

2016

## *Protective Plan Provisions for Employer-Sponsored Employee Benefit Plans*

Kathryn J. Kennedy

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### Recommended Citation

Kathryn J. Kennedy, *Protective Plan Provisions For Employer-Sponsored Employee Benefits Plans*, 18 Marq. Ben. & Soc. Welfare L. Rev. 1 (2017)

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# PROTECTIVE PLAN PROVISIONS FOR EMPLOYER-SPONSORED EMPLOYEE BENEFIT PLANS

**Kathryn J. Kennedy\***

Federal case law has provided plan sponsors of the Employee Retirement Income Security Act of 1974 (ERISA) covered plans with the ability to insert plan provisions that are more favorable to the plan sponsor rather than the plan participant or beneficiary (so-called “protective plan provisions”). This Article first examines what is the “plan document” for purposes of ERISA and what protective plan provisions should be considered for insertion into the plan document and its related “instruments.”

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## I. INTRODUCTION

Federal case law has broadened the right of employee benefit plan sponsors to insert plan provisions that are more favorable to the sponsor than to the plan participants or beneficiaries. This Article examines those so-called “protective plan provisions,” both in the retirement and in the welfare plan context. Before reviewing such provisions, it is important to understand what constitutes a “plan document” for ERISA’s Title I purposes, and to the extent there are single or multiple plan documents, to understand what provisions should be considered in a plan document for enforcement purposes. This Article is divided into three parts: (1) what constitutes the plan document and for what purpose; (2) what specific “instruments” could be considered in the plan document or an instrument which governs the plan, and what problems develop if those instruments are not consistent with the plan document; and (3) what protective plan provisions should be considered for insertion into the plan documents and related instruments.

There are two important contexts in which the plan and other “instruments” must be identified. ERISA provides a cause of action under Section 501(a)(1)(B) for participants to receive benefit payments required “under the terms of [the] plan.”<sup>1</sup> Hence, the terms of the plan are relevant in determining such benefit payments.<sup>2</sup> ERISA also requires the plan fiduciary to act “in accordance with the documents and instruments governing the plan”<sup>3</sup> or face a breach of fiduciary claim under the prudent person standard under ERISA Section 502(a)(2).<sup>4</sup> Thus, the plan

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<sup>1</sup> 29 U.S.C. § 1132(a)(1)(B) (2012).

<sup>2</sup> *Id.* (providing a cause of action by the participant or beneficiary “to recover benefits due to him under the terms of [the] plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]”).

<sup>3</sup> *Id.* at § 1104(a)(1)(D) (following documents and instruments governing the plan is required to the extent those documents and instruments are consistent with the provisions of Title I and IV).

<sup>4</sup> *Id.* at § 1132(a)(2) (providing for a cause of action for appropriate relief under ERISA § 409, which imposes personal liability on a plan fiduciary who breaches any

fiduciary must know what “document and instruments” constitute the plan document, as there are numerous instruments that may be used in administering the plan, as well as the terms of those multiple plan documents. There is a third cause of action under ERISA Section 502(a)(3) that permits the participant beneficiary or fiduciary to enjoin acts that violate the terms of the plan or ERISA Title I, to redress the violation, or to enforce the terms of the plan or ERISA Title I.<sup>5</sup> This is a broad cause of action covering claims to enforce rights under the plan, including rights to benefits, and statutory rights.

## II. WHAT IS A “PLAN DOCUMENT” UNDER ERISA?

Under ERISA’s “General Provisions,” Section 3 contains definition provisions.<sup>6</sup> While the section defines what constitutes an employee benefit plan, it does not define what constitutes the plan document or instrument establishing such plan.<sup>7</sup>

### A. *Requirements of ERISA Section 402*

ERISA Section 402 is the closest relevant provision because it requires that “[e]very employee benefit plan shall be established and maintained pursuant to a written instrument” (i.e., the plan document).<sup>8</sup> Under the law’s “Fiduciary Responsibility” provisions, ERISA Section 402 mandates that the *content* of that plan document include certain items.<sup>9</sup> First, the plan must name at least one fiduciary (i.e., the named fiduciary) and the procedure by which an employer, employee, or

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fiduciary duties to restore plan losses or disgorge any profits made through the use of plan assets).

<sup>5</sup> *Id.* at § 1132(a)(3).

<sup>6</sup> *Id.* at § 1002(3).

<sup>7</sup> *See id.* (“the term ‘employee benefit plan’ or ‘plan’ means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.”).

<sup>8</sup> 29 U.S.C. § 1102.

<sup>9</sup> *Id.* at § 1102(a)-(b).

organization identify a fiduciary with respect to such plan.<sup>10</sup> Second, the plan must set forth the “procedure for establishing and carrying out a funding policy and method” (applicable in the retirement plan context) that is consistent with the objectives of the plan and the terms of ERISA.<sup>11</sup> Third, the plan must describe any procedures for allocating “responsibilit[y] for the operation and administration of the plan[,]” including the procedures for allocating such responsibilities among named fiduciaries, and for named fiduciaries to designate other non-named fiduciaries to carry out fiduciary responsibilities.<sup>12</sup> Fourth, the plan must provide a procedure for amending the plan and the identity of the person who has the authority to amend the plan.<sup>13</sup> Lastly, the plan must “specify the basis on which payments are made to [(i.e., contributions)] and from [(i.e., benefit payments)] the plan.”<sup>14</sup>

ERISA Section 402 also provides *optional* provisions to be set forth in the plan including: authority for any person or group of persons to serve in *multiple* fiduciary capacities with respect to the plan (e.g., trustee and plan administrator);<sup>15</sup> authority for a named fiduciary or a new fiduciary who has been designated by a named fiduciary to carry out fiduciary responsibilities under the plan to “employ one or more persons to render advice” regarding its responsibilities;<sup>16</sup> or authority for a fiduciary named to control or manage the assets of the plan to appoint an investment manager or multiple investment managers to manage the assets of the plan, including the power to acquire and dispose of plan assets.<sup>17</sup> This type of provision is applicable in the retirement plan context, as welfare benefits are typically funded on a self-insured, pay-as-you-go basis or with insurance

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<sup>10</sup> *Id.* at § 1102(a)(1)-(2).

