RECORD NO. 13-2233

In The
United States Court of Appeals
For The Eighth Circuit

SALVADOR SILVA,

Plaintiff – Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY; SAVVIS COMMUNICATIONS CORPORATION,

Defendants – Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI AT ST. LOUIS

BRIEF OF APPELLANT

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SUMMARY OF THE CASE AND REQUEST FOR ORAL ARGUMENT

This is an Employee Retirement Income Security Act of 1974 ("ERISA") case involving an improper denial of life insurance benefits. A magistrate judge erroneously held that Plaintiff could not seek equitable relief pursuant to section 502(a)(3) of ERISA, which authorizes a participant to seek "appropriate equitable relief," because the relief he sought was compensatory. That holding contradicts the United States Supreme Court's decision in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011) ("Amara") and the holdings of the Fourth, Fifth, and Seventh Circuits – the only circuits to have revisited section 502(a)(3) post-*Amara*. *Kenseth v. Dean Health Plan, Inc.*, No. 11-1560, slip op. at 23-24 (7th Cir. June 13, 2013); *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448, 452 (5th Cir. 2013); *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 181 (4th Cir. 2012).

The magistrate judge also erroneously granted summary judgment as to Plaintiff's section 502(a)(1)(B) of ERISA claim. That was improper because Defendants' interpretation of the Plan is arbitrary and capricious, the Statement of Health requirement relied on to deny Plaintiff's claim for benefits was unnoticed and therefore unenforceable, and Plaintiff's section 502(a)(3) claims may require the existence of a section 502(a)(1)(B) claim to be viable.

Because of the importance, novelty, and complexity of the legal issues raised by this appeal, a 30 minute oral argument is requested.

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JURISDICTIONAL STATEMENT

This appeal involves claims arising under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. The plaintiff, Salvador Silva, filed this action in the United States District Court for the Eastern District of Missouri. The federal courts have jurisdiction pursuant to 29 U.S.C. § 1132(e) and 42 U.S.C. § 1291. This appeal is taken from a final order, dated May 16, 2013. A timely Notice of Appeal was filed on June 3, 2013.

STATEMENT OF THE ISSUES

1. Did the district court err in denying as futile Plaintiff's request for leave to amend his first amended complaint on the basis that Plaintiff had failed to seek "appropriate equitable relief" under section 502(a)(3) of ERISA?

29 U.S.C. § 1132(a)(3)

CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011)

Kenseth v. Dean Health Plan, Inc., No. 11-1560 (7th Cir. June 13, 2013)

Gearlds v. Entergy Servs., Inc., 709 F.3d 448 (5th Cir. 2013)

McCravy v. Metro. Life Ins. Co., 690 F.3d 176 (4th Cir. 2012)

2. Did the district court err in granting summary judgment on Plaintiff's claim for life insurance benefits under section 502(a)(1)(B) of ERISA?

29 U.S.C. § 1132(a)(1)(B)

CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011)

Wilkins v. Mason Tenders Dist. Council Pension Fund, 445 F.3d 572 (2d Cir. 2006)

STATEMENT OF THE CASE

In this case, a man named Abel Silva ("Decedent") purchased life insurance worth $429,000 through his employer. He applied, paid for, was issued, and was informed he had been issued such a policy. After he died, Defendants refused to pay on the policy. The beneficiary is Decedent's father ("Plaintiff").

Defendants premised their coverage denial on the absence of a so-called "Statement of Health." According to Defendants, all insurance applicants must submit a "Statement of Health" before being issued a policy, and Decedent failed to do so. A magistrate judge agreed, and denied Plaintiff the relief he sought.

The magistrate judge erred. This is an ERISA case. ERISA requires that beneficiaries' entitlements be set forth in the governing plan documents. ERISA also requires that plans furnish a summary plan description ("SPD") that notifies beneficiaries of circumstances that could result in the denial of benefits.

Here, the ERISA plan document does *not* require that a "Statement of Health" be produced before a valid policy can issue. Moreover, no SPD ever explained that a "Statement of Health" was needed. Indeed, Defendants prepared no SPD of any kind. A missing document the plan does not mention and the SPD does not explain cannot invalidate a paid-for insurance policy.

ERISA unquestionably provides relief in such circumstances. Plaintiff sought, *inter alia*, "appropriate equitable relief" under section 502(a)(3) of ERISA. The Supreme Court of the United States has recently held that equitable theories of surcharge, reformation, and estoppel are cognizable remedies under Section 502(a)(3). *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1878 (2011) ("Amara"). All three equitable remedies are available to Plaintiff in this case.

