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

REPLY BRIEF OF APPELLANT

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INTRODUCTION

Abel Silva ("Decedent"), worked for Savvis Communications Corporation. Savvis sponsors a plan (the "Savvis Plan") covered by the Employee Retirement and Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"). Through the Savvis Plan, Decedent applied for a life insurance policy (the "Policy") – insured by Metropolitan Life Insurance Company. He named his father ("Plaintiff") as beneficiary. Savvis withheld premiums from Decedent's paycheck. And MetLife accepted those premiums until Decedent's untimely death.

After unsuccessfully seeking the Policy's death benefit, Plaintiff filed this lawsuit against Savvis and MetLife ("Defendants"). He asserted two independent ERISA claims. In his initial complaint, Plaintiff sought the Policy's death benefits pursuant to 29 U.S.C. § 1132(a)(1)(B) (the "Section 1132(a)(1)(B) claim"). Subsequently, Plaintiff sought to amend his complaint to include alternative causes of action pursuant to 29 U.S.C. § 1132(a)(3) (the "Section 1132(a)(3) claims"). Specifically, Plaintiff argued that Defendants breached their fiduciary duties under ERISA which entitle him to "appropriate equitable relief" *irrespective* of whether he was entitled to death benefits under the Policy's terms.

The district court dismissed the Section 1132(a)(3) claims on the pleadings and then granted summary judgment against Plaintiff on his Section 1132(a)(1)(B) claim. As explained below, each of these decisions constitutes reversible error.

ARGUMENT

I. PLAINTIFF'S SECTION 1132(a)(3) CLAIMS WERE IMPROPERLY DISMISSED AT THE PLEADING STAGE.

The district court determined "that the proposed third amended complaint would be futile" because "the relief sought by Plaintiff is unavailable as 'other appropriate equitable relief.'" R. 155 (quoting 29 U.S.C. § 1132(a)(3)(B)). As the district court acknowledged, a finding of futility is unwarranted if the proposed complaint states a cognizable claim that can survive a Rule 12(b)(6) motion to dismiss. R. 150 (citing *In re Senior Cottages of Am., LLC*, 482 F.3d 997, 1001 (8th Cir. 2007)). The district court failed to appreciate, however, that the proposed third amended complaint asserts paradigmatic claims for "appropriate equitable relief" under Section 1132(a)(3). As such, reversal is warranted.

A. Defendants Do Not Even *Attempt* to Defend the Lower Court's Holding.

Relying on *Pichoff v. QHG of Springdale, Inc.*, 556 F.3d 728 (8th Cir. 2009), the district court "held that the relief sought by plaintiff – compensation for the benefits that would have been paid but for the defendants' errors – was 'compensatory in nature and unavailable under § 1132(a)(3)(B).'" R. 153 (quoting *Pichoff*, 556 F.3d at 732). Put simply, the court believed that Plaintiff failed to plead a viable Section 1132(a)(3) claim because the relief sought was akin to compensatory damages. In the court's view, such a claim is foreclosed by *Pichoff*.

As the Department of Labor ("DOL") explained at length in its amicus brief, however, the holding of *Pichoff* was expressly abrogated by a recent decision of the United States Supreme Court. Brief of the Secretary of Labor, Thomas E. Perez, as Amicus Curiae In Support of Plaintiff-Appellant at 10-21 ("DOL Amicus Brief") (discussing *Amara*, 131 S. Ct. 1866). Indeed, the holding of *Pichoff* – which was also the law in other circuits prior to *Amara* – has been squarely rejected by every circuit to have revisited the issue. *See Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869 (7th Cir. 2013); *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448 (5th Cir. 2013); *Skinner v. Northrop Grumman Ret. Plan B*, 673 F.3d 1162 (9th Cir. 2012); *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176 (4th Cir. 2011). *See also* Brief of Appellant at 20-24.