<sup>11</sup> *Id.* at § 1102(b)(1).

<sup>12</sup> *Id.* at § 1102(b)(2).

<sup>13</sup> *Id.* at § 1102(b)(3).

<sup>14</sup> 29 U.S.C. § 1102(b)(4).

<sup>15</sup> *Id.* at § 1102(c)(1).

<sup>16</sup> *Id.* at § 1102(c)(2).

<sup>17</sup> *Id.* at § 1102(c)(3).

premiums.<sup>18</sup> However, multiemployer welfare plans may be funded with trusts.<sup>19</sup>

Aside from ERISA Section 402, various other ERISA provisions require certain types of plans to contain required terms: under ERISA Section 203, pension plans must provide minimum vesting standards, which are different for defined benefit plans than for defined contribution plans;<sup>20</sup> under ERISA Section 205, joint and survivor and preretirement survivor annuities must be provided to surviving spouses of deceased vested participants;<sup>21</sup> and under ERISA Section 206, the form and timing of benefits under a pension plan are subject to a number of caveats that must be set forth in the plan, including anti-alienation provisions.<sup>22</sup>

Generally, in the retirement plan context, the plan document is regarded as a *single* document with the above-required provisions, as opposed to multiple documents that collectively serve as the plan document in other contexts. This is certainly the case with *qualified* retirement plans, as employers generally submit a single plan document for a determination letter to affirm the qualified status of the plan document. The Supreme Court affirmed this concept in the *CIGNA Corp. v. Amara*<sup>23</sup> decision by stating that ERISA Section 402 requires the plan to be established by the plan sponsor who “creates the basic terms and conditions of the plan, executes a written instrument containing those terms and conditions, and provides in that instrument ‘a procedure’ for making amendments.”<sup>24</sup> The case involved a traditional defined benefit pension plan that was

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<sup>18</sup> *Id.* at § 1102(c)(1)-(3).

<sup>19</sup> *E.g.*, *Boucher v. Williams*, 13 F. Supp. 2d 84, 95 (D. Me. 1998); *Manny v. Cent. States, Se. & Sw. Areas Pension & Health & Welfare Funds*, 388 F.3d 241, 243 (7th Cir. 2004).

<sup>20</sup> 29 U.S.C. § 1053.

<sup>21</sup> *Id.* at § 1055(a).

<sup>22</sup> *Id.* at § 1056.

<sup>23</sup> 563 U.S. 421, 438 (2011).

<sup>24</sup> *Id.* at 437.

converted to a cash balance retirement plan.<sup>25</sup> The Supreme Court addressed the issue of conflicting terms between the single plan document and the summary plan description,<sup>26</sup> which is discussed later in this Section.

The Supreme Court has also referenced plan documents in the plural.<sup>27</sup> In *Kennedy v. Plan Adm'r for DuPont Sav. and Inv. Plan*,<sup>28</sup> the Court concluded that a benefit claim “stands or falls by . . . the directives of the plan documents[.]”<sup>29</sup> The case involved a former spouse’s waiver of her spousal benefits under an ERISA pension plan that was not subject to a qualified domestic relations order (QDRO).<sup>30</sup> Under the terms of the plan, if there were no surviving spouse or designated beneficiary at the time of death, benefits would be distributed to the participant’s estate.<sup>31</sup> The issue presented was whether the plan administrator was to follow the terms of the plan in the face of a possible federal common-law waiver that did not satisfy as a QDRO.<sup>32</sup> Similarly, in *Curtiss-Wright Corp. v. Schoonejongen*,<sup>33</sup> the Court affirmed that ERISA’s statutory “scheme . . . is built around reliance on the face of written plan documents[.]” referring to plan documents in the plural.<sup>34</sup> This was in reference to express legislative history that stated “[a] written plan is to be required in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan,” (emphasis omitted) again referring to plan documents in the plural.<sup>35</sup> The case

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<sup>25</sup> *Id.* at 424.

<sup>26</sup> *Id.* at 436-38.

<sup>27</sup> See *infra* notes 28-36 and accompanying discussion.

<sup>28</sup> 555 U.S. 285, 286 (2009) (which allows for “a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits[.]” quoting from *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)).

<sup>29</sup> *Id.* at 300.

<sup>30</sup> *Id.* at 288.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 291-92.

<sup>33</sup> 514 U.S. 73 (1995).

<sup>34</sup> *Id.* at 83.

<sup>35</sup> *Id.* (quoting H.R. Rep. No. 93-1280, p. 297 (1974) U.S. Code Cong. &



asked whether a postretirement health plan's standard reservation clause constituted a valid amendment procedure for purposes of ERISA Section 402(b)(3).<sup>36</sup>

Two other ERISA provisions refer to "instruments governing the plan"<sup>37</sup> or "instruments under which the plan is established or operated[.]"<sup>38</sup> suggesting that other agreements or contracts could set forth terms of the plan. Under the "Reporting and Disclosure Requirements" sections,<sup>39</sup> ERISA Section 104(b)(4) sets forth certain disclosure requirements applicable to the plan administrator. The administrator must, upon written request of any plan participant or beneficiary, furnish the most recent summary plan description (SPD), Form 5500 (an annual return and report of the employee benefit plan), terminal reports, collective bargaining agreements, trust agreements, contracts, or "other instruments under which the plan is established or operated."<sup>40</sup> The latter indicates that multiple instruments could constitute parts of the plan document.