No contrary Eighth Circuit precedent survives *Amara*. The district court was mistaken in concluding otherwise. R. 155 (citing *Pichoff v. QHG of Springdale, Inc.*, 556 F.3d 728 (8th Cir. 2009) and holding that "the Supreme Court's holding in [*Amara*] does not affect the Eighth Circuit's holding in *Pichoff* . . . ."). Since *Amara*, every circuit to have revisited section 502(a)(3) of ERISA has concluded that it authorizes monetary relief even if it is "compensatory." *See Kenseth v. Dean Health Plan, Inc.*, No. 11-1560, slip op. at 23-24 (7th Cir. June 13, 2013); *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448, 452 (5th Cir. 2013); *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 181 (4th Cir. 2012).

The magistrate judge erroneously refused to permit Plaintiff to amend his complaint and then granted Defendants' motion for summary judgment. But Defendants' position cannot survive a surcharge, reformation, or estoppel challenge sanctioned by *Amara*. Nor, in any event, is Defendants' position one justified by the language of the Plan. Reversal is warranted.

STATEMENT OF THE FACTS

Until his death, Decedent worked for Savvis Communications Corporation ("Savvis"). R. 146, 271. Savvis sponsors the "Group Life and Supplemental Life Plan for Employees of Savvis Communications Corporation and Its Affiliates" (the "Savvis Plan" or the "Plan"). R. 39, 146. The Savvis Plan is insured by Metropolitan Life Insurance Company ("MetLife"). R. 146, 271.

Decedent was a participant in the Savvis Plan. R. 46. In 2004, he applied for Basic Life Insurance coverage in the amount of $171,000. R. 331, 338-39. Then, in 2009, he applied for Supplemental Life Insurance coverage in the amount of $429,000, to be effective January 1, 2010. R. 236-37. He named his father (Plaintiff) as the sole beneficiary of the Supplemental Life Insurance policy. R. 237. As it comes to this Court, this litigation relates solely to the parties' dispute over Decedent's Supplemental Life Insurance. R. 83-84.[1]

1. The Savvis ERISA Plan

The Savvis Plan is an "employee welfare benefit plan" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"). R. 15, 39-40. *See also* 29 U.S.C. § 1002(1) (defining the term "employee welfare benefit plan" or "welfare plan"). All ERISA plans must be governed by a written plan document.

[1] There was a dispute between putative beneficiaries of Decedent's Basic Life Insurance policy. A settlement agreement was reached, and a magistrate judge subsequently and correctly dismissed all claims relating to that policy.

29 U.S.C. § 1102(a)(1). The plan document in this case is entitled the "MetLife Certificate of Insurance." R. 369, 520. It is 96 pages long, and a complete copy is included in Appellant's Appendix. R. 367-462.

The Plan specifically identifies Savvis as its administrator. R. 151, 454. *See also* 29 U.S.C. § 1002(16) (defining the term "administrator" as "the person specifically so designated by the terms of the instrument under which the plan is operated"). As plan administrator, Savvis has important statutory obligations under ERISA. As relevant here, Savvis is required to prepare a summary plan description ("SPD") for participants. *See* 29 U.S.C. §§ 1022(a) & 1024(b) (describing administrator's duty to prepare SPD). An SPD must contain certain critical disclosures, such as the "requirements respecting eligibility" and "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b). Those disclosures must be "written in a manner calculated to be understood by the average plan participant." 29 U.S.C. § 1022(a). And the administrator must furnish this SPD to participants in a manner "reasonably calculated to ensure actual receipt." 29 U.S.C. § 1022(a); 29 C.F.R. § 2520.104b-1(b)(1).

As plan administrator, Savvis is also bound by important fiduciary duties under ERISA because it exercises discretionary authority respecting the administration of the Savvis Plan. *See, e.g.*, 29 U.S.C. § 1002(21)(A)(iii) ("A person is a fiduciary

with respect to a plan to the extent . . . he has any discretionary authority or discretionary responsibility in the administration of such plan."). For example, Savvis administers the enrollment application process of the Plan's life insurance policies, and it administers the collection of premium payments from participants. R. 165, 227. Savvis is required to act with "care" and "prudence" and must "discharge [its] duties with respect to [its] plan solely in the interest of the participants and beneficiaries." *See* 29 U.S.C. § 1104(a)(1).

MetLife is also a fiduciary of the Plan because it exercises discretionary authority in several respects: (1) it determines what conditions will be specified for enrollment; (2) it determines whether such conditions have been satisfied; (3) it determines whether it will accept premium payments; and (4) it determines whether to grant or deny claims for benefits. R. 159, 229, 246. *See also* 29 U.S.C. § 1002(21)(A)(i) ("A person is a fiduciary with respect to a plan to the extent . . . 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."). As a fiduciary of the Savvis Plan, MetLife is also required to act in conformity with the duties of care and prudence established by ERISA. *See* 29 U.S.C. § 1104(a)(1).

2. Denial of Plaintiff's Claim Based on Alleged Faulty Enrollment

As noted above, Decedent sought to obtain Supplemental Life Insurance in 2009. R. 236-37. Savvis requires employees to enroll for all insurance through the use of an online system. R. 195. Decedent used that system to submit an application for Supplemental Life Insurance coverage in the amount of $429,000, to be effective January 1, 2010. R. 236-37.

