SPECIAL REPORT

LARGEST ERISA CLAIMS
01/16/2015

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THE IMPORTANCE OF FIDUCIARY LIABILITY INSURANCE
(IT’S NOT JUST ABOUT 401(K) PLANS)

- Fiduciary liability insurance will defend and pay, where required, for settlement and judgments arising out of employee benefit plans that are governed by the Federal ERISA statute.

- The ERISA statute relates to employee benefit plans. The attached claims examples have 80 ERISA claims:

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<thead>
<tr>
<th>BENEFIT PLANS</th>
<th># OF CLAIMS</th>
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<tbody>
<tr>
<td>Health Insurance</td>
<td>18</td>
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<td>Group Life</td>
<td>11</td>
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<tr>
<td>Group Disability</td>
<td>15</td>
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<td>ESOP</td>
<td>04</td>
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<td>Pension Plans &amp; 401(k) Plans</td>
<td>36</td>
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<td><strong>TOTAL</strong></td>
<td><strong>84</strong></td>
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47 of 84 claims (or 56%) of ERISA claims are for other than 401(k) plans.
Many business people say that they are not concerned about claims against them as the fiduciary of their 401(k) Plan because it is “self-directed.”

- As you can see, in a random sampling of ERISA claims, only 45% of the claims actually relate to 401(k) Plans.

**THIS SAMPLING OF BENEFIT PLANS DEMONSTRATES THAT THE MAJORITY OF ERISA CLAIMS RELATE TO OTHER EMPLOYEE BENEFITS SUCH AS GROUP HEALTH, GROUP LIFE, GROUP DISABILITY, AND ESOP CLAIMS.**

(See the following descriptions of ERISA / Fiduciary claims.)
DESCRIPTIONS OF ERISA / FIDUCIARY CLAIMS

1. **Rochow v Life Insurance Company of N.A.**
   - **Fiduciary Duty Claim.** Employer forced plaintiff to resign in 2002 due to short term memory loss, etc. whereby he could no longer perform his duties as president. A month later he was diagnosed with HSV-Encephalitis, a rare and severely debilitating brain infection. LINA denied long-term disability benefits because his employment ended before his disability began. ERISA has a goal of ensuring that plan fiduciaries act solely in the interest of the participants and providing benefits, not in punishing the defendant, while also having a goal of providing inexpensive and expeditious dispute resolution. Although discovery may slow down litigation in some cases, risk of liability and extensive discovery will act as an incentive to ensure plan administrators act in the interest of the plan participants throughout the claims process. Facts showed that LINA continually ignored its own plan definitions, wrongly denying benefits for 5 years after the initial request. Plaintiff recovered an additional award for disgorgement of profits in the amount of $3.8M as damages for the breach of fiduciary duty claim in addition to denied benefits.

2. **Kimberly A. Frazier v Life Ins. Co. of N.A.**
   - **Long-Term Disability**
   - Employee working as a “mail sorter” for a publishers printing company sought to obtain long-term disability (“LTD”) and other benefits allegedly owed her under an employer-sponsored insurance policy when, at the age of 42, she suffered pain in her back that radiated down both legs, underwent an MRI of her lumbar spine, began physical therapy and later lumbar epidural injections. Her employer's benefit plan administrator had the discretionary authority to deny the claim, which it did. Counsel at oral argument determined that denial of benefits was rational and that the denial of benefits was neither arbitrary nor capricious. They did not support a claim that the administrator could be liable for termination of assistance.

3. **Confidential**
   - **Autism Denied Under Group Health**
   - In an ERISA claim alleging that the plan administrator acted arbitrarily in denying insurance benefits, two families of children with autism brought suit against defendant national insurance company and its subsidiaries in a federal court on behalf of all other similarly-situated families who were denied coverage for applied behavior analysis therapy. The insurer had designated coverage as “experimental.” The court found that such distinctions do
not preclude class certification because the defendant insurer has determined, on a class-wide basis, that ABA is experimental therapy in all cases. The court granted class certification to the families and, thereafter, granted the families’ motion to expand the class to include both current and former insured beneficiaries. After the parties briefed numerous contested class certification issues, the parties agreed on a settlement.

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<th>4. CIGNA Corp. v Amara</th>
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<td>CIGNA changed its <strong>pension plan</strong> from a “<strong>defined benefit plan</strong>” to a “<strong>cash balance</strong>” <strong>defined contribution</strong> plan in 1998. To do this, they converted the previously accumulated old-plan benefits to an “opening amount” in each employee’s cash balance account. The method for making and calculating this opening amount became a source of dispute. A class of about 25,000 beneficiaries sued. The federal district found violation by CIGNA that would likely cause members harm; however, The Supreme Court ejected decisions and remanded the case for further proceedings and, in the process, made several observations that will impact multiple facets of ERISA administrator, likening them respectively to the settlor and the fiduciary of a trust. They made it clear that a summary plan description created by the plan administrator is not legally binding like the actual plan document created by the plan sponsor.</td>
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<th>5. Tussey v Abb</th>
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<td>The district court certified the case to be a class action suit and refused to dismiss the case, also ruling that failure to disclose revenue sharing payments to plan participants is not a breach of fiduciary duty, as it is not explicitly required by ERISA or the DOL (Dept. of Labor). Following a 4-week bench trial, favor was found with the plaintiffs, awarding damages of nearly $37K. Though there were a number of deficiencies found, the primary lapse was in not following its detailed investment policy. Result: $35M verdict against <strong>401(k) plan</strong> fiduciaries, plus $1.7M against provider for improper use of “float” income. <strong>Failure to monitor administrative fees, failures as to fund selection, and misuse of revenue sharing</strong> for non-plan related purposes. Key fiduciary lessons: Follow all of plan’s governing documents which may include the IPS, negotiate with service providers for decreased fees/rebates when compensation levels are no longer supportable, do not appear to be motivated by ulterior purposes such as the employer’s financial interests, monitor service provider conflicts of interest, follow third party expert advice or document reasons why not, and when it comes to fiduciary process, document.</td>
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13. **Hahn Acquisition Corp v Hahn et al.**

**Mishandling of Plan Funds**

Plaintiff-corporation brought an ERISA action against benefit plan fiduciaries, claiming the fiduciaries mishandled plan funds. Action was dismissed because plaintiff was not a proper party. Plaintiff was not a participant, beneficiary, or fiduciary under the plan and was not the Secretary of Labor so, according to precedent and the plain language of the statute, plaintiff does not have a right of action under ERISA.

14. **Hamilton et al. v Carell et al.**

**Who is a Fiduciary**

Plaintiff-independent ERISA trust fund fiduciary sued defendant-third party administrator regarding alleged breaches of fiduciary duties arising out of certain investment services defendant provided to the fund. The district court properly found that defendant was not acting as an ERISA fiduciary during the relevant time period within the meaning of 29 USC Sect. 1002(21)(A). Defendant did not exercise discretionary authority or control over the management or administration of the 14 collateralized mortgage obligations at issue, nor did defendant give investment advice for a fee.

15. **Briscoe et al. v Fine et al.**

**Who is a Fiduciary**

Employees filed a class-action lawsuit against 5 defendant-employer’s (Fine) former officers and directors and third-party administrator of its healthcare plan, Preferred Health Plan, alleging that plaintiffs violated their fiduciary duties imposed by ERISA. PHP knew that Fine was in directors and officers liability financial straits and unable to fund the plan, which was the basis for PHP’s termination of the agreement. PHP knew that Cobra payment monies from former Fine employees were not Fine’s money, but money belonging to the Plan and its participants. Yet, PHP sent the balance of the plan’s account to Fine, a bankrupt employer. This was not prudent conduct. PHP clearly failed to act for the exclusive purpose of providing benefits to plan participants. The district court decided that Fine was not an ERISA fiduciary. On appeal, 1) the court agreed with the district court that the Fines were not ERISA fiduciaries because they did not exercise any discretionary authority control respecting management of such plan or in the disposition of its assets, and 2) it was concluded that the district court erred by ruling that PHP was not an ERISA fiduciary with respect to the assets of the company’s healthcare plan over which PHP had control. (Affirmed in part, reversed in part and remanded.)
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<th>16. Briscoe et al. v Preferred Health Plan</th>
<th>Who Is a Fiduciary (affirm district court’s order)</th>
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<td>In <em>Briscoe I</em> (above), the appeals court determined that PHP 1) did not exercise discretionary authority or control in managing the plan; however, it was concluded that it did <strong>exercise a degree of authority over the disposition of the plan’s assets</strong> and, therefore, qualified as a <strong>fiduciary</strong>, and 2) was only a fiduciary to the extent that it took specific actions with respect to assets under its control, a holding consistent with prior decisions of the court. Competent evidence showed that PHP had exercised control over assets, but only to the extent that PHP allotted to itself an administrative fee and returned the remaining funds after its relationship with Fine was terminated. The 6th Circuit Ct. of Appeals affirmed the district court’s order, granting plaintiff summary judgment and limiting PHP’s liability of $10,679.59.</td>
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<th>17. Hoger v Rospatch Corp</th>
<th>Who is a Plan Fiduciary</th>
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<td>Plaintiff sued defendant-employer for an ERISA violation. Defendant did not have ERISA liability because it was not the plan fiduciary and never knew about the ERISA violation. After a corporate reorganization, defendant terminated plaintiff CEO of one of defendant’s subsidiaries. Plaintiff sued for violation of ERISA by company <strong>failing to put stock in his 401(k) plan</strong>. Parties filed cross-motions for summary judgment. Defendant was responsible for administration of the plan, but had designated an administrative committee as the actual plan fiduciary. <strong>After the delegation, defendant did not have any further liability for the stock mix-up</strong> unless it had actual knowledge of the error. There was no evidence of such knowledge. As a result, defendant was not liable under ERISA for the error. After dismissal of plaintiff’s ERISA claims, defendant moved for attorney fees under Sec. 1132(g) of the act. Defendant’s motion, denied.</td>
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<th>18. Miller v Retirement Funding Corp</th>
<th>Breach of Fiduciary Duties</th>
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<td>Plaintiff was trustee of a <strong>defined benefit plan which received investment advice from defendant</strong>. But, some of the advice was unsound and caused the plan financial losses. The plan was terminated and replaced. Plaintiff sued defendant for breach of fiduciary duties under ERISA and for state law claims. Plaintiff is trustee of a terminated ERISA plan and has no standing to sue defendant-investment advisor for ERISA claims regarding the terminated plan. Court agrees that once the plan is terminated, plaintiff’s status changes from trustee to former trustee, lacking standing to assert ERISA claims for breaches of fiduciary duties. The plan participants, not plaintiff, are the <strong>proper parties to bring ERISA claims</strong>. The court also concluded the state law claims are preempted by ERISA. Complaint was dismissed.</td>
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19. **James et al. v Pirelli Armstrong Tire Corp**
   *Misled Employee, re: Early Retirement Pkg*
   
   Former employer misled plaintiff about **ERISA medical benefits** as part of an **early retirement package**. Federal district court erred by limiting relief to only those individuals who directly asked questions about the benefits and were given misleading information. Plaintiff’s claims were dismissed. A breach of ERISA fiduciary duties occurs when it provides, on its own initiative, misleading information about the future benefits of a plan. Judgment was reversed.