Under the "Fiduciary Responsibility" sections,<sup>41</sup> ERISA Section 404(a)(1)(D) requires a plan fiduciary to discharge his or her duties with respect to the plan solely in the interests of the participants and beneficiaries "in accordance with the documents and instruments governing the plan[.]"<sup>42</sup> The question arises as to whether the "instruments" referred to in these two sections are identical or whether they simply overlap.<sup>43</sup> In the *Curtiss-Wright* decision, the Supreme Court characterized the documents subject to the disclosure

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Admin. News pp. 4639, 5077, 5078 (emphasis added)).

<sup>36</sup> *Id.* at 75.

<sup>37</sup> 29 U.S.C. § 1104(a)(1)(D).

<sup>38</sup> *Id.* at § 1024(b)(4).

<sup>39</sup> *Id.* at §§ 1021-1031.

<sup>40</sup> *Id.* at § 1024 (with penalties of \$110 per day for failure to comply under 29 U.S.C. § 1132(c)(1)). See also 29 C.F.R. § 2575.502c-3 (2015).

<sup>41</sup> 29 U.S.C. §§ 1101-1114.

<sup>42</sup> *Id.* at § 1104(a)(1)(D).

<sup>43</sup> See *id.* at §§ 1024(a)(6), 1104(a)(1)(D).

requirements under ERISA Section 104(b)(4) as the “governing plan documents” required under ERISA Section 402(b).<sup>44</sup> Their purpose is to provide a “clear set of instructions” to participants to obtain benefits.<sup>45</sup> However, the Supreme Court was solely addressing the question of what constitutes the plan documents for purposes of the fiduciary requirements of ERISA Section 402(b)(3).<sup>46</sup>

Regulatory guidance and case law may be useful in identifying what types of instruments are to be considered for either or both purposes under ERISA Sections 104(b)(4) and 404(a)(1)(D). Each section will be examined separately. The distinction is important, as ERISA Section 104(b)(4) is a disclosure requirement whereby the penalty falls upon the plan administrator to pay a fee for failing to disclose, whereas failure to comply with ERISA Section 404(a)(1)(D) creates a participant cause of action for breach of fiduciary duty to comply with the governing plan documents and instruments.

***B. Plan documents and instruments for ERISA Section 104(b)(4) purposes***

The Department of Labor (DOL) has issued several advisory opinions on what constitutes “other instruments under which the plan is established or operated” for purposes of ERISA Section 104(b)(4).<sup>47</sup> Its first opinion stated that “other instruments” include any documents or instrument setting forth “procedures, formulas, methodologies, or schedules [used] in determining or calculating a participant’s or beneficiary’s benefit entitl[ed] under a[] . . . plan[.]”<sup>48</sup> This includes any document, or

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<sup>44</sup> See *Curtiss-Wright*, 514 U.S. at 83 (noting that “ERISA gives effect to this ‘written plan documents’ scheme through a comprehensive set of ‘reporting and disclosure’ requirements, see 29 U.S.C §§ 1021-1031”).

<sup>45</sup> *Fox Valley & Vicinity Const. Workers Pension Fund v. Brown*, 897 F.2d 275, 283 (7th Cir. 1990).

<sup>46</sup> See *Curtiss-Wright*, 514 U.S. at 83-85.

<sup>47</sup> *E.g.*, DOL Adv. Op. 97-11A (Apr. 10, 1997); DOL Adv. Op. 96-14A (July 31, 1996).

<sup>48</sup> DOL Adv. Op. 96-14A (July 31, 1996).

provisions thereof, that “establishes or amends the plan in question” or that “establishes a claims procedure.”<sup>49</sup> However, it does not necessarily include “all contracts between a plan and third parties who render services to the plan[.]” which may or may not include a third party agreement.<sup>50</sup>

Most of the circuits that have opined on the “catch-all” part of ERISA Section 104(b)(4) take a strict approach on its construction and limit these “other instruments” to formal or legal documents under which the plan is established or governed. Accordingly, most circuit courts reject the premise that other documents that relate to the plan, such as actuarial valuation reports, are not formal legal documents.<sup>51</sup>

In *Faircloth v. Lundy Packing Co.*,<sup>52</sup> the Fourth Circuit found the statutory language of ERISA Section 104(b)(4) “clear and unambiguous,” and therefore, the court did not need to rely upon the legislative history, nor traditional rules of statutory construction.<sup>53</sup> The court defined “instrument” to mean “[a] formal or legal document in writing, such as a contract, deed, will, bond or lease[.]”<sup>54</sup> Thus, “instruments” was defined as “encompass[ing] formal or legal documents under which a plan is set up or managed.”<sup>55</sup> The Fourth Circuit rejected the minority approach set forth in the Sixth Circuit’s holding in *Bartling v.*

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<sup>49</sup> DOL Adv. Op. 97-11A (Apr. 10, 1997).

<sup>50</sup> *Id.*; *Brown v. J.B. Hunt Transport Servs., Inc.*, 586 F.3d 1079, 1088-89 (8th Cir. 2009) (stating that claim manuals or guidelines used in claims procedures are not covered); *Hively v. BBA Aviation Benefit Plan*, 331 Fed. Appx. 510, 511 (9th Cir. 2009) (stating that the plan’s administrative service agreement may be covered if it “governs the relationship between . . . the plan participants and the provider” or “relate[s] only to the manner in which the plan is operated”).