After Decedent submitted his enrollment application, Savvis began to withhold premium payments from his paychecks. R. 198, 227. Those premium payments were then sent to MetLife, and MetLife accepted them without objection. R. 246. Decedent continued making payments until his death on June 27, 2010. R. 287. And a Benefits Election summary provided by Savvis to Decedent indicated that his active elections as of January 1, 2010 consisted of $171,000 in Basic Life Insurance and $429,000 in Supplemental Life Insurance. R. 331.

Shortly after Decedent passed away, Plaintiff submitted an administrative claim for the proceeds of the Supplemental Life Insurance policy. R. 342. To Plaintiff's surprise, MetLife denied his claim. As grounds for the denial, MetLife cited two provisions of the Savvis Plan.[2] R. 342-43. Relying on those two provisions,

[2] The provisions cited by MetLife provide that:

> 5. if You make a request during an annual enrollment period to increase the amount of Your Supplemental Life Insurance to an option which is more than one level above Your current amount of Supplemental Life Insurance.

MetLife determined that Decedent was not covered because he had not complied with an enrollment procedure requiring "evidence of insurability." R. 343.

Plaintiff was understandably confused. Decedent was unquestionably eligible for Supplemental Life Insurance. *See* R. 409 (expressly providing that eligibility extends to "All Full-Time employees of the Policyholder [Savvis].") R. 409. Decedent actively elected $429,000 in Supplemental Life Insurance. R. 331. Savvis withheld and remitted premium payments on behalf of Decedent to MetLife who accepted those premium payments until Decedent's death. R. 198, 227, 246. And, perhaps most importantly, it was unclear how or why Decedent did not meet the enrollment condition on which MetLife's denial was based (i.e., "evidence of insurability"). R. 560 (letter from MetLife claims administrator admitting that the term "evidence of insurability is not defined in the Plan").

> If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will not be increased.
>
> . . .
>
> 9. if You make a late request for Supplemental Life Insurance. A late request is one made more than 31 days after You become eligible.
>
> If You do not give Us evidence of insurability or the evidence of insurability is not accepted by US as satisfactory, You will not be covered for Supplemental Life Insurance.

R. 342-43, 427.

3. The Enrollment Confusion – Admitted Violation of ERISA

"Evidence of insurability" is not defined in the Plan. Defendants maintain, however, that an internal document called a "Statement of Health," must be submitted by participants like Decedent as "evidence of insurability." R. 167, 560.

Even construing the plan language favorably to defendants, the plan does not provide that a "Statement of Health" form must be submitted to be eligible for life insurance. R. 560. And even if the plan did so provide, ERISA imposes upon administrators a separate notice requirement. Whatever a plan says regarding a material term, a beneficiary can only be bound if he is properly noticed. Savvis failed to comply with this most basic and important requirement. Savvis was obligated to prepare and disseminate to participants an SPD explaining in layman's terms the material provisions of the Savvis Plan, including the "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." *See* 29 U.S.C. § 1022(b). It failed to do so. R. 520.

Decedent paid, Savvis passed along, and MetLife accepted, premium payments without objection until his death. R. 246, 287. Savvis also provided an Enrollment Benefits summary to Decedent specifying that his Supplemental Life Insurance election was "active" as of January 1, 2010. R. 331.

Defendants' general practice was not to require *any participant* who enrolled via Savvis's online enrollment system to submit an additional Statement of Health

form. MetLife, in an investigation after the fact, claimed that a systemic failure in Savvis's online enrollment system caused participants to fail to submit a Statement of Health. R. 565. Defendants somehow read ERISA to exculpate their systemic failure and invalidate a paid-for policy. ERISA does no such thing.[3]

4. Procedural History

On January 24, 2011, Plaintiff filed this lawsuit in state court seeking declaratory relief for the withheld Supplemental Life Insurance benefits pursuant to Missouri state law. R. 14, 35, 37. Defendants removed the action on the basis of ERISA preemption, R. 14-15, and then answered, R. 39. In the answer, Defendants asserted that Plaintiff was not entitled to benefits under Decedent's Supplemental Life Insurance policy because Decedent had not submitted evidence of insurability. R. 40.

On June 22, 2011, Plaintiff filed the first amended complaint. R. 61. The complaint asserted a claim for benefits pursuant to 29 U.S.C. § 1132(a)(1)(B) – also known as section 502(a)(1)(B) of ERISA. R. 63-64. *See also* 29 U.S.C. § 1132(a)(1)(B) (permitting a plaintiff to recover "benefits due . . . under the terms of his plan"). On July 28, 2011, Defendants answered that complaint, denying all

[3] As MetLife explains, the enrollment system: (1) was unmonitored; (2) did not direct applicants to the Statement of Health form; (3) did not direct individuals on when, how, or where to submit a completed Statement of Health; and (4) did not notify Human Resources when an insured needed to fill out a form. R. 565.

allegations relating to that claim. R. 68. Subsequently, a magistrate judge granted Plaintiff's motion to file the first amended complaint. R. 83.