In concluding that the proposed third amended complaint failed to state a viable Section 1132(a)(3) claim, the district court inexplicably asserted that *Pichoff* was not overruled by *Amara*. R. 155 ("In short, the Supreme Court's holding in *CIGNA Corp.* [131 S. Ct. 1866 (2011)] does not affect the Eighth Circuit's holding in *Pichoff*, 556 F.3d at 732, that the relief sought by Plaintiff is unavailable as 'other appropriate equitable relief.' 29 U.S.C. 1132(a)(3)(B)."). Unsurprisingly, Defendants do not even *attempt* to defend that holding. *See* Brief of Appellees (failing to refute, or engage in any way, the fundamental position taken by Plaintiff and the DOL – i.e., that *Pichoff* was expressly overruled by *Amara*). *Id.* at 21

(noting that "[t]his Court may affirm the district court's rulings on any basis supported by the record.").

B. Defendants' Alternative Ground for Affirmance Is Untenable.

Unwilling to defend the district court's holding, Defendants urge affirmance on alternative grounds. Specifically, Defendants argue that all Section 1132(a)(3) claims were properly dismissed because "a plaintiffs ability to seek relief in a 29 U.S.C. § 1132(a)(1)(B) claim forecloses him or her from pursuing the same relief in a 29 U.S.C. § 1132(a)(3) claim." Brief of Appellees at 26 (citing *Conley v. Pitney Bowes*, 176 F. 3d 1044, 1047 (8th Cir. 1999)).[1] As explained below, Defendant's position is baseless.[2]

Every plaintiff is entitled to plead alternative theories of relief. Fed. R. Civ. P. 8(a)(3) ("A pleading that states a claim for relief must contain . . . a demand for the relief sought, which may include relief in the alternative or different types of relief."); Fed. R. Civ. P. 18 ("A party asserting a claim . . . may join, as independent or alternative claims, as many claims as it has against an opposing

[1] Defendants advanced this argument in the lower court. R. 151 n.9, n.10, and accompanying text. Rather than accept the argument, however, the district court merely explained Plaintiff's response and then moved on to the *Pichoff* issue described above. R. 151.

[2] Defendants concede that alternative argument is the only Section 1132(a)(3) issue before the Court. Brief of Appellees at 7 (defining the Section 1132(a)(3) issue as "[w]hether the District Court properly denied Plaintiff leave to amend to assert a claim under ERISA § 502(a)(3)(B), when Plaintiff had available and was asserting a claim for plan benefits under ERISA § 502(a)(1)(B).").

party."); *Peter Kiewit Sons's Co. v. Summit Constr. Co.*, 422 F.2d 242, 271 (8th Cir. 1969) ("Federal Rule of Civil Procedure 8[] clearly permits setting forth two or more statements of a claim alternately or hypothetically and stating as many separate claims as may exist regardless of consistency . . . .").

In this case, Plaintiff's proposed third amended complaint properly asserted two distinct claims under ERISA: the Section 1132(a)(1)(B) claim and the Section 1132(a)(3) claims. R. 120-23. To be clear: these are two alternative – and not duplicative – theories of liability:

- The Section 1132(a)(1)(B) claim is based entirely on the language of the ERISA plan at issue. *See* 29 U.S.C. § 1132(a)(1)(B) (permitting an ERISA plaintiff to seek "benefits due . . . under the plan."). Put simply, if the Savvis Plan does not require submission of a Statement of Health, then Plaintiff will prevail on this claim. If, however, the Savvis Plan does require submission of a Statement of Health, then the Section 1132(a)(1)(B) claim will fail.

- By contrast, the Section 1132(a)(3) claim is not based on the language of the ERISA Plan at all. *See* 29 U.S.C. § 1132(a)(3)(B) (permitting an ERISA plaintiff to seek "other appropriate equitable relief."). Instead, it is based on the various acts of fiduciary misconduct committed by Savvis and MetLife (e.g., gross mismanagement of the life insurance enrollment process, acceptance of premium payments from someone who Defendants maintain was ineligible,

etc.). It is well settled that such instances of fiduciary breach trigger a claim under Section 1132(a)(3). *See Amara*, 131 S. Ct. at 1880; *Varity Corp. v. Howe*, 516 U.S. 489, 492 (1996); *Kenseth*, 722 F.3d at 891-92; *Gearlds*, 709 F.3d at 452; *Skinner*, 673 F.3d at 1165-66; *McCravy*, 690 F.3d at 180-81.