<sup>51</sup> *Brown v. Am. Life Holdings, Inc.*, 190 F.3d 856, 861-62 (8th Cir. 1999) (limiting disclosure to formal documents that establish or govern the plan, not all documents under which the plan conducts operation, thereby rejecting disclosure of “corporation actions replacing members of the [plan’s] [a]dministrative [c]ommittee, minutes of the [a]dministrative [c]ommittee meetings, and written communications with” the plan’s trustee).

<sup>52</sup> 91 F.3d 648 (4th Cir. 1996), *cert. denied*, 519 U.S. 1077 (1997).

<sup>53</sup> *Id.* at 653.

<sup>54</sup> *Id.* (quoting BLACK’S LAW DICTIONARY 801 (6th ed. 1990)).

<sup>55</sup> *Id.*

*Fruehauf Corp.*<sup>56</sup> that suggested courts should favor a presumption of disclosure under ERISA Section 104(b)(4) because the statutory language did not support such presumption.<sup>57</sup> Even with its stricter test, the court in *Faircloth* held that the plan's funding and investment policies were disclosable because "[a]s described in the [plan], the funding and investment policies set forth [the employer]'s obligations to fund the [plan] and explain the responsibilities regarding investing the assets of the [plan]."<sup>58</sup>

In *Bd. Of Trs. of the CWA/ITU Negotiated Pension Plan v. Weinstein*,<sup>59</sup> the Second Circuit followed suit and construed "instruments" for ERISA Section 104(b)(4) purposes as limited to formal legal documents that govern the plan's operation, in contrast with routine documents with which the plan conducts its operations, citing the Fourth Circuit's decision in *Faircloth*.<sup>60</sup> The Eighth Circuit in *Brown v. Am. Life Holdings, Inc.*<sup>61</sup> agreed with the narrow interpretation of "instruments" to "only formal documents that establish or govern the plan."<sup>62</sup> The Seventh Circuit in *Ames v. Am. Nat'l Can Co.*<sup>63</sup> concurred with its sister circuits, noting that a contrary "interpretation would make hash of the statutory language, which on its face refers to a specific set of documents: those under which a plan is established or

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<sup>56</sup> 29 F.3d 1062, 1072 (6th Cir. 1994).

<sup>57</sup> 91 F.3d at 654-56 (rejecting disclosure of the IRS determination letter, the plan's bonding policy, the ESOP plan's appraisal reports and supporting documentation, the minutes of the plan meetings, and the cost-sharing and trustee expense policies, but allowing disclosure of the plan's funding and investment policies).

<sup>58</sup> *Id.* at 656.

<sup>59</sup> 107 F.3d 139 (2d Cir. 1997).

<sup>60</sup> *Id.* at 142.

<sup>61</sup> 190 F.3d 856 (8th Cir. 1999) (rejecting disclosure of documents relating the replacement of the members of the ESOP administrative committee, minutes of administrative committee meetings, or written communications with the plan's trustee).

<sup>62</sup> *Id.* at 861.

<sup>63</sup> 170 F.3d 751, 758-59 (7th Cir. 1999) (rejecting disclosure of the agreement to sell a division to a successor employer, certain division board resolutions, and names of individual fiduciaries).

operated.”<sup>64</sup> The First Circuit in *Doe v. Travelers Ins. Co.*<sup>65</sup> interpreted instruments as “formal legal documents that underpin the plan” thereby rejecting disclosure of mental health guidelines because the plan administrator “was not bound to use them, nor did patients have any legal rights under them.”<sup>66</sup>

In contrast, the Sixth and Ninth Circuits have construed the reach of ERISA Section 104(b)(4) more broadly.<sup>67</sup> In *Bartling v. Fruehauf Corp.*,<sup>68</sup> in connection with a pending sale, the employer informed plan participants of the replacement of their existing pension plan with a new plan by providing a letter with employment data used to calculate vested benefits upon plan termination.<sup>69</sup> Counsel for the participant plaintiffs requested the plan’s determination letter, actuarial reports for the past three years, benefit computation sheets, and a portion of the purchase agreement that related to plan benefits.<sup>70</sup> The Sixth Circuit held that disclosure of the actuarial reports is required under ERISA Section 103(d) to be filed every third year of the plan, and thus are “indispensable to the operation of the plan.”<sup>71</sup> The court reasoned that the purpose behind ERISA’s disclosure rules was “to ensure that ‘the individual participant knows exactly where he stands with respect to the plan,’” quoting the language in the Supreme Court’s *Firestone Tire & Rubber Co. v. Bruch* decision.<sup>72</sup> The court advocated for a presumption in “favor” of disclosure so as to assist participants in understanding their rights.<sup>73</sup> The court also required disclosure of the calculation procedure without explicit

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<sup>64</sup> *Id.* at 758.

<sup>65</sup> 167 F.3d 53, 60 (1999).

<sup>66</sup> *Id.*

<sup>67</sup> See *infra* notes 68-79 and accompanying discussion.

<sup>68</sup> 29 F.3d 1062 (6th Cir. 1994).

<sup>69</sup> *Id.* at 1065.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at 1070.

<sup>72</sup> *Id.* (quoting *Firestone v. Bruch* 489 U.S. 101, 118 (1989), which had quoted from the legislative history at H.R.Rep. No. 93-533, p. 11 (1973)).