On October 20, 2011, Plaintiff filed a motion for leave to file a Second Amended Complaint. R. 85. Before that motion was ruled on and after *CIGNA Corp. v. Amara*, 131 S.Ct. 1866, 1880 (2011) ("Amara") was decided, Plaintiff filed a motion for leave to file a third amended complaint. R. 112. In relevant part, the third amended complaint sought to add two counts – one for breach of fiduciary duty and another for failure to prepare and furnish an SPD. R. 122-123. As remedies for these violations of ERISA, Plaintiff sought relief pursuant to 29 U.S.C. § 1132(a)(3) – also known as section 502(a)(3) of ERISA – in the form of "restitution or surcharge or damages." R. 122-123. *See also* 29 U.S.C. § 1132(a)(3) (permitting a plaintiff to recover "appropriate equitable relief" to remedy a violation of ERISA). He also sought generalized relief in the form of "any other relief this Court deems just and proper." R. 122-123.

Defendants opposed Plaintiff's motion to file a third amended complaint on the grounds that such an amendment would be futile (i.e., Plaintiff had failed to state a claim on which relief could be granted). R. 128.[4] Specifically, Defendants argued that section 502(a)(3) of ERISA "is limited to classic equitable relief and does not

[4] Defendant did not contend that the requirement of good cause for granting leave to amend was unmet, and the magistrate judge expressly found that good cause was present. R. 149.

extend to compensatory damages such as those Plaintiff seeks." R. 133-135. Plaintiff responded that this claim was viable in light of *Amara*.

A magistrate judge mistakenly adopted Defendants' position. The judge agreed that Plaintiff's claims could not be maintained because the relief sought was compensatory, not equitable. R. 155 (citing *Pichoff v. QHG of Springdale, Inc.*, 556 F.3d 728 (8th Cir. 2009) for the proposition that "[t]o determine whether a plaintiff requests legal or equitable relief, [the court] ask[s] whether the value of the harm done that forms the basis for the damages is measured by the loss to the plaintiff or the gain to the defendant, and whether the money sought is specifically identifiable as belonging in good conscience to the plaintiff.").

Subsequently, the parties filed cross-motions for summary judgment as to Plaintiff's section 502(a)(1)(B) claim (from the first amended complaint). The parties' dispute involved three issues: (1) whether the plan administrator's interpretation of the Plan as requiring a "Statement of Health" was arbitrary and capricious; (2) whether the "Statement of Health" requirement was improperly noticed; and (3) whether (assuming the plan administrator's interpretation was proper) the withholding and acceptance of premiums constituted waiver of the Statement of Health requirement. R. 177-83, 195-96, 204-09, 214, 220-21, 241-46, 267-68. Plaintiff also disputed many of the dispositive facts concerning disclosure of the Statement of Health requirement claimed by Defendants to be undisputed.

R. 196 (Paragraphs 23, 24, and 26) (disputing whether applicants were prompted by the enrollment system to submit a Statement of Health and whether applicants were furnished an SPD).

On December 10, 2012, the magistrate judge granted Defendants' motion for summary judgment as to Plaintiff's section 502(a)(1)(B) claim. R. 270. First, the judge inexplicably held that Decedent had been provided with an SPD notifying him of the Statement of Health precondition for insurance eligibility. R. 279-81. Second, the judge held that Defendants' interpretation of the Plan was not arbitrary and capricious because (1) "the supplemental life insurance coverage [Decedent] requested was not effective until his application, including [evidence of insurability], was approved by MetLife" and (2) it was not unreasonable "to require [Decedent] to obtain the statement of health form the benefits department." R. 285. Third, the judge held that the acceptance of premium payments did not constitute waiver of the evidence of insurability requirement. R. 287. Finally, the judge concluded that Plaintiff could not obtain a remedy under the doctrine of equitable estoppel.[5] R. 289-93.

Implicitly agreeing that Defendants breached their fiduciary duties under

[5] Plaintiff had expressly disclaimed that he was pursuing an estoppel remedy in conjunction with his motion for summary judgment on his section 502(a)(1)(B) claim. R. 209. Estoppel arguments arise in connection with section 502(a)(3) claims.

ERISA, the magistrate judge granted Plaintiff's motion for summary judgment but limited damages to withheld insurance premiums. R. 294. On January 7, 2013, Plaintiff moved pursuant to Federal Rule of Civil Procedure 59 to alter or amend the judgment, R. 300, and the magistrate judge denied the motion. R. 321. A notice of appeal was subsequently filed. R. 12.

SUMMARY OF THE ARGUMENT

Plaintiff's claims in this case are authorized under two remedial provisions of ERISA, section 502(a)(1)(B) and section 502(a)(3). The magistrate judge erred by disposing of Plaintiff's claims. Reversal is warranted.

