice she received of her rights with respect to an appeal of the denial of her claim failed to notify her of the time by which she needed to file a civil action. The court explained that even if it were to conclude that the ERISA regulations did require United of Omaha to include the time limit for bringing a civil action in its notice, the failure to do so in this instance would not entitle Plaintiff to a tolling of the three-year limitations period specified in the Plan. A complete copy of the Plan was sent to Plaintiff’s counsel at a time that she had, at a minimum, nearly a year left before the expiration of the three-year limitations period. The court concluded that Plaintiff’s action is time-barred by the three-year limitations period specified in the Plan.

C. Third Circuit

One year statute of limitations did not accrue until Reliance issued its January 9, 2015 Other Income decision letter, which Reliance claimed was a “voluntary, extra-contractual

review” of Plaintiff’s Rehabilitation benefits after it already issued an earlier final denial letter of Plaintiff’s challenge to Reliance’s interpretation of the Rehabilitation Provision; finding the lawsuit timely but summary judgment entered in favor of Reliance on the underlying benefit calculation dispute. [Patrick v. Reliance Standard Life Ins. Co., No. CV 15-169-SLR-SRF, 2016 WL 4573877 \(D. Del. Aug. 31, 2016\)](#) (Magistrate Judge Sherry R. Fallon).

State law claims alleging failure to properly pay long-term disability benefits and interest due under a long-term disability plan are preempted by ERISA but leave to amend denied since the ERISA claim is time-barred; concluding that claims against the administrator for improperly calculating and paying benefits accrued on the date proof of disability was required to be filed, for purposes of three-year contractual limitations period and the claim accrued for purposes of default four-year limitations period when the participant received the first benefits check with erroneously calculated benefits; limitations period would not be tolled. [Haase v. Metro. Life Ins. Co., No. CV 15-2864, ___F.Supp.3d___, 2016 WL 4076418 \(E.D. Pa. Aug. 1, 2016\)](#) (Judge Eduardo C. Robreno). Haase is a long-term disability claimant who challenged MetLife’s offset of Workers’ Compensation benefits and alleged an underpayment of benefits starting in 2005. Plaintiff did not file suit related to the alleged underpayment until 2015. The court found that Haase’s claims were time-barred both under the disability plan’s contractual three-year limitation period and also under the default rules. Under the Plan, the three-year limitation period expired in April 2006, which is three years following the deadline for filing “proof of disability.” But, even if the contractual limitations period did not apply to the facts of this case, the court concluded that Haase’s claims would still be time-barred applying the four-year statute of limitation for Pennsylvania breach of contract claims. The accrual date for the statute of limitations is governed by federal law. Applying the Third Circuit’s “clear repudiation” rule, Plaintiff claim accrued as early as the date that Plaintiff received the first check with erroneously calculated benefits, which was sometime in 2003. The very latest his claim could have accrued is in 2008 when Plaintiff’s attorney first notified MetLife of the underpayment. The court found that under both scenarios Plaintiff’s claim is time-barred. Lastly, the court found that the statute of limitations was not tolled while Plaintiff participated in MetLife’s internal appeal process as set forth in the Plan.

Assuming arguendo the *Abell* Plaintiffs had “actual knowledge” of the alleged breach by November 10, 1999, the court declined to find the claim time barred since the action was “commenced” within the limitations period by the filing of the complaint; commencement of an action does not require that service be completed within the time established by [Rule 4\(m\)](#). [Romero, et al. v. Allstate Insurance Company, et al., No. 01-3894, 2016 WL 3654265 \(E.D. Pa. July 6, 2016\)](#) (Judge Andrews).

D. Fourth Circuit

Lawsuit challenging vesting requirements of deferred stock incentive plan filed 27 years too late. [Bond v. Marriott Int’l, Inc., No. 15-1160, ___Fed.Appx.___, 2016 WL 360801 \(4th Cir. Jan. 29, 2016\)](#) (Before SHEDD, DIAZ, and HARRIS, Circuit Judges). In this unpublished PER CURIAM opinion, the Fourth Circuit found that the Appellant’s claims challenging the vesting

requirements of Marriott's Deferred Stock Incentive Plan are barred by the statute of limitations. The court found that Marriott informed the Appellants in 1978 that the Plan was exempt from ERISA's vesting requirements but that the Appellants then waited more than 30 years to file suit. Here, the court found that Marriott clearly repudiated any right the Appellants had to the vesting requirements of ERISA in 1978 and the Appellants' ERISA claims are untimely under Maryland's three-year statute of limitations for contract actions. The court reversed the district court's grant of summary judgment to the Appellants on that ground and granted summary judgment to Marriott. Because this conclusion is dispositive, the court did not reach the question of whether Marriott's Plan was a valid top hat plan, and vacated the district court's later order granting summary judgment to Marriott.

E. Fifth Circuit

Hartford Life denied Plaintiff's claim for long-term disability benefits on December 6, 2011, and issued its final written decision affirming the benefit denial on August 24, 2012. The Plan contains a 3-year limitations period that begins to run at the time "proof of loss" is due, which in this case was March 5, 2012 (90 days after the start of the period for which Hartford Life would have been liable for payment). The last day Plaintiff could have sued for benefits under the plan was March 5, 2015, but she did not file suit until March 30, 2016—more than a year after the limitations period expired. Motion to dismiss granted. [Jones v. Hartford Life & Accident Ins. Co., No. 2:16-CV-316, 2016 WL 5887601 \(E.D. Tex. Oct. 7, 2016\)](#) (Judge Rodney Gilstrap).

For a § 1132(c) claim for failure to timely produce plan documents, the most analogous limitations period supplied by Louisiana law is Civil Code article 3492's one-year period governing delictual actions. Plaintiff filed suit more than one year after his § 1132(c) claim accrued and the claim is time-barred. [Babin v. Quality Energy Servs., Inc., No. CV 15-5124, 2016 WL 5390391 \(E.D. La. Sept. 27, 2016\)](#) (Judge Jay C. Zainey).

In matter where LINA had paid LTD benefits but then terminated the claim, finding that the three-year contractual limitation period started, at the earliest, on September 12, 2012, the date Plaintiff was informed that his appeal had been closed. The present suit was timely filed. [Hughes v. Life Ins. Co. of N. Am., No. CV 15-2941, 2016 WL 5231811 \(E.D. La. Sept. 22, 2016\)](#) (Judge Eldon E. Fallon).

Finding ERISA Section 510 claims time-barred because, even considering tolling, Plaintiffs filed them more than two years after receiving notice that their employment under the R830 contract would terminate and they were forced into a single exclusive agency independent contractor program. [Gregory v. Allstate Ins. Co., No. 3:15-CV-113, 2016 WL 4617404 \(S.D. Tex. Sept. 2, 2016\)](#) (Judge George C Hanks, Jr.); [Roberts v. Allstate Ins. Co., No. 3:15-CV-112, 2016 WL 4619287 \(S.D. Tex. Sept. 2, 2016\)](#) (Judge George C Hanks, Jr.).

Contractual limitations period bars late filed disability claim. [Wilson v. Provident Life & Accident Ins. Co., No. CV 14-499-SDD-EWD, 2016 WL 1057036 \(M.D. La. Mar. 14, 2016\)](#) (Judge Shelly D. Dick). Following the Supreme Court’s decision in *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, which held that “a participant and a plan may agree by contract to a particular limitations period, even one that starts to run before the cause of action accrues, as long as the period is reasonable,” the court found that a disability policy’s limitations period is not unreasonable nor exceeds the applicable statute of limitations. Plaintiff claimed to be disabled on October 13, 2008, and had he timely filed a claim at this time, under the terms of the Policy, his proof of loss would have been due no later than May 13, 2010. Plaintiff submitted proof of loss on April 22, 2013. The court found that Plaintiff had three years from May 13, 2010, or May 13, 2013, to file his lawsuit but did not do so until August 11, 2014. Notably, Provident did not issue a final decision on his claim until June 4, 2014. The court found that Plaintiff’s claim must be dismissed because his claim has prescribed under the terms of the Policy.

180-day limitations period to bring a civil action is reasonable. [Smith v. The Boeing Co., No. 3:15-CV-2533-D, 2016 WL 892749 \(N.D. Tex. Mar. 9, 2016\)](#) (Judge Sidney A. Fitzwater). Plaintiff challenged Boeing’s determination to not pay her spousal benefits because she was not listed as his spouse at the time of his retirement. In denying her claim, Boeing informed Plaintiff that she had the right under ERISA to appeal this determination, and, if the decision on appeal was adverse to her, to file a civil action under ERISA § 502(a) no later than 180 days following the decision on appeal. Plaintiff timely appealed the decision to Boeing’s Employee Benefit Plans Committee and the Committee upheld the denial of benefits. The Committee advised Plaintiff that she had the right to bring a civil action under ERISA § 502(a) within 180 days following the decision on appeal but she did not do so for more than five months following the Plan’s deadline. Plaintiff did not dispute that the Plan required her to bring a claim within 180 days, or that she was aware of the limitations provision. On Boeing’s motion to dismiss, the court found that Plaintiff’s action is barred by limitations and that the 180-day limitations period for bringing a civil action is reasonable. As such, the court dismissed the action with prejudice.

F. Sixth Circuit

Constructive knowledge is inadequate to impose three-year statute of limitations under 29 U.S.C. § 1113. [Stockwell v. Hamilton, No. CV 15-11609, 2016 WL 612757 \(E.D. Mich. Feb. 16, 2016\)](#) (Judge Linda V. Parker). Plaintiff Douglas Stockwell is a Trustee and participant in the ERISA-regulated Union Pension Fund (“Pension Fund”), and he is also the Union’s Business Manager and Chief Financial Officer. The other plaintiff is the International Union of Operating Engineers Local 324 (“Union”). In their Complaint, Plaintiffs allege that Defendants breached their fiduciary duties while acting as officers and employees of the Union and the Pension Fund, in violation of Sections 404 and 406 of ERISA, 29 U.S.C. §§ 1104, 1106. Defendants moved to dismiss on the basis that the claims are time-barred. The court declined to construe the “actual knowledge” requirement of 29 U.S.C. § 1113 to include constructive knowledge, where

Plaintiffs did not have actual knowledge of the wrongful conduct but the Pension Fund Trustees and counsel for the Board of Trustees and Pension Fund had actual knowledge. The court explained that the plain language of the statute clearly reflects that Congress did not intend the limitations period to run from the actual knowledge of anyone other than the person bringing suit. The court held that actual knowledge of Plaintiffs is relevant to determine when ERISA's statute of limitations begins to run and the lawsuit is not time-barred.

Whether plaintiffs knew or should have known about denial of ERISA plan benefits remains a question of fact that cannot be resolved at early juncture in litigation. [Jammal v. American Family Insurance Group, et al., No. 1:13 CV 437, 2016 WL 165447 \(N.D. Ohio Jan. 14, 2016\)](#) (Judge Donald C. Nugent). Defendants moved for partial summary judgment on Plaintiffs' claims on the basis of untimeliness. The court previously denied Defendants' motion to dismiss and found that because Defendants classified Plaintiffs as independent contractors, a limited period of equitable tolling should apply up until Plaintiffs became aware that they were, in fact, consistently being treated as employees and not as independent contractors. On Defendants' motion for partial summary judgment on Plaintiffs' claims for benefits, the court explained that Plaintiffs cannot be held responsible for discovering that they had been denied benefits before they had reason to know that they were owed such benefits. Further, in order to know they were being denied benefits, they would have to know not only that they were being treated as employees, but that employees of the company were entitled to benefits under an ERISA plan. The court determined that the question of when Plaintiffs should have known that they were entitled to and had, in fact, been denied benefits under ERISA health, life, and termination benefit plans remains a question of fact that cannot be resolved at this stage of the litigation. On the fiduciary breach claim, the court found that there has been no information presented indicating when the benefit claims should have vested, which would be relevant to when the claim accrued, nor has there been any information presented that would establish as a matter of law that Plaintiffs could or should have known all of the relevant facts that were the basis for this ERISA claim for breach of fiduciary duty prior to the actual denial of termination benefits at the time of their termination. As such, the court denied Defendants' motion for partial summary judgment.

G. Seventh Circuit

In matter alleging breach of fiduciary duty to procure and deliver the funds in Plaintiff's pension accounts that he requested back in 1988, finding that Plaintiff had actual knowledge of the essential facts needed to assert his claim for breach of fiduciary duty in 1989, and the three-year statute of limitations provided by ERISA expired in 1992. Even if Plaintiff asserts a claim for denial of benefits, the 10-year statute of limitations began accruing in 1988 when Plaintiff first elected to take a lump sum payment, and it expired in 1998 (nearly seventeen years prior to Plaintiff filing his Complaint). [Utley v. Prairie Power, Inc., No. 15-CV-03324, 2016 WL 3030222 \(C.D. Ill. May 26, 2016\)](#) (Judge Sue E. Myerscough).

H. Eighth Circuit

Affirming district court's grant of summary judgment in favor of Sun Life on grounds that Plaintiff's long-term disability claim is time-barred under the Plan's contractual limitations period (although district court concluded that Sun Life had not abused its discretion in denying the LTD benefits application); Minnesota Statutes § 62A.04 does not apply to group insurance policies; Minnesota's notice prejudice law does not apply to issue of whether the lawsuit was timely. [Schmitz v. Sun Life Assurance Co. of Canada, No. 14-3701, F.3d , 2016 WL 4434566 \(8th Cir. Aug. 22, 2016\)](#) (Before RILEY, Chief Judge, COLLOTON and KELLY, Circuit Judges).

I. Ninth Circuit

The Ninth Circuit in this case previously held that the plan beneficiaries' claims regarding the selection of mutual funds in 1999 were time-barred under the six-year limit of 29 U.S.C. § 1113(1). The Supreme Court vacated the decision on the basis that fiduciaries have an ongoing duty to monitor investments even absent a change in circumstances. The *en banc* court held that [Phillips v. Alaska Hotel & Rest. Emps. Pension Fund, 944 F.2d 509 \(9th Cir. 1991\)](#), which held that when a fiduciary violated a continuing duty over time, the three-year limitations period set forth in 29 U.S.C. § 1113(2) began when the plaintiff had actual knowledge of a breach in a series of discrete but related breaches, does not apply to the continuing duty claims at issue under § 1113(1). To be considered timely, only a "breach or violation," such as a fiduciary's failure to conduct its regular review of plan investments, need occur within the six-year statutory period of § 1113(1); the initial investment need not be made within the statutory period. [Tibble v. Edison International, No. 10-56406, F.3d , 2016 WL 7321373 \(9th Cir. Dec. 16, 2016\)](#) (Before: SIDNEY R. THOMAS, Chief Judge, and STEPHEN REINHARDT, BARRY G. SILVERMAN, M. MARGARET MCKEOWN, RICHARD A. PAEZ, RICHARD R. CLIFTON, CARLOS T. BEA, MILAN D. SMITH, JR., JACQUELINE H. NGUYEN, PAUL J. WATFORD and MICHELLE T. FRIEDLAND, Circuit Judges).

Finding that *pro se* plaintiff's claims related to the denial of long-term disability benefits is time-barred since he did not file suit until two years after the expiration of the limitations period (which was three years following the denial of his administrative appeal) but granting leave to amend to permit Plaintiff to allege facts which would support a theory of timeliness. [Zelhofer v. Metro. Life Ins. Co., No. 2:16-CV-00773 TLN AC, 2016 WL 4126724 \(E.D. Cal. Aug. 3, 2016\)](#) (Magistrate Judge Allison Claire).

Granting Defendants’ motion for summary judgment and finding time-barred Plaintiffs’ breach of fiduciary duty claim related to Defendants’ decision to invest \$100 million of pension fund assets in an investment fund known as the Longview or Ultra Fund, where the court found that the “true” breach was Defendants’ decision to approve, without exercising the requisite due diligence of a prudent investigation, the Longview investment and relationship with Amalgamated Bank in the first place, which was consummated at the latest on October 22, 2007, when the Investment Management Agreement with Amalgamated Bank was signed; six-year statute of limitations does not run from last “capital call,” which occurred in February 2009. [Slack v. Burns, No. 13-CV-05001-EMC, 2016 WL 3916292 \(N.D. Cal. July 20, 2016\)](#) (Judge Edward M. Chen).

In lawsuit arising from alleged misinformation about pension benefits, denying Boeing’s motion for summary judgment on the basis of the applicable statute of limitations since there remains a genuine issue of material fact as to whether Plaintiffs were provided the necessary information to alert them to their claims and Plaintiffs are entitled to further discovery under Rule 56(d). [Monper v. Boeing Co., No. C13-1569 RSM, 2016 WL 1703839 \(W.D. Wash. Apr. 28, 2016\)](#) (Judge Ricardo S. Martinez).

Claim for long-term disability benefits time barred based on plan’s 3-year contractual limitations period where proof of loss was due February 21, 2012 and complaint was filed three years beyond that date. [Townesley v. Lifewise Assurance Co., No. C15-1228-JCC, 2016 WL 1393548 \(W.D. Wash. Apr. 8, 2016\)](#) (Judge John C. Coughenour).