20. **Guyan v Professional Benefits Administrators**
   
   Four company plaintiffs (Permco, Precision Gear, Pritchard, and HAPCA) had each established an **employee benefit plan** under ERISA funded by a combination of employer contributions and covered employee payroll deductions. PBA would provide the services for the plans. PBA Federal district court ruled that defendant was a fiduciary with respect to plaintiffs’ employee benefit plans; therefore, PBA could be sued for breaching its duty as an ERISA fiduciary after it **misappropriated over $1.4M in plan funds** for its own purposes while medical claims remained unpaid. Damages were awarded to each plaintiff. PBA appealed on the basis that the district court incorrectly determined that it was an ERISA fiduciary. Court of Appeals affirmed that PBS was a fiduciary under ERISA.

21. **Richards v GM**
   
   Defendant-employer acting in bad faith **breached fiduciary duties owed to plaintiffs under ERISA** by firing plaintiffs and unilaterally offsetting ... non-forfeitable benefits in the **stock option purchase plan**. Plaintiffs, as former employees, could direct defendant to withhold up to 15% of their pay to purchase defendant’s stock and other investments under their ERISA benefit plans. Defendant claims that plaintiffs, with the help of the local plan administrator, were able to “back date” their investment choices. Defendant fired plaintiffs after learning of this scheme. The court held there is **no individual action for breach of fiduciary duty**.

22. **Griffin et al. v Flagstar Bancorp, Inc., et al.**
   
   Class-action lawsuit was filed by 2,952 **401(k)** plan participants, all former Flagstar Bank employees, who claimed ERISA duties were breached by **continuing to offer its own stock as an investment option even though the bank was in serious financial trouble**. Though the district court granted Flagstar’s motion to dismiss the case, the circuit court reversed, claiming that a prudent fiduciary would have discontinued offering Flagstar stock at some point during the class period. During settlement talks, they accepted a mediator’s proposal to
pay the plan $3,000,000, which would be allocated to plan participants pro rata. The plaintiffs calculated a range of damages based on when Flagstar’s allegedly imprudent plan administration began ($17.8M (2006), $3.5M (2007), and $1.5M (2009). U.S. District Court Judge agreed that the $3M settlement appeared an excellent result, given the uncertainties of the plaintiff’s chances of ultimately prevailing on the issue of liability in this very uncertain area of ERISA and given the challenges they faced in establishing the operative date of imprudence.

23. **Hi-Lex Controls, Inc., et al. v Blue Cross and Blue Shield of Michigan**

Hi-Lex corporation, on behalf of itself and the Hi-Lex Health & Welfare Plan, filed suit in 2011 alleging that BCBSM **breached its fiduciary duty** under ERISA by inflating hospital claims by as much as 13% with **hidden surcharges**, keeping the markups as additional administrative compensation, then providing false reports that hid the markups. Evidence showed that Blue Cross knew its customers were unaware of the markups. Defendant argued it did not breach any fiduciary duties required by ERISA because the disputed fees had been fully disclosed and plaintiff had agreed to pay them.

The district court granted summary judgment to Hi-Lex as to whether BCBSM a) functioned as an ERISA fiduciary and 2) its actions amounted to **self-dealing**. Following a bench trial, the district court found that Hi-Lex’s claims were not time-barred and that BCBSM had violated ERISA’s general fiduciary obligations. The court also awarded pre- and post-judgment interest. The Sixth Circuit Court of Appeals affirmed.

A threshold issue regarding whether BCBSM functioned as an ERISA fiduciary: In relevant part, ERISA provides that “a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.” The term person is defined broadly to include a corporation such as BSBSM. *Id.* § 1002(9). In one case, this statute “impose(d) fiduciary duties . . . on entities that exercise ‘any authority or control’ over the covered assets.” 444 F.3d 478,490-91 (6th Cir. 2006). Another: “(T)he assets of an employee benefit plan generally are to be identified on the basis of ordinary notions of property rights.” AO 92-24A at *2. Under this analysis, “the assets of a
welfare plan generally include any property, tangible or intangible, in which the plan has a beneficial ownership interest.”  *Id.*

In this case, the SPD (Summary Plan Description), which ERISA requires to be distributed to plan participants, establishes that Hi-Lex’s intention was to place plan assets for its self-funded Health Plan with BCBSM in its capacity as TPA. The SPD specifically notes that Hi-Lex “is not (a) direct payor of any benefits” and “no special fund or trust” exists from which self-insured benefits are paid. 29 U.S.C. § 1106(b)(1) states that a fiduciary “shall not deal with the assets of the plan in his own interest or for his own account.” The court interprets this statute as having an “absolute bar against self dealing.” § 1104(a): ERISA imposes three broad duties on qualified fiduciaries: 1) the duty of loyalty, 2) the prudent person fiduciary obligation, and 3) the exclusive benefit rule.

U.S. District Court ruled that Hi-Lex was entitled to $5,111,431 for damages, attorneys’ fees, along with prejudgment interest of $914,241 (the court utilized a blended rate for each of the 17 years during which the disputed fees were charged, a range from 6.13% to 0.14%).

| 24. Smith, et al. v Provident Bank, et al. | ERISA benefit plan trustee breached its fiduciary duty to a plan participant after being replaced as plan trustee because it was still a fiduciary because it controlled the plan assets. Six months after participant instructed Provident to purchase shares of Ameritrust Bank stock, Provident was removed as trustee for the Plans and was replaced by Society Bank. Weeks later he discovered Ameritrust shares were missing from his account. Provident had transferred the money which represented the purchase price less dividends he had received. However, the shares had largely increased. It was disputed as to what he should be compensated because the value of the stock continued to rise. He and the plans filed an ERISA action against Provident for its fiduciary duty as plan trustee and for damages. They also asserted negligence and common law claims against all the defendants for conversion. |

| 25. Best, et al. v Cyrus | In error, the federal district court ruled that defendant-ERISA plan trustee could not be liable for breach of his fiduciary duties when he did not ensure that contributions and repayments were made to the plan. Even though he was not specifically directed to act under the plan document, he still breached his fiduciary duties because a trustee has a duty |
Failure to File 5500 Forms

Failure to act in the interest of the plan’s beneficiaries. ERISA imposes additional duties on trustees through its incorporation of the common law of trusts. The lower court correctly ruled that defendant did not breach a fiduciary duty when he did not file the Form 5500 annual report “because this was outside the scope of his duties...” The district court correctly concluded that the plan administrator, the Kentucky State AFL-CIO, was responsible for filing that form.


Even though defendants were holding funds owed to plaintiff’s welfare benefit plan, defendants did not qualify as “fiduciaries” under ERISA. Injured in a hunting accident, defendant’s medical expenses were paid by plaintiff’s welfare benefit plan. According to the plan, it became subrogated to any damages he received from the tortfeasor. After hiring defendant attorney to sue and obtaining a large settlement, plaintiff wanted the entire amount. Plaintiff has moved for summary judgment. The court must reject the view that defendants are “fiduciaries” because they had authority over the disposition of plan assets. Plaintiff may be able to recover the funds under a federal common law breach of contract theory.


Plaintiffs, former managers of defendant-corporation, claimed that individual defendants, directors of the corporation as well as trustees of an employee stock ownership trust, told them that company stock would be put into the ESOT and ESOP. Instead, available stock was sold to the individual defendants personally. Statute of Limitations: Defendants argued that plaintiffs’ ERISA claims are time-barred by a three-year limitation period under ERISA. This limitation applies to claims accruing when plaintiffs first had knowledge of the ERISA violation. The record is contradictory on the accrual issue. Because of this factual conflict, the court cannot decide the limitations issue.