First, the magistrate judge erroneously held that Plaintiff's section 502(a)(3) could not be maintained because Plaintiff sought compensatory relief. That holding is contradicted by the Supreme Court's decision in *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011) and the holdings of the Fourth, Fifth, and Seventh Circuits – each of which confirm that section 502(a)(3) authorizes compensatory make-whole monetary relief. *Kenseth*, No. 11-1560, slip op. at 23-24; *Gearlds*, 709 F.3d at 452; *McCravy*, 690 F.3d at 181. Plaintiff is entitled to pursue the remedies of surcharge, reformation, and estoppel to obtain relief from Defendants' serious violations of ERISA.

Second, the magistrate judge erroneously granted summary judgment as to

Plaintiff's section 502(a)(1)(B) claim. That was improper because Defendants' interpretation of the Plan is arbitrary and capricious, the Statement of Health requirement was unnoticed and therefore unenforceable, and Plaintiff's section 502(a)(3) claims may require the existence of a section 502(a)(1)(B) claim to be viable.

ARGUMENT

I. THE MAGISTRATE JUDGE ERRED IN DISMISSING (ON THE PLEADINGS) PLAINTIFF'S 29 U.S.C. § 1132(a)(3) CLAIM FOR "EQUITABLE RELIEF" TO REMEDY VIOLATIONS OF ERISA.

In this case, a magistrate judge erroneously dismissed Plaintiff's 29 U.S.C. § 1132(a)(3) claims because the judge misapprehended the Supreme Court's decision in *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011).[6] *Amara* clearly authorizes Plaintiff to pursue make-whole compensatory relief in the form of surcharge, reformation, or estoppel to remedy Defendants' serious violations of ERISA.

A. This Case Involves Egregious Violations of ERISA by Defendants.

Congress enacted ERISA to ensure that participants and beneficiaries would receive benefits to which they are entitled. *See Conkright v. Frommert*, 130 S.Ct 1640, 1648 (2010). ERISA does not require employers to establish benefit plans. *Id.* Instead, it "induc[es] employers to offer benefits by assuring a predictable set

[6] The magistrate judge's dismissal is reviewed de novo. *Carney v. Houston*, 33 F.3d 893, 894 (8th Cir. 1994).

of liabilities, under uniform standards of primary conduct." *Id.* Those standards of primary conduct are quite clear, as is Defendants' violation of them in this case.

Defendants violated ERISA in two very meaningful ways. This resulted in Decedent's alleged failure to comply with a term of the Plan requiring the evidence of insurability (or, as interpreted by Defendants, a Statement of Health). First, Defendants failed to prepare and furnish a plain language summary of the terms of the Plan designed to apprise Decedent of his obligations under the Plan (i.e., an SPD). Second, Defendants breached their fiduciary duties of care and prudence in their ongoing administration of the Plan and disposition of its assets.

Failure to furnish an SPD. ERISA requires a plan administrator to prepare and furnish an SPD to all participants. 29 U.S.C. § 1022(a). The SPD must include certain important disclosures, must be "written in a manner calculated to be understood by the average plan participant," and must be "sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." *Id.* Among those important disclosures are the "requirements respecting eligibility" and "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b). Once the administrator has prepared an appropriate SPD, the administrator must furnish it to participants using "measures reasonably calculated to ensure actual receipt." 29 U.S.C. § 1022(a); 29 C.F.R. § 2520.104b-1(b)(1).

Savvis, as plan administrator of the Savvis Plan, unquestionably violated this statutory duty. First, and most importantly, it did not prepare a summary *at all*. As counsel for Savvis concedes, Savvis did not prepare and distribute an independent summary of the Plan to Decedent, but rather allegedly distributed only a copy of the plan document. R. 520.

This case presents a paradigmatic example of the problem with distributing a plan document in lieu of a plain language summary. It presents precisely the type of situation that Congress sought to prevent in enacting the SPD requirement: the failure of a participant to satisfy a confusing obligation buried in a long, complex legal document. The plan document in this case is 96 pages long. It describes the terms of the Plan at the level of detail and sophistication appropriate for a plan document but not an SPD. To take the example most relevant to this case, the plan document cryptically provides "We require evidence of Insurability satisfactory to Us." R. 427. That phrase was defined internally by Defendants to refer to a form called a Statement of Health. A proper SPD – one that discloses the "requirements respecting eligibility" and "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits" – would have defined the phrase "evidence of insurability satisfactory to Us" and explained the requirement of submitting a Statement of Health. Had Savvis done that, an average participant like Decedent could have understood and complied with the requirement. But

Savvis provided no summary and as a result Decedent (and approximately 200 other participants) did not comply with that alleged term of the Plan. R. 565.