Lawsuit for long-term disability benefits is time-barred based on Plan’s contractual limitations period where the claimant did not file a claim until after the limitations period had run. [Upadhyay v. Aetna Life Ins. Co., No. 14-15420, Fed.Appx. _____, 2016 WL 1128183 \(9th Cir. Mar. 23, 2016\)](#) (Before McKEOWN, TALLMAN, and M. SMITH, Circuit Judges). In this long-term disability matter, the Ninth Circuit held the district court properly granted Aetna summary judgment on the ground that Plaintiff’s action was untimely under the disability plan provisions, which provide that “No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.” Plaintiff was required to file a claim for benefits by July 1, 2007; and the three-year contractual limitations period ended on July 1, 2010. However, Plaintiff did not file her claim for benefits until December 13, 2010, and she did not file a lawsuit until March 4, 2013. Therefore, the court determined that Plaintiff’s ERISA action is untimely under the provisions of the Plan. The court further held that Aetna did not waive its contractual limitations defense despite failing to inform Plaintiff, in its denial letters, of the Plan’s contractual limitations period for filing suit under ERISA. The court explained that under California law, an insurance company cannot waive a contractual limitations defense when the limitations period has already run. Even if Aetna could waive the contractual limitations period, Plaintiff did not show “an element of detrimental reliance or some misconduct” on the part of

Aetna. The court rejected Plaintiff’s argument that Aetna’s contractual limitations defense fails because the defense is “an impermissible attempt to circumvent” California’s notice-prejudice rule. This is because Aetna does not have to show prejudice in order to prevail on a limitations defense challenging the timing of the ERISA action itself. Lastly, the court found that the district court was correct in denying Plaintiff’s motion for reconsideration where Plaintiff raised the argument that her suit was timely under the Supreme Court’s decision in *Heimeshoff* and § 10350.7 of the California Insurance Code because this argument was not raised in Plaintiff’s summary judgment opposition brief but could have been raised since the legal principle announced in *Heimeshoff*—that a controlling statute could supplant a plan’s contractual limitations period—was already law in the Ninth Circuit at the time Plaintiff filed her opposition brief.

J. Tenth Circuit

Granting Defendants’ Motion for Partial Dismissal Under Rule 12(b)(6) because claims are time barred by the one-year contractual limitations period, and concluding that (1) an average plan participant would not consider the SPD’s limitations provision to be ambiguous; (2) 29 C.F.R. § 2560.503-1(g)(1)(iv) only requires initial denial letters to include time limits applicable to a plan administrator’s internal review procedures; (3) 29 C.F.R. § 2560.503-1(j)(4) does not require the plan administrator to include any time limits for review procedures in the final denial letters. [Michael C.D. & Michael D. v. United Healthcare, United Behavioral Health, Georgia-Pacific Llc, & The Georgia-Pacific Lifechoices Benefits Program \(501\), No. 2:15-CV-306-DAK, 2016 WL 2888984 \(D. Utah May 17, 2016\)](#) (Judge Dale A. Kimball).

Affirming district court’s dismissal of employee benefit plans’ breach of fiduciary duty claim against Defendants for being time-barred, where plans had actual knowledge in August 2010 that employer contributions were not being made, statute of limitations ran in August 2013, and lawsuit was not filed until December 2014. [Mid-S. Iron Workers Welfare Plan v. Harmon, No. 15-6064, 2016 WL 1445067 \(10th Cir. Apr. 13, 2016\)](#) (Before GORSUCH, McKAY, and BACHARACH, Circuit Judges).

Claims challenging changes to retiree prescription drug benefits are time-barred. [International Brotherhood of Electrical Workers, Local #111, et al. v. Public Service Company of Colorado & Xcel Energy Inc., et al., No. 12-CV-01694-PAB-MEH, 2016 WL 1258544 \(D. Colo. Mar. 31, 2016\)](#) (Philip A. Brimmer). This putative class action challenges Defendants’ changes to retirees’ prescription drug benefits, including a “Members Pay the Difference” (“MPD”) program. Defendants argued that Plaintiffs’ “new claims” as they relate to allegations concerning MPD are barred by the applicable statute of limitations because the MPD was

implemented in January 2006. The court found that the claims related to MPD's policy on "dispense as written" prescriptions accrued in February 2013, when Defendants informed Plaintiffs for the first time that MPD operates in a manner inconsistent with Defendants' representation in connection with the Vandeventer Grievance (a March 2010 grievance addressing the description of MPD in a document received by an employee in anticipation of his own retirement). The court further found that because MPD was implemented on January 1, 2006, any claim that is not based on the alleged February 2013 discovery concerning MPD's implementation was time-barred as of January 1, 2009. Thus, the court determined that the Class Representatives' ERISA claim will be dismissed to the extent that plaintiffs allege that MPD itself violates the Plan even if retirees are not required to pay more for "dispense as written" prescriptions.

K. Eleventh Circuit

In matter seeking to recover optional life insurance benefits and an accidental death insurance benefit, granting summary judgment in favor of Liberty Life, finding that lawsuit is barred by policy's contractual limitations period requiring that any legal action be filed no more than one year after the time Proof of claim is required and satisfactory proof of loss must be given to Liberty Life no later than 30 days after the date of loss. Here, the insured died on December 27, 2013 and Plaintiff was required to file suit by January 27, 2015 but did not file suit until June 12, 2015. [Webb v. Liberty Life Assurance Co. of Boston, No. 1:15-CV-2508-TWT, 2016 WL 3087455 \(N.D. Ga. June 1, 2016\)](#) (Judge Thomas W. Thrash, Jr.).

XXIII. *Statutory Damages & Notice Violations*

A. Third Circuit

When Plaintiff, who is African-American, learned that two white employees had received much larger lump-sum retirement payments than he did despite having held similar positions at Sysco for about the same number of years, he brought suit under ERISA and the New Jersey Law Against Discrimination. The court affirmed the dismissal of his complaint because he failed to state a claim under either act. With respect to the ERISA statutory penalty claim, the court held that Plaintiff's allegation that Defendants did not provide him with information about his retirement benefit did not state a claim under ERISA Section 1132(c)(1). [Galman v. Sysco Food Servs. of Metro N.Y. LLC, No. 16-1744, F.App'x](#) , 2016 WL 7158009 (3d Cir. Dec. 8, 2016) (Before: AMBRO, SHWARTZ, and FUENTES, Circuit Judges).

Discover is not be liable for a COBRA notification violation under the ERISA because it is not the “plan administrator.” Only the plan administrator is liable for statutory penalties based on a COBRA notification violation. In this case, the “Employee Benefits Committee of Discover Financial Services” is the plan administrator. [Myrick v. Discover Bank, No. 16-1966, F.App’x , 2016 WL 5859702 \(3d Cir. Oct. 7, 2016\)](#) (Before: VANASKIE, SCIRICA and FUENTES, Circuit Judges).

Finding that Defendant Reppert, Inc. is not liable under 29 U.S.C. § 1132(c)(1) for any failure to produce any other custodial agreements for the 401(k) Plan (apart from the custodial agreement with Nationwide Trust Company, FSB), and imposing a document penalty of \$15,959.00 for its failure to timely produce plan documents for the period December 6, 2008 to October 2, 2009 and for its failure to timely produce its custodial agreement with the Nationwide Trust Company, FSB for the period May 17, 2012 to January 1, 2015. [Askew v. R.L. Reppert, Inc., No. 11-CV-04003, 2016 WL 5661714 \(E.D. Pa. Sept. 30, 2016\)](#) (Judge James Knoll Gardner).

Medical provider with valid assignment adequately alleged claim for document penalties. [Prof'l Orthopedic Associates v. Qualcare, Inc., No. CV137523KMJBC, 2016 WL 642378 \(D.N.J. Feb. 16, 2016\)](#) (Judge McNulty). Plaintiff, a doctor with a valid assignment from his patient, brought a claim for penalties under 29 U.S.C. § 1132(c)(1) against Defendant for failing to produce documents relating to the insurance claims review process. The court declined to dismiss this claim. Here, it is alleged that Plaintiff made the request for documents, not the actual plan participant, Patient A.L. However, under the terms of the Assignment, Patient A.L. authorized the release of “any and all plan documents, insurance policy and/or settlement information upon written request from the provider”, the plaintiff. The complaint alleges that Plaintiff sought the documents from both Qualcare and Meridian, as plan administrator, and no documents were provided in response to the request. The court determined that no more is required to state the elements of a 502(c) claim.

Statutory penalties awarded against plan administrator for failing to produce required documents pertaining to 401(k) plan. [Askew v. R.L. Reppert, Inc., et al., No. 11-CV-04003, 2016 WL 447060 \(E.D. Pa. Feb. 5, 2016\)](#) (Judge James Knoll Gardner). Plaintiff filed a six-count Class Action Complaint. Count One alleges violations of ERISA document production requirements and seeks statutory penalties pursuant to 29 U.S.C. § 1132(c)(2) against Reppert, Inc. as plan administrator. The court granted Plaintiff’s motion for partial summary judgment and dismissal in part on Count One because it concluded that defendant Reppert, Inc. failed to produce any required documents pertaining to the 401(k) Plan within thirty days of Plaintiff’s written request and because defendant failed to produce a custodial agreement with Nationwide Trust Company, FSB. The court denied summary judgment on Count One in part because it found that (1) defendant Reppert, Inc. was not obligated to produce any documents regarding the Davis Bacon Plan; (2) defendant Reppert, Inc. fulfilled any document production obligations it had with respect to trust agreements, periodic benefits statements, notice of vested deferred

benefits, disclosure of financial reports, Section 404(c) disclosures, notice of qualified default investment, notice of availability of investment advice, and depository documents for the 401(k) Plan; (3) Plaintiff has not provided sufficient evidence to demonstrate entitlement to any custodial agreements other than the Nationwide Trust Company agreement; and (4) there are genuine disputes of material fact relating to what, if any, penalties should be imposed on defendant for such failure.

B. Fifth Circuit

Denying Outreach Defendants' Motion to Dismiss Plaintiff's claims under 29 U.S.C. §§ 1022(a) and 1024(b) because the Court can draw the reasonable inference that Plaintiff alleges Defendants failed to meet the thirty-day deadline. That Plaintiff did not specifically allege to whom her alleged requests were sent, that the requests were sent to the plan administrator, or that her requests were made in writing, are not fatal to her claim, to the extent she intends to state a claim under § 1024(b)(4). Also, the Fifth Circuit has suggested in dicta that where a plan names a plan administrator, an entity other than the named administrator may nonetheless be held liable as a de facto administrator where the plan delegates the administrator's duties to that entity. [Simmons v. Outreach Health Cmty. Care Servs. LP, No. EP-15-CV-286-KC, 2016 WL 3162147 \(W.D. Tex. June 3, 2016\)](#) (Kathleen Cardone).

Summary judgment denied on COBRA notice claim. [Newton v. Prator, No. CV 14-3116, 2016 WL 698170 \(W.D. La. Feb. 18, 2016\)](#) (Judge Elizabeth Erny Foote). In Defendant's motion for summary judgment, he argued that Plaintiff is not entitled to recovery on his COBRA claim for two alternative reasons: 1) Plaintiff fails to demonstrate as a matter of law that Defendant violated COBRA because Defendant sent Plaintiff notice of termination with his last known address and all that COBRA requires of an employer is to send notice to the last known address, not to ensure actual delivery; 2) Plaintiff has not demonstrated that he is entitled to any damages even if there is still a genuine dispute of fact about whether Defendant fulfilled his COBRA notice obligations. On liability, the court determined that there is a genuine dispute about whether Caddo Parish Sheriff's Office ("CPSO") operated in good faith in giving Amerifax notice of Plaintiff's termination. Plaintiff alleged that he gave CPSO an updated address in 2010 and therefore CPSO knew that they were sending Amerifax an old address when they notified it of his termination. The court found that there remains a genuine issue of material fact as to good faith. On the issue of damages, the court determined that Plaintiff is not entitled to statutory damages because 29 U.S.C. § 1132(c) only applies to administrators that violate their obligations under § 1666, not to employers or their obligations under § 1666. Instead, damages for an employer's failure to notify an administrator under § 1666(a)(2) is found in ERISA's general damages provision, 29 U.S.C. § 1132(a)(3)(B). The court explained that because Plaintiff alleged a violation of COBRA's notice provision, his damages are limited to the post-termination medical expenses he incurred minus the COBRA premium he would have had to pay

to cover those expenses. The court determined that it cannot rule that as a matter of law Plaintiff is not entitled to relief on his claim because there is a dispute of material fact as to whether Plaintiff demonstrated compensatory damages.

C. Sixth Circuit

Denying Liberty Life’s claim for alleged overpayment in long-term disability case, where the SSDI award causing a retroactive overpayment was issued after the administrative record already closed. “Having successfully moved the Court to strike the only evidence of Plaintiff’s receipt or possession of Social Security Disability benefits, Defendant proffers no evidence to support its request for refund.” [Folds v. Liberty Life Assurance Co. of Boston, No. 4:15-CV-00354, 2016 WL 5661615 \(N.D. Ohio Sept. 30, 2016\)](#) (Judge Benita Y. Pearson).

In a dispute between a health care provider and a no-fault automobile insurance company regarding payment of insured’s charges for medical care, where the insured is covered by both an ERISA plan and a no-fault automobile insurance policy, concluding that the ERISA Plan provision at issue, which excludes coverage required by no-fault auto insurance, is an absolute exclusion and not an escape-type coordination-of-benefits provision. [Bronson Health Care Grp., Inc. v. State Farm Mut. Auto. Ins. Co., No. 1:15-CV-823, 2016 WL 5661664 \(W.D. Mich. Sept. 29, 2016\)](#) (Judge Gordon J. Quist).

D. Seventh Circuit

Statutory penalties under 29 U.S.C. § 1132(c)(1) do not apply generally to violations of 29 U.S.C. § 1024 but rather apply only where an administrator “fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary.” 29 U.S.C. § 1132(c)(1)(B). [Bhattacharya v. Capgemini N. Am., Inc., No. 16 C 7950, 2016 WL 7049082 \(N.D. Ill. Dec. 4, 2016\)](#) (Judge Matthew F. Kennelly).

E. Ninth Circuit

Affirming the district court’s decision to impose a penalty on ING North America for its failure to timely produce the Plan Document after Plaintiff requested all documents relevant to Lee’s claim for long-term disability benefits; joining the First, Second, Third, Sixth, Seventh, Eighth, and Tenth Circuits in holding that a failure to follow claims procedures imposed on benefits plans, such as outlined in 29 C.F.R. § 2560.503–1(h)(2)(iii) does not give rise to penalties under 29 U.S.C. § 1132(c)(1) and reversing district court’s assessment of the penalty against ING for not producing claim-related emails; [Sgro v. Danone Waters of North America, Inc., 532 F.3d 940 \(9th Cir. 2008\)](#) stating to the contrary is nonbinding dicta. [Lee v. ING Groep, N.V., No. 14-15848, ___ F.3d ___, 2016 WL 3974176 \(9th](#)

[Cir. July 25, 2016](#)) (Before: Jerome Farris, Diarmuid F. O’Scannlain, and Morgan Christen, Circuit Judges). In *Lee*, a case involving a denied long-term disability benefit claim, the plaintiff brought suit against the plan administrator challenging the denial of his benefits and seeking statutory penalties for failing to timely produce requested documents. Those documents included Plan documents as well as email communications.

The district court awarded a penalty in the amount of \$27,475, finding that it was bound by the Ninth Circuit decision in *Sgro v. Danone Waters of North America, Inc.*, 532 F.3d 940 (9th Cir. 2008), where the Court had affirmed an award of statutory penalties based on a failure to produce notes kept by claims personnel. The Ninth Circuit explained that the relevant language in *Sgro* is non-binding dicta and penalties under 29 U.S.C. § 1132(c)(1) can only be assessed against “plan administrators” for failing to produce documents that they are required to produce as plan administrators. Because 29 C.F.R. § 2560.503–1(h)(2)(iii) does not impose any requirements on plan administrators, it cannot form the basis for a penalty under 29 U.S.C. § 1132(c)(1).

The district court stated that its penalty of \$25 per day for both failing to produce the Plan document and the claim-related emails would be the same even if it was only considering the failure to produce the Plan document, but the Ninth Circuit noted that the district court found the failure to produce the Plan document to be “inadvertent.” As such, it vacated the penalty award and remanded to the district court to assess a penalty based solely on the failure to timely produce the Plan document.

No statutory penalties of \$110 per day under 29 U.S.C. § 1132(c)(1) against the disability plan and insurer for failing to produce documents required by 29 C.F.R. § 2560.503-1(h)(2)(iii). [Lin v. Metro. Life Ins. Co., No. C 15-2126 SBA, 2016 WL 1611036 \(N.D. Cal. Apr. 22, 2016\)](#) (Judge Sandra Brown Armstrong).