<sup>73</sup> *Id.*

reasoning.<sup>74</sup>

In *Hughes Salaried Retirees Action Comm. v. Admin'r of the Hughes Non-Bargaining Retirement Plan*,<sup>75</sup> retirees under the pension plan requested the plan administrator furnish the names and addresses of other plan participants.<sup>76</sup> The Ninth Circuit affirmed the district court's denial for such request under ERISA Section 104(b)(4), stating that the ordinary meaning of the statute "limits the universe of documents falling within that phrase to documents similar in nature to those specifically identified," describing the terms and conditions of the plan or the plan's administration and financial status.<sup>77</sup> The court concluded that a list of plan participants provided no information about the plan.<sup>78</sup> Relying on the legislative history, the documents requiring disclosure under ERISA Section 104(b)(4) include those that permit

"the individual participant [to] know[] exactly where he stands with respect to the plan[,] what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted."<sup>79</sup>

The Ninth Circuit clarified its interpretation in *Shaver v. Operating Eng'rs Local 428 Pension Trust Fund*,<sup>80</sup> stating that

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<sup>74</sup> *Bartling*, 29 F.3d at 1071.

<sup>75</sup> 72 F.3d 686 (9th Cir. 1995). See also *Shaver v. Operating Eng'rs Local 428 Pension Trust Fund*, 332 F.3d 1198, 1202 (9th Cir. 2003) (holding that "other instruments" refers to "legal documents that describe the terms of the plan, its financial status, and other documents that restrict or govern the plan's operation" such that itemized list of plan expenditures do not have to be disclosed because they "relate only to the manner in which the plan is operated.").

<sup>76</sup> *Id.* at 688.

<sup>77</sup> *Id.* at 689.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* at 690 (quoting the legislative history at S. Rep. No. 127, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C. C.A.N. 4838, 4863).

<sup>80</sup> 332 F.3d 1198 (9th Cir. 2003).

“instruments” for ERISA Section 104(b)(4) was confined to “legal documents that describe the terms of the plan, [the plan’s] financial status, and other documents that restrict or govern the plan’s operation.”<sup>81</sup> Other district courts have allowed ancillary documents such as a stock valuation report to measure benefits by the value of the stock<sup>82</sup> and a manual with charts necessary for the calculation of benefits.<sup>83</sup>

***C. Plan documents and instruments for ERISA Section 404(a)(1)(D) purposes***

ERISA Section 404(a)(1) sets forth ERISA’s fiduciary standards of care.<sup>84</sup> ERISA Section 404(a)(1)(A) requires the fiduciary to act “for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan[.]”<sup>85</sup> ERISA Section 404(a)(1)(D) requires fiduciaries to act “in accordance with the documents and instruments governing the plan” to the extent they are consistent with ERISA, making reference to multiple documents and instruments.<sup>86</sup> ERISA Section 404(a)(1) uses the phrase “documents and instruments governing the plan[.]”<sup>87</sup> whereas ERISA Section 104(b)(4) uses the phrase “instruments under which the plan is established or operated.”<sup>88</sup>

A few courts have addressed two questions: whether “instruments” under ERISA Section 104(b)(4) are the same as “documents and instruments” under ERISA Section 404(a)(1)(D),<sup>89</sup> and whether ERISA Section 404(a)(1) imposes additional disclosure obligations beyond those found in ERISA

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<sup>81</sup> *Id.* at 1202. (rejecting disclosure of a list of plan expenditures as they “relate only to the manner in which the plan is operated.”).

<sup>82</sup> *See* *Werner v. Morgan Equip. Co.*, 15 EBC 2295, 2301 (N.D. Cal. 1992).

<sup>83</sup> *See* *Lee v. Dayton Power & Light Co.*, 604 F. Supp. 987, 1002 (S.D. Ohio 1985).

<sup>84</sup> 29 U.S.C. § 1104(a)(1).

<sup>85</sup> *Id.* at § 1104(a)(1)(A).

<sup>86</sup> *Id.* at § 1104(a)(1)(D).

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at § 1024(b)(4).

<sup>89</sup> *See infra* notes 91-109 and accompanying discussion.

Section 104(b)(4).<sup>90</sup>

The Ninth Circuit in *Hughes Salaried Retirees Action Comm. v. Admin. of the Hughes Non-Bargaining Retirement Plan*<sup>91</sup> affirmed its earlier ruling in *Acosta v. Pacific Enters.*<sup>92</sup> that any disclosure required under ERISA Section 404(a)(1)(A) was limited to information that relates to the provision of benefits or the defrayment of expenses.<sup>93</sup> The court held that the disclosure of names and addresses of participants was not required under either ERISA Sections 404(a)(1)(A) or 104(b)(4), and that it did not have to address the issue of the relationship between ERISA Sections 404(a)(1) and 104(b)(4) as to whether documents were not disclosable under ERISA Section 104(b)(4), but arguably disposable under ERISA Section 404(a)(1)(A).<sup>94</sup>

The Supreme Court in *Kennedy v. Plan Admin. for DuPont Savings and Investment Plan*<sup>95</sup> had the opportunity to define the category of “documents and instruments governing” the plan for purposes of ERISA Section 404(a)(1)(D).<sup>96</sup> In that case, a participant died unmarried, and the terms of the plan called for the distribution of benefits to be made to his estate.<sup>97</sup> Prior to his death, the participant had married and named his spouse as beneficiary to the benefits, but upon their subsequent divorce in which his spouse waived her rights to his benefits, the participant did not remove his former spouse as beneficiary on

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<sup>90</sup> See *infra* notes 110-121 and accompanying discussion.

<sup>91</sup> 72 F.3d 686, 693 (9th Cir. 1995).

<sup>92</sup> 950 F.2d 611 (9th Cir. 1991).