There is also no evidence that the plan document was even distributed to participants like Decedent. Savvis claims that it distributed the plan document to participants but has never specified by what means, making it impossible to determine whether it used "measures reasonably calculated to ensure actual receipt." R. 254. It also claims that the existence of a copy of the plan document accessible through Savvis's intranet complies with the SPD disclosure requirements of ERISA. R. 254. But while the Department of Labor's ("DOL") regulations authorize electronic disclosure, it has strict requirements about the form of such disclosures:

> [An administrator complies with its disclosure obligation if n]otice is provided to each participant, beneficiary or other individual, in electronic or non-electronic form, at the time a document is furnished electronically, that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes changes in the benefits provided by your plan) and of the right to request and obtain a paper version of such document.

29 C.F.R. § 2520.104b-1(c)(iii). The DOL regulations clearly require affirmative notice and distribution of an SPD, not the mere existence of such a document on an employer's intranet, as was allegedly the case here.

Breach of fiduciary duties. Defendants also engaged in clear violations of their fiduciary duties of care and prudence as established by ERISA. 29 U.S.C. §

1104(a)(1). First, Savvis, as discussed above, failed to prepare and distribute an SPD to Decedent, which constitutes an independent breach of fiduciary duty.

Second, Savvis failed to implement an enrollment system that would prevent or detect errors in enrollment and remedy them. As MetLife explained, a systemic failure in Savvis's online enrollment system caused approximately 200 participants to fail to submit a Statement of Health because the system did not direct applicants to the Statement of Health form and did not direct individuals on when, how, or where to submit a completed Statement of Health. R. 565. That failure went completely undetected and unremedied because the enrollment system was not monitored and did not notify Human Resources when an insured needed to fill out a form. R. 565.

Third, Savvis and MetLife breached their fiduciary duties of care and prudence by withholding and accepting premium payments from Decedent without informing him of the requirement to submit a Statement of Health. That breach was compounded by Savvis's Election Benefits summary which showed that Decedent had actively elected Supplemental Life Insurance coverage as of January 1, 2010. This misconduct gave Decedent and hundreds of other similar participants the false impression that they had met all prerequisites for coverage.

Finally, MetLife breached its duties of care and prudence by denying Plaintiff's claim for benefits due to its own malfeasance. MetLife cannot hide behind its

delegation of authority to Savvis to collect Statement of Health forms to avoid liability since it was vested with discretion to determine whether an applicant had submitted "evidence of insurability satisfactory to [it]" and decided to impose the Statement of Health requirement in the first place. R. 560.

B. In *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011), The Supreme Court Made Clear That 29 U.S.C. 1132(a)(3) Allows Plaintiff to Seek Make-Whole Monetary Relief to Remedy Violations of ERISA.

ERISA authorizes participants and beneficiaries to bring a civil action "to obtain other appropriate equitable relief" to enforce any provisions of the statute. 29 U.S.C. § 1132(a)(3). For well over a decade, there has been continued judicial confusion over when a claim for compensatory monetary relief can constitute "equitable relief" under 29 U.S.C. § 1132(a)(3).

Longstanding Supreme Court precedent holds that, for a remedy to be available under section 502(a)(3) of ERISA, that remedy must fall within "those categories of relief that . . . were typically available in equity." *Amara*, 131 S. Ct. at 1878 (quoting *Mertens v. Hewitt Associates*, 508 U.S. 248, 256 (1993)) (internal quotations omitted). While lower courts have struggled to identify whether particular remedies met that definition, and were thus available under section 502(a)(3), the Supreme Court's recent decision in *Amara* has made the Court's task here straightforward. Specifically, the *Amara* Court held that section 502(a)(3) claimants may pursue the traditional equitable remedies known as "surcharge,"

"reformation," and "estoppel." *Amara*, 131 S. Ct at 1879-1880. Every circuit to have revisited section 502(a)(3) post-*Amara* has held that such remedies unquestionably authorize compensatory, make-whole monetary relief. *Kenseth*, No. 11-1560, slip op. at 23-24; *Gearlds*, 709 F.3d at 452; *McCravy*, 690 F.3d at 181.

C. Relying on Pre-*Amara* Eighth Circuit Precedent, the Magistrate Judge Incorrectly Dismissed Plaintiff's 29 U.S.C. § 1132(a)(3) Claims.

In disagreement with the holdings of the Fourth, Fifth, and Seventh Circuits, the magistrate judge took the contrary and overruled position that a plaintiff cannot not pursue remedies pursuant to 29 U.S.C. § 1132(a)(3) that are compensatory. R. 155 (citing *Pichoff v. QHG of Springdale, Inc.*, 556 F.3d 728 (8th Cir. 2009) and noting that "the Supreme Court's holding in [*Amara*] does not affect the Eighth Circuit's holding in *Pichoff* . . . ."). The judge mistakenly believed that "Plaintiff's [claims are] defeated by the remedy-less regulatory vacuum created by ERISA's broad preemption of state law claims and the Supreme Court's narrow interpretation of other appropriate equitable relief." R. 293 (citing *Pichoff*, 556 F.3d at 732) (internal quotation marks omitted). But the law of ERISA, as made clear by *Amara*, permits maintenance of Plaintiff's claims for compensatory relief via surcharge, reformation, or estoppel.