Breach of Fiduciary Duties: Both claims are defective: 1) Misrepresentation that stock would be sold to ESOT and ESOP: Statements were vague and defendants uttered them while acting in a personal, not fiduciary role. 2) Purchase of stock for themselves: Defendants do not have ERISA liability for decisions to act in their personal rather than fiduciary capacities.
<table>
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<th>Case</th>
<th>Description</th>
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<td>28. Holsey v Unum Life Ins. Co. of America, et al.</td>
<td>Anesthesiologist Plaintiff sued defendant-employer and insurance company claiming he was wrongfully denied disability payments when he became totally disabled due to blindness. He also has diabetes. When applying for disability benefits, he was told there was a pre-existing condition exclusion. Plaintiff argued he was misled as to his benefits. Plaintiff had not established that defendant-employer was acting in a fiduciary capacity when it communicated with plaintiff regarding his benefits. Also there was much argument as to which, exactly, the disability was in order to ascertain the “pre-existing condition” exclusion. Final judgment was in favor of defendant.</td>
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<td>29. Van Noord v Advantage Health, et al.</td>
<td>Where the amount of life insurance benefits defendant-employer agreed to provide plaintiff’s husband was ambiguous, defendant must pay plaintiff the greater amount. Where a summary of an ERISA plan is different than the actual plan, the circuit court ruled that the summary may be relied upon by the employee. Where there is an ambiguity in benefit coverage in ERISA plans, the court must construe that ambiguity in favor of the employee.</td>
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<td>30. Grindstaff, et al. v Green, et al.</td>
<td>Plaintiff-employees and their union sued defendant-corporation and others for breach of fiduciary duty under ERISA. Plaintiffs’ claims centered around an ESOP. Also, defendant Board of Directors refused to accept plaintiffs’ contract proposal for the amendment of the ESOP Plan to provide for pass-through voting; however, the district court found that plaintiffs failed to state a claim. Also, management entrenchment in an ESOP-owned company implicates a violation of ERISA-mandated fiduciary duties when the entrenched management appoints members of the administrative committee that controls the stock voting rights of the ESOP. The court found that the right to direct the voting of an ESOP’s shares, even when used to perpetrate one’s own incumbency, does not, by itself, constitute a plan asset.</td>
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<td>31. Olson v Chem-Trend Inc.</td>
<td>During his employment, plaintiff participated in defendant’s employee stock option plan (ESOP) and accumulated 744 shares of stock. After discharge, he asked for redemption of the ESOP stock. Defendant used a recent audit to value the stock at $126.58 per share. Eight months later, the president retired and the company was sold. The ESOP stock was sold for $270 per share. Plaintiff sued defendant with regard to the redemption of his stock, believing they assigned an unrealistically low value to his stock and withheld information.</td>
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about the impending sale of the company. The court determined: 1) There was no evidence that defendant supplied false information about ESOP rights, even though it may not have given plaintiff all the information he would have liked. It was plaintiff's responsibility to ask first. 2) Defendant did not have a fiduciary duty to inform plaintiff of its contingent corporate events, advising him that the company might be sold at some time in the future when its president retired. Complaint was dismissed.

32. **Wright, et al. v Heyne, et al.**

*Investment Advisors Sued for Breach of Fiduciary Duties*

Plaintiff-ERISA plan trustees sued defendant-investment advisors for breaching fiduciary duties when making investment decisions and charging commissions. Defendants were properly granted summary judgment based on ERISA's three-year statute of limitations because plaintiffs had “actual knowledge of the breach or violation.” After reviewing circuit court precedent and case-law from other circuits, it was concluded that the relevant knowledge required to trigger the statute of limitations is knowledge of the facts or transaction that constituted the alleged violation. It is noted that plaintiffs had actual knowledge of the material facts upon which their claims for breach of ERISA fiduciary duties were based more than three years before they filed the action.

33. **Judge v Metropolitan Life Ins. Co.**

*Life Insurance Policy Dispute, MetLife Denied*

Plaintiff plan participant was covered by his employer's term life insurance policy which provided for early payment of benefits if employee became permanently disabled, which was defined by the plan as being unable to do the employee’s own job and any other job for which he was fit by education, training or experience. Plaintiff was a baggage handler and ramp agent for Delta Airlines, underwent heart surgery and applied for benefits, not being able to return to any type of work. His treating providers recommended restrictions, but that he was recovering well with no evidence of complications. His doctors advised against returning to work. Key Issues: Was MetLife required to 1) obtain vocational evidence, 2) send plaintiff for an IME, 3) use a doctor, rather than nurse, to review medical files? Answer to all, “No.” In 2013, the court found that plaintiff was not permanently disabled and that MetLife had no conflict of interest that affected its denial decision.
34. **Gardner v Heartland Industrial Partners**

During the sale of Metaldyne, an automotive supplier, the prospective buyer, Ripplewood, discovered that Metaldyne would owe plaintiffs, former executives, approximately $13,000,000 as a result of the sale, under a *change-of-control provision* in its Metaldyne’s **SERP** “Supplemental Executive Retirement Plan.” It threatened to back out of the deal. In response, executives persuaded Metaldyne’s Board to declare the SERP invalid without notifying plaintiffs. The sale closed a month later. One executive personally collected more than $10,000,000 as a result. Plaintiffs claimed tortious interference with contractual relations. Plaintiffs were not seeking their SERP benefits, therefore they did not have a claim for benefits under ERISA. Rather, they sought damages from defendants, and not from SERP, for defendants’ **tortious activity**.

35. **US Airways v McCutchen**

Injured by a third party’s negligent driving in a car accident, plaintiff’s employer-sponsored **health benefits plan** paid his medical bills. Plaintiff retained attorneys, seeking to recover all of his accident-related damages estimated at $1,000,000. Case settled for $10,000 because the driver had limited insurance and 3 other people were seriously injured or killed. Plaintiff received $100,000 from his own insurer. 40% of his total $110,000 recovery went to his attorneys, leaving him with $66,000. The justices held that the plan would recoup all medical costs it paid on the man’s behalf after he recovered in a third-party personal injury suit. The court applied the “common fund” doctrine and reduced US Airways’ recovery on a pro rata share. **Plan provisions should always take precedence above equitable remedies.** ERISA is subject to equitable limitations.

36. **Bidwell/Wilson v University Medical Center/Lincoln Retirement Services Co.**

Breach of fiduciary duty under ERISA in connection with the transfer of Bidwell’s and Wilson’s **investments** from a stable value fund to a Qualified Default Investment Alternative was denied. Upon proper notice, participants who previously elected a specific investment could become non-electing plan participants if they **fail to respond to a specific request for an election**. The court found that the method of notice was sufficient because it was “reasonably calculated to ensure actual receipt.” Participants who fail to take requested action after having been given notice should not be heard to complain of the consequences.
### 37. Seaway Food Town, Inc. v Medical Mutual of Ohio

Seaway alleged that BC/BS breached its fiduciary duties to Seaway by failing to (1) use accurate data to estimate the amount of discounts BC/BS expected to receive from *healthcare* providers, (2) disclose the true nature and extent of the *provider discounts* it actually received, and (3) pass along to Seaway the provider discounts it actually received. Seaway also alleged Ohio common law claims of breach of contract and conversion. Seaway sought various reliefs, including restitution in the amount of provider discounts retained by BC/BS. Contrary to Seaway's argument, the court found that Section 9.5 of the 1991 and 1994 Group Contracts did not authorize defendant to exercise discretion with respect to any funds resulting from the provider discounts. Section 9.5 specifically authorizes BC/BS to retain such funds for its "sole benefit." The "sole benefit" language precluded it from exercising discretion with respect to such funds. The court held that BC/BS's adherence to Section 9.5 did not give rise to ERISA fiduciary status.

### 38. Libbey-Owens-Ford Co v BCBS of Ohio, et al.

Defendant, BCBS, received claims from *medical providers*, paid them, and had the authority to resolve disputes over coverage and claims. When it paid hospital claims, defendant customarily received a 3% discount or rebate, as well as other rebates when it eliminated any unnecessary charges. Defendant did not pass these rebates along to plaintiff. Plaintiff sued for an *accounting and restitution of the rebates*. Its chief claims were based on ERISA; however, district court determined defendant was not an ERISA fiduciary. Plaintiff appealed the dismissal and it was discovered ERISA did apply because an employee welfare benefit plan was at stake. Because defendant had discretionary authority to grant or deny claims, it was an ERISA fiduciary. Neither ERISA nor the parties’ agreement specifically required defendant to account to plaintiff; however, ERISA incorporates various common law trust principles, including a fiduciary’s duty to account and must tell plaintiff about the rebates.


Employee was diagnosed with breast cancer, her doctor recommended specific bone marrow transplant with high-dose chemotherapy, *coverage was denied* by defendant-plan administrator (CC Systems) because of the *experimental nature* of the treatment, and claim was referred to plaintiff-employer (Lansing General), who authorized treatment and paid for the treatment. But, when plaintiff submitted its claim to defendant-SLI, SLI denied it because treatment was experimental. Plaintiff sued CC Systems and SLI for reimbursement. CC
Systems argues it is not an ERISA fiduciary. Court disagreed because the statute provides that not only the persons named as fiduciaries by a benefit plan, but also anyone else who exercises discretionary control or authority over the plan’s management is an ERISA fiduciary. Sixth Circuit Court contended CC Systems did not have actual decision-making authority, but could merely suggest what type of insurance plaintiff should buy, and therefore concluded CC Systems was not an ERISA fiduciary with respect to these areas.

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<th>Hoeberling v Nolan</th>
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<td><strong>Profit Sharing Plan - Dismissed</strong></td>
<td>Plaintiff sued in his “individual capacity” for defendant’s breach of fiduciary duties in connection with the management of an ERISA profit sharing plan’s investments. Defendant was granted summary judgment because ERISA does not permit such suits. Recognizing this, Plaintiff argued to recover damages in his individual capacity for defendant’s alleged breach of fiduciary duties under “other equitable relief” language. Binding Supreme Court and Sixth Circuit precedent preclude an award of monetary damages. Accordingly, defendant was entitled to the dismissal of plaintiff’s claims as a matter of law.</td>
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<td><strong>Employee Stock Ownership Plan (ESOP)</strong></td>
<td>Former salaried employee-plaintiffs participated in a Savings and Stock Ownership Plan including both a voluntary 401(k) retirement plan and an ESOP. Even though the stock contained in defendant-corporation’s employee stock ownership plan (ESOP) declined in value between the sale of a subsidiary and the stock’s eventual transfer to the subsidiary’s benefit plan, the trial court properly found that defendant’s plan administrators did not violate their fiduciary duties by failing to immediately distribute the stock or diversity the stock. When defendant approved a $50 per share cash dividend and sold their Division, the buyer continued to employ employees under comparable term and conditions which included trust-to-trust transfer of plan assets. The transfer completed 18 months later during which time the value of the stock decreased from $50 to $10/share. Plaintiffs sued for federal securities laws fraud, ERISA violations, RICO claims, and common law claims. They also moved for class certification. Trial court granted defendants summary judgment on all but plaintiffs’ ERISA claims. Plaintiffs appealed. Result from Appeal: It was held that the district court did not err in determining that defendants’ failure to diversity or liquidate the ESOP funds was not a breach of their fiduciary duties. Plaintiffs need to prove that a prudent fiduciary acting under similar circumstances would have made a different investment decision.</td>
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<td>Section</td>
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<td>42.</td>
<td>Allinder v Inter-City Products Corp. (USA)</td>
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<td>43.</td>
<td>Sengpiel v B F Goodrich</td>
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or managing them. Actions taken as a corporate business decision may be subject to ERISA’s fiduciary standards, even though the employer’s decision itself is not. The action taken may ultimately affect the security of employees’ welfare benefits, but that does not automatically render the action subject to ERISA’s fiduciary duties. Only discretionary acts of plan management or administration or acts designed to carry out the purpose of the plan are subject to ERISA’s fiduciary duties. BFG applying a percentage classification to implement its business decision did not amount to an exercise of discretion of this character. The district court correctly found that BFG’s actions were simply not the kind of plan management or administration that triggers ERISA’s fiduciary duties.