<sup>93</sup> *Hughes Salaried Retirees Action Committee v. Administrator of the Hughes Non-Bargaining Retirement Plan*, 72 F.3d 686, 694 (9th Cir. 1995) (quoting *Acosta v. Pacific Enters.*, 950 F.2d 611, 619 (9th Cir. 1991)).

<sup>94</sup> *Id.* at 694-95.

<sup>95</sup> 555 U.S. at 285, 300 (reinforcing the mandate in 29 U.S.C. § 1132(a)(1)(B) “that a participant or beneficiary may bring a cause of action ‘to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]’”).

<sup>96</sup> *Id.* at 288.

<sup>97</sup> *Id.* at 289.



the plan's designation form.<sup>98</sup> The participant's estate claimed the benefits that had been paid to the former spouse.<sup>99</sup> The Supreme Court declined to rule as to whether beneficiary designation forms were "documents and instruments governing the plan" under ERISA Section 404(a)(1)(D), as the terms of the plan and summary plan description, both of which were "documents and instruments governing the plan[.]" directed the plan administrator to pay benefits to the participant's designated beneficiary.<sup>100</sup>

The Ninth Circuit recently ruled on this issue.<sup>101</sup> In the case of *Becker v. Williams*,<sup>102</sup> a participant had designated his spouse as beneficiary under the plan, but upon his divorce, attempted to change the beneficiary designation to his son through a telephone conversation instead of signing and returning the required form as required by the plan.<sup>103</sup> The district court granted the former spouse's motion for summary judgment and declined, upon a subsequent motion by the decedent's son, to reconsider its judgment.<sup>104</sup> The Ninth Circuit reversed, holding that the beneficiary designation forms were not "plan documents" for purposes of ERISA Section 404(a)(1)(D).<sup>105</sup> Drawing on guidance from the *Hughes Salaried Retirees Action Comm.* case, the court interpreted "instruments" for ERISA Section 104(b)(4) purposes as only "those documents that provide individual participants with information about the

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<sup>98</sup> *Id.* at 290.

<sup>99</sup> *Id.* at 304.

<sup>100</sup> *Id.* Only one court of appeals had addressed this issue prior to the Kennedy decision. In the case of *McGowan v. NJR Serv. Corp.* 423 F.3d 241, 245-46 (3d Cir. 2005), the Third Circuit suggested that virtually all "documents on file with the [P]lan[.]" including beneficiary designation forms, fit within the "documents and instruments governing the plan[.]"

<sup>101</sup> *Becker v. Williams*, 777 F.3d 1035 (9th Cir. 2015).

<sup>102</sup> *Id.*

<sup>103</sup> *Id.* at 1036-37.

<sup>104</sup> Order Granting Motion for Summary Judgment, *Becker v. Mays-Williams*, No. C11-5830, 2012 WL 6150561, at \*3 (W.D. Wash. Dec. 11, 2012), *recons'd denied*, Order Denying Defendant's Motion for reconsideration, *Becker v. Williams*, No. C11-5830, 2013 WL 241370, at \*1 (W.D. Wash. Jan. 22, 2013).

<sup>105</sup> *See Becker*, 777 F.3d at 1039-40.

plan and benefits.”<sup>106</sup> The court further interpreted “those documents” as documents necessary to tell “exactly where [the participant] stands with respect to the plan—what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits . . . .”<sup>107</sup> Although the Supreme Court in *Kennedy* suggested that the “instruments” in ERISA Section 104(b)(4) may overlap with the “documents and instruments governing the plan” in ERISA Section 404(a)(1)(d), the category described in ERISA Section 404 is even narrower than that of ERISA Section 104.<sup>108</sup> The court remarked that this result is due to the *CIGNA Corp. v. Amara* decision, in which the Supreme Court excluded the statutory mandated summary plan description listed in ERISA Section 104 as a source of the plan’s governing terms.<sup>109</sup>

As to the second issue, a few courts have addressed the issue of whether ERISA Section 404(a)(1)(D) creates additional disclosure obligations beyond those found in ERISA Section 104(b)(4).<sup>110</sup> The Fourth Circuit in the *Faircloth* decision (discussed above) held that ERISA Section 404(a)(1)(D) did not impose additional disclosure obligations beyond those imposed by ERISA Section 104(b)(4), but the court did not resolve the issue as to whether the “instruments” were the same under both provisions.<sup>111</sup> The Ninth Circuit in *Shaver v. Operating Eng’rs Local 428 Pension Trust Fund*<sup>112</sup> held that disclosure of certain plan expenditures was not required under ERISA Section 104(b)(4) as “instruments,” and as such, was not the

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<sup>106</sup> *Id.* at 1039.

<sup>107</sup> *Id.*

<sup>108</sup> *Id.* at 1039-40.

<sup>109</sup> *Id.* at 1039 n. 3 (citing the Supreme Court’s case of *CIGNA Corp. v. Amara*, 131 S.Ct. 1866, 1878 (2011) (“[T]he summary documents, important as they are, provide communication with beneficiaries *about* the plan, but . . . their statements do not themselves constitute the *terms*.”)).

<sup>110</sup> See *infra* notes 117-121 and accompanying discussion.

<sup>111</sup> See *Faircloth*, 91 F.3d at 658.