Surcharge. Surcharge is "a form of monetary 'compensation' for a loss

resulting from a trustee's breach of duty." *Amara*, 131 S. Ct. at 1880 (citing Restatement (Third) of Trusts § 95, and Comment a (Tent. Draft No. 5, Mar. 2, 2009). Surcharge, in the words of Justice Breyer, is more than typically equitable; it was "exclusively equitable." *Id.* (emphasis added). *See also Manhattan Bank v. Walker*, 130 U.S. 267, 271 (1889) ("The suit is plainly one of equitable cognizance, the bill being filed to charge the defendant, as a trustee, for breach of trust."); *Princess Lida of Thurns & Taxis v. Thompson*, 305 U.S. 456, 458, 464 (1939) (describing authority of state court, in a "suit in equity," "to surcharge [a trustee] with losses incurred"); 4 John N. Pomeroy, A Treatise on Equity Jurisprudence § 1080, at 229 (5th ed. 1941); John Adams, Jun., The Doctrine of Equity; Being a Commentary on the Law as Administered by the Court of Chancery 93 (1850); 2 Joseph Story, Commentaries on Equity Jurisprudence § 1266-78, at 519-34 (12th ed. 1877); 3 Austin W. Scott & William F. Fratcher, The Law of Trusts § 199.3, at 206 (4th ed. 1987).

The surcharge claim here is simple. Defendants breached various duties owed to Decedent resulting in losses to his designated beneficiary, Plaintiff, in the amount of $429,000 (the amount of coverage Decedent purchased in Supplemental Life Insurance). Consequently, Plaintiff is entitled to maintain a claim for such breaches of trust and obtain make-whole monetary relief. *Kenseth*, No. 11-1560, slip op. at 23-24; *Gearlds*, 709 F.3d at 452; *McCravy*, 690 F.3d at 181.

Reformation. "Inequitable conduct" as well as conduct "violative of ERISA" are grounds for reformation. *See, e.g.*, *Simmons Creek Coal Co. v. Doran*, 142 U.S. 417, 435 (1892) (inequitable conduct sufficient ground for reformation); *Nechis v. Oxford Health Plans*, Inc., 421 F.3d 96, 103-04 (2d Cir. 2005) (conduct violative of ERISA one predicate for reformation claim).

Here, Defendants' engaged in precisely the type of impermissible conduct that warrants the remedy of reformation. First, Defendants failed to prepare and disseminate an SPD – in clear violation of ERISA – which would have informed Decedent of the requirement to submit evidence of insurability in the form of a Statement of Health. Next, Defendants relied on Decedent's failure to comply with this unnoticed term to deny Plaintiff benefits, even though the sole purpose of the Statement of Health is for MetLife's "review[] in connection with underwriting," not to determine who is eligible for coverage. R. 409, 560. Such inequitable conduct unquestionably supports reformation of the Savvis Plan to strike the unnoticed term (i.e., evidence of insurability).

Estoppel. At equity, courts applied estoppel in cases where a defendant's misrepresentations rose to the level of "gross negligence . . . as to amount to constructive fraud" and such misrepresentations were relied on to another's detriment. *See Brant v. Virginia Coal & Iron Co.*, 93 U.S. 326, 335 (1876); *Henshaw v. Bissell*, 85 U.S. 255, 271 (1873).

In this case, Defendants engaged in many, compounding violations of ERISA on which Decedent relied to his detriment. First, Defendants misrepresented Decedent's enrollment status in two ways: (1) Savvis issued Decedent a Benefits Election summary that showed he had "actively" elected $429,000 in insurance coverage; and (2) Savvis withheld and MetLife accepted premium payments from Decedent. Second, Defendants misrepresented the Statement of Health requirement by including a vague provision in the Plan requiring "evidence of insurability satisfactory to [MetLife]" and by failing to define that phrase in the Plan, which it distributed in lieu of an SPD. Plaintiff was not alone in relying on Defendants' representations; hundreds of other individuals relied on Defendants' representations in exactly the same way (i.e., they did not submit a Statement of Health). Such extensive malfeasance undoubtedly arises to the level of "gross negligence . . . as to amount to constructive fraud." Plaintiff is thus entitled to seek estoppel of enforcement of the evidence of insurability requirement.

II. THE MAGISTRATE JUDGE ALSO ERRED IN DISMISSING (VIA SUMMARY JUDGMENT) PLAINTIFF'S 29 U.S.C. § 1132(a)(1)(B) CLAIM FOR LIFE INSURANCE BENEFITS.

In denying Plaintiff's claim for benefits, Defendants' relied on a single provision of the Plan that Decedent would have easily satisfied had he been able to understand its meaning. To be clear: Defendants have never suggested that Decedent was ineligible for Supplemental Life Insurance. That position would be

indefensible. *See* R. 409 (expressly providing that eligibility extends to "All Full-Time employees of the Policyholder [Savvis]."). Defendants have also never suggested that Decedent did not make his premium payments. R. 198, 227, 246. Instead, Defendants denial of benefits is predicated entirely on Decedent's failure to submit a "Statement of Health." R. 560.