| 44. | **Dawson, et al. v Detroit Lumber & Building Ass’n Retirement Plan, et al.** | During the seven years or so that plan trustees decided to terminate its employee benefit plan and when the actual termination commenced, the Pension Benefit Guaranty Corporation objected to the termination. During those years, other employers contributing to the plan incurred extra financial obligations. Plaintiffs sued the plan, defendant-McLeods, and others, alleging violation of ERISA. Eventually, the other defendants were dismissed leaving the McLeods as the only defendants. Meanwhile, another contributing employer to the plan, C.J. Link, intervened and filed a third-party complaint against the lawyers, alleging state law claims of fraud and malpractice against the lawyers for failing to terminate the plan expeditiously. The McLeods, as well as the lawyers, filed a motion to dismiss with regard to the third-party complaint, complaining that the claims are “time-barred.” Result: The court agreed. ERISA imposes a six-year limitation period for claims brought against plan fiduciaries; for non-fiduciary claims, analogous state limitations law applies which, in this case, is also a six-year limitation period. Link brought state tort claims against the lawyers, arguing that ERISA pre-empted the claims. The court rejected this view because the lawyers were outside parties, not ERISA fiduciaries. Link’s claims remain state law claims for which there is no independent federal jurisdiction. Dismissed for lack of jurisdiction. |
| 45. | **Consumers Energy v Smith Barney Corp. Trust v** | Defendant-investment firm, SBCT, was under the mistaken impression that plaintiff-plan administrator replaced defendant as an individual plan custodian, liquidating savings and pension investments. Investments were liquidated and plaintiff was sent the proceeds. Plaintiff says the liquidation was a mistake and that it was only replacing the “general
| **Comerica Bank** | Custodian” with Comerica (third-party defendant) and not the individual custodians, such as defendant. Plaintiff sued for breach of fiduciary duties; defendant countersued with contingency claims and also sued Comerica. Consumers Energy and Comerica both moved for summary judgment. Result: A) Consumers Energy is denied summary judgment because 2 primary issues of material fact remained: 1) Whether SBCT failed to act with care, skill, and prudence in selling over $32M of plan investments; and 2) Whether they were sold without any request or authorization to do so. B) Comerica was found to not have discretionary investment authority, but still may have breached fiduciary duties owed to the plans such as the duty to accurately and expeditiously communicate material information to Consumers regarding plan assets. Therefore, Comerica’s lack-of-discretionary-authority argument in favor of summary judgment lacked merit. |
| **Schaefer v Multibrand** | In a settled Dept. of Labor claim, plaintiff-corporate directors and trustees were claimed to have breached their fiduciary duties by purchasing company stock at inflated prices for employee stock ownership plans. An arbitrator concluded that an indemnification agreement was void, disregarding clearly established legal precedent, including that of the Sixth Circuit court, that they are enforceable. Result: Sect. 410(a) of ERISA declares that if there is any provision in an agreement that purports to relieve a fiduciary from responsibility, diminishing its statutory obligations, it shall be void as against public policy. However, Sect. 410(b) provides that insurance may be purchased to cover a fiduciary’s potential liability. Release agreements are, thus, void; insurance agreements, enforceable, transferring the liability to another party. The arbitrator’s decision was vacated. ERISA states that a) a fiduciary may purchase insurance to cover potential liability and b) an employer may purchase insurance to cover potential liability of fiduciaries. |
| **Tassinere v American Nat’l Ins. Co.** | Plaintiff-agents filed a suit against defendant-directors for breach of fiduciary duty. Plaintiffs appealed the dismissal and alleged that defendant failed to secure certain pension benefits. District court determined that 1) the claim for breach was time-barred, and 2) plaintiffs’ common law claims were preempted by ERISA. Affirmed by appeals court. Plaintiff argued that defendant-insurance company reneged on its promise to contribute money into the retirement plan and that this promise to pay into the fund was in the defendants’ |
recruiting manual. A letter written by defendant-company’s regional director was also shown to include a schedule of the matching contributions. District court ruled the claim was barred by the **Statute of Limitations** and that they had actual knowledge of the claim when plaintiff-Tassinare sent a protest letter to the Internal Revenue Service at least 7 years prior to the filing of the suit. On appeal, plaintiffs dispute having actual knowledge of the claim that long ago and that they didn’t know exactly what type of pension contributions American National had made and that American Nat’l consistently refused their requests for information about their retirement benefits, thereby not actually learning of the director’s failure to make matching contributions until they received the final plan distribution a couple years later. Under 29 USC 1113(2) a plaintiff with knowledge of a non-fraudulent breach must file suit within 3 years. Plaintiff filed a few years after the deadline. Plaintiffs challenged the district court’s conception of what constitutes “actual knowledge,” not only the directors’ failure to make matching payments, but also the directors’ failure to sue their own company to compel the missing payments. The court did not agree with the “failure to sue” portrayal due to ERISA’s common law of trusts due to the fact that there never was any prospect of litigation between the employer and the plan fiduciary because, according to the agents, the directors performed both of these functions.

48. **Burmania v Hartford**

*Denial of Long-Term Disability Benefits*

Plaintiff suffered from multiple objectively verified medical conditions, causing him pain and limiting his ability to walk, stand, squat, and bend. The issue on appeal was whether those problems prevented him from performing sedentary work or not. Plaintiff contended that the denial of his claim for long-term disability benefits was arbitrary and capricious because defendant did not have any rational basis for ignoring the opinions of his three treating physicians in favor of the flawed opinions of two non-treating physicians which defendant paid for in order to review his claim for disability benefits. Result on appeal: One of the plaintiff’s doctors admitted reluctance to assess plaintiff’s functional capacity and his lack of any objective evidence or explanation supporting his findings regarding his inability to sit, stand, or walk. The court was satisfied that defendant provided a **reasoned explanation for its termination of long-term disability benefits** and that its determination that plaintiff was not prevented from performing one or more of the essential duties of “any occupation” was not arbitrary or capricious.
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<th>49.</th>
<th><strong>Wohlfert v Sealed Power Technologies Accidental Death &amp; Dismemberment Plan</strong></th>
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<td><strong>When does Life Insurance Benefit Go Into Effect?</strong></td>
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<td>Plaintiff's husband was enrolled in the $100,000 <em>life insurance coverage benefit</em> plan provided for employees by defendant-SPT. Only <em>active workers</em> could receive benefits. Laid off workers were eligible for the benefit if they paid the premiums themselves. When plaintiff was laid off he did not continue payment of the premium. The parties dispute whether he was given information about the payment option. Though he was scheduled to return from layoff of a specific day, the personnel office called him on that day, extending his layoff for another week. Plaintiff claims defendant told him that his benefits would go into effect during that week. Defendant denies this. <strong>Plaintiff drowned on the morning he was to return back to work</strong>, just hours before his shift began. Plaintiff sought insurance benefits claiming her husband had become an active worker on that day. Defendants refused to provide the insurance, arguing he had not become an active worker until he actually resumed working. Plaintiff sued all defendants for 1) insurance benefits and 2) for breach of fiduciary duty. Result: The court rejected the claim as defendants made a reasonable interpretation that laid off workers regained benefits eligibility only by resuming work. Michigan insurance law also adopts actual return to work as the bright line for judging benefits eligibility. However, plaintiff may proceed with breach of fiduciary claim against SPT defendants. Contrary to defendants’ view, ERISA does allow plaintiffs to receive <em>individual remedies</em> for breaches. However, the court could not dispose of the claim now because factual issues were given about the benefits advice SPT’s personnel office gave plaintiff.</td>
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<th>50.</th>
<th><strong>James v Pirelli</strong></th>
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<td><strong>Early Retirement Program</strong></td>
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<td>Plaintiffs participating in an <em>early retirement program</em> received benefits different than the ones explained to them. They sued defendant for damages pursuant to ERISA. The trial court erred in holding that only 2 of the 21 employees were entitled to damages due to the fact that defendant breached its fiduciary duties to 2 former workers by providing <em>misleading responses</em> to their direct questions regarding their ERISA benefits. The remaining employees were wrongfully found to not be entitled to damages because they did not receive inaccurate information in response to their direct questions. Result: The Sixth Circuit court reversed, finding it unnecessary that employees ask specific questions. The breach occurs when the employer or plan administrator on its own initiative provides misleading information about the plan to plaintiffs in group meetings and exit interviews. The defendant’s fiduciary duty to</td>
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plaintiffs was triggered even though not all plaintiffs asked specific questions about the future benefits of the plan.