Court awards \$10,000 in penalties for the delay in providing CBA and LLC Agreement and Contract. [Barling v. Uebt Retiree Health Plan, No. 14-CV-04530-VC, 2016 WL 687965 \(N.D. Cal. Feb. 19, 2016\)](#) (Judge Vince Chhabria). Plaintiff sought statutory penalties for the Plan’s failure to timely provide certain documents: (i) the Summary Plan Description; (ii) the Trust agreement; (iii) the Collective Bargaining Agreement; (iv) the Amended and Restated Limited Liability Company Agreement for the UFCW – Employers Benefit Plans of Northern California Group Administration, LLC; and (v) the contract between the Plan and the UFCW– Employers Benefit Plans of Northern California Group Administration, LLC. The Plan admits that it did not provide these documents within the 30-day timeframe set forth in 29 U.S.C. §§ 1024(b)(4); 1132(c). The court considered any bad faith or intentional misconduct by the administrator, the length of delay, the number of requests made and the extent and importance of the documents withheld, and any prejudice to the participant. The court found that Plaintiff was not prejudiced by the delay in receiving the SPD and the Trust Agreement. The delay was relatively short and there’s no evidence of bad faith. The court did find that the delay in providing the Collective Bargaining Agreement was excessive and it took many requests from Plaintiff’s counsel. For this, the court awarded Plaintiff \$5,000. Lastly, the court found that the LLC Agreement and Contract are documents within the scope of 29 U.S.C. § 1024(b)(4) and the

year-long delay in providing these documents was excessive. For this, the court awarded Plaintiff \$5,000. The court ordered Defendants to pay Plaintiff a total of \$10,000 in statutory penalties.

Master Business Agreement referenced in claim and appeal denial letters is not a disclosure required by Section 1024(b)(4). [Gurasich v. IBM Ret. Plan, No. 14-CV-02911-DMR, 2016 WL 362399 \(N.D. Cal. Jan. 29, 2016\)](#) (Magistrate Judge Donna M. Ryu). Plaintiff sought Section 502(c)(1)(B) penalties against Defendants for not producing the Master Business Agreement (“MBA”), which is the May 2, 1992 agreement between IBM, Siemens Communication Systems, Inc., and Siemens Aktiengesellschaft that is referenced in Appendix C of the 1994 version of the IBM Plan. The Plan Administrator referenced the MBA in the initial denial letter as well as the denial of Plaintiff’s appeal. Plaintiff argued that Defendants were required to produce the MBA during the administration of her claim pursuant to 29 U.S.C. § 1024(b)(4) and Defendants’ failure to produce the MBA resulted in a violation of 29 C.F.R. § 2560.503–1, which is an implementing regulation for 29 U.S.C. § 1133. The court denied Plaintiff’s motion for summary judgment, finding that IBM was not required to produce the MBA under section 1024(b)(4). The court noted that the Ninth Circuit narrowly construes the disclosures required by section 1024(b)(4) and Plaintiff put forward no evidence that the MBA is a contract, or other instrument under which the IBM Plan is established or operated, provides participants with information about the plan and benefits, or otherwise qualifies as an instrument similar in nature to the documents specifically enumerated in the statute. The court also determined that a violation of 29 C.F.R. § 2560.503-1(h)(2)(iii), which requires that a benefits plan provide a claimant copies of all documents, records, and other information relevant to the claimant’s claim for benefits, does not trigger liability under 29 U.S.C. § 1132(c)(1)(B).

F. Tenth Circuit

Section 1133(2) does not provide for a private cause of action and document penalties are only available against the designated plan administrator. [Swanson v. Aetna Life Insurance Company, No. 15-CV-0785-WYD-CBS, 2016 WL 54118 \(D. Colo. Jan. 5, 2016\)](#) (Judge Wiley Y. Daniel). Plaintiff brought suit for the denial of Accidental Death and Personal Loss benefits under an ERISA plan sponsored by Bank of America. Aetna, the claims administrator, denied the claim on the basis that Plaintiff’s +-spouse’s death was not a covered loss under the terms of the plan. Plaintiff brought two claims for relief, the first for benefits under 29 U.S.C. § 1133(2) and the second for penalties under 29 U.S.C. § 1132(c)(1). The court found that Section 1133(2) does not provide for a private cause of action for the recovery of denied benefits, rather it provides for a full and fair review of a denial decision. Based on case law, failure to comply with this procedural requirement does not create a private remedy. Here, Plaintiff did not allege any failure on the part of the plan, but instead asserted that Aetna and Bank of America failed under the requirements of this subsection of the statute. But, the Tenth Circuit has established that there is no private right of action under Section 1133 for claims against employers or plan

administrators. The court also found that Plaintiff's § 1132(c)(1)(B) claim could only be brought against the plan administrator, Bank of America, and not Aetna. Plaintiff only requested documents from Aetna. Plaintiff had dismissed Bank of America from the case and the court rejected Plaintiff's contention that she inadvertently failed to correct the stipulation to dismiss Aetna instead of Bank of America. The court granted Defendants' motion to dismiss on both claims.

XXIV. Subrogation/Reimbursement Claims

A. SCOTUS

ERISA Section 502(a)(3) does not authorize health benefit plan to seek recovery from participant's general assets. [Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan, No. 14-723, ___ S. Ct. ___, 2016 WL 228344 \(U.S. Jan. 20, 2016\)](#) (Justice Alito joining in part, Justice Ginsberg dissenting). This case involved an ERISA health benefit plan's attempt to enforce an equitable lien against a participant's third-party settlement. The court held that when an ERISA-plan participant wholly dissipates a third-party settlement on nontraceable items (i.e., food, travel), the plan fiduciary may not bring suit under ERISA Section 502(a)(3) to attach the participant's separate assets. The Supreme Court reversed and remanded the case to the district court to determine, in the first instance, whether Montanile kept his settlement fund separate from his general assets and whether he dissipated the entire fund on nontraceable assets.

By way of background, Montanile was a participant in the Board of Trustees of the National Elevator Industry Health Benefit Plan ("the Plan") when his automobile was struck by a drunk driver. The Plan paid more than \$120,000 in Montanile's medical expenses, but the written Plan instrument required Montanile to reimburse the Plan out of any third-party recovery related to his injuries. After suing the drunk driver, Montanile obtained a \$500,000 settlement, from which he netted about \$240,000 after attorneys' fees and costs. Montanile's attorney and the Plan attempted to reach an agreement about the Plan's right to reimbursement but discussions broke down. At that point, Montanile's attorney put the Plan on notice that he was distributing the client's share of the settlement to the client unless the Plan objected within 14 days, which it did not.

After six months of negotiations ended, the Plan brought suit against Montanile under ERISA Section 502(a)(3), which in relevant part provides that plan fiduciaries can file civil suits to obtain appropriate equitable relief to enforce the terms of the plan. The Plan requested that the district court enforce an equitable lien upon any settlement funds in the actual or constructive possession of Montanile and to enjoin Montanile from dissipating the funds. At that point Montanile had spent almost all of the settlement funds.

The Supreme Court granted certiorari to resolve a conflict among the Courts of Appeals over whether an ERISA fiduciary can enforce an equitable lien against a defendant's assets when the participant dissipates the specifically identified fund. In coming to its decision, the Supreme Court went back to the days of the divided bench to ascertain whether the equitable relief the Plan seeks was typically available in premerger equity courts. Under its precedent, the Court found that the basis of the Plan's claim is equitable but the *remedy* the Plan seeks – enforcement of an equitable lien by agreement against the participant's general assets – is not equitable.

Prior to its decision in *Montanile*, the Supreme Court had decided three major ERISA reimbursement/subrogation cases in over the past decade, the last two of which did not bode well for the subrogation defendant. First, in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), the Court held that enforcement of a constructive trust or an equitable lien required that the money or property could clearly be traced to particular funds or property in the defendant's possession. In *Great-West*, because the plan fiduciaries sought legal relief based on a contractual obligation to pay money, instead of restitution obtained from specific funds or identifiable property in the participant's possession, the fiduciaries could not seek reimbursement under Section 502(a)(3). Next, in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), the Court held that a plan's equitable lien by agreement was enforceable because the Plan sought specifically identifiable funds that were within the possession and control of the beneficiaries. The beneficiaries had placed the proceeds of their tort action settlement in a separate investment account. Similarly, in *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), the Court found that the plan could enforce an equitable lien against specifically identifiable funds within the beneficiaries' control – that is, a portion of the settlement they had gotten.

The Supreme Court explained that the Plan's underlying *remedy* would have been equitable had it *immediately* sued to enforce the lien against the settlement fund then in *Montanile*'s possession. The Court found support for its position on this issue by turning to standard equity treatises. Those treatises make clear that a plaintiff can enforce an equitable lien only against specifically identified funds that remain in the defendant's possession or against traceable items that the defendant purchased with the funds (i.e., a car). The Supreme Court rejected the Plan's arguments that certain exceptions apply to this rule, including the principles of substitute money decrees, deficiency judgments, and the swollen assets doctrine.

Justice Alito joined the majority except for the discussion concerning the majority's rejection of the Plan's argument that enforcing plan documents according to their terms and of protecting plan assets would be best served by allowing plans to enforce equitable liens against a participant's general assets. Justice Ginsberg dissented, finding that the Court erred in *Great-West* by reading ERISA as unraveling four years of fusion of law and equity. Justice Ginsberg also found that it was a bizarre conclusion to permit a participant to escape reimbursement obligations by spending the settlement funds rapidly on nontraceable items.

B. First Circuit

Entering judgment in favor of Unum on its counterclaim for overpaid long-term disability benefits as a result of a personal injury settlement in the amount of \$58,938.75. This includes a 7.5% reduction applied by the court for Plaintiff's permanent physical scarring. Court found that Unum's failure to review photographs of Plaintiff and determine whether any portion of the net settlement should be allocated to scarring was arbitrary and capricious. [Sugalski v. Paul Revere Life Ins. Co., No. CV 14-40015-TSH, 2016 WL 4473412 \(D. Mass. Aug. 24, 2016\)](#) (Judge Hillman).

C. Second Circuit

Granting Defendants' motion for reconsideration based upon the Supreme Court's recent decision in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, 136 S. Ct. 651 (2016), which abrogated the Second Circuit's decision in *Thurber v. Aetna Life Insurance Company*, 712 F.3d 654 (2d Cir. 2013), which the court relied upon in reaching its previous conclusions. Plaintiff does not have a claim for equitable relief because the funds are not traceable and the Plan document does not impose an equitable lien. Defendants are entitled to summary judgment on their counterclaim and should be awarded the amount owed under the settlement agreements between the parties which are not expressly preempted by ERISA. [District Photo Inc. Health Care Plan v. Dimitri Pyrros, M.D. and Zelen Pyrros, M.D., P.C., No. 13CV4285JFBSIL, 2016 WL 5407869 \(E.D.N.Y. Sept. 28, 2016\)](#) (Judge Joseph F. Bianco).

A party seeking a constructive trust on benefits allegedly incorrectly paid does not have to specifically identify, in an initial pleading, the location or account numbers of the funds the party seeks to recover; whether the monthly pension benefit payments received by Plaintiffs from Defendants have been dissipated is a matter upon which the defendants are entitled to discovery. [Metzgar v. U.A. Plumbers & Steamfitters Local No. 22 Pension Fund, No. 13-CV-85V\(F\), 2016 WL 1545186 \(W.D.N.Y. Apr. 15, 2016\)](#) (Judge Lawrence J. Vilaro).

D. Third Circuit

In suit claiming that Defendants violated New Jersey's Collateral Source Statute by seeking and accepting reimbursement from him after he successfully recovered compensation for a car accident in which he was involved, the court denied Defendants' motion to dismiss the fiduciary duty claims because the court will look to New Jersey law, rather than the plan language, in adjudicating Plaintiff's fiduciary duty claims, such that *Harrow v. Prudential*

Ins. Co. of America, 279 F.3d 244 (3d Cir. 2002) does not support dismissal of the fiduciary duty claims. The court also denied Defendants' motion to strike the class action allegations as premature. [Minerley v. Aetna, Inc., No. CV 13-1377 \(NLH/KMW\), 2016 WL 7013456 \(D.N.J. Nov. 30, 2016\)](#) (Judge Noel L. Hillman).

In lawsuit asserting that Defendant is not entitled to withhold payment of medical benefits as a "set-off" against moneys that Defendant claims are owed to it as a result of a previous accident, the court found that Defendant's motion to dismiss based on its res judicata argument is procedurally proper and Defendant was not required to bring the motion as a summary judgment motion. This court's previous grant of summary judgment in favor of Defendant qualifies as a final judgment on the merits in a prior suit for the purposes of res judicata. [Mclaughlin v. Board of Trustees of The National Elevator Industry Health Benefit Plan, No. CV 16-3121, 2016 WL 5955530 \(D.N.J. Oct. 13, 2016\)](#) (Judge Anne E. Thompson).

Certifying the following question for interlocutory appeal pursuant to 28 U.S.C. 1292(b): **Whether the terms of an ERISA Plan requiring a plan participant to reimburse the Plan in full without reduction for attorney's fees preempts or supersedes a claim brought by a third party attorney against the Plan for unjust enrichment under the common fund doctrine where the Plan has been reimbursed in full by the plan beneficiary.** [UnitedHealth Grp. Inc. v. MacElree Harvey, Ltd., No. CV 16-1026, 2016 WL 5239675 \(E.D. Pa. Sept. 21, 2016\)](#) (Judge C. Darnell Jones, II). In this case, the court certified for interlocutory appeal pursuant to 28 U.S.C. 1292(b) the following question:

Whether the terms of an ERISA Plan requiring a plan participant to reimburse the Plan in full without reduction for attorney's fees preempts or supersedes a claim brought by a third party attorney against the Plan for unjust enrichment under the common fund doctrine where the Plan has been reimbursed in full by the plan beneficiary.

This followed the court's previous decision where it ruled that a plan fiduciary can sue under ERISA § 502(a)(3) to receive either (1) injunctive or declaratory judgment that participant's counsel cannot recover attorney's fees from the plan from monies the plan received pursuant to a subrogation and reimbursement clause that specifically exempts attorney's fees, or (2) in the alternative, declaratory judgment that the participant indemnify the plan for any attorney's fees participant's counsel recovers from the plan. The court determined that it is "equitable relief" when a plan administrator seeks an equitable lien against a fund already in its possession so as to prevent claims against the fund by non-parties to the Plan and it is "equitable relief" when a plan administrator seeks a declaration that a participant indemnify the Plan.

This case highlights the obstacles for personal injury attorneys after the Supreme Court's decision in [U.S. Airways v. McCutchen, 133 S.Ct. 1537 \(2013\)](#).

Plaintiffs' breach of contract claim against Defendant based on health plan's subrogation and reimbursement terms must be dismissed because the breach of contract claim is a legal remedy that is not available under ERISA's equitable recovery scheme. And, because the contract claim requires interpretation of the ERISA plan, the claim is preempted.

[GoDaddy.com LLC v. Monson, No. CV-16-0948-PHX-DKD, F.Supp.3d , 2016 WL](#)

[5109906 \(D. Ariz. Sept. 20, 2016\)](#) (Judge David K. Duncan). Monson was injured in a motorcycle accident while he was covered by the GoDaddy Welfare Benefit Plan. Through settlement, he recovered tort damages for his injuries and the Plan demanded reimbursement of the medical expenses it covered from the settlement proceeds pursuant to the Plan's terms for subrogation and reimbursement. When Monson did not comply, GoDaddy initiated this action seeking legal and equitable relief. The court determined that GoDaddy's breach of contract claim against Monson based on the Plan's subrogation and reimbursement terms must be dismissed because the breach of contract claim is a legal remedy that is not available under ERISA's equitable recovery scheme. And, because the contract claim requires interpretation of the ERISA plan, the claim is preempted.

A plan fiduciary can sue under ERISA § 502(a)(3) to receive either (1) injunctive or declaratory judgment that participant's counsel cannot recover attorney's fees from the plan from monies the plan received pursuant to a subrogation and reimbursement clause that specifically exempts attorney's fees, or (2) in the alternative, declaratory judgment that the participant indemnify the plan for any attorney's fees participant's counsel recovers from the plan. It is "equitable relief" when a plan administrator seeks an equitable lien against a fund already in its possession so as to prevent claims against the fund by non-parties to the Plan and it is "equitable relief" when a plan administrator seeks a declaration that a participant indemnify the Plan. [Unitedhealth Grp. Inc. v. MacElree Harvey, Ltd., No. CV 16-1026, 2016 WL 4440358 \(E.D. Pa. Aug. 23, 2016\)](#) (Judge Jones, II).

E. Fifth Circuit

Granting summary judgment to Prudential on Prudential's Counterclaim against Plaintiff for recoupment of the STD Benefits paid to Plaintiff in error after Prudential discovered that the STD benefits related to a medical condition that Plaintiff was receiving medical treatment for during the pre-existing condition period contained in the Plan. [Manuel v. Turner Indus. Grp., LLC, No. CV 14-599-SDD-RLB, 2016 WL 5404151 \(M.D. La. Sept. 26, 2016\)](#) (Judge Shelly D. Dick).

In matter where health plan is seeking to recoup medical expenses it paid on behalf of Defendant from a third-party settlement, denying summary judgment to both parties on the basis that neither party established as a matter of law that either Humana Health Plan or Humana Insurance Company are, or are not, plan fiduciaries with respect to the reimbursement claim at issue. [Humana Health Plan, Inc. v. Nguyen, No. CV H-13-1793, 2016 WL 4718194 \(S.D. Tex. Sept. 8, 2016\)](#) (Judge Sim Lake).

Settlement agreement does not preclude an assignee from enforcing its subrogation and reimbursement rights. [Cont'l Ins. Co. v. Dawson, No. 15-10510, ___ Fed.Appx. ___, 2016 WL 1055371 \(5th Cir. Mar. 15, 2016\)](#) (Before KING, JOLLY, and PRADO, Circuit Judges).