<sup>112</sup> 332 F.3d 1198 (9th Cir. 2003).

basis for a breach of fiduciary claim, indicating that the “instruments” covering both the disclosure and fiduciaries standards were similar or identical.<sup>113</sup> The Fifth Circuit raised the issue in *Murphy v. Verizon Communication, Inc.*,<sup>114</sup> but rendered it moot, as the appellants had already received their required relief.<sup>115</sup> However, the court in *Murphy* pointed out the tension in its prior decisions.<sup>116</sup> In *Ehlmann v. Kaiser Found. Health Plan of Tex.*,<sup>117</sup> the court held that ERISA Section 404(a)(1) “should not add to [a] specific disclosure requirement[]” that ERISA already provides,<sup>118</sup> whereas in *Kujanek v. Houston Poly Bag I, Ltd.*,<sup>119</sup> the court held that a plan administrator breaches its fiduciary duties by withholding plan documents and rollover information that was specifically requested by a participant.<sup>120</sup> The administrator in *Murphy* breached its duties when it “failed to act in [the plan participant’s] best interest and “for the exclusive purpose of providing benefits to participants[,]” as required by Section 404(a)(1).”<sup>121</sup>

The lessons learned from this case law are as follows: to the extent certain documents are regarded as “instruments” relating to the plan document, the protective plan provisions discussed in the second part of this Article should be inserted into *all* related documents if the plan sponsor wishes to reduce litigation over the issue.

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<sup>113</sup> *Id.* at 1202.

<sup>114</sup> 587 Fed. Appx. 140 (5th Cir. 2014).

<sup>115</sup> *Id.* at 146.

<sup>116</sup> *Id.* at 147.

<sup>117</sup> 198 F.3d 552 (5th Cir. 2000).

<sup>118</sup> *Id.* at 555-56.

<sup>119</sup> 658 F.3d 483 (5th Cir. 2011).

<sup>120</sup> *Id.* at 488-89.

<sup>121</sup> *Murphy v. Verizon Commc’ns*, No. 13-11117, Appeal from U.S. Dis. Ct. for the N. Dis. Tex. at 13 (5th Cir. Dec. 3, 2014).

### III. WHAT SPECIFIC DOCUMENTS SUCH AS INSURANCE POLICIES, TRUST AGREEMENTS, INVESTMENT POLICY STATEMENTS, AND SPDS ARE CONSIDERED PLAN DOCUMENTS OR INSTRUMENTS GOVERNING THE PLAN?

The next part addresses the specific issues as to whether certain documents, such as an insurance policy, a trust agreement, an investment policy statement, and an SPD are considered plan documents or related instruments, and for what purposes.

#### A. *Insurance Policies as Plan Documents*

On the health and welfare side, if the benefits are insured, there may only be an insurance policy or contract rather than a separate plan document.<sup>122</sup> The issue of whether the insurance policy may constitute the plan document generally arises in two contexts: in a cause of action for eligibility of policy benefits, or under the standard of review for determining eligibility for benefits, both under ERISA Section 502(a)(1)(B).<sup>123</sup> The Eighth Circuit in *Ibson v. United Healthcare Services, Inc.*<sup>124</sup> held that an insurance policy alone constituted a plan document because it met the requirements of identifying “(1) the intended benefits, (2) the class of beneficiaries, (3) a source of funding, and (4) the procedures for receiving benefits.”<sup>125</sup> These four requirements address two of the standards of ERISA Sections 402(b)(1) and 402(b)(4), namely the procedure for establishing and carrying out a funding policy and deciding how benefits are to be paid, but not the two other requirements relating to procedures for

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<sup>122</sup> *Ibson v. United Healthcare Servs., Inc.*, 776 F.3d 941, 944 (8th Cir. 2014), *cert. denied*, 135 S.Ct. 2351 (2015) (“[A]n employer’s purchase of an insurance policy to provide health care benefits for its employees can constitute an Employee Welfare Benefit Plan for ERISA purposes.”) (quoting *Robinson v. Linomaz*, 58 F.3d 365, 368 (8th Cir. 1994)).

<sup>123</sup> 29 U.S.C. § 1132(a)(1)(B).

<sup>124</sup> 776 F.3d 941 (8th Cir. 2014).

<sup>125</sup> *Id.* at 944. (quoting *Petersen v. E.F. Johnson Co.*, 366 F.3d 676, 678 (8th Cir. 2004)).

allocating responsibilities for the operation and administration of the plan, and for amending such plan.<sup>126</sup>

The typical scenario in which the question arises is in the context of the court's standard of review regarding a plan administrator's denial of a benefit claim.<sup>127</sup> Generally, the standard of review in a benefits denial claim is *de novo*, unless the plan administrator has been granted discretionary authority under the plan to determine eligibility for benefits or to construe *the terms of the plan*.<sup>128</sup> If there is no plan document—as is the case for many insured welfare plans—courts look to other related documents for such grants of discretion.<sup>129</sup> The issue is critical, as courts routinely affirm the benefits denial of the plan administrator if the administrator has the requisite discretionary power.<sup>130</sup>

If there is an insurance policy that provides for the payment of employer-sponsored benefits in lieu of a separate plan document, the question that then arises is whether the insurance policy can confer such discretionary authority to the

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<sup>126</sup> 29 U.S.C. §1102(b).