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<th>51.</th>
<th><strong>Wernimont v Unum Ins. Co.</strong></th>
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<td>Not long after an auto accident injury, plaintiff began to report a number of neurological symptoms and his employer noticed his pace and quantity of work decreased during his contract term at Fiduciary Solutions. Six months later he was informed his contract would be terminated. Plaintiff submitted a <strong>long-term disability</strong> claim to the defendant who denied the benefits because plaintiff had not 1) sustained the necessary 20% loss in earnings required by the definition of disability and 2) plaintiff had not demonstrated lost income due to sickness or injury. Result: The court noted that it must accept a <strong>plan administrator's rational interpretation</strong> of a plan even in the face of an equally rational interpretation offered by the participants. Also, defendant’s administrative records supported the denial of benefits and was not arbitrary and capricious.</td>
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<td>Plaintiff-members believed defendant-union <strong>breached its fiduciary duties</strong> regarding <strong>insurance premiums.</strong> Plaintiffs participated in questions/answer sessions regarding the policy. Defendants distributed bulletins as well as question/answer sheets. Defendants’ answers to questions were extraordinarily misleading or outright false. Sufficient evidence was provided that showed <strong>incomplete and inaccurate information</strong> was given. Result: Defendants were improperly granted summary judgment. Because plaintiffs raised a genuine issue of material fact as to whether defendants breached their fiduciary duty by abandoning their responsibilities, overly relying on an untrustworthy advisor and misleading beneficiaries, 6th Circuit Court of Appeals reversed and remanded the decision of the district court.</td>
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<th>53.</th>
<th><strong>Peek v Commissioner</strong></th>
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<td>Peek and Fleck funded Newco with <strong>IRA funds</strong> so that each IRA was a 50% owner. Newco purchased the assets of a going concern. Peek and Fleck personally guaranteed a loan to the seller of the assets and went to work for Newco which paid them wages. Wives formed a partnership that housed Newco which paid rent to the partnership. After 2 years, both IRAs converted to Roth and the tax was paid. In the 5th year Newco was sold. No income from the sale was recognized. Three years later, IRS audited and issued a 90-day letter claiming that the payment of wages and rent was a <strong>prohibited transaction.</strong> Taxpayers sued in Tax Court</td>
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relying on plan asset rules (IRA assets not used). IRS sought to add claim based on indirect prohibited transactions resulting from the guarantee of the loan. (Tax Court allowed.) Court determined that even though loan did not involve a plan or its assets, the guarantee gave rise to indirect prohibited transactions.

54. **Taveras v UBS AG**

This 2nd Circuit Court case involved two UBS 401(k) plans that held UBS stock as an investment. The price declined over 74% from trading high. “Moench” presumption of prudence upheld for plan that stated that UBS stock “shall” be an investment option. No presumption of prudence for plan that did not require or strongly encourage company stock investments. Key lessons for fiduciaries: 1) Wording of plan document language pertaining to company stock investments is of the utmost importance. 2) Need to establish intent to retain company stock as a matter of settlor/plan design.

55. **Harris v Amgen, Inc.**

A 9th Circuit Court case involved two Amgen 401(k) plans that held company stock as an investment. There was a price decline due to publicity of drug safety concerns. There was no presumption of prudence because plans provided only that they “may” provide for a company stock fund. Key lessons for fiduciaries: (Similar to the Taveras case, above.) The prior 9th Cir. Ct. precedent upholding “Moench” presumption generally did not apply because plan language did not “require or encourage” company stock investments.

56. **Church Pension Plan Litigation**

Five cases were filed against church-affiliated health care systems attacking reliance on ERISA “church plan” exemption. The cases dealt with underfunding, failure to provide ERISA-required notices, no PBGC (Pension Benefit Guaranty Corporation) coverage, and PT’s (prohibited transactions). Three theories advanced by plaintiffs were: Exemption unconstitutional as applied to plan sponsors, IRS/DOL rulings misinterpret exemption, and plan sponsors operate as if they are secular organizations. Status of Cases: At least 3 Motions to Dismiss were filed, there were no dispositive rulings as of yet, and the plaintiffs’ attorneys could be waiting to see where they can get favorable precedents.

57. **Andochick v Byrd**

ERISA preempted a state court order requiring Andochick to turn over benefits received under ERISA retirement and life insurance plans owned by his deceased ex-wife. ERISA obligates a plan administrator to pay plan proceeds to the named beneficiary, here
Andochick. The only question before the court was whether ERISA prohibits a state court from ordering Andochick, who had previously waived his right to those benefits, to relinquish them to the administrators of his ex-wife’s estate. Andochick appealed the district court’s grant of the administrators’ motion to dismiss the ERISA preemption claim. Result: The 4th Circuit Ct. of Appeals affirmed: ERISA requires that “every employee benefit plan . . . be established and maintained pursuant to a written instrument” that “specifies the basis on which payment are made to and from the plan.” ERISA then directs the plan administrator to discharge his duties “in accordance with the documents and instruments governing the plan.” In Kennedy v Plan Administrator for DuPont Savings & Investment Plan, the Supreme Court held that an ERISA plan administrator must distribute benefits to the beneficiary named in the plan documents regardless of any state-law waiver purporting to divest that beneficiary of his right to the benefits. However, Kennedy left open the question of whether, once the benefits are distributed by the administrator, a decedent’s estate can enforce a waiver against the plan beneficiary. The 4th Cir. Ct. recently answered this question in the affirmative. Lessons Learned: 1) Plan fiduciary is insulated from liability if it follows the plan terms and documents in distributing to the named beneficiary. 2) Be cautious with QDROs (Qualified Domestic Relations Orders) and make certain to retain them and follow them. 3) Keep good records. 4) Make every effort to obtain beneficiary designations.

58. “In-House” Plan Litigations (3)

3 Cases, re: Retirement Plan Investment. Plaintiffs pulled fund providers under ERISA fiduciary umbrella via their own plan sponsorship. Conflict of interest equaled less deferential court review of fiduciary conduct. Satisfaction of PT exemption unequaled prudent fiduciary conduct.

1) Bilewicz v FMR (Fidelity): The claim was that Fidelity’s officers chose high-fee Fidelity mutual fund products to benefit Fidelity. Evidence indicated that they repeatedly added funds to the plan with little or no track record, the plan’s fees were very high for a multi-billion dollar plan, and that they failed to follow sound fiduciary practices for multi-billion dollar plans. Plaintiffs sought to make this case a class action.

2) Knee v JP Morgan: This ERISA case concerned fairly complex retirement plan investment fund structures. Ultimately, the case was a simple scheme of self-dealing. Defendants
abused their fiduciary responsibilities to acquire control from another company of a "stable" retirement fund by first driving it into the ground and then acquiring its asset management and participants at no cost. In a 72-page Arbitration Award against JPM and in favor of that company, American Century Corporation, the arbitrators found that JPM had committed the wrongful conduct alleged and awarded American Century in excess of $132M in damages.

3) Krueger v Ameriprise: Plaintiffs alleged that Ameriprise and plan fiduciaries breached their fiduciary duty under ERISA with respect to the Ameriprise 401(k) plan by using Ameriprise-affiliated funds in the fund menu and that these funds charged excessive fees or underperformed relevant benchmarks. Other issues involved the use by “in-house” plans of financial services companies of “in-house” funds. The issue regarded the application of ERISA’s prudence standard to the selection and monitoring of funds in a 401(k) plan fund menu and the application of the rules laid out in that regard.

59. Plambeck v The Kroger Co.

*Medical Claim Denied*

Plaintiff asserted a claim for money contending a right to equitable relief to be reimbursed for a denied medical claim for the amount she would have been reimbursed if her medical claim had not been denied under her health insurance. The District Court rejected this interpretation of Amara and noted that it simply sought relief to equitable, not legal, relief. There must be egregious facts to justify equitable recompense. Employers and plan sponsors should note the possibility of money damages and ensure that all communications with participants are clear and not susceptible to an unintended interpretation.

60. DiFelice v U.S. Airways

*401(k) Savings Plan – Stock Drop case*

Participants in US Airways’ 401(k) Savings Plan filed a case against US Airways and the plan’s directed trustee, alleging a breach of fiduciary duties by 1) failing to provide complete and accurate information regarding investments in USAG stock, and 2) including USAG stock as an investment option in the plan in light of USAG’s directors and officers liability financial condition. The trial court decided defendants should not be liable simply because USAG stock was a too risky investment; instead, they based their opinion on a portfolio management theory in which an investment should not be judged by its individual risk and return characteristics, but by its contribution to the risk and return of a portfolio of investments. Also, the risks facing US Airways and USAG were publicly disclosed and reflected in the
company’s stock price. Because investors who assume greater risk have the possibility of
greater returns, the price of USAG shares gave participants the opportunity to realize a
potential return far in excess of other plan options. Therefore, **offering a high-risk, high-
yield investment option is not imprudent if sufficient investment options are offered**
with information necessary to construct a diversified portfolio. The court of appeals agreed;
however, also held that the prudence of each investment option needed to be evaluated
independently, as opposed to as part of a portfolio of investments. It was noted that the
company stock fund was among 12 options, the plan placed no conditions on investment of
matching contributions by the company (unlike many other plans) and the fiduciaries warned
participants of the high risks of the stock fund. The court of appeals believed it was important
that the fiduciaries monitored the performance of the stock fund by holding regular meetings,
considering whether to continue to hold the stock in the plan, seeking advice of outside
counsel, and retaining an independent fiduciary when the Company was considering
reorganization. Results of Court of Appeal’s first ERISA “stock drop” case: Following a 6-
day bench trial in the federal district court it was ruled that US Airways and the trustee of its
401(k) plan did not breach their ERISA fiduciary duties by continuing to allow the stock of its
parent company, USAG, to remain an investment option in the plan while both US Airways
and USAG were in grave financial condition and eventually subjected to bankruptcy
protection. Defendants acted consistent with their ERISA duties.