Continental Insurance Company, acting as an assignee, filed a lawsuit in federal district court to enforce its subrogation and reimbursement rights against Defendant Dawson. In connection with a Texas state court action against a third-party responsible for Dawson's injuries, Continental and Aetna intervened in the state lawsuit, asserting liens upon any settlement or judgment. Dawson and Continental executed a settlement agreement for a complete discharge of Continental's liability for compensation and past medical care. Thereafter, Aetna filed a claim with the DOL against Continental for reimbursement of medical benefits Aetna paid on Dawson's behalf and they agreed to settle the claim. The court found that the terms of an agreement between Aetna and Continental, where Aetna assigned to Continental its subrogation and reimbursement rights connected to Dawson's medical treatment, did not preclude Continental from enforcing the subrogation rights that Aetna had assigned to it nor did it limit Continental's recovery from Dawson to the amount of its lien specified in the Agreement, which Dawson had already paid. Under the settlement, Aetna agreed both to assign the full value of its \$282,774.51 lien against Dawson and to assist Continental in collecting that lien in Dawson's then-pending state lawsuit. The Fifth Circuit reversed and remanded the district court's grant of summary judgment in favor of Dawson.

F. Sixth Circuit

Plaintiff filed this action to enforce the terms of an ERISA Plan regarding the Plan's reimbursement and lien rights in a settlement fund currently being held in escrow as security for that lien. In a counterclaim, Kilduff alleges that the Plan should have paid more of her medical bills. The court granted the Plan's motion to dismiss Defendant's amended counterclaim and its motion for judgment on the pleadings or default regarding Plaintiff's complaint. The court found that the net effect of any additional payments to providers would not have granted any relief to Kilduff under the Plan. [Sterling Collision Centers, Inc. v. Kilduff, No. 16-10103, 2016 WL 6873399 \(E.D. Mich. Nov. 22, 2016\)](#) (Judge John Corbett O'Meara).

The court granted summary judgment in favor of Standard on its breach of contract counterclaim, finding that it is entitled to \$40,633.75 from Plaintiff, the amount that she was overpaid as a result of her receiving Kentucky Retirement Systems benefits and SSDI benefit payments. The court dismissed Standard's restitution and recoupment counterclaim as it seeks the same relief as its breach of contract counterclaim. For the same reason, the court also dismissed Standard's declaratory relief counterclaim on the basis that any LTD benefit payable would be less than the amount she owes Standard. [Graves v. Standard Ins. Co., No. 3:14-CV-00558-CRS-DW, 2016 WL 6875786 \(W.D. Ky. Nov. 21, 2016\)](#) (Judge Charles R. Simpson, III).

Denying motion to dismiss ERISA reimbursement claim brought under 29 U.S.C. Section 1132(a)(3); finding that the Health Plan's reimbursement claim is not barred because the

SPD is legally binding, where it states that it serves as a “written plan document and summary plan description;” and the Plan stated a claim for reimbursement under the SPD even though Defendant did not execute an “optional” separate agreement to reimburse. [CHS/Community Health Systems, Inc. v. Ledford, No. 3:16-CV-00387, 2016 WL 4506094 \(M.D. Tenn. Aug. 29, 2016\)](#) (Judge Sharp).

In matter where no-fault auto insurer brought an action under federal common law and, in the alternative, under ERISA § 502(a) against an ERISA health plan administrator seeking a declaration of coverage and reimbursement or recoupment from the plan administrator for the cost of a plan participant’s medical care, affirming the district court’s dismissal of Farm Bureau’s claim because it has no standing to bring a claim under federal common law or ERISA § 502(a). [Farm Bureau General Insurance Company of Michigan v. Blue Cross Blue Shield of Michigan, No. 15-2323, ___ F.App’x ___, 2016 WL 3924243 \(6th Cir. July 21, 2016\)](#) (Before: COOK and KETHLEDGE, Circuit Judges; SARGUS, Chief District Judge).

ERISA health plan entitled to reimbursement for medical expenses paid and no-fault automobile insurer must reimburse the plan participant. [McClure v. United Parcel Service Flexible Benefits Plan, et al., No. 1:14-CV-845, 2016 WL 524109 \(W.D. Mich. Feb. 10, 2016\)](#) (Judge Gordon J. Quist). Plaintiff sued Defendants, the United Parcel Service Flexible Benefits Plan (the UPS Plan) and State Farm Mutual Automobile Insurance Company (State Farm), seeking declaratory and injunctive relief under ERISA that State Farm—his automobile insurer—is primarily liable for payment of the medical expenses that McClure incurred as a result of a 2011 automobile accident and that, to the extent UPS is entitled to reimbursement for expenses it paid for Plaintiff’s medical care from any third-party recovery that McClure might obtain, State Farm must reimburse Plaintiff for his repayment to the UPS Plan. The court found that the UPS Plan’s Coordination of Benefits clause does not “expressly disavow” claims payable under a no-fault policy. Rather, it simply allows for the reduction of benefits to the extent the participant is entitled to benefits from another source. The court declared that the UPS Plan is entitled to reimbursement from any third-party recovery that Plaintiff obtains, so long as the third party was responsible for the injuries and related medical expenses encompassed in the UPS Plan’s claim for reimbursement, and that the UPS Plan may obtain such reimbursement directly from Plaintiff without intervening in the state-court action. The Court also declared that State Farm is obligated to reimburse Plaintiff for any amount that he is required to reimburse the UPS Plan, to the extent the medical expenses that the UPS Plan paid are within the terms of State Farm’s Personal Injury Protection coverage.

G. Seventh Circuit

Affirming dismissal of self-funded ERISA plan’s action against several individual health insurers seeking reimbursement for medical expenses it paid on behalf of beneficiaries covered under both the ERISA plan and the insurers’ policies. The court held that the

ERISA plan's action for declaratory judgment seeking declaration that health insurers were liable for future medical expenses incurred by beneficiaries who were covered by both ERISA plan and health insurance policies was not ripe for review, and as a matter of apparent first impression, relief sought by ERISA plan was legal, and thus not authorized under ERISA. [Cent. States, Se. & Sw. Areas Health & Welfare Fund by Bunte v. Am. Int'l Grp., Inc., No. 15-2237, ___ F.3d ___, 2016 WL 6205750 \(7th Cir. Oct. 24, 2016\)](#) (Before FLAUM, WILLIAMS, and SYKES, Circuit Judges).

Entering Temporary Restraining Order enjoining and prohibiting Defendants, their agents, servants, employees, attorneys, and all persons acting in concert and participation with them, be enjoined as follows: (1) Defendants are restrained from spending, transferring, or dissipating all or any portion of the proceeds of a \$500,000.00 settlement between Defendants and Roger Cone, Defendant in Case No. 08-L-168 in the Circuit Court of Madison County, Illinois, in connection with a personal injury claim brought by Defendants against Roger Cone; and (2) Defendants are restrained from transferring, dissipating, or in any way disposing of any identifiable or traceable assets that Defendants may have acquired with any of the proceeds of such settlement. [Trustees Of The Carpenters' Health And Welfare Trust Fund Of St. Louis v. Lanny H. Darr, et al., No. 10-CV-0130-SMY-SCW, 2016 WL 2766615 \(S.D. Ill. May 13, 2016\)](#) (Judge Staci M. Yandle).

H. Ninth Circuit

In matter seeking to enforce an ERISA health plan's reimbursement clause in light of a third-party tort settlement, the court found that although the SPD is the only document detailing the terms of the Plan, and contains provisions giving the Plan the right to reimbursement from third party recoveries, JDA can enforce the reimbursement provision under § 1132(a)(3). The court rejected Defendants argument that (1) they did not promise to reimburse JDA because they did receive a copy of the SPD and (2) the reimbursement provision is unconscionable. [JDA Software Inc. v. Berumen, No. CV-14-01565-PHX-DLR, 2016 WL 6143188 \(D. Ariz. Oct. 21, 2016\)](#) (Judge Douglas L. Rayes).

In interpleader action involving distribution of car accident settlement funds, finding that Defendant Southwest Airlines has a first priority lien over plaintiff's attorney's fees, and consistent with ERISA, Southwest's repayment plan is entitled to full reimbursement from settlement proceeds. [G. Dallas Horton & Associates v. Cynthia Harris, et al., No. 215CV1693JCMGWF, 2016 WL 4060306 \(D. Nev. July 28, 2016\).](#)

Disability insurer did not waive right to enforce plan terms and agreement regarding overpayment due to other income benefits. [Smith v. Liberty Life Assurance Co. of Boston, No. 4:14-CV-00495-CWD, 2016 WL 866299 \(D. Idaho Mar. 3, 2016\)](#) (Magistrate Judge Candy W. Dale). In this case, Plaintiff, a long-term disability claimant, challenged Liberty Life's right

to withhold her disability payments to satisfy an overpayment on her claim resulting from her receipt of retroactive Social Security Disability Insurance (SSDI) benefits. Plaintiff had previously resolved a subrogation lien Liberty Life had on her claim for money she received from a third party for her injuries. Plaintiff argued that Liberty Life waived its ability to enforce the policy's subrogation provision against her based on its previous agreement to "waive [its] short term and long term subrogation amounts." The court found that Liberty Life did not waive its right to seek reimbursement for the SSDI award. Liberty Life previously resolved its subrogation claim under Section 7 of the policy but its right to withhold payment of benefits due to the SSDI award falls under Section 4 of the policy covering "Other Income Benefits." Also, Plaintiff had signed a reimbursement agreement, wherein she agreed that in exchange for Liberty Life not reducing her LTD benefits by an estimated SSDI award, Plaintiff would pay back any overpayment of LTD benefits resulting from a future SSDI award.

XXV. *Venue*

A. Second Circuit

Forum selection clause in retirement plan is enforceable against plaintiff who retired prior to plan amendment adding forum provision. [Malagoli v. AXA Equitable Life Ins. Co., No. 14-CV-7180 \(AJN\), 2016 WL 118170 \(S.D.N.Y. Mar. 24, 2016\)](#) (Judge Alison J. Nathan). The court concluded that the forum selection clause in the retirement plan is enforceable against Plaintiff and granted AXA's motion to transfer venue to the District of New Jersey. The court found that the forum selection clause is not *per se* invalid under ERISA. The court noted that neither party addressed whether or not New Jersey is "one of the three forums [otherwise] permitted by" § 1132(e)(2) so that argument is waived. The court concluded that the forum selection clause requiring Plaintiff to bring suit in the District of New Jersey is not invalid in the face of ERISA's special venue provision. The court also concluded that because AXA reserved the right to make certain amendments to the Plan, Plaintiff did not have any vested rights in a choice of forum as of his January 2004 retirement and the forum selection clause is thus not invalid on that ground. Lastly, the court found that the forum selection clause is not invalid due to improper notice under ERISA since the court is satisfied that Defendants' sent Plaintiff a copy of the SMM via First Class Mail, a method of delivery specifically authorized by regulation. *See* 29 C.F.R. § 2520.104b-1(b)(1).

B. Third Circuit

In matter challenging the termination of benefits, enforcing the Retiree Group Insurance Plan's forum selection clause and transferring this matter, pursuant to 28 U.S.C. § 1404(a), to the Central District of Illinois; deficiency of notice cannot be a basis for finding the

forum selection clause unenforceable; Plaintiff's physical and financial constraints represent private factors the court may not consider when ruling on a motion to transfer pursuant to a valid forum selection clause. [Mathias v. Caterpillar, Inc., No. CV 16-1846, 2016 WL 4502350 \(E.D. Pa. Aug. 29, 2016\)](#) (Judge Eduardo C. Robreno).

In matter challenging the denial of [accidental death benefits](#) for a death that occurred to Virginia resident while staying at a rental home in Florida, granting Defendants motion to transfer venue under [28 U.S.C. § 1404\(a\)](#) to the Eastern District of Virginia since, although Defendants could be found in New Jersey, injuries sustained occurred in Virginia because of Defendants' wrongful denial of insurance benefits and the private and public factors weigh in favor of transfer. [Janosko v. United of Omaha Life Ins. Co., No. CV 16-1137 \(RBK/KMW\), 2016 WL 4009818 \(D.N.J. July 25, 2016\)](#) (Judge Kugler).

C. [Fifth Circuit](#)

In this lawsuit alleging wrongful termination in violation of ERISA Section 510, the court found that the forum-selection clause in the parties' separation agreement is valid and binding. The court transferred the case to the United States District Court for the Northern District of Texas. [Collins v. Acad. Partnerships, LLC, No. 316CV00100MPMJMV, 2016 WL 6772790 \(N.D. Miss. Nov. 15, 2016\)](#) (Judge Michael P. Mills).

D. [Sixth Circuit](#)

Granting motion to transfer long-term disability case filed in Western District of Kentucky to the Northern District of Alabama where court determined that the latter is the more convenient venue. [Youngblood v. Life Insurance Company Of North America, No. 3:16-CV-34-TBR, 2016 WL 1466559 \(W.D. Ky. Apr. 14, 2016\)](#) (Judge Thomas B. Russell).

Transfer of venue is appropriate where only connection to plaintiff's choice of forum is location of plaintiff's attorney. [Perry v. Metropolitan Life Insurance Company, No. 3:15-CV-884-TBR, 2016 WL 1181783 \(W.D. Ky. Mar. 25, 2016\)](#) (Judge Thomas B. Russell). The court granted MetLife's motion to transfer venue to the Middle District Georgia after concluding that the Middle District of Georgia is more convenient and has the greater interest in deciding this case. Plaintiff resides within the jurisdiction of the Middle District of Georgia, the alleged breach occurred in the Middle District of Georgia since the breach occurs where the plaintiff is to receive benefits, Plaintiff had worked Columbus, and her medical providers are in Georgia. The only connection to Kentucky is that Plaintiff's counsel is located there but the court affords counsel's location no weight.

Forum-selection clause in employment agreement is enforceable. [Enkema v. FTI Consulting, Inc., No. 3:15-1167, 2016 WL 951012 \(M.D. Tenn. Mar. 14, 2016\)](#) (Judge E. Clifton Knowles).

Defendant moved to compel mediation and arbitration and to dismiss the complaint which Plaintiff brought for breach of contract, tortious interference with prospective business relationships, fraud, and violation of ERISA. The relevant Employment Agreement requires that the parties mediate, and then arbitrate their disputes. Section 24(g) of the Employment Agreement provides in full:

(g) NOTWITHSTANDING ANYTHING TO THE CONTRARY IN THIS AGREEMENT, IN THE EVENT THE CONTROVERSY, CLAIM, DISPUTE OR DISAGREEMENT ARISES UNDER ANY PROVISION OF SECTION 11, 12 OR 13 OF THIS AGREEMENT, EITHER PARTY SHALL NOT BE REQUIRED TO SUBMIT SUCH MATTER TO ARBITRATION, BUT IN ITS OR THEIR SOLE DISCRETION, MAY BRING LEGAL ACTION IN ANY STATE OR FEDERAL COURT SITUATED IN BALTIMORE, MARYLAND AND EMPLOYEE HEREBY CONSENTS TO THE JURISDICTION OF SUCH COURT AND PERSONAL JURISDICTION THEREIN. THE PARTIES AGREE TO WAIVE JURY TRIAL IN CONNECTION WITH ANY OF SUCH ACTIONS.

The court agreed with Defendant that the only logical reading of the forum-selection clause is that the parties must either arbitrate, or if one of them chooses not to arbitrate, that party may file suit, but only in Baltimore. Since Plaintiff has chosen not to arbitrate, the court found that his only alternative is a legal action in Baltimore. The court ordered that the action be transferred to the United States District Court for the District of Maryland in Baltimore.

Long-term disability lawsuit transferred from W.D. Ky to W.D. Va, the district where Plaintiff resides. [Coffey v. Hartford Life & Accident Insurance Company, No. 3:15-CV-378-TBR, 2016 WL 154128 \(W.D. Ky. Jan. 11, 2016\)](#) (Judge Thomas B. Russell). The court granted the Hartford Life and Accident Insurance Company's Motion to Transfer Venue to the United States District Court for the Western District of Virginia. In this lawsuit involving the denial of long-term disability benefits, Plaintiff resides in Virginia. The only connection to Kentucky is Plaintiff's attorney's location and that communications from Hartford had a return address to a Kentucky Post Office Box. Hartford submitted a declaration supporting its position that Plaintiff's claim was processed and reviewed by its offices in Simsbury, Connecticut and Minneapolis, Minnesota. Considering all of the relevant factors, the court found that private and public considerations support transfer.

E. Seventh Circuit

In these putative class actions alleging that Wheaton Franciscan Services and others violated ERISA in administering Wheaton's employee pension plan, the court denied Defendants' motion to transfer both cases to the Eastern District of Missouri pursuant to 28 U.S.C. § 1404(a). The court found that a forum selection clause added to the plan on

March 1, 2016 does not apply to Plaintiffs' claims. [Curtis v. Wheaton Franciscan Servs., Inc., No. 16 C 4232, 2016 WL 6432579 \(N.D. Ill. Oct. 31, 2016\)](#) (Judge Gary Feinerman).

The court joins the majority of courts that have concluded that ERISA does not preclude forum selection clauses. Lack of notice to Plaintiff about the forum selection clause does not make the clause fundamentally unfair and unenforceable. The case must be transferred to the Eastern District of Missouri because each of the pension plans contains a mandatory forum selection clause requiring all actions relating to or arising under the plans to be resolved in that venue. [Feather v. SSM Health Care, No. 16-CV-393-NJR-SCW, 2016 WL 6235772 \(S.D. Ill. Oct. 25, 2016\)](#) (Judge Nancy J. Rosenstengel).