Unsurprisingly, plaintiffs are regularly permitted to plead Section 1132(a)(1)(B) and Section 1132(a)(3) claims in the alternative. *See, e.g., Amara*, 131 S. Ct. at 1878-79 (discussing the availability of relief under Section 1132(a)(3) after concluding that no relief was available under Section 1132(a)(1)(B)); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001) (permitting both Section 1132(a)(1)(B) and Section 1132(a)(3) claims at the pleading stage); *DeVito v. Aetna, Inc.*, 536 F. Supp. 2d 523, 534 (D.N.J. 2008) ("claims under § 1132(a)(3) are not properly dismissed at the motion to dismiss stage merely because a plaintiff has also brought a claim under § 1132(a)(1)(B)"); *Bell v. Guardian Life Ins. Co.*, No. 08-01629, 2008 WL 4852840, at *4-5 (D.N.J. 2008) ("Plaintiff should be able to assert § 502(a)(l)(B) and § 502(a)(3) claims at this stage of the litigation because parties are permitted to plead in the alternative.").

The contrary position urged by Defendants is predicated on a fundamental misunderstanding of Justice Breyer's observation in *Varity Corp. v. Howe* that 29 U.S.C. § 1132(a)(3) "act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that [§ 1132] does not elsewhere adequately remedy."

Varity, 516 U.S. at 512. As Justice Breyer went on to explain, he was quite clearly referring only to instances where a plaintiff "repackage[s] his or her 'denial of benefits' claim as a claim for 'breach of fiduciary duty.'" *Id.* at 513. Such duplicative pleading arises in practice because ERISA defines the failure to follow the terms of a written plan as a breach of fiduciary duty. 29 U.S.C. § 1104(a)(1)(D) ("[A] fiduciary shall discharge his duties in . . . accordance with the documents and instruments governing the plan). A simple example will illustrate this point:

Imagine that a plaintiff asserts a Section 1132(a)(1)(B) claim arguing that the terms of her ERISA plan cover a particular medical procedure. Further imagine that she asserts a Section 1132(a)(3) claim where the only basis for such claim is that, by ignoring plan terms authorizing the medical procedure, the administrator breached its fiduciary duty. In such a case, the Section 1132(a)(3) claim is clearly duplicative and serves no independent purpose. That is because there is no separate predicate from which the fiduciary breach arises. Or, put differently, both the Section 1132(a)(1)(B) and Section 1132(a)(3) claims will turn on the court's interpretation of the disputed ERISA plan term(s).[3]

[3] Each case on which Defendants rely merely stands for the uncontroversial *Varity* proposition that a plaintiff may not "repackage his or her 'denial of benefit' claim as a claim for 'breach of fiduciary duty.'" *See Conley*, 176 F.3d at 1047 (considering and rejecting on the merits the various allegations of fiduciary breach – allegations of procedural irregularities in the benefit determination process – as

The allegations in this case could not be more different. Here, there is a separate predicate for the Section 1132(a)(3) claim — a series of specific and admitted misrepresentations that harmed Plaintiff (e.g., gross mismanagement of the enrollment process, acceptance of life insurance premiums). Nothing in *Varity* stands for the proposition that a plaintiff who brings a Section 1132(a)(1)(B) claim (based on the disputed plan terms of the plan) somehow loses the right to bring a Section 1132(a)(3) claim (based on misrepresentations) that arguably caused the same injury.

That is hardly surprising. The alternative rule urged by Defendants would mean that every ERISA plaintiff with an independent Section 1132(a)(3) fiduciary breach claim would lose the right to litigate such a claim if she also had an unrelated Section 1132(a)(1)(B) benefits claim. And such would be the case *even if* the fiduciary breach claim were strong and the benefits claim were weak (and, ultimately, unsuccessful). That cannot possibly be what Congress intended in passing ERISA. At a minimum, every ERISA plaintiff is permitted to plead and maintain an independent Section 1132(a)(3) claim until the disposition of her Section 1132(a)(1)(B) claim. If, as happens in some cases, the Section

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part of evaluating the plaintiff's Section 1132(a)(1)(B) claim); *Pilger v. Sweney*, No. 12-2698, 725 F.3d 922, slip op. at 7 (8th Cir. 2013) (rejecting plaintiff's Section 1132(a)(3)(B) claim "because it[] mirrors [plaintiff's] § 1132(a)(1)(B) claim." (emphasis added)). And to the extent any Eighth Circuit case law suggests that a plaintiff may not plead Section 1132(a)(3) claims and Section 1132(a)(1)(B) in the alternative, such precedent cannot possibly survive *Amara*.