61. **Nelson v Hodowal**

   **401(k) Plan’s Failure to Disclose – Stop Drop case**

   Plaintiffs were participants in the defined-contribution supplemental pension plan of their
employer Indianapolis Power & Light Company (the Thrift Plan) and filed a class action
against their plan’s fiduciaries alleging breach of ERISA duties based on defendants’ failure
to disclose to plan participants that they had sold most of their own stock in the company.
The lawsuit arose out of a merger between AES Corp. and IPALCO Holdings whereby all
IPALCO shares in one of its subsidiaries’ 401(k) plans were replaced by shares of AES.
Following the merger, AES stock lost more than 90% of its value. Participants in IPALSO’s
401(k) plan alleged that the plan’s fiduciaries 1) should have removed all IPALCO and AES
stock as a plan investment, 2) failed to disclose their sales of nearly all of their own IPALCO
and AES stock, and 3) should not have allowed matching contributions, made in IPALCO
stock, to be converted to AES stock upon the merger. The trial court denied defendants’
Motion to Dismiss and partially denied defendants’ Motion for Summary Judgment, and after a 6-day trial, the court found in favor of defendants on all claims. District court concluded defendants had no reason to foresee any decline in the price of AES’s stock and that reasonable fiduciaries would have deemed AES a suitable stock. District court found in favor of defendants. Result: On appeal, plaintiffs challenged only one aspect; namely, whether defendants breached their fiduciary duties by promoting AES while at the same time divesting their own holdings in AES stock. The 7th Circuit Ct. of Appeals affirmed a defense verdict in the second “stock drop” case to be tried to conclusion.

62. **Edgar v Avaya, Inc.**

   401(k) Plan’s Failure to Disclose – Stop Drop case

   3rd Court of Appeals affirmed dismissal of an ERISA stock drop case. Plaintiffs alleged that plan fiduciaries *breached their duties of prudence and disclosure* by offering Avaya common stock as an investment option in Avaya’s 401(k) plans. They alleged the price of the stock was artificially inflated by inaccurate earnings forecasts and that fiduciaries were liable for failing to disclose material adverse facts that eventually led to a 25% decline in the stock’s value. But, the court found that the plan required that Avaya’s stock be offered as an option, thereby deeming the continuance of the stock offering a presumption of prudence. Though the stock price declined, it did not constitute the type of “directors and officers liability situation” that would require defendants to disobey the term of the plans. The court held there was no abuse of discretion. The court also rejected plaintiffs’ duty of disclose claim. The fiduciaries did not have a duty to give investment advice or opine as to the stock’s condition. The fiduciaries could have been in violation of insider trading laws if they divested stock before news of the adverse developments was shared with the market.

63. **In re Schering-Plough Corp.**

   ERISA Litigation re: Retirement Plan Disclosures

   This case relates to discerning when financial representations in SEC filings give rise to a fiduciary claim under ERISA. In general, *statements made in communications that are required only by federal securities* laws, such as SEC filings, do not constitute fiduciary communications for purposes of ERISA liability. However, when financial statements are incorporated by reference into plan documents or when plan participants are encouraged to review the company’s SEC filings, those statements may be deemed to have been made in a fiduciary capacity. In this case, the SPD (Summary Plan Description) merely advised participants that they could obtain copies of prospectuses and financial reports upon request,
but did not expressly incorporate the SEC filings or encourage reliance by participants. Result: The court, nevertheless, held that the SPD *impliedly incorporated the filings*. A $12.5M settlement was reached in this case, accusing the pharmaceutical giant of mishandling its *retirement plan* by *improperly steering employees into buying company stock*.

64. **O’Neil v O’Neil**  
*Life Insurance Beneficiary, Not Removed*  
Decedent never removed his wife as the *beneficiary* on his ERISA-based *life insurance policy*. Defendant-wife did not violate a separate-maintenance judgment by making a claim for the proceeds upon his death because under ERISA, the judgment was insufficient to extinguish her rights to the proceeds.

65. **Constance O’Neil v Unum Life Ins. Co. of America**  
*Disability Benefits Declined*  
In Plaintiff’s Motion to Remand, plaintiff maintained the case was improperly removed from the Cumberland County Superior Court because her sole count alleges a *breach of contract* claim governed by state law. Defendant asserted the claim is pre-empted by ERISA. Case History: Originally hired as an associate in a law firm, plaintiff became a partner and shareholder of the firm. Years later, the law firm submitted a long-term disability claim on behalf of plaintiff, who did receive *disability benefits* for 1 ½ years, until defendant notified her by letter that she was no longer eligible to receive disability benefits. Plaintiff appealed; defendant denied her appeal following its review. Plaintiff initiated suit and asserted breach of contract against defendant in state court. Analysis: 1) ERISA does preempt plaintiff’s breach of contract claim *if the disability plan is an “employee benefit plan.”* Yes, it is. 2) Does the party have standing under ERISA? Yes, if she was a “participant” or “beneficiary” under the plan. Plaintiff can only maintain standing as a “participant” if she was an employee. In determining whether she was an employer or employee, it was finally agreed that she was an employee based on her minor degree of control over the firm’s disability and that plaintiff was paid on a monthly basis from the law firm. Yes, she is a “participant.” Result: The district court recommended the court deny plaintiff’s Motion to Remand.

66. **Krohn v Huron Memorial Hospital**  
*Disability Benefits*  
Registered nurse-plaintiff suffered a closed-head injury in a car accident resulting in permanent disability, making her eligible for *both short- and long-term disability benefits* for a period of 23 years. Defendant’s personnel assistant discussed options with plaintiff’s husband and said 1) employees would normally opt for the car insurance and that they
normally paid a higher rate, and 2) they couldn’t collect any money from the short-term disabilities if they were collecting it from other companies. He completed the disability benefits application indicating that the plaintiff was expected to return to work within 5 months, and when he returned the form he told the assistant that the plaintiff had decided to collect lost-wage benefits through her auto insurance policy. The application was placed in the employee file and was not submitted to the long-term disability insurance company. Benefits under the auto policy expired 3 years later, so plaintiff applied for long-term benefits; however, it was denied because notice of the claim was not given within 30 days of the loss. Plaintiff sued. Defendant believed it did not breach fiduciary duty because employee did not request specific benefit information, was expected to return to work before being eligible for benefits, and received a handbook explaining the benefits. Result: The judge knew defendant was armed with periodic updates about plaintiff’s disability status and that the defendant owed plaintiff a duty to inform her carefully, completely, and accurately of the long-term disability benefits so she could weigh her options and make informed decisions. Having provided her a summary plan description 4 years prior, before a request for information, does not excuse defendant from its duty to respond to later inquiries regarding benefits. Also, a plaintiff’s failure to specifically ask for information about long-term disability benefits does not absolve a defendant of its fiduciary duty to give information about choices. 6th Circuit Ct. reversed claims and decided defendant was liable for the lost benefits that the plaintiff sustained after it gave the employee incomplete benefit information and did not forward the employee’s benefit application to the insurance carrier.

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67. **Muhammad v Ford Motor Co.**

Plaintiff-employee participant in benefit plan was negligent in providing updated eligibility information by way of documentation when asked by employer-defendant four times to do so. As there was no proof in the way of income tax returns or proof of residency of four of his dependents, defendant chose to deduct payments from the plaintiff’s paycheck as reimbursement for benefit payments that were made on those dependents’ behalf. Although the plaintiff provided a divorce judgment indicating that he was obligated to provide health benefits for one of his daughters until she turned 18, the tax returns he supplied did not list that daughter as a dependent. As a result, the court agreed that the defendant did not act arbitrarily or capriciously by determining the daughter was ineligible for coverage after she
turned 18. The court also held that the plaintiff failed to exhaust his administrative remedies with respect to the three remaining audits which were never appealed internally before filing suit. It is a recent trend that with the rising cost of health insurance, more and more employers that offer some type of employee benefit plan are conducting dependent eligibility audits as a way to control costs by confirming eligibility through some form of documentation rather than simply accepting an employee’s word.

**68. Peshke v Lincoln Life & Annuity Co. of N.Y.**

*Disability Claims & Exhaustion of Admin. Remedies before Appealing*

Human Relations VP-Plaintiff submitted a short-term *disability claim*, due to chronic neck/back pain, to defendant-employer listing his work restrictions for the next 2 months. Defendant approved and, subsequently, extended payments for another month and notified plaintiff if further extension was requested, he would need to provide current medical documentation including medical records and physical therapy notes. In evaluation of the April – July medical records, defendant noted “overall improvement” in plaintiff’s condition, increased range of motion in all directions and decreased neck pain. So, defendant sent a letter to plaintiff that no benefits would be paid after July 28 because the medical documentation failed to support restrictions that would prevent him from working in his occupation as a VP, therefore, failing to satisfy the plan’s definition of “total disability” which requires the insured not be able to perform each of the main duties of his own occupation. Plaintiff was informed of his right to request a review of the decision and to submit medical records, lab and x-ray results. Plaintiff submitted an appeal letter without further medical documents, clarifying he was only seeking “partial disability.” Medical consultations and examinations of records showed nothing. Defendant informed plaintiff that he failed to satisfy the plan’s definition of “partial disability.” He was advised he could pursue final administrative appeal in writing by May 16, including medical records, and that he also had the right to bring a civil action. Skipping the second appeal, plaintiff filed a complaint in circuit court, instead. Defendant asserted affirmative defense that plaintiff failed to exhaust his administrative remedies under ERISA and the plan by failing to pursue a second administrative appeal. Despite this, and with more than 60 days still remaining in which to request the second level appeal, plaintiff still failed to *exhaust his administrative remedies*. Result: Circuit court found plaintiff’s second appeal would clearly have been futile because if he could have performed his “own occupation” then clearly he could perform “any occupation.” The short-
term disability plan required submission of a written appeal **within 180 days** of the denial of the claim, and since the time to file a second administrative appeal had long since passed, the matter was dismissed, with prejudice.