In matter involving retirement benefit claim, denying Defendants' Motion to Dismiss or Transfer Venue to the Northern District of Illinois where the alleged breaches took place in the Northern District of Indiana: Plaintiff resides in the Northern District of Indiana, it is the district in which the Plaintiff expected to receive benefits, and Plaintiff alleges that Defendants failed to pay her benefits and provide her notices of the "cessation of future retirement benefit accruals as required by ERISA § 204(h)." [Macdonald v. Associates for Restorative Dentistry Ltd. Pension Plan, No. 2:16-CV-168-TLS, 2016 WL 4506872 \(N.D. Ind. Aug. 29, 2016\)](#) (Judge Theresa L. Springmann).

Amended Memorandum and Order denying Defendants OSF HealthCare System, OSF HealthCare System Human Resources Committee and Plan Administrator for the OSF Plans' Motion to Change Venue to the Central District of Illinois. [Smith v. OSF Healthcare Sys., No. 16-CV-0467-SMY-PMF, 2016 WL 4380021 \(S.D. Ill. Aug. 17, 2016\)](#) (Judge Staci M. Yandle).

In matter challenging the "Church Plan" status of OSF HealthCare System Plans, denying Defendants' motion to transfer venue to the Central District of Illinois, where: (1) this case was filed six days before the related case of *Bailey, et al. v. OSF HealthCare Sys., et al.* (C.D. Ill) and the scope of the claims is not as expansive as this case and the plaintiffs were employed by different entities; (2) Plaintiffs were employed by St. Anthony Health Center, located in Alton, Illinois and 6,700 OSF Plan participants reside in this district; (3) the relevant documents are maintained in both districts so denial of the motion will have minimal impact on access to sources of proof; and (4) Defendants failed to meet their burden to show that judicial economy weighs in favor of transfer where the court agreed that the "speed to trial" statistics are over-inclusive. [Smith v. OSF Healthcare Sys., No. 16-CV-0467-SMY-PMF, 2016 WL 3965957 \(S.D. Ill. July 25, 2016\)](#) (Judge Staci M. Yandle).

Interest of justice requires granting Unum's motion to transfer long-term disability case from W.D. Wisconsin to District of Massachusetts, where Plaintiff is a Massachusetts resident, obtained benefits under a plan located and administered in Massachusetts, and

received medical treatment in Massachusetts. [Leader v. Unum Life Insurance Company Of America, No. 16-CV-027-JDP, 2016 WL 1559187 \(W.D. Wis. Apr. 18, 2016\)](#) (Judge James D. Peterson).

F. Ninth Circuit

In matter seeking withdrawal liability payments, granting Defendants' motion to transfer the case to the Central District of California, since the facts of this case bear little relation to a Washington forum, and the convenience of potential witnesses and parties, as well as the interests of justice, favor transfer. [Northwest Administrators, Inc. v. Crown Disposal Company, Inc., et al., No. C16-792-JPD, 2016 WL 4734309 \(W.D. Wash. Sept. 12, 2016\)](#) (Judge James P. Donohue).

In suit alleging HED claims against long-term disability plan administrators, granting Defendants' motion to transfer venue to the District of Arizona (where Plaintiff resides) since the only connection to the Northern District of California is Defendants' contractual relationship with the Intel Corporation Long Term Disability Plan (Intel headquartered in Santa Clara) and their communications with Plaintiff's counsel; reserving for decision by transferee court the issue of whether Plaintiff has alleged any conduct that can survive ERISA preemption. [Daie v. Intel Corp., No. C 16-02205 WHA, 2016 WL 4208291 \(N.D. Cal. Aug. 10, 2016\)](#) (Judge William Alsup).

In lawsuit for long-term disability benefits, denying Defendants' Motion to Transfer the case to the Southern District of New York, where Defendant Standard is an insurance company that conducts business throughout the United States, including in both California and New York, the group policyholder is headquartered in northern California, and designated Santa Clara as "the situs of plan administration," and where Plaintiff is a resident of New York but chose to file suit in the Northern District of California. [Sharma v. Globalfoundries U.S., Inc., No. 5:15-CV-03631-EJD, 2016 WL 2742399 \(N.D. Cal. May 11, 2016\)](#) (Judge Edward J. Davila).

Motion to transfer venue denied where private and public considerations weigh against transfer. [Daie v. Intel Corp., No. C 15-05255 WHA, 2016 WL 641646 \(N.D. Cal. Feb. 18, 2016\)](#) (Judge William Alsup). In this lawsuit for long-term disability benefits, Defendants moved to transfer venue to the District of Arizona or, in the alternative, to the San Jose division. Plaintiff is a resident of Fountain Hills, Arizona. Defendant Intel Corporation Long Term Disability Plan is funded by Plaintiff's former employer, defendant Intel Corporation, a Delaware corporation with its headquarters in Santa Clara, California. Intel delegated responsibility for the initial adjudication of claims and first-level appeals to defendant Reed Group, Ltd., a Colorado corporation with its headquarters in Colorado. Intel delegated responsibility for final appeals to Claim Appeal Fiduciary Services, Inc., a Colorado corporation

with offices in Colorado and Georgia. Considering 29 U.S.C. Section 1132(e)(2) and 28 U.S.C. Section 1404(a), the court denied the motion. The parties agreed that the action could have been brought in the District of Arizona, inasmuch as Plaintiff resided in Arizona when the alleged breach occurred, and he would have received his long-term benefits there, but the convenience of the parties and witnesses and the interest of justice do not counsel towards transfer. With respect to the private convenience and fairness factors, claims for the recovery of benefits are generally tried solely on the administrative record and Plaintiff's counsel explicitly stated that there would be no discovery or live testimony, and counsel for Defendants agreed. Reed and CAFS do not have a presence in either district and both companies adjudicated claims for all of Intel, which included a significant number of personnel based in California, so Reed and CAFS should have been prepared to litigate in California. And practically, transferring the case would cause unnecessary administrative delays and would require both sides to retain new counsel or impose travel expenses for existing counsel. With respect to public-interest factors, the court determined that court congestion is a neutral factor. As of June 2015, the District of Arizona had 416 pending cases per active judge while this district had 459 per active judge. Additionally, the median time from filing to disposition for civil actions in both districts was 7.8 months. Moreover, this court is already familiar with this matter, having ruled on an earlier remand motion and still-pending separate action (now proceeding in state court). If that action later becomes removable, then it would land in this court again and could be related, so both cases could be assigned to the same judge. The court found that this consideration also answers the alternative request for transfer to the San Jose division.

Forum selection clause requires Arizona resident to litigate disability claim in Missouri.

[Clause v. Sedgwick Claims Mgmt. Servs., Inc., No. CIV 15-388-TUC-CKJ, 2016 WL 213008 \(D. Ariz. Jan. 19, 2016\)](#) (Judge Cindy K. Jorgenson). In lawsuit for denied long-term disability benefits, Defendants moved to dismiss, or in the alternative, to transfer venue, based on a forum-selection clause contained in the Ascension Long-Term Disability Plan. The provision requires any action arising under the Plan to be resolved only in the District Court for the Eastern District of Missouri. Notwithstanding that Missouri is more than 1,000 miles from Plaintiff's home and most recent place of work, the court found the venue provision enforceable and transferred the matter to E.D. Missouri. In so doing, the court found that there is no evidence of a bad-faith motive by Defendants, fraud or overreaching and Plaintiff had sufficient notice since the clause is included in both the Plan and the SPD. Additionally, Defendants represented that the SPD is posted on the Carondelet Health Network benefits website, and participants are notified that an SPD is available upon request at any time from the benefits department.

G. Tenth Circuit

Granting Defendant's motion in the alternative to transfer venue to the Eastern District of California in lawsuit by Utah medical provider against a Northern California company, to recover cost of treatment it provided to a California resident who was a participant in the

Defendant's health plan. [IHC Health Services, Inc. dba Mckay Dee Hospital v. Eskaton Properties, Inc., No. 2:16-CV-3-DN, 2016 WL 4769342 \(D. Utah Sept. 13, 2016\)](#) (Judge David Nuffer).

H. Eleventh Circuit

In interpleader action involving disputed life insurance funds, the court denied the competing beneficiaries' motion to transfer the action to the U.S. District Court for the Eastern District of Michigan. Applying the Section 1404(a) factors, the court found it appropriate to retain the action. [Kristen Jacques, et al. v. Sheryl Jacques, No. 8:16-CV-1297-T-33TGW, 2016 WL 6493927 \(M.D. Fla. Nov. 2, 2016\)](#)

XXVI. *Withdrawal Liability & Unpaid Benefit Contributions*

A. Second Circuit

Granting Plaintiffs' motion, pursuant to Federal Rule of Civil Procedure ("Fed. R. Civ. P.") 37, seeking to strike the Defendants' answer, and Fed. R. Civ. P. 55, seeking to enter a default judgment against the Defendants. [Gesualdi v. Metro. Enterprises, Inc., No. 15CV1378ADSGRB, 2016 WL 6988830 \(E.D.N.Y. Nov. 29, 2016\)](#) (Judge Arthur D. Spatt).

The court granted the petition to confirm the arbitration award and directed the Clerk of Court to enter judgment in the amount of \$59,346.07, plus pre-judgment interest calculated at a rate of 9% per annum from September 5, 2015 through the date of judgment in this action. The court also granted Petitioners' request for \$1,910.00 in attorney's fees and costs. [Trustees of the N.Y. City Dist. Council of Carpenters Pension Fund v. Jessica Rose Enterprises Corp., No. 15-CV-9040 \(RA\), 2016 WL 6952345 \(S.D.N.Y. Nov. 28, 2016\)](#) (Judge Ronnie Abrams).

Granting petitioners' motion to confirm the arbitration award in the amount of \$304,180.22 and awarding petitioners \$715.50 in attorneys' fees and \$400.00 in costs. [Trustees of Empire State Carpenters Annuity v. C.R. Edwards Constr. Co., Inc., No. 15-CV-5232, 2016 WL 6875969 \(E.D.N.Y. Nov. 22, 2016\)](#) (Judge Joseph F. Bianco).

The court confirmed the arbitrator's award of \$435,821.09 and ordered Bayview to pay an additional \$902.50 in attorneys' fees and costs associated with this litigation. [Trustees of Empire State Carpenters Annuity v. Bayview Custom Constr. Corp., No. 15-CV-6574 \(JFB\), 2016 WL 6892147 \(E.D.N.Y. Nov. 22, 2016\)](#) (Judge Joseph F. Bianco).

Confirming the arbitrator's award of \$239,901.47 and ordering Allied to pay an additional \$737.50 in attorneys' fees and costs associated with this litigation. [Trustees of Empire State](#)

[Carpenters Annuity, Apprenticeship, Labor–Management Cooperation, Pension & Welfare Funds v. Allied Design & Constr., LLC, No. 15CV3854JFBAKT, F.Supp.3d , 2016 WL 6818881 \(E.D.N.Y. Nov. 18, 2016\)](#) (Judge Joseph F. Bianco).

Plaintiffs’ motion to confirm the arbitration award of \$228,625.43 in delinquent contributions, interest, damages, and attorneys’ fees. [Trustees for the Mason Tenders Dist. Council Welfare Fund v. One Ten Restoration Corp., No. 15-CV-10000 \(JPO\), 2016 WL 6780007 \(S.D.N.Y. Nov. 16, 2016\)](#) (Judge J. Paul Oetken).

Following grant of default judgment in unpaid fringe benefit contributions case, granting Plaintiffs’ motion to compel the production of (1) two years of bank statements relating to a Chase checking account previously owned by Gillette; (2) tax returns filed by Gillette for the years 2009, 2010, 2011, and 2012; (3) a form W-2 for the \$7,953 in income reflected on Gillette’s 2013 tax return; and (4) twelve months of credit card statements relating to a Credit One account owned by Gillette. [Ferrara v. Bd Haulers Inc., No. 11-CV-940 \(ADS\), 2016 WL 6683474 \(E.D.N.Y. Nov. 12, 2016\)](#) (Judge Arthur D. Spatt).

Granting motion to confirm the arbitration award against Defendant TNS Management Services, Inc. [Trustees for the Mason Tenders Dist. Council Welfare Fund v. TNS Mgmt. Servs., Inc., No. 16-CV-1120 \(AJN\), 2016 WL 6208559 \(S.D.N.Y. Oct. 20, 2016\)](#) (Judge Alison J. Nathan).

In decade-long dispute between two employee benefit funds concerning the right to contributions made by employers pursuant to a number of collective bargaining agreements, Plaintiffs are awarded judgment in the amount of \$2,460,777.33 plus interest. [Silverman v. Miranda, No. 6 CIV. 13222 \(ER\), 2016 WL 5793395 \(S.D.N.Y. Sept. 30, 2016\)](#) (Judge Edgardo Ramos).

Denying motion to dismiss in delinquent contributions matter where a fiduciary moved to dismiss the fiduciary duty claim against him on the basis that the terms of an earlier settlement agreement, plaintiffs waived their right to proceed against him, and that the Amended Complaint fails to state a claim for breach of fiduciary duty. [Trustees of the New York City Dist. Council of Carpenters Pension Fund v. Metro. Enterprises, Inc., No. 16 CIV. 284 \(PAE\), 2016 WL 5334982 \(S.D.N.Y. Sept. 22, 2016\)](#) (Judge Paul A. Engelmayer).

Denying Plaintiff’s motion for partial summary judgment with leave to renew following an evidentiary hearing before Magistrate Judge Locke on the issue of fraud in the execution, and specifically whether defendant Angelo Stanco had a reasonable opportunity to read the Assumption Agreement prior to execution. [Trustees of the United Plant v. Am. Paving & Masonry Corp., No. 15CV1223SJFSIL, 2016 WL 4991542 \(E.D.N.Y. Sept. 15, 2016\)](#) (Judge Feuerstein).

Granting Plaintiff's motion for summary judgment and ordering Defendant to pay Plaintiff withdrawal liability in the amount of \$66,158.00 within 30 days of the date of this Order; awarding the following amounts in statutory damages to be paid within 30 days of the date of this Order: (1) prejudgment interest in the amount of \$19,847.40, with \$992.37 monthly interest accruing from August 2015 through the month of payment; (2) liquidated damages in the amount of \$19,847.40 with \$992.37 monthly interest accruing from July 2015 through the month of payment; (3) attorney's fees in the amount of \$13,797.00; and (4) miscellaneous costs in the amount of \$794.52. [Finkel v. Athena Light & Power LLC, No. 14-CV-3585 \(DLI\)\(PK\), 2016 WL 4742279 \(E.D.N.Y. Sept. 11, 2016\)](#) (Judge Dora Lizette Irizarry).

Granting motion for default judgment against Tap Steel, Inc, in the amount of \$576,747.92 plus post-judgment interest pursuant to 28 U.S.C. § 1961(a); and default judgment against Timothy A. Paluck, in the amount of \$315,804.12 plus post-judgment interest pursuant to 28 U.S.C. § 1961(a). [Iron Workers Local 12 Pension Fund v. Tap Steel, Inc., No. 1:14-CV-913\(GLS/CFH\), 2016 WL 4703729 \(N.D.N.Y. Sept. 8, 2016\)](#) (Judge Gary L. Sharpe).

Defendants' motion to dismiss the first amended complaint for lack of subject-matter jurisdiction and failure to state a claim is granted in part and denied in part. There is subject-matter jurisdiction but the FAC's second, fourth, sixth, eighth, and ninth claims are dismissed for failure to state a claim. [Trustees of the Metal Trades Branch Local 638 Pension Fund v. Henick-Lane, Inc., No. 15 CIV. 1726 \(LLS\), 2016 WL 4618970 \(S.D.N.Y. Sept. 2, 2016\)](#) (Judge Louis L. Stanton).

Granting Defendant's partial motion for summary judgment and finding that they were not required to pay contributions for revenue generated by foreign audio streams. [Am. Fed'n of Musicians v. Atl. Recording Corp., No. 1:15-CV-6267-GHW, 2016 WL 4481090 \(S.D.N.Y. Aug. 23, 2016\)](#) (Judge Gregory H. Woods).

Granting Plaintiffs' motion for a default judgment against Defendant in the amount of \$183,227.55, consisting of: (1) \$111,353.66 in unpaid contributions, (2) \$44,351.52 in interest, (3) \$21,720.15 in liquidated damages, (4) \$2,442.22 in attorneys' fees and costs and (5) \$3,360.00 in audit costs. [Trustees of the Local 7 Tile Indus. Welfare Fund v. Penn Valley Tile, Inc., No. 15CV3891MKBREER, 2016 WL 4384717 \(E.D.N.Y. Aug. 16, 2016\)](#) (Judge Margo K. Brodie).

Granting motion for default judgment including damages in the total amount of \$1,030,265.28, representing unpaid contributions, accrued interest, liquidated damages, attorneys' fees, and costs; continuing per diem interest at the rate of \$291.74, from October 1, 2014 until judgment is entered; and denying the portion of the motion seeking injunctive

relief. [Gesualdi v. Reid, No. 14-CV-4212\(ADS\)\(GRB\), F.Supp.3d , 2016 WL 4098554 \(E.D.N.Y. July 29, 2016\)](#) (Judge Arthur D. Spatt).