The alleged requirement of submitting a Statement of Health can be found nowhere in the Plan. Rather, such a requirement is based exclusively on Defendants' interpretation of a cryptic term requiring "evidence of insurability satisfactory to [MetLife]." Defendants moved for summary judgment on the basis that its interpretation of that term was not arbitrary and capricious, and the magistrate judge agreed.[7] R. 284-85. That position is untenable.

A. Defendants' Position Is an Arbitrary and Capricious Interpretation of the Relevant Plan Language.

In the words of the Supreme Court: "Applying a deferential standard of review does not mean that the plan administrator will prevail on the merits. It means only that the plan administrator's interpretation of the plan will not be disturbed if reasonable." *Conkright*, 130 S. Ct. at 1651. Even construing the Plan language favorably to Defendants, the Plan does not require that a "Statement of Heath" be submitted as a precondition to enrollment. The Plan merely states that a

[7] The magistrate judge's grant or denial of summary judgment is reviewed de novo. *Get Away Club, Inc. v. Coleman*, 969 F.2d 664, 666 (8th Cir. 1992).

participant must supply "evidence of insurability satisfactory to [Metlife]." And it is clear that MetLife was satisfied in this case because it accepted Decedent's premium payments.

B. The "Evidence of Insurability" Term Is Unenforceable for Lack of Notice.

Savvis did not distribute an SPD apprising Decedent that he was required to submit a Statement of Health, which is identified nowhere in the Plan. Where a plaintiff is "likely prejudiced" as a result of a deficient SPD, a plaintiff has a cognizable claim under section 502(a)(1)(B) for benefits and the unnoticed plan term is unenforceable. *See Wilkins v. Mason Tenders Dist. Council Pension Fund*, 445 F.3d 572, 583-85 (2d Cir. 2006). In this case, Decedent was unquestionably prejudiced by Savvis's violation of its duty to furnish an SPD because that misconduct caused Decedent to fail to submit a Statement of Health and caused the resulting denial of Plaintiff's claim for the proceeds of the life insurance policy for which Decedent had paid. The magistrate judge erroneously determined that Plaintiff was not likely prejudiced only by deeming important disputed facts as undisputed. First, Defendants alleged that Decedent was prompted by the online enrollment system to complete a statement of health form. R. 195. Plaintiff disputed this fact because "it is unclear exactly what the employee was told by the online system and how, because the record has no indication of what they were

told, just a second-hand report." R. 195. Second, Defendants alleged that a copy of the Plan was distributed to participants. R. 196. Plaintiff disputed this fact as well on the basis that it was unsupported by any evidence. R. 196. Summary judgment was thus clearly improper because of the existence of genuine issues of material fact.

C. In Any Event, Defendants' Position Will Not Survive an Estoppel or Reformation Challenge.

The magistrate judge's order disposing of Plaintiff's section 502(a)(1)(B) claim must be reversed for another independent reason. *Amara* left open the question of whether a plaintiff who is awarded the remedies of estoppel or reformation is entitled to monetary compensation directly under section 502(a)(3) or whether a plaintiff must seek monetary compensation in the form of benefits due under the reformed or post-estoppel terms of the plan under section 502(a)(1)(B). As discussed above, Plaintiff is entitled to pursue the equitable remedies of surcharge, reformation, and estoppel pursuant to section 502(a)(3). To ensure that those claims remain viable, the order of the magistrate judge disposing of Plaintiff's section 502(a)(1)(B) claims must be reversed.

CONCLUSION

The orders of the magistrate judge denying Plaintiff's request for leave to amend his complaint to add claims pursuant to 29 U.S.C. § 1132(a)(3) and granting summary judgment in favor of Defendants as to Plaintiff's claims pursuant to 29 U.S.C. § 1132(a)(1)(B) should be reversed.

Dated: July 17, 2013

Respectfully submitted,

/s/ Peter K. Stris

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 28.1(e)(2) or 32(a)(7)(B) because this brief contains 6,592 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally-spaced typeface using Microsoft Word for Mac 2011 in 14 point Times New Roman font.

Dated: July 17, 2013

/s/ Peter K. Stris
Counsel for Appellant

CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of July, 2013, I caused this Brief of Appellant to be filed electronically with the Clerk of the Court using the CM/ECF System, which will send notice of such filing to the following registered CM/ECF user:

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I further certify that the Brief of Appellant has been scanned for viruses using ClamXav Anti-Virus and according to the program is free of viruses.

I also certify that on this 17th day of July, 2013, the required number of copies of the Appellant's Appendix have been filed with the Clerk of the Court, via UPS Next Day Air, and one copy of the same was served, via UPS Next Day Air, on Counsel for Appellees at the above listed address.

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