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<th>69. Boyle v BCBS of N.C.</th>
<th>The father and legal guardian of a minor child suffering from autism (ABA) seeks to recover full health care benefits from defendant Continental Automotive Welfare Benefits Plan who refuses to provide or allow for coverage for a scientifically validated and beneficial treatment for autism, despite the State of North Carolina’s finding that ABA is not an experimental treatment. Result: Based on the plan language and a review of the Administrative Record, the administrator’s decision to deny coverage after the transition period was <strong>not arbitrary and capricious</strong>. The <strong>administrator cannot go beyond the plan language</strong> and was within its discretion in denying the out-of-network services. The administrator’s decision was affirmed.</th>
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<td><strong>Health Care Benefits Denied</strong></td>
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<th>70. Karen McClain v Eaton Corp. Disability Plan</th>
<th>An assembler with Eaton Corporation suffered a back injury on the job. She had purchased the highest level of long-term disability insurance which was designed to replace 70% of her monthly base pay. She received disability benefits during the first 24 months under the First Tier of the Plan’s coverage which defined her disability as being “totally and continuously unable to perform the essential duties of your regular job. The Second Tier coverage, however, provides coverage if “you are totally and continuously unable to engage in any occupation . . .” The Court of the Appeals found that the administrator’s interpretation of the Plan’s language was consistent with multiple other federal court citations, as well as the fact that plaintiff was working part time which showed she was not unable to perform any occupation. Finally, after reviewing medical information and skills assessments the court determined the defendants were not arbitrary nor capricious in determining plaintiff was not totally disabled from doing any work. In the absence of clear language permitting part-time employment, courts have uniformly declined to consider a claimant who is capable of working part-time, eligible for benefits under a general disability policy. The defendants’ decision was the result of a “deliberate principled reasoning process.”</th>
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<td><strong>Disability Benefits (ERISA)</strong></td>
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71. **Haviland v Metropolitan Life Insurance Co.**

Retiree Life Insurance Benefits / GM Bankruptcy

GM provided its salaried retired employees with **continuing life insurance**. As part of its re-organization, GM reduced the amount of life insurance to $10,000. The retirees sued MetLife based on letters received saying, “this life insurance remains in effect, without cost to you, for the rest of your life.” 1) Because the GM plan and summary plan description both adequately reserved GM the right to amend, reduce, or end the benefit, the promissory estoppel claim was rejected because the “reservation of rights” language was unambiguous. The letters were merely a description of the retirees’ current benefit; not a statement about future benefit. 2) The breach of fiduciary duty claim was also rejected because the information was a **truthful statement of the retirees’ current benefit**. 3) The retirees’ claims that MetLife had breached the GM plan’s terms and claims of unjust enrichment and for equitable restitution were also quickly rejected.

72. **International Union, UAW v General Motors**

Health Coverage

Although in 1999 Delphi Corporation 1) separated from the “Old GM,” then 2) in 2005 filed for bankruptcy, and 3) in 2006 a class of Delphi retirees agreed that their health coverage would be provided by a VEBA trust, and 4) in 2007, Delphi, Old GM, and the UAW entered into a Memorandum of Understanding which, among other provisions, conditionally required Old GM to pay $450M to the VEBA, 5) and in 2009 Old GM filed bankruptcy and sold most of its assets to “New GM,” 6) about the same time, New GM and the UAW entered into an **agreement that specified the retiree obligations** that New GM was going to assume. This agreement did not mention the $450M payment but did have a provision that said that **New GM’s obligations for Old GM retirees were fixed and capped** by this 2009 agreement. In 2010, the UAW filed suit against New GM seeking them to pay the $450M. After reviewing the complicated history, the court held that the 2009 agreement extinguished any obligation that new GM had to pay the $450M. The Judge found the 2009 contract fair, reasonable, and in retirees’ best interests. Whether New GM has a moral obligation regarding the payment is another matter and not relevant.
### 73. James v Liberty Life Assurance Co. of Boston

**Disability Claim**

As a passenger rear-ended by a truck, a 55-year old female buyer for DTE Energy initially sustained arm and back pain and later, mental health treatments for depression and posttraumatic stress disorder. Her claim for disability benefits was denied with defendant claiming that plaintiff failed to provide objective evidence that her condition precluded her from performing her job. The court granted judgment in favor of plaintiff with respect to **long-term disability benefits** under the two-year “regular occupation” coverage retroactive to February 24, 2012. The court declined to address potential qualification under the “any occupation” coverage and potential application of the “mental health symptoms” rider because these issues will not be ripe before February 24, 2014 and may involve a different or expanded administrative record. Therefore, it remanded to Liberty Life consideration of her eligibility for benefits beginning February 24, 2014.

### 74. Kathy Braun v Sun Life Assurance Company of Canada and NEMACO

**Employer Failed to Process Employee’s Request for Optional Higher Life Benefit**

Nemaco employee died three years after he began paying for Optional Group Life Insurance through payroll deductions. At the time of his death he was entitled to $100,000, although he was only paid $40,000. Plaintiff’s complaint is based on the ERISA and federal common law regarding **breach of the terms of an employee group benefit plan** to provide certain life insurance benefits in the amounts and at the coverage levels promised and for recovery of damages, costs, and attorney fees incurred. Plaintiff requests full benefits, disgorgement of profits or gain, reasonable attorney fees, and an order for defendants to disclose plan documents and internal documents.

### 75. Plan Participants v ABB Inc.

**Fiduciary Liability (Excessive 401(k) Plan Fees)**

In one of the first 401(k) fee cases to go to trial, ABB was ordered to pay $35,200,000 and Fidelity Investments to pay $1,700,000 in a suit over ABB’s 401(k) plan. The judge said ABB and Fidelity **violated their fiduciary duty** to employees and retirees by, among other things, “selecting more expensive share classes . . . when less expensive share classes were available.” Revenue-sharing payments generated by ABB’s 401(k) plan subsidized other services that Fidelity provided to ABB. It was to ABB’s benefit that **opaque revenue sharing**
was used rather than hard dollar fees which were clearly visible to the participants. A lower court awarded $13,400,000 to ABB plan participants in the part of a case that dealt with ABB, in violation of its fiduciary duties to 401(k) participants, failing to monitor its plan’s internal costs whereby excessive fees were paid by not negotiating for rebates from investment companies whose funds were offered in the plan. There is much significance in this ruling extending far beyond ABB. It sends a powerful message to other plan sponsors that they are not doing their fiduciary duty simply by offering low-cost funds as investment options. Cases can also be very costly to litigate. Court records show that ABB spent $42,000,000 on lawyers’ fees defending the matter. This may be a reason that the law firm of Schlichter Bogard & Denton in St. Louis is virtually alone in bringing many 401(k) cases. The firm risks, according to one judge, “breathtaking amounts of time and money while overcoming many obstacles for the benefit of employees and retirees.” Also, cost savings from these settlements can be very significant. Partner Jerome Schlichter began suing companies over fiduciary failures eight years ago and has settled six 401(k) cases including those of General Dynamics, International Paper, Caterpillar, and Lockheed Martin. These cases are gaining traction in the courts. The settlements have generated $125,000,000 in recoveries to 300,000 participants, minus legal fees and secured major reductions in plan costs for the future. Five more cases are pending. The Labor Department, regarding its actions against plan sponsors on fee-related matters, cited that cases against Sunkist as well as National Rural Electric Cooperative Association together generated recoveries of $28,900,000 to plan participants. The department’s fee disclosure rules, put in place in 2012, have driven down costs for participants. Schlichter also filed a lawsuit, among others, over excessive 401(k) fees with Kraft Foods, resulting in a $9,500,000 settlement. (Schlichter stated that plan sponsors and fiduciaries cannot serve their own interests with the employees’ retirement assets. Instead of getting lower fees for ABB employees in their 401(k) Plan, ABB and Fidelity used employees’ retirement assets to benefit themselves.)

76. **William Beaumont Hospital v Federal**

Plaintiff hospital entered into an agreement to settle an antitrust claim action for $11,342,904. Defendant insurance company had agreed to insure 80% of loss arising out of antitrust claims, but denied coverage based on certain exclusions. In March, 2013, U.S. District Court for the Eastern District of Michigan granted plaintiff’s motion for judgment on the pleadings,
ruling that the carrier has the obligation to defend or indemnify the plaintiff in a pending antitrust suit. This resulted in a net award of $9,074,323 which is 80% of the antitrust claim settlement.

77. **Cultrona v Nationwide Life Ins. Co.**

**Life Benefits**

Plaintiff’s decedent applied for **accidental death benefits** from her insurer, Nationwide, when her intoxicated husband returned home, apparently passed out and died from positional asphyxiation and acute ethanol intoxication. The federal district court correctly ruled that an intoxication exclusion precluded plaintiff’s claim for accidental death benefits. In a denial letter for plaintiff’s claim, the explanation indicated “the loss is precluded from coverage by Exclusion 12” although, unfortunately, the letter cited an earlier version of Exclusion 12: “The *Covered Person* being deemed and presumed, under the law of the locale in which the Injury is sustained, to be driving or operating a motor vehicle while under the influence of alcohol or intoxicating liquors.” In a letter seven days later, StarLine acknowledged the erroneous reference to an earlier version of Exclusion 12 and further explained it was amended to remove the reference to “driving or operating a motor vehicle.” The court properly assessed the insurer a statutory penalty of $55 per day (total, $8,910) for its delayed response to plaintiff’s written request to furnish a copy of the insurance policy. Plaintiff questioned Nationwide’s Benefits Administrative Committee’s full and fair review of her claim, Ohio’s drunk-driving statute, cause of death, etc. The court also adopted a new standard on a going-forward basis that recognized BAC’s argument of a **clear-notice** standard, a standard that several sister circuit courts have adopted, that would clearly state which documents and administrative records are being requested by the plaintiff. In this case, the accidental-death policy was not provided to plaintiff’s counsel until June 2012, following a November 2011 letter requesting documents.