Granting Petitioners' motion to confirm the arbitration award in the amount of \$34,689.79 and awarding petitioners \$372.50 in attorneys' fees and \$467.50 in costs. [Trustees of Empire State Carpenters Annuity, Apprenticeship, Labor-Mgmt. Cooperation v. Dipizio Constr., Inc., No. 15CV2592JFBAYS, 2016 WL 3033722 \(E.D.N.Y. May 25, 2016\)](#) (Judge Joseph F. Bianco).

Confirming Arbitration Award granting Petitioners \$7,940.30 plus an additional \$835 in attorneys' fees and costs incurred in connection with the instant action for a total award of \$8,775.30. [Trustees of Empire State Carpenters Annuity v. Baroco Contraction Corp., No. 15CV5690DRHSIL, 2016 WL 2889007 \(E.D.N.Y. May 17, 2016\)](#) (Judge Denis R. Hurley).

Granting summary judgment in favor of National Retirement Fund and the Fund's manager in withdrawal liability action against Caesars Entertainment Corporation and Caesars Entertainment Resort Properties, LLC. [Nat'l Ret. Fund v. Caesars Entm't Corp., No. 15CV2048LAKJLC, 2016 WL 2621068 \(S.D.N.Y. May 5, 2016\)](#) (Judge James L. Cott).

Recommending the grant of Plaintiff's motion for summary judgment, seeking to collect an outstanding withdrawal liability payment, as well as interest and liquidated damages, which they contend are due and owing in light of Defendants' expulsion from the Fund. [Nat'l Ret. Fund v. Caesars Entm't Corp., No. 15CV2048LAKJLC, 2016 WL 2621068 \(S.D.N.Y. May 5, 2016\)](#) (Magistrate Judge James L. Cott).

"This Court (1) confirms the \$460,042.99 arbitration award in favor of Petitioners, along with 5.25% interest from August 7, 2015 through the date of this judgment; and (2) awards Petitioners attorneys' fees and costs in the amount of \$1,060." [Trustees of the New York City Dist. Council of Carpenters Pension Fund v. V. Power Enterprises Inc., No. 15CV6978, 2016 WL 1629345 \(S.D.N.Y. Apr. 22, 2016\)](#) (Judge William H. Pauley III).

B. Third Circuit

Granting motion for default judgment and ordering Defendants to pay Plaintiffs the principal amount of \$13,683.21, representing the amount of unpaid contributions to Plaintiff Funds and Union, and pre-judgment interest in the amount of \$415.761 and liquidated damages amounting to \$2,045.74. [Serv. Employees Int'l Union Local 32BJ, Dist. 36 v. Shamrockclean Inc., No. CV 16-3374, 2016 WL 7178418 \(E.D. Pa. Dec. 9, 2016\)](#) (Judge R. Barclay Surrick).

In action seeking to audit the books and records of Defendant, River Front Recycling Aggregate, LLC, a civil construction contractor, and to collect any unpaid contributions

revealed by the audit, the court denied Defendant's motion to dismiss under Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief may be granted, where it claimed that it was not a signatory to any of the agreements that would require it to submit to audits. [Bd. of Trustees of the Int'l Union of Operating Engineers Local 825 Pension Fund v. River Front Recycling Aggregate, LLC](#), No. CV 15-8957 (JBS-KMW), 2016 WL 6804869 (D.N.J. Nov. 16, 2016) (Judge Jerome B. Simandle).

The complaint sufficiently pled that the letter's evergreen clause binds MRS to the 2012-2015 CBA and the NLRB's holding in *Luterbach* does not nullify the 2012-2015 CBA with respect to MRS. [Carpenters Health And Welfare Fund of Philadelphia and Vicinity, et al. v. Management Resource Systems Inc.](#), No. 15-2508, ___ F.3d ___, 2016 WL 4750520 (3d Cir. Sept. 13, 2016) (Before: McKEE, Chief Judge, FISHER and GREENAWAY, JR., Circuit Judges).

Finding that the employer's withdrawal liability was calculated under a reasonable interpretation of the plan and its supplementary documents, and affirming the arbitrator's opinion and award. [Miller & Son Paving, Inc. v. Teamsters Pension Trust Fund of Philadelphia And Vicinity](#), No. CV 15-4869, 2016 WL 4802752 (E.D. Pa. Sept. 14, 2016) (Gerald Austin McHugh).

Granting in part and dismissing in part Count 4 of Plaintiff's Complaint alleging that Business Entity Defendants are responsible for Duramix's withdrawal liability because they were under the "common control" of Duramix. [Bd. of Trustees of the Trucking Employees of N. Jersey Welfare Fund, Inc. v. 160 E. 22nd St. Realty, LLC](#), No. CV 15-889 (ES) (JAD), 2016 WL 4582046 (D.N.J. Sept. 2, 2016) (Judge Esther Salas).

Dismissing as moot the plaintiffs' motion for the court's entry of default judgment against the defendant, and granting plaintiffs' supplemental motion for the court's entry of default judgment against the defendant. [Trustees of the Pipefitters & Plumbers Local 524 Pension & Annuity Plan v. Yannuzzi, Inc.](#), No. CV 3:15-2085, 2016 WL 4479394 (M.D. Pa. Aug. 25, 2016) (Judge Malachy E. Mannion).

Granting Fund's motion to dismiss Plaintiff's first amended complaint because Plaintiff failed to allege facts to support its claim that the Fund had a duty under the federal common law of pension plans to disclose to Plaintiff the change in interest rate assumptions, thus Plaintiff failed to state a claim for fraud by omission or negligent misrepresentation by omission. [Elbeco Inc. v. Nat'l Ret. Fund](#), No. 5:15-CV-00318, 2016 WL 3902933 (E.D. Pa. July 19, 2016) (Judge Joseph F. Leeson).

Granting Plaintiffs' motion for default judgment against Defendant Phillips Enterprise, Inc. ("Phillips") seeking damages and equitable relief under ERISA and the LMRA for Phillips's alleged failure to timely pay certain contributions, reports and deductions due

pursuant to the parties' Collective Bargaining Agreement. [Bd. of Trustees of the Laborers Dist. Council Constr. Indus. Pension Fund v. Phillips Enter., Inc., No. CV 15-06490, 2016 WL 2939509 \(E.D. Pa. May 20, 2016\)](#) (Judge Gerald J. Pappert).

Granting Plaintiffs' motion for default judgment against Defendant in the following amounts: (1) \$14,065.98 in unpaid contributions; (2) \$1,513.31 in accrued interest on the unpaid contributions; (3) \$1,513.31 in "double interest" as provided by ERISA Section 1132(g)(2)(C)(i); (4) \$1,625.10 in accrued interest on late contribution payments; (5) \$3,243.50 in attorneys' fees and costs; and (6) \$1,800 in audit fees. [Bd. of Trustees of the Laborers Dist. Council Constr. Indus. Pension Fund v. Phillips Enter., Inc., No. CV 15-06490, 2016 WL 2939510 \(E.D. Pa. May 20, 2016\)](#) (Judge Gerald J. Pappert).

C. Fourth Circuit

The court granted Plaintiffs' Motion for Default Judgment and awarded the Trustees a total of \$784,124.83 in unpaid contributions. The court also granted attorneys' fees in the total amount of \$1,222.50 and \$645 in costs. [Trustees of the Nat'l Automatic Sprinkler Indus. Welfare Fund v. All-State Fire Prot., Inc., No. CV TDC-16-1433, 2016 WL 6996131 \(D. Md. Nov. 29, 2016\)](#) (Judge Theodore D. Chuang).

The court recommended that Plaintiff's Motion for Default Judgment be granted and Plaintiff be awarded: \$8,700.40 for delinquent pension fund contributions; \$3,454.03 in interest; \$2,796.76 as liquidated damages; \$1,597.86 as audit fees; and \$1,906.50 in attorneys' fees and costs. [Nat'l Elec. Benefit Fund v. Code Eng'g Servs., Inc., No. CV TDC-16-1685, 2016 WL 6926404 \(D. Md. Nov. 28, 2016\)](#) (Magistrate Judge William Connelly).

Granting Plaintiffs' Motion to Amend Judgment and modifying Judgment to include an additional award of liquidated damages in the amount of \$1,125.95 for NEBF and \$5,792.06 for NEAP. [Nat'l Elec. Benefit Fund v. Coastal Elec. & Envtl. Servs., Inc., No. GJH-15-1698, 2016 WL 6092643 \(D. Md. Oct. 18, 2016\)](#) (Judge George J. Hazel).

Granting Plaintiff's Motion to Amend Judgment and modifying Judgment to include an additional award of liquidated damages in the amount of \$407.08. [Nat'l Elec. Benefit Fund v. Donald A. Pusey, Inc., No. GJH-15-2659, 2016 WL 6092691 \(D. Md. Oct. 18, 2016\)](#) (Judge George J. Hazel).

Granting default judgment in favor of Plaintiffs in the amount of \$117,094.26, broken down as follows: \$38,494.50 in unpaid contributions, liquidated damages and interest due to Welfare Fund; \$28,395.36 in unpaid contributions, liquidated damages and interest due to the Pension Fund; \$4,817.91 in unpaid contributions, liquidated damages and interest due to the Apprenticeship Fund; \$22,198.26 in unpaid contributions, liquidated damages and interest due to the Account Fund; \$4,688.45 in unpaid union dues withheld from

employees' wages but not remitted to Local 26; \$9,928.31 in unpaid contributions, liquidated damages and interest due to the NEBF; \$49.12 in unpaid contributions, liquidated damages and interest due to the National Labor Management Cooperation Committee; \$491.15 in unpaid contributions, liquidated damages and interest due to the Labor Management Cooperation Committee; and attorneys' fees and costs of \$8,031.20. [Trustees of the Electrical Welfare Trust Fund, et al. v. Technology Service Group, LLC, No. GJH-14-3018, 2016 WL 5462800 \(D. Md. Sept. 27, 2016\)](#) (Judge George J. Hazel).

Granting default judgment in favor of Plaintiffs in the amount of \$80,250.66 as follows: \$62,224.48 in contributions and dues owed; \$11,833.91 in liquidated damages; \$2,892.27 in interest assessed at interest rates ranging between 6% and 18% per the terms of the respective trust agreements; \$2,805.00 in attorneys' fees and \$495.00 in costs. [Trustees of the Bricklayers Local 1 of MD, VA & DC Health & Welfare Fund v. WW Reid Masonry, LLC, No. GJH-15-3238, 2016 WL 4595674 \(D. Md. Sept. 2, 2016\)](#) (Judge George J. Hazel).

Entering default judgment in favor of Plaintiffs in the amount of \$86,226.35 as follows: \$33,959.80 in contributions owed; \$44,917.05 in liquidated damages; \$1,192.00 in attorneys' fees; \$595.00 in costs; and \$5,562.50 in interest assessed at the rate of 12% per annum on paid contributions through the date of payment and assessed on unpaid contributions through January 22, 2016 and continuing to accrue through the date of payment. [Trustees of the Nat'l Automatic Sprinkler Indus. Welfare Fund v. Altitude Fire Prot., LLC, No. GJH-15-2662, 2016 WL 4082622 \(D. Md. July 29, 2016\)](#) (Judge George Jarrod Hazel).

Ordering Defendant to pay \$2,035.38 in delinquent contributions; interest in the amount of \$679.72; attorney's fees and costs in the amount of \$992.80; audit fees in the amount of \$366.93; any additional fees and costs incurred by Plaintiff in connection with the enforcement of a judgment; interest on all amounts awarded; and, post-judgment interest until paid. [Nat'l Elec. Benefit Fund v. Donald A. Pusey, Inc., No. GJH-15-2659, 2016 WL 3129112 \(D. Md. June 1, 2016\)](#) (Judge George J. Hazel).

Granting Plaintiff's motion for summary judgment seeking to recover on a fringe benefit bond on which Defendant, Western Surety Company, is the surety. [Sheet Metal Workers' Local Union No. 100 Washington v. W. Sur. Co., No. GJH-15-1175, 2016 WL 2903553 \(D. Md. May 17, 2016\)](#) (Judge George J. Hazel).

D. Sixth Circuit

Recommending that the motion for default judgment be granted and judgment be entered against Defendant in the amount of \$77,075.66 in unpaid contributions, liquidated damages, and interest, \$400.00 in court costs, and \$2,730.00 in attorneys' fees. [Boards of](#)

[Trustees of Ohio Laborers' Fringe Benefit Programs v. RMH Concrete & Foundations, Inc., No. 2:16-CV-721, 2016 WL 7111603 \(S.D. Ohio Dec. 7, 2016\)](#) (Magistrate Judge Terence P. Kemp).

Affirming district court's motion to dismiss Old Blast, Inc. and Joyce Denonville's lawsuit claiming that ERISA's imposition upon Old Blast of withdrawal liability to the Fund was unconstitutional. [Old Blast, Inc., et al., v. Operating Engineers Local 324 Pension Fund, No. 16-1260, F.App'x, 2016 WL 6407244 \(6th Cir. Oct. 31, 2016\)](#) (Before: CLAY, KETHLEDGE, and DONALD, Circuit Judges).

"The Court will grant Plaintiffs' motion for final judgment, and will enter judgment for Plaintiffs and against Defendants E&R Masonry Construction, Inc., Brick Masonry, Inc., BMC Masonry, Inc., Roberto Sanchez, Efrain Sanchez and Ulices Sanchez for \$664,347.92, including \$442,056.68 in fringe benefit contributions owed for the period of November 2012 through October 2015, \$132,687.74 in liquidated damages and interest, and \$89,603.50 in attorney fees and costs. Defendants will be held jointly and severally liable." [Bricklayers Pension Trust Fund - Metro. Area v. E&R Masonry Constr., Inc., No. 2:13-CV-14917, 2016 WL 6395966 \(E.D. Mich. Oct. 28, 2016\)](#) (Judge Stephen J. Murphy, III).

Recommending that the motion for default judgment be granted and judgment be entered against Defendant in the amount of \$6,755.70 in liquidated damages, and interest; interest from the date of judgment at the rate of 1% per month; and \$400.00 in costs. [Boards of Trustees of Ohio Laborers' Fringe Benefit Programs v. Olive Leaf Landscaping, Inc., No. 2:16-CV-686, 2016 WL 6211329 \(S.D. Ohio Oct. 25, 2016\)](#) (Magistrate Judge Terence P. Kemp).

Recommending that Plaintiff's motion for default judgment be granted and judgment be entered against Defendant in the amount of \$10,495.95 in fringe benefit contributions, liquidated damages, and interest; \$1,785.00 in attorney's fees; interest from the date of judgment at the rate of 1% per month; and \$400.00 in costs. [Boards of Trustees of Ohio Laborers' Fringe Benefit Programs v. CJ&L Constr., Inc., No. 2:16-CV-745, 2016 WL 6122574 \(S.D. Ohio Oct. 20, 2016\)](#) (Magistrate Judge Terence P. Kemp).

Granting Defendant Thomas Blanton's Motion for Relief from Entry of Default because Plaintiffs will be only minimally prejudiced, Defendant has a meritorious defense, and Defendant's conduct was not culpable. [Wilson v. Blanton, No. 2:16-CV-00390, 2016 WL 5408889 \(S.D. Ohio Sept. 28, 2016\)](#) (Judge Algenon L. Marbley).

Defendant is entitled to dismissal under Fed. R. Civ. P. 12(b)(6) for failure to state a claim where the complaint does not allege any of the "facts" supposedly contained in Ex. E that arguably establish Defendant's identity as a "successor employer." Rule 8 requires every factual allegation to be explicitly included among the numbered paragraphs of the complaint. [Local 109 Board Of Trustees Of The Operative Plasterers And Cement Masons](#)

[Pension Fund v. All American Acoustic And Drywall, Inc., No. 5:15-CV-2361, 2016 WL 5232828 \(N.D. Ohio Sept. 22, 2016\)](#) (Judge Sara Lioi).

Granting unopposed motion for summary judgment in favor of the Plaintiffs in the amount of \$65,704.95, (Delinquent Fringe Benefits: \$51,642.57; Liquidated Damages: \$10,036.25; Interest: \$4,026.13), plus attorneys fees and costs. [Cleveland Bakers and Teamsters Health and Welfare Fund, et al., v. Pincus Bakery, Inc., No. 1:15 CV 2349, 2016 WL 5231809 \(N.D. Ohio Sept. 21, 2016\)](#) (Judge Donald C. Nugent).

Granting summary judgment to Plaintiffs on its claims to collect withdrawal liability. [Bd. of Trustees of the Ohio Carpenters' Pension Fund v. Ramunno Builders, Inc., No. 4:15CV0424, 2016 WL 4729305 \(N.D. Ohio Sept. 12, 2016\)](#) (Judge Benita Y. Pearson).

Granting Plaintiff Stevens' request to enforce the Arbitrator's Award and denying Defendants' request to vacate or modify the Arbitrator's Award; ordering Defendants to refund Stevens' interim withdrawal liability payments with interest from the date paid. [Stevens Engineers & Constructors, Inc. v. Iron Workers Local 17 Pension Fund, No. 1:15 CV 1965, 2016 WL 4479486 \(N.D. Ohio Aug. 25, 2016\)](#) (Judge Donald C. Nugent).

Finding 2012 arbitration award to be ambiguous and ordering the matter remanded back to the Joint Grievance Committee for clarification. [Local 1982, Int'l Longshoremen's Ass'n v. Midwest Terminals of Toledo, Int'l, Inc., No. 3:12 CV 1384, 2016 WL 4367076 \(N.D. Ohio Aug. 16, 2016\)](#) (Judge Jeffrey J. Helmick).