1132(a)(1)(B) claim fails (either at the summary judgment stage or after a trial), the independent Section 1132(a)(3) claim *must* be adjudicated. Defendants have not – and cannot – advance any argument (or cite any authority) to the contrary.

II. PLAINTIFF'S SECTION 1132(a)(1)(B) CLAIM WAS IMPROPERLY DISMISSED AT THE SUMMARY JUDGMENT STAGE.

Refusing to take responsibility for the harm Defendants caused, the plan administrator imposed a *post hoc* condition on Decedent's eligibility for insurance and denied Plaintiff's claim for benefits on the basis that Decedent failed to submit a "Statement of Health." R. 560. Such a document is never defined (or even mentioned) in the Savvis Plan, and Defendants did not prepare or distribute a Summary Plan Description ("SPD") that disclosed the alleged requirement that such a document be submitted. Because it was arbitrary and capricious to deny Decedent coverage for failing to submit a Statement of Health, the district court erred in granting summary judgment in favor of Defendants on Plaintiff's Section 1132(a)(1)(B) claim. Reversal is warranted.

A. The Plan Administrator's Claim Denial Was Arbitrary and Capricious.

The plan administrator denied Plaintiff's claim for benefits on the sole ground that the Savvis Plan requires the submission of a Statement of Health as a precondition to enrollment and Decedent did not submit one. R. 560. But the Plan does not require a Statement of Health. Rather, the Plan cryptically provides only

that "We require evidence of insurability satisfactory to Us." R. 427. The Plan never explains the meaning of that phrase.

Decedent applied for the Policy using Defendants' online system. R. 236-37. Thereafter, he paid – and Defendants accepted – his premiums each month until his death. R. 246, 287. Defendants even confirmed his election of $429,000 in Supplemental Life Insurance benefits in a written document provided to Decedent. R. 331. They never gave Decedent any indication that he was not covered. To the contrary, everything they did confirmed Decedent's coverage. In light of Defendants' conduct, Decedent reasonably believed that his insurance application was "satisfactory" to MetLife.

Now that Decedent is dead, Defendants take the position that there was an internal requirement that he submit a form called a "Statement of Health" as a precondition to enrollment. But nowhere does the Plan identify such a requirement. Nor does the Plan inform a participant (1) how to obtain such a form, (2) where to send the form, or (3) what information to include. It is no exaggeration to say that it was literally impossible for Decedent to read the Plan and know how to comply with this alleged Statement of Health requirement. Unsurprisingly, roughly 200 other individuals found themselves in precisely the same position. R. 565 (investigation of MetLife confirming that approximately 200 participants failed to submit a Statement of Health).

Defendants imposition of this *post hoc* Statement of Health requirement is a textbook example of arbitrary and capricious decisionmaking. As such, reversal is warranted. *See Conkright v. Frommert*, 130 S.Ct 1640, 1651 (2010) ("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.").

B. The Arbitrary and Capricious Nature of the Plan Administrator's Claim Denial Is Confirmed by Defendants' Failure to Furnish an SPD.

The plan administrator also failed to distribute an SPD disclosing its interpretation that the Plan requires a "Statement of Health." To avoid confusing participants, ERISA requires plan administrators to furnish an SPD. *See* 29 U.S.C. §§ 1022(a) & 1024(b). An SPD must contain 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). It must be "written in a manner calculated to be understood by the average plan participant." 29 U.S.C. § 1022(a). This "usually require[s] the limitation or elimination of technical jargon and of long, complex sentences." 29 C.F.R. § 2520.102-2(a). Recently, the Supreme Court reaffirmed the "basic summary plan description objective: clear, simple communication." *Amara*, 131 S. Ct. at 1877-78 (citing 29 U.S.C. §§ 1001(a) and 1022(a)).