78. **United Steel, Paper, Forestry, et al., v Kelsey-Hayes Co., et al.**

**Group Health Care Coverage Discontinued**

In September 2011, TRW (which had purchased Kelsey-Hayes) sent a letter to plaintiffs indicating it would **discontinue group health care coverages** in 2012. Instead, defendants would provide “Health Reimbursement Accounts” (HRAs), designed to function as a health care voucher system. The letter indicated 1) TRW would make a one-time contribution into the HRA of $15,000 per eligible retiree and eligible spouse in 2012; 2) in 2013, TRW would provide a $4,800 credit into the HRAs for each eligible retiree and eligible spouse; and 3)
TRW indicated it retained the right to amend or terminate the HRAs. Plaintiffs would use these funds to purchase their own insurance from among a variety of providers. The HRAs differed from the prior group coverages in that the risk was shifted and, potentially costs, off of defendants and on to plaintiffs. Plaintiffs would now bear the risk of expenses that exceed the company contribution. Beyond 2013, however, both TRW and Kelsey-Hayes failed to commit to any funding of the HRAs. District court allowed plaintiffs to proceed as a class and granted their motion for summary judgment on all claims, ruling that the CBAs (Community Based Alternative program) established a commitment to lifetime health care benefits for plaintiffs and families and that defendants’ unilateral implementation of the HRAs constituted a breach of the CBAs. District court ordered defendants to reinstate the “status quo” health coverages that had been in effect up until 2012 and also awarded attorney fees to plaintiffs. Defendants appealed. Circuit Court judge concluded that Kelsey-Hayes violated its promise to provide retirees health-insurance coverage for life when it 1) created the HRAs to fund for only two more years (2012-2013) and 2) when it reserved the right to eliminate all retiree healthcare coverage after that. A decision to fund an alternative form of coverage for two years does not deliver a lifetime commitment. A reservation of rights to end all coverage is the opposite of a lifetime commitment. The court notes that no health-insurance program remains fixed and no company offers the same plan year in, year out. Binding a company to provide benefits in the same way for the duration of a retiree’s life is not feasible. This case highlights the perils of handcuffing a company to one mode of providing retiree benefits. The case was remanded to the district court to determine whether the company is willing to fund the HRAs beyond 2013 and, if so, at what amounts. The district court would be asked to determine whether the company’s method of providing healthcare coverage amounted to a reasonable equivalent of what the company had provided before.

79. Nilratan Javery v Lucent Technologies Long Term Disability Plan Disabled

As a software engineer employee of Lucent, Plaintiff participated in its long-term disability plan (the administration of the Plan was delegated to a third party, CIGNA) which is offered to those who meet its defined requirements for eligibility. While plaintiff’s work was fast-paced and involved supporting Lucent employees and consultants around the clock, in excess of 70-75 hours per week over 5-6 months straight, plaintiff developed back pain in 2002 and he sought treatments until his doctor advised he stop working in 2005. He then received short-
term disability benefits for 26 weeks. Plaintiff’s denial from the administrator to begin receiving long-term benefits in 2005 brought him to filing Chapter 13 personal bankruptcy in 2007. In 2009 plaintiff filed a complaint in the U.S. District Court regarding his denial of benefits being in violation of ERISA. In early 2011 the district court denied motions and remanded his claim to the plan administrator for further review. Plaintiff submitted additional evidence to the plan administrator. Medical tests were examined. In late 2011 the plan administrator again denied plaintiff’s claim for benefits. Plaintiff’s failure to disclose a claim in the bankruptcy proceeding was finally accepted as an omission that was wholly inadvertent and that he did not act in bad faith. He and his spouse had disclosed the claim to their bankruptcy attorney in writing and had discussed the claim with their attorney; therefore, this error was the fault of the attorney, not the plaintiff. In final conclusion, the order of the district court was reversed due to the plaintiff having submitted numerous medical reports, having visited over a dozen medical experts, and the doctors that knew him best had concluded, unequivocally, that plaintiff was unable to work at the relevant time. Defendant offered little to contradict this evidence. The matter was remanded to the district court with instructions that it enter judgment in favor of plaintiff on the administrative record.

80. **Brian Sexton v Panel Processing, Inc. and Panel Processing of Coldwater**

Plaintiff, acting as both general manager and trustee for Panel Processing's employee retirement plan, was fired six months after he emailed the chairman of the board wherein he asked for immediate remedy for the board’s actions and violations of the board refusing to seat two newly-elected trustees he and another had campaigned for, as well as removing he and the other campaigner as trustees. There was no response to the email, nor was there any further action from plaintiff, until plaintiff’s dismissal which prompted him to sue the company for violating the State’s **Whistleblower Protection Act** and for breaching his employment contract. Surprisingly, the company invoked **complete preemption**, a doctrine that converts state law claims into federal claims. Under this banner, the company re-characterized Sexton’s state whistleblower claim as an **ERISA** claim, then removed the transfigured lawsuit to federal court. Relevant law says, in part, “It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to (the Act).” At this point, both parties took, as a given, that the company fired plaintiff because
of his email to the chairman of the board. The above relevant law was studied in depth, also taking into consideration that plaintiff did not send the email in connection with an official investigation nor in response to a question or request for information, even what you might call a nunc pro tunc theory of “giv(ing) information . . . in any inquiry.” Consideration was given, also, to the different ways Congress has dealt with retaliation in the workplace, enacting roughly 40 anti-retaliation laws which tend to include two distinct types of prohibitions that protect employees who 1) oppose, report or complain about unlawful practices; 2) participate, testify or give information in inquiries, investigations, proceedings or hearings. Plaintiff disclosed, also, that he did not disclose violations of the law to the public or to the authorities, but threatened to sue his employer unless it did as he demanded. Discussion ensued regarding why Congress may have enacted provisions in Section 1140, either to protect the jobs of whistleblowers or to protect the integrity of inquiries. Section 1140’s reference to “inquiry(ies) or proceeding(s)” suggests that Congress had the latter objective in mind. There is much interpretation and question as to ambiguity that is sufficient to trigger a liberal interpretation in favor of the employee or not and what is reasonable interpretation of a statute. Most federal statutes that prohibit retaliation do include separate clauses protecting employees who complain about or oppose unlawful practices. Congress chose not to include a similar clause in ERISA and the court respects that choice and affirms.

81. **Bu jan v Dura Automotive Systems**

Executive assistant plaintiff was in Germany assisting with a business conference. The hotel and grounds where employees were staying and having the conference was an old, converted castle. Plaintiff was walking back after dark to the main hotel where the rooms were located and fell from a bridge into what used to be an old castle moat. The fall resulted in a T-9 spinal fracture with paralysis. Plaintiff argued that she was still within the course of her employment when the injury happened; that she was on the premises where work was being performed; and that she was covered while making her way back to the hotel room. Defendant’s insurer argued that the injury occurred after all work activities had ceased for the day, and that plaintiff engaged in an activity for which the major purpose was social and recreational when the injury occurred; therefore, plaintiff should be excluded from coverage. The matter settled before the Oakland County Workers’ Compensation Bureau for $2,836,000 on 08/05/14.
82. **Ruff v Ruff & Operating Engineers’ Local 324 Pension Fund**

In December 1989, decedent while married to defendant, retired and began receiving benefits from the Pension Fund which provided for surviving spousal benefits. They divorced in 1993 and entered into a consent agreement which was incorporated into a divorce judgment. Verbage laid out the pension benefits. In 1997 the decedent married plaintiff and in 2011 he executed a beneficiary election form awarding plaintiff “any death benefits” that he was entitled to from the Pension Fund. “Surviving spouse benefits” were not referenced. The decedent passed away shortly after executing the beneficiary form, and plaintiff received certain death benefits from the Pension Fund. Plaintiff also applied for monthly surviving spouse benefits, but the Pension Fund denied her request, stating that plaintiff was not the spouse at the time of the decedent’s retirement, as required by section 1.22. However, because defendant was the decedent’s spouse at the time of his retirement, the Pension Fund paid defendant monthly surviving spouse benefits of $521.08. Consequently, plaintiff filed the instant action against defendant, alleging breach of contract, promissory estoppel, and unjust enrichment, and sought declaratory relief and imposition of a constructive trust. Many similar cases were analyzed and referenced, including what a “reasonable person” would have understood in the divorce judgment language, as well as “good faith” waivers of surviving spouse benefits, etc. Based on the language of the Pension Fund, defendant was “the person who was married to the Retired Employee Participant for at least one (1) year on his date of Retirement,” and thus, is the eligible surviving spouse. Because the plain language of the divorce judgment does not establish a waiver, but instead establishes that defendant, as a party to the divorce, is entitled to the surviving spouse benefits, the court concluded that the trial court erred by entering judgment for plaintiff. The trial court’s grant of summary disposition for plaintiff was reversed and the case was remanded to the trial court for entry of an order dismissing plaintiff’s case in its entirety.

83. **Joseph Moyer v Metropolitan Life Ins. Co.**

Solvay America employee, Moyer, participated in its ERISA-governed Long Term Disability Plan. He applied for disability benefits in 2005. MetLife initially approved the claim, but reversed its decision in 2007 after determining Moyer retained the physical capacity to perform work other than his former job. Moyer filed an administrative appeal, and MetLife affirmed the revocation of benefits. Moyer’s adverse benefit determination letter included
Disability Denial

notice of the right to judicial review but failed to include notice that a **three-year contractual time limit** applied to judicial review. The Summary Plan Description failed to provide notice of either Moyer’s right to judicial review or the applicable time limit for initiating judicial review. In 2012 Moyer sued MetLife, seeking recovery of unpaid plan benefits. The district court concluded that MetLife provided Moyer with constructive notice of the contractual time limit for judicial review. Moyer appealed, requesting **equitable tolling**. Being unaware of the contractual time limit, Moyer filed his complaint late. He asked the U.S. Court of Appeals to toll the filing deadline, alleging that MetLife **breached its obligations** under ERISA by failing to include in his benefit revocation letter the time limit for seeking judicial review. The court agreed that on the date his revocation letter was sent, it was required to include the time limit for judicial review. ERISA § 1133 governs adverse benefit determination letters.

84. **Smith v Continental Casualty Co.**

The federal district court’s upholding of an insurance company’s denial of plaintiff’s application for **short-term disability benefits** was vacated because the denial was arbitrary and capricious. The record shows that in denying the claim, CCC, the plan administrator, incorrectly asserted in a letter that plaintiff had returned to work when, in fact, this was not true. In addition, there were unexplained discrepancies in the number of pages of medical records sent for review and the actual number of pages reviewed. Plaintiff’s treating physician was not interviewed, nor was plaintiff seen by an independent examiner. Finally, CCC never obtained plaintiff’s job description. In summary, the process CCC used in making Smith’s disability determination rendered a decision that was arbitrary and capricious. The case was vacated and remanded.