Recommending that the motion for default judgment be granted and judgment be entered against the defendant in the amount of \$38,714.73 plus interest from June 15, 2016, and continuing beyond the date of judgment, at the rate of \$13.74 per day, and that Defendant make its books and records available for audit at a reasonable time if requested by Plaintiffs. [Carol A. Wilson, Adm'r, et al. v. Bryan Waller, No. 2:16-CV-119, 2016 WL 3769332 \(S.D. Ohio July 15, 2016\)](#) (Magistrate Judge Terence P. Kemp).

Recommending that the motion for default judgment be granted and judgment be entered against the Defendant in the amount of \$12,962.13, with interest on the unpaid contributions of \$10,777.13 to run at the rate of 1% per month from the date of judgment. [Boards of Trustees of Ohio Laborers' Fringe Benefit Programs v. Headlands Contracting & Tunneling, Inc., No. 2:16-CV-433, 2016 WL 3769328 \(S.D. Ohio July 15, 2016\)](#) (Magistrate Judge Terence P. Kemp).

In matter seeking judgment against Flynn for delinquent fringe benefit contributions, awarding \$80,139.98, plus reasonable costs and attorneys' fees. [Trustees of the Painting](#)

[Indus. Ins. Fund v. Edward R. Flynn Co., No. 1:15 CV 269, 2016 WL 3211963 \(N.D. Ohio June 7, 2016\)](#) (Judge Donald C. Nugent).

Recommending grant of motion for default judgment filed by plaintiff Boards of Trustees of Ohio Laborers' Fringe Benefit Programs against defendant Waugh Excavating, LLC. [Boards of Trustees of Ohio Laborers' Fringe Benefit Programs v. Waugh Excavating, LLC, No. 2:16-CV-213, 2016 WL 2892483 \(S.D. Ohio May 18, 2016\)](#) (Magistrate Judge Terence P. Kemp).

E. Seventh Circuit

Denying motion for contempt against Defendant Schuh for frustrating Plaintiff's attempt to obtain the payroll records to determine the amounts to which they are entitled by the default judgment without an additional step being taken first. [Trustees of Local 309 Elec. Health v. Schuh, No. 16-CV-0275-MJR-RJD, 2016 WL 7188121 \(S.D. Ill. Dec. 12, 2016\)](#) (Judge Michael J. Reagan).

In suit for unpaid contributions, the Court grants Plaintiff's motion to avoid fraudulent transfer and to award attorney's fees and costs. The Court directed Daniel Martinak to turn over the amount of \$41,000 to Plaintiff within three days of entry of this order. [Carpenters Pension Fund of Illinois v. Martinak, No. 13 C 5720, 2016 WL 7188158 \(N.D. Ill. Dec. 10, 2016\)](#) (Judge Matthew F. Kennelly).

The court entered judgment in favor of Plaintiffs against Defendant Five Star Flooring, L.L.C., in the amount of \$10,783.44 together with statutory judgment interest from and after November 30, 2016, and together with attorneys' fees and court costs. [Tharp v. Five Star Flooring, L.L.C., No. 2:14-CV-458-PRC, 2016 WL 6994157 \(N.D. Ind. Nov. 30, 2016\)](#) (Magistrate Judge Paul R. Cherry).

The court determined that Dodge of Naperville and Burke Automotive violated § 515 of ERISA and are jointly and severally liable to the Trustees for damages under § 502(g)(2). [Trustees of Auto. Mechanics Indus. Welfare & Pension Funds of the Int'l Ass'n of Mechinists & Aerospace Workers AFL-CIO, Local 710 v. Dodge of Naperville, Inc., No. 10 CV 7408, 2016 WL 6803083 \(N.D. Ill. Nov. 15, 2016\)](#) (Judge Charles R. Norgle, Sr.).

Granting Plaintiff's Motion for Default Judgment and awarding \$68,665.29 in unpaid contributions, interest, and liquidated damages, and \$ 8,056.98 in attorneys' fees and costs. [E. Cent. Illinois Pipe Trades Health & Welfare Trust Fund v. River Valley Mech. Serv., Inc., No. 116CV01147JBMJEH, 2016 WL 6745506 \(C.D. Ill. Nov. 15, 2016\)](#) (Judge Joe Billy McDade).

"Judgment shall be entered in favor of the Fund for \$25,039.51 in delinquent contributions, \$5,007.90 in liquidated damages, and \$8,806.89 in audit costs. In addition,

Sebert shall pay the Fund interest on the delinquent contributions until the entry of final judgment, as well as the Fund's attorney's fees and costs." [Chicago Area Int'l Bhd. of Teamsters Severance & Ret. Fund v. Sebert Landscaping Co., No. 14-CV-00338, 2016 WL 6395456 \(N.D. Ill. Oct. 27, 2016\)](#) (Judge Andrea R. Wood).

Granting motion for default judgment and ordering Defendant to pay Plaintiffs a total of \$37,211.39 in delinquent contributions, penalties, processing fee, attorneys' fees, and costs. [Trustees of the Michiana Area Elec. Workers Health & Welfare Fund v. Vanderheyden, Inc., No. 2:16-CV-0306-PPS-PRC, 2016 WL 6134721 \(N.D. Ind. Oct. 21, 2016\)](#) (Judge Philip P. Simon).

Upholding arbitration award of withdrawal liability in its entirety. Plaintiff's motion to enforce the award in part is granted, as is Defendant's motion to enforce, in part, the arbitration award. [Quad/Graphics, Inc. v. Graphic Commc'ns Conference of the Int'l Bhd. of Teamsters \(GCC-IBT\), Nat'l Pension Plan, No. 15 C 3439, 2016 WL 5720474 \(N.D. Ill. Sept. 30, 2016\)](#) (Judge Rebecca R. Pallmeyer).

Dismissing with prejudice the trustees' claim that they are entitled to a judgment at this time for the full amount of the accelerated withdrawal liability since a pension fund cannot immediately get the full amount of an employer's withdrawal liability after deciding to accelerate only part of it. [Bauwens v. Dunning Elec. Servs., Inc., No. 16 C 4548, 2016 WL 4530330 \(N.D. Ill. Aug. 30, 2016\)](#) (Judge Matthew F. Kennelly).

Granting Plaintiffs' Motion for Summary Judgment on issue that Defendant has waived its right to arbitration, but denying Plaintiffs' request for a permanent injunction. [Cent. States, Se. & Sw. Areas Pension Fund v. K&M Equip., Inc., No. 15 C 11586, 2016 WL 4270215 \(N.D. Ill. Aug. 15, 2016\)](#) (Judge James B. Zigel).

Directing the Clerk to enter judgment in favor of Plaintiffs and against Defendants John Kny Painting & Decorating, Inc. and Fine Finishes & Restoration, Inc. on alter ego claim, and in favor of Defendant John H. Kny and against Plaintiffs on the piercing the corporate veil claim. On the alter ego claim, awarding Plaintiffs damages against John Kny Painting & Decorating, Inc. and Fine Finishes & Restoration, Inc., jointly and severally, in the amount of \$3,126,133.66. [Trustees of the Chicago Painters & Decorators Pension Fund v. John Kny Painting & Decorating, Inc., No. 14 C 6507, 2016 WL 2958372 \(N.D. Ill. May 23, 2016\)](#) (Judge Matthew F. Kennelly).

Funds are entitled to the sum of \$32,773.98 in contributions from Wright together with liquidated damages, costs and attorneys' fees. [Chicago Reg'l Council of Carpenters Pension Fund v. Wright Construction & Installation, Inc., No. 11 C 6928, 2016 WL 2755325 \(N.D. Ill. May 12, 2016\)](#) (Judge Harry D. Leinenweber).

In suit brought by Multiemployer pension fund against employer, seeking declaration that employer was not entitled to refund of its contributions to pension account for an employee

who the employer now alleged to be ineligible under collective bargaining agreement to participate in the fund, holding that employer was not entitled to refund, and approval by Pension Benefit Guaranty Corporation (PBGC), of new fee schedule for private arbitration of an employer's liability for withdrawing from participation in underfunded multiemployer pension fund, is not required for the new fees to be charged. [Cent. States, Se. & Sw. Areas Pension Fund v. Bulk Transp. Corp., No. 15-3208, ___ F.3d ___, 2016 WL 1719335 \(7th Cir. Apr. 29, 2016\)](#) (Before POSNER, EASTERBROOK, and KANNE, Circuit Judges).

Finding that Equipment Leasing was a trade or business under common control with Sidney Truck such that it is jointly and severally liable for withdrawal liability, and granting summary judgment against all Defendants. [Cent. States v. Sidney Truck & Storage, Inc., No. 14 C 3663, 2016 WL 1594967 \(N.D. Ill. Apr. 21, 2016\)](#) (Judge John Robert Blakey).

Granting Funds' motion for summary judgment, finding that CBA obligated Wingra to make contributions to two of the Union's member benefit funds, Plaintiffs Central States, Southeast and Southwest Areas Pension Fund and Central States, Southeast and Southwest Areas Health and Welfare Fund. [Cent. States, Se. v. Wingra Redi-Mix, Inc., No. 12-CV-04084, 2016 WL 1555579 \(N.D. Ill. Apr. 18, 2016\)](#) (Judge Andrea R. Wood).

Confirming arbitration award finding that Defendant did not owe any withdrawal liability based on defense of equitable estoppel. [Laborers' Pension Fund & James S. Jorgensen v. W.R. Weis Company, Inc., No. 15 C 07867, 2016 WL 1535163 \(N.D. Ill. Apr. 15, 2016\)](#) (Judge Edmond E. Chang).

F. Eighth Circuit

Entering judgment against Defendants in the sum of \$71,159.76 because Plaintiffs have established that defendant is liable to them for \$64,937.50 in unpaid fringe benefit contributions, \$697.41 in interest, and \$4,224.09 in liquidated damages, for a total of \$69,859.00, plus \$1,300.76 in legal fees and costs. [St. Louis-Kansas City Carpenters Reg'l Council v. Earl Banze Constr. Co., No. 4:16-CV-1196-CEJ, 2016 WL 7188132 \(E.D. Mo. Dec. 12, 2016\)](#) (Judge Carol E. Jackson).

The court granted Plaintiffs' motion for attorney's fees, costs, and audit costs in the following amounts: \$28,343.34 in attorney's fees, \$16,563.10 in audit costs, and \$1,931.22 in court costs. These amounts were added to the previous summary judgment award of \$95,854.99. [Iron Workers St. Louis Dist. Council Annuity Trust v. United Ironworkers, Inc., No. 4:15-CV-00713-AGF, 2016 WL 7178747 \(E.D. Mo. Dec. 9, 2016\)](#) (Judge Audrey G. Fleissig).

The court granted in part Plaintiffs' Motion to Enforce Terms of Settlement Agreement and ordered the entry of judgment against defendant Wellington Concrete, LLC in the amount of \$16,575.00. [Constr. Indus. Laborers Pension Fund v. Wellington Concrete, LLC, No. 4:15-CV-804 CAS, 2016 WL 7013038 \(E.D. Mo. Dec. 1, 2016\)](#) (Judge Charles A. Shaw).

“Plaintiffs are entitled to judgment against defendant Thermal Mechanical Insulation, LLC, in the amount of \$58,489.11, which includes \$16,314.01 in contributions, \$3,730.51 in liquidated damages, \$6,618.09 in interest, and \$3,485 in audit accounting fees for the audit period of October 1, 2011 through July 31, 2013, and \$28,341.50 in attorneys' fees and litigation fees and costs.” [Boards Of Trustees Of The Northwest Insulation Workers Welfare Trust v. Thermal Mechanical Insulation, LLC, No. CV 15-09-BLG-SPW, 2016 WL 6561290 \(D. Mont. Nov. 4, 2016\)](#) (Judge Susan P. Watters).

Entering default judgment against Defendants as to all Counts of Plaintiffs' complaint seeking to recover delinquent contributions. [St. Louis-Kansas City Carpenters Regional Council, et al. v. Joseph Construction, Inc. & Ricky Roach, No. 4:16-CV-00929-AGF, 2016 WL 6524342 \(E.D. Mo. Nov. 3, 2016\)](#) (Judge Audrey G. Fleissig).

Granting in part and denying in part Plaintiffs' Motion for Summary Judgment. Granting motion with respect to X-L's counterclaim asserting that Plaintiffs breached the Site Agreement or the Reciprocal Agreement by failing to enforce the Reciprocal Agreement, but denying the motion with respect to X-L's counterclaim for equitable restitution. [Greater St. Louis Construction Laborers Welfare Fund, et al. v. X-L Contracting, Inc., No. 4:14-CV-946-SPM, 2016 WL 6432768 \(E.D. Mo. Oct. 31, 2016\)](#) (Magistrate Judge Shirley Padmore Mensah).

Granting Plaintiffs' motion for default judgment against defendant ILMO in the amount of \$15,686.43 in delinquent fringe benefit contributions, interest, and liquidated damages, against defendants ILMO and Rogers in the amount of \$41,418.12 in principal and interest on two promissory notes on which they defaulted, and against defendants ILMO and Rogers in the amount of \$1,084.40 in attorneys' fees and costs. [St. Louis – Kansas City Carpenters Regional Council, et al. v. ILMO Contracting, LLC, et al., No. 4:16 CV 751 CDP, 2016 WL 5371586 \(E.D. Mo. Sept. 26, 2016\)](#) (Judge Catherine D. Perry).

Entering summary judgment on behalf of Plaintiffs and against Defendant in the amount of \$95,854.99 for delinquent contributions, liquidated damages, and interest relating to bonuses, the Edwards Brothers, and ironworkers in Indiana. [Iron Workers St. Louis District Council Annuity Trust, et al. v. United Ironworkers, Inc., No. 4:15-CV-00713-AGF, 2016 WL 5371585 \(E.D. Mo. Sept. 26, 2016\)](#) (Judge Audrey G. Fleissig).

Granting Plaintiffs' motion for civil contempt as to defendant J L Brown Contracting Service, Inc. for failure to comply with the October 6, 2015, order directing it to produce its records for inspection by Plaintiffs. [Greater St. Louis Construction Laborers Welfare Fund, et](#)

[al. v. J L Brown Contracting Service, Inc., No. 4:15-CV-960-CEJ, 2016 WL 5076189 \(E.D. Mo. Sept. 20, 2016\)](#) (Judge Carol E. Jackson).

Granting summary judgment in favor of Plaintiffs, three multiemployer fringe benefit funds and their fiduciaries, against Defendant for delinquent contributions, but granting summary judgment to Defendant to the extent it relates to alleged delinquent contributions based on bonuses, hours worked by the Edwards Brothers (Defendant claimed it did not employ), and hours worked by ironworkers in Indiana covered by a different union and fund. [Iron Workers St. Louis District Council Annuity Trust, et al. v. United Ironworkers, Inc., No. 4:15-CV-00713-AGF, 2016 WL 4701588 \(E.D. Mo. Sept. 8, 2016\)](#) (Judge Audrey G. Fleissig).

Declining Plaintiffs' request to enter default judgment against Defendants because the evidence offered is not sufficient to support the requested judgment, but Plaintiffs have an opportunity to cure the deficiencies in their evidence. [St. Louis – Kansas City Carpenters Regional Council, et al., v. ILMO Contracting, LLC, et al., No. 4:16 CV 751 CDP, 2016 WL 4537921 \(E.D. Mo. Aug. 30, 2016\)](#) (Judge Catherine D. Perry).

Finding that Plaintiffs are entitled to a default judgment against Defendant A & W in the total amount of \$12,262.26, consisting of audit amounts of \$7,700.65 in contributions, supplemental dues, liquidated damages, and interest; \$901.00 in accounting fees; and \$3,660.61 in attorneys' fees and costs. [Greater St. Louis Construction Laborers Welfare Fund, et al. v. A & W Construction Company, Inc., No. 4:14CV1650RLW, 2016 WL 4411400 \(E.D. Mo. Aug. 18, 2016\)](#) (Judge Ronnie L. White).

Granting Plaintiffs' Motion for a Creditor's Bill in Equity and to Pierce the Corporate Veil. [Painters District Council No. 2, et al. v. Sustainable Construction, Group, LLC., et al., No. 4:12-CV-00492 ERW, 2016 WL 4124110 \(E.D. Mo. Aug. 3, 2016\)](#) (Judge E. Richard Webber).

Granting summary judgment in favor of Plaintiff on lawsuit seeking withdrawal liability against Defendants Susie's Construction, Inc., an administratively dissolved Missouri corporation, and its former officers, Susie York and Bud (Myson) York. [Local Union 513 Pension Fund, et al. v. Susie's Construction, Inc., et al., No. 4:15-CV-01322 JAR, 2016 WL 4036908 \(E.D. Mo. July 28, 2016\)](#) (Judge John A. Ross).

Granting Plaintiffs' motion for entry of judgment and finding the total amount due and owing the Control Board from Fore Mechanical for delinquent contributions, liquidated damages, and attorneys' fees and costs for the Audit Period is \$69,852.18. [James Bigham, John Quarnstrom, Robert Vranicar, Jim Bowman, Mike McCauley, & Matt Fairbanks as Trustees of the Sheet Metal Local #10 Control Bd. Trust Fund, & the Sheet Metal Local #10](#)

[Control Bd. Trust Fund vs. Fore Mech. Inc., No. 14CV03076MJDSER, 2016 WL 3034157 \(D. Minn. May 27, 2016\)](#) (Judge Michael J. Davis).