In accepting the plan administrator's interpretation of the Plan, the district court concluded that Decedent had received an adequate SPD. R. 280 ("Defendants properly provided Abel with a SPD."). It erred for three independent reasons.

1. Defendants did not prepare a summary of the Savvis Plan at all. Instead, they claim to have given Decedent a copy of the Savvis Plan Document. Defendants' believe that this satisfies ERISA's SPD requirements. *See* Brief of Appellees at 33. They are wrong. Put simply, a document cannot summarize itself. *See, e.g.*, *Hansen v. Cont'l Ins. Co.*, 940 F.2d 971, 981 (5th Cir. 1997), *abrogated on other grounds by Amara*, 131 S. Ct. at 1877-78 ("By definition, a summary description of the policy does not reproduce each and every term, word for word, of the policy.").[4] *See also* Brief of Appellant at 26-27; DOL Amicus Brief at 21-24.

2. Even if a plan document could function as an SPD, it would make no difference here because the Savvis Plan Document does not disclose the "requirements respecting eligibility" and "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits" in language that can be understood by the average participant. *See* 29 U.S.C. §§ 1022(a) and 1022(b).

[4] Defendants claim that that "courts have recognized that a single document may function as both the Plan Document and the summary plan description." Brief of Appellees at 33 (citing *Alday v. Container Corp. of America*, 906 F.2d 660, 662 n.2 (11th Cir. 1990)). The case they cite, however, did not involve a dispute over whether a plan document could be distributed in lieu of an SPD.

Critically, the Plan never explains that the phrase "We require evidence of insurability satisfactory to Us" could be interpreted by Defendants to effectively mean "We require the submission of a form called a 'Statement of Health' which you must obtain from your Human Resources Department, complete, and return to Us in order to be eligible to enroll in the Plan." The interpretation of a critical requirement such as this should have been disclosed in an SPD to Decedent. The Savvis Plan Document is also long and highly technical. At 96 pages, the Plan is difficult for a lawyer to understand, let alone an average Savvis employee like Decedent. *See also* DOL Amicus Brief at 23 (observing that "the certificate certainly does not qualify as a summary plan description"). It was thus arbitrary and capricious to deny Plaintiff's claim for benefits on the ground that Decedent had failed to submit a Statement of Health.

3. There are several genuine issues of material fact as to whether Decedent ever received a copy of the Savvis Plan. For example, Defendants failed to establish (1) that Decedent received a copy of the original plan document when he was hired in 2004, see DOL Amicus Brief at 24-25; (2) that Decedent received an updated copy of the plan document after MetLife assumed Hartford Life's position as claims administrator in 2008, see *id.* at 24-25; and (3) that Defendants complied with the DOL's regulations governing electronic dissemination of an SPD, see *id.* at 25-26.

Because Decedent was never apprised of the "Statement of Health" requirement through either the Plan or an SPD, it was arbitrary and capricious for the plan administrator to deny the Section 1132(a)(1)(B) claim. Consequently, the district court's grant of summary judgment in favor of Defendants should be reversed.[5]

CONCLUSION

For the reasons set forth above, 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 claim pursuant to 29 U.S.C. § 1132(a)(1)(B) should be reversed.

Respectfully submitted,

Dated: September 30, 2013

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[5] Defendants appear to concede that summary judgment on the Section 1132(a)(1)(B) claim should be reversed if dismissal of Plaintiff's Section 1132(a)(3) claim is reversed because Plaintiff pleaded claims for estoppel and reformation. *See* Brief of Appellees (failing to refute, or engage in any way, Brief of Appellant, Section II.C).

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 3859 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B).

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: September 30, 2013

/s/ Peter K. Stris
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CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of September, 2013, I caused this Reply 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 30th day of September, 2013, the required number of copies of the Appellant's Appendix shall be filed with the Clerk of the Court, via UPS Next Day Air, and one copy of the same shall be served, via UPS Next Day Air, on Counsel for Appellees at the above listed address.

Dated: September 30, 2013

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