Concluding that Stika Concrete and General Contracting is the alter ego of Stika Concrete Contracting Co., Inc.; that the corporate veil should be pierced to enable Plaintiffs to collect the balance of the default judgment against Stika Concrete Contracting Co., Inc. (Original Stika) from Stika Concrete and General Contracting (New Stika); and that Plaintiffs are entitled to a creditor's bill in equity to satisfy the judgment against Stika Concrete Contracting Co., Inc. [Cement Masons Local 527, et al. v. Stika Concrete Contracting Co., Inc., No. 4:14-CV-1030-JAR, 2016 WL 2894716 \(E.D. Mo. May 18, 2016\)](#) (Judge John A. Ross).

Granting Motion for a Creditor's Bill in Equity and to Pierce the Corporate Veil. [Greater St. Louis Construction Laborers Welfare Fund, Et Al., V. Stika Concrete Contracting, Co., Inc., et al., No. 4:14-CV-01406 ERW, 2016 WL 2803229 \(E.D. Mo. May 13, 2016\)](#) (Judge E. Richard Webber).

Granting default judgment and awarding Plaintiffs outstanding contributions in the amount of \$7,500.66, liquidated damages in the amount of \$799.59, interest in the amount of \$80.00, and attorneys' fees and court costs in the amount of \$1,031.16, for a total of \$9,411.41. [Louis-Kansas v. Edwards-Kamadulski, LLC, No. 4:16-CV-00302-NCC, 2016 WL 1624019 \(E.D. Mo. Apr. 25, 2016\)](#) (Judge Henry Edward Autrey).

R&S has produced evidence sufficient to challenge Plaintiffs' audit at the summary judgment stage. [James Bigham, John Quarnstrom, Robert Vranicar, Jim Bowman, Mike McCauley, & Matt Fairbanks, as Trustees of the Sheet Metal Local #10 Control Bd. Trust Fund, & the Sheet Metal Local #10 Control Bd. Trust Fund, Plaintiffs, v. R&S Heating & Air Conditioning, Inc., Defendant., No. CV 14-1357 \(DWF/FLN\), F.Supp.3d , 2016 WL 1626838 \(D. Minn. Apr. 22, 2016\)](#) (Judge Donovan W. Frank).

G. Ninth Circuit

[Automotive Industries Pension Trust Fund; et al. v. Tractor Equipment Sales, Inc., et al., No. 14-17371, __F.App'x__, 2016 WL 7422710 \(9th Cir. Dec. 23, 2016\)](#) Before: HAWKINS, BERZON, and MURGUIA, Circuit Judges). The court affirmed the district court's decision to not enforce withdrawal liability under ERISA against three rental properties owned by the Van Tuyls because they did not constitute a commonly-controlled "trade or business" under 29 U.S.C. § 1301(b)(1). The Van Tuyls devoted little time to the real estate beyond depositing the income and performing minimal maintenance as required. The court found that the nature of the

real estate activity in this case is thus more akin to holding a long-term income-producing investment.

Because the Complaint does not sufficiently allege facts that demonstrate Defendant's intent to be bound by the CBA, and because Plaintiff's arguments in response to Defendant's motion to dismiss are largely drawn from documents that the Court cannot consider in ruling on Defendant's motion, the Court granted Defendant's motion to dismiss Plaintiffs' Complaint. [Bd. of Trustees of the Bay Area Roofers Health & Welfare Trust Fund v. Gudgel Yancey Roofing Inc., No. 16-CV-04310-LHK, 2016 WL 7049240 \(N.D. Cal. Dec. 5, 2016\)](#) (Judge Lucy H. Koh).

Awarding \$27,836.88 in damages: \$20,866.82 for delinquent contributions; \$4,173.36 in liquidated damages; \$2,245.59 in attorneys' fees; \$551.11 in litigation costs; plus interest, at the rate of one percent (1%) per month, commencing when payment was due beginning on January 21, 2015, and continuing until payment is made. [Bd. of Directors of the Motion Picture Indus. Pension Plan v. S&L Tramondo, Inc., No. CV 16-3683-RSWL-KS, 2016 WL 6781094 \(C.D. Cal. Nov. 16, 2016\)](#) (Judge Ronald S.W. Lew).

Awarding \$13,935.12 in delinquent contributions between January 1, 2011, and June 20, 2015, \$2,935.97 in interest, \$1,920 in audit costs, and \$1,727.47 in attorney's fees. [Constr. Laborers Trust Funds for S. California Admin. Co. v. Tennyson Elec., Inc., No. 216CV04908ODWGJSX, 2016 WL 6602571 \(C.D. Cal. Nov. 8, 2016\)](#) (Judge Otis D. Wright).

Granting Plaintiffs' motion for summary judgment as to Rady Concrete's liability with respect to the projects for which Rady Concrete submitted any signed remittance forms. Granting Defendants' motion with respect to there being no liability under the June 1, 2009 Compliance Agreement beyond the completion of the AHFC Fairbanks project or with respect to projects for which no remittance forms at all were submitted. [Alaska Trowel Trades Pension Trust v. Rady Concrete Constr., LLC, No. 3:15-CV-00061-SLG, 2016 WL 6518430 \(D. Alaska Nov. 2, 2016\)](#) (Judge Sharon L. Gleason).

The record does not support an inference that Michael's had notice of the predecessor flooring company's potential withdrawal liability and it is not liable as a successor employer. [Resilient Floor Covering Pension Trust Fund Bd. of Trustees v. Michael's Floor Covering, Inc., No. 11-CV-05200-JSC, 2016 WL 5407848 \(N.D. Cal. Sept. 28, 2016\)](#) (Magistrate Judge Jacqueline Scott Corley).

Ordering final judgment immediately in favor of Plaintiffs: 1) against Dynamic as to Counts I and IV and against Aguinaldo as to Count II, in the amount of \$18,349.75, pursuant to the February 3, 2015 Order Adopting Magistrate Judge's Findings and Recommendation and the instant Order; and 2) against Dynamic and Aguinaldo as to the civil contempt sanction, in the amount of \$2,294.88, pursuant to the May 26, 2016 Order Granting in Part and Denying in Part Plaintiffs' Request for Sanctions Against Defendant

Dynamic Interiors LLC and the instant Order. [Hawaii Masons' Health & Welfare Fund, Etc. v. Dynamic Interiors, LLC, No. 14-00434 LEK-RLP, 2016 WL 5219453 \(D. Haw. Sept. 20, 2016\)](#) (Judge Leslie E. Kobayashi).

In fringe-benefit contributions matter, granting default judgment to Plaintiffs and awarding a judgment in the total amount of \$186,452.85 against Defendants, joint and several. [The Board of Trustees of The Construction Industry And Laborers Health And Welfare Trust, et al. v. Safety Sealed Water Systems LLC, et al., No. 215CV00180APGVCF, 2016 WL 4708465 \(D. Nev. Sept. 7, 2016\)](#) (Judge Andrew P. Gordon).

Plaintiffs are entitled to liquidated damages equal to 12% of the amount of the delinquent contributions for January through April 2016, interest at the rate of twelve percent (12%) per annum for the delinquent contributions, attorneys' fees, and costs from Barry Civil. [Locals 302 And 612 Of The International Union Of Operating Engineers Construction Industry Health And Security Fund, et al. v. Barry Civil Construction, Inc., No. C16-0404-JPD, 2016 WL 4528462 \(W.D. Wash. Aug. 29, 2016\)](#) (Magistrate Judge James P. Donohue).

Granting Plaintiff's motion for summary judgment requiring Defendants Central Machine Works, Inc. and Soway, LLC, jointly and severally, to pay the full amount of the employer withdrawal liability assessed by Plaintiff in accordance with the relevant ERISA provisions, and granting Defendants Paul and Sylvia Sowa's motion for summary judgment with regard to any personal liability for the withdrawal liability in accordance with Plaintiff's statement that it does not hold the individuals personally liable for that assessment. [Bd. of Trustees of the W. Metal Indus. Pension Fund v. Cent. Mach. Works, Inc., No. C14-00802 RAJ, 2016 WL 3906894 \(W.D. Wash. July 19, 2016\)](#) (Judge Richard A. Jones).

Adopting in part Magistrate Judge's Findings and Recommendation as follows: (1) modifying one statement to read, "The Audit revealed Gulf Coast may owe Plaintiffs amounts up to \$876,177.41 in contributions, \$354,761.21 in dues, \$160,925.90 in liquidated damages, and \$465,859.45 in interest;" (2) granting Gulf Coast's motion to compel arbitration of the amounts due under the Agreement based on the March 2015 audit and Gulf Coast's liability for amounts accruing after the March 2015 audit; (3) remanding matter to Arbitrator William P. Hobgood; (4) dismissing the Union's claim under the LMRA without prejudice, and staying the Trusts' ERISA claims; (5) denying Gulf Coast's motion to dismiss the Trusts' claim for liquidated damages and the alternative motion to transfer this action to the Middle District of Florida with leave to refile. [Regional Local Union No. 846, et al. v. Gulf Coast Rebar, Inc., a Florida Corp., f/k/a Gulf Coast Placers, Inc., a Florida Corp., No. 3:11-CV-658-AC, 2016 WL 3765707 \(D. Or. July 13, 2016\)](#) (Judge Michael H. Simon).

Granting motion for summary judgment is granted in favor of Plaintiffs in the amount of \$38,893.31, which is comprised of the following amounts: \$7,845.25 in unpaid

contributions; \$2,939.25 in interest on unpaid contributions as of September 14, 2015, on which additional interest will continue to accrue until paid; \$2,939.25 as an amount equal to the greater of the interest on unpaid contributions or liquidated damages provided for under the plan, on which additional interest will continue to accrue until paid; \$12,229.36 in reasonable attorney's fees and costs of the action, consisting of \$11,528.50 in fees and \$700.86 in costs; and \$12,940.20 in audit costs. [Trustees Of The Bricklayers & Allied Craftworkers Local 13 Defined Contribution Pension Trust For Southern Nevada, et al., v. G.G. Construction, Inc., et al., No. 214CV01448RFBNJK, 2016 WL 3769346 \(D. Nev. July 14, 2016\)](#) (Judge Richard F. Boulware, II).

Denying Defendant's motion to dismiss in its entirety with respect to GCIU's claim for delinquent contributions, but granting Defendant's Motion to Stay GCIU's § 1399(a) claim. [GCIU-EMployer Ret. Fund v. Quad/Graphics, Inc., No. 216CV00100ODWAFMX, 2016 WL 3027336 \(C.D. Cal. May 26, 2016\)](#) (Judge Otis D. Wright, II).

Entering default judgment against Defendant and in favor of Plaintiffs and awarding \$63,777.20 in total damages: \$14,560.53 for delinquent contributions; \$17,238.89 in interest; \$17,238.89 in liquidated damages; \$10,305.00 for Audit fees; \$3,973.73 in attorney's fees; and \$460.16 in litigation costs. [Bd. of Directors of The Motion Picture Indus. Pension Plan v. Oil Factory, Inc., No. 15-9841-RSWL-AGRX, 2016 WL 3027337 \(C.D. Cal. May 25, 2016\)](#) (Judge Ronald S.W. Lew).

Plaintiffs sued for contributions that Trayer owed as an employer, but allegedly did not pay, to the plans. Trayer counterclaimed for the refund of contributions that it allegedly paid by mistake. Court granted Plaintiff's motion under Rule 12(b)(6) to dismiss Counterclaim 2, for common-law restitution, and Counterclaim 3, which has morphed from a claim for civil penalties under 29 U.S.C. § 1132(c)(1)(B) into a request for the attorney's fees and costs (of bringing this particular counterclaim) as "equitable relief" under 29 U.S.C. § 1132(a)(11)(B). [Sheet Metal Workers Pension Trust of N. California v. Trayer Eng'g Corp., No. 15-CV-04234-LB, 2016 WL 1745676 \(N.D. Cal. May 3, 2016\)](#) (Magistrate Judge Laurel Beeler).

Court's previous order is void for lack of subject matter jurisdiction because the parties are not diverse from one another and Trustees' alter ego claim does not arise under federal law. [Trustees Of The Construction Industry And Laborers Health And Welfare Trust vs. PRO-CUT LLC, Defendant., No. 212CV00205GMNVCF, 2016 WL 1688001 \(D. Nev. Apr. 26, 2016\)](#) (Judge Gloria M. Navarro).

H. Tenth Circuit

The court granted Defendant's request for an order under Fed. R. Civ. P. 15 granting it leave to file its proposed Amended Answer and Counterclaim, which adds numerous new factual allegations in support of its affirmative and other defenses and return-of-contributions counterclaim. [BAC Local Union 15 Welfare Fund v. McGill Restoration, Inc., No. 16-CV-2082-JAR-TJJ, 2016 WL 7179464 \(D. Kan. Dec. 9, 2016\)](#) (Magistrate Judge Teresa J. James).

In suit for unpaid fringe benefit contributions, the court granted Plaintiff's motion to dismiss Defendant's counterclaim for attorneys' fees, costs, and expenses, but not its counterclaim for refund of contributions; restitution; unjust enrichment. [BAC Local Union 15 Welfare Fund v. McGill Restoration, Inc., No. 16-2082-JAR-TJJ, 2016 WL 6905721 \(D. Kan. Nov. 23, 2016\)](#) (Judge Julie A. Robinson).

Granting Plaintiffs' Motion for Default Judgment and directing clerk to enter default judgment against Defendant in the following amounts: Contributions: \$12,857.28, Liquidated Damages: \$1,542.88, Interest: \$400.40, Attorney's Fees: \$1,700.00, Costs: \$556.25 (TOTAL: \$17,056.81). [Boilermaker-Blacksmith National Pension Fund, et al. v. South Buffalo Electric, Inc., No. 15-9937-CM, 2016 WL 2989291 \(D. Kan. May 24, 2016\)](#) (Judge Carlos Murguia).

Withdrawal liability may be assessed against all entities in a construction-industry employer's common-control group at time that withdrawal liability is triggered by continuation or resumption of covered work. [Ceco Concrete Const., LLC v. Centennial State Carpenters Pension Trust, No. 15-1021, ___ F.3d ___, 2016 WL 1743394 \(10th Cir. May 3, 2016\)](#) (Before KELLY, MATHESON, and MORITZ, Circuit Judges).

I. Eleventh Circuit

Granting the Pension Fund's motion to strike Defendants' affirmative defenses and the Pension Fund's motion for judgment on the pleadings; finding that Defendants are jointly and severally liable to Plaintiff for unpaid contributions, interest on the unpaid contributions, and reasonable attorneys' fees and costs of the action under 29 U.S.C. § 1132(g) (2). [Rice v. Muns Grp., Inc., No. 1:15-CV-200, 2016 WL 4499457 \(S.D. Ga. Aug. 26, 2016\)](#) (Judge J. Randal Hall).

Granting Plaintiffs' motion for default judgment and awarding damages provided expressly under sections 502 and 515 of ERISA. [Birmingham Plumbers and Steamfitters Local 91 Pension Plan; Birmingham Plumbers and Steamfitters Local 91 Welfare Fund, v. Iron](#)

[Mountain Construction, Inc., No. 2:15-CV-00499-MHH, 2016 WL 4137972 \(N.D. Ala. Aug. 4, 2016\)](#) (Judge Madeline Hughes Haikala).

J. D.C. Circuit

On Plaintiff Service Employees International Union’s National Industry Pension Fund’s motion for summary judgment for its outstanding withdrawal liability against Defendant Scientific Commercial Systems Corporation, granting the motion and discarding each of SCSC’s defenses. [Serv. Employees Int’l Union Nat’l Indus. Pension Fund v. Sci. & Commercial Sys. Corp., No. CV 13-1705 \(JEB\), F.Supp.3d , 2016 WL 5313006 \(D.D.C. Sept. 22, 2016\)](#) (Judge James E. Boasberg).

Granting Plaintiffs’ motion requesting an entry of default judgment, monetary damages, attorney’s fees, and an injunction to conduct an audit of the company’s books and records to determine if there are any delinquent contributions. [Boland v. Smith & Rogers Constr. Ltd., No. 15-CV-01386 \(CRC\), F.Supp.3d , 2016 WL 4435180 \(D.D.C. Aug. 19, 2016\)](#) (Judge Christopher R. Cooper).

Granting Fund’s third motion for default judgment on the proper amount of damages, found to be \$209,003.86 of withdrawal liability, interest and liquidated damages calculated according to the methods outlined in the Fund’s Pension Plan documents, and \$8,568.50 in attorneys’ fees and costs. [Serv. Employees Int’l Union Nat’l Indus. Pension Fund v. Glenn’s Bldg. Servs., Inc., No. CV 14-1942 \(JDB\), 2016 WL 4132192 \(D.D.C. Aug. 3, 2016\)](#) (Judge John D. Bates).

Granting Fund’s second motion for default judgment as to liability but denied as to damages due to failure to establish the proper amount of damages. [Serv. Employees Int’l Union Nat’l Indus. Pension Fund v. Glenn’s Bldg. Servs., Inc., No. CV 14-1942 \(JDB\), 2016 WL 1452328 \(D.D.C. Apr. 13, 2016\)](#) (Judge John D. Bates).