<sup>127</sup> See *Moberly v. Metlife*, No. CIV.A. 6:06-297DCR, Memorandum Opinion and Order at 6 (E.D. Ky. June 8, 2007); *Stewart v. Bell Atl. Long Term Disability Plan for Mgmt. Employees*, No. 12 C 6175 at 11-12 (N.D. Ill. Dec. 19, 2013); *Frerichs v. Hartford Life & Acc. Ins. Co.*, 875 F. Supp. 2d 923, 938 (D. Minn. 2012); *Baker v. Hartford Life & Acc. Ins. Co.*, No. 4:14-CV-209-BLW at 6-7 (D. Idaho Feb. 23, 2015); *Cleary v. Boeing Co. Employee Health & Welfare Ben. Plan (Plan 503)*, No. 11-CV-00403-WJM-BNB at 11 (D. Colo. July 31, 2013); *Harvey v. Standard Ins. Co.*, 850 F. Supp. 2d 1269, 1276 (N.D. Ala. 2012); *Bell v. Shenandoah Life Ins. Co.*, 589 F. Supp. 2d 1268, 1372 (M.D. Ga. 2008); *Pettaway v. Teachers Ins. & Annuity Ass'n of Am.*, 699 F. Supp. 2d 185, 198 (D.D.C. 2010); *LeBlanc v. Sullivan Tire Co.*, 526 F. Supp. 2d 75, 79 (D. Me. 2007); *Gates v. United Healthcare Ins. Co.*, No. 11-CV-3487 (KBF) at 20 (S.D.N.Y. Nov. 7, 2014); *Smith v. Liberty Life Assur. Co. of Boston*, No. CIV.A. TDC-14-0203 at 4 (D. Md. Mar. 3, 2015); *Parkridge Med. Ctr., Inc. v. CPC Logistics, Inc. Grp. Ben. Plan*, No. 1:12-CV-124 at 8 (E.D. Tenn. Aug. 2, 2013).

<sup>128</sup> *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

<sup>129</sup> *Tuttle v. Varian Med. Sys. Inc.*, 15 F. Supp. 3d 944, 949 (D. Ariz. 2013) (turning to the insurance policy itself as the plan document); *Frazier v. Life Ins. Co. of N. Am.*, 725 F.3d 560, 566 (6th Cir. 2013) (characterizing the insurance policy as both a plan asset and the plan document).

<sup>130</sup> *Tuttle*, 15 F. Supp. 3d at 956 (holding that the plan documents, consisting of various portions of the policy, “granted discretionary authority to the decisionmaker” and affirming the use of that authority); *Frazier*, 725 F.3d at 571 (affirming the claim denial).

plan fiduciary. Several circuits have affirmed use of the insurance policy as sufficient to determine a grant of discretionary authority to the plan administrator to avoid the *de novo* standard of review.<sup>131</sup> Four circuits have addressed the issue of whether discretionary authority that is not present in the insurance policy, but appeared in either a certificate of insurance or a summary plan description, is sufficient.<sup>132</sup> The Seventh, Ninth, and Eleventh Circuits did not rely on these external documents to confer discretionary authority when the insurance policy was silent,<sup>133</sup> but the Second Circuit affirmed the grant of discretionary authority through the summary plan description.<sup>134</sup> However, the Second Circuit case is a pre-*Amara* decision and may be decided differently today.<sup>135</sup>

The National Association of Insurance Commissioners (NAIC) adopted a model act in 2002 entitled “Prohibition on the Use of Discretionary Clauses Model Act,” prohibiting the use of discretionary clauses in health insurance policies beginning in

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<sup>131</sup> *Frazier v. Life Ins. Co. of N. Am.*, 725 F.3d 560, 566 (6th Cir. 2013); *Ruiz v. Continental Casualty Co.*, 400 F.3d 986, 991-92 (7th Cir. 2005) (affirming the grant of discretionary authority to the plan administrator in the certificate for insurance); *Ross v. Rail Car Am. Group Disability Income Plan*, 285 F.3d 735, 739 n. 5 (8th Cir. 2002); *Cinelli v. Sec. Pac. Corp.*, 61 F.3d 1437, 1441 (9th Cir. 1995); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 856 (4th Cir. 1994); *Musto v. Am. Gen. Corp.*, 861 F.2d 897, 900-01 (6th Cir. 1988); *Shaw v. Conn. Gen. Life Ins. Co.*, 353 F.3d 1276, 1282-83 (11th Cir. 2003).

<sup>132</sup> *Grosz-Salomon v. Paul Revere Life Insurance Co.*, 237 F.3d 1154, 1158 (9th Cir. 2001); *Shaw v. Connecticut General Life Insurance Company*, 353 F.3d 1276, 1282 (11th Cir. 2003); *Sperandeo v. Lorillard Tobacco Co.*, 460 F.3d 866, 872 (7th Cir. 2006); *Murphy v. Int’l Bus. Machs. Corp.*, 23 F.3d 719, 721 (2d Cir. 1994).

<sup>133</sup> *See Grosz-Salomon*, 237 F.3d at 1158-61 (where the underlying policy provided that “[t]his policy and any application made by the policyholder or by an employee make up the entire contract between the parties,”); *Shaw*, 353 F.3d at 1283 (where the underlying policy stated “[n]o change in this contract will be valid unless approved by the Insurance Company and evidenced by endorsement on this contract or by amendments to this contract”); *Sperandeo*, 460 F.3d at 871 (noting that the certificate and summary plan description were “not incorporated by reference into the policy or plan”).

<sup>134</sup> *See Murphy v. Int’l Bus. Machs. Corp.*, 23 F.3d 719, 721 (2d Cir. 1994) (affirming the grant of discretionary authority pursuant to the summary plan description and the employee information package, with no explanation as to the terms of the underlying severance plan).

<sup>135</sup> *See* discussion *infra* Section III.D.

2002.<sup>136</sup> The NAIC then amended its model act in 2004 to apply to disability insurance policies.<sup>137</sup> As a result, some state insurance departments have prohibited insurers from using discretionary clauses in their insurance policies, either health insurance, disability insurance, or both, on the grounds that they are illusory.<sup>138</sup> Three circuits—the Sixth, Seventh, and Ninth—have held that such state insurance laws prohibiting discretionary clauses in insurance policies are not preempted by ERISA.<sup>139</sup> Thus, such insurance policies may not grant discretionary authority to the insurer.<sup>140</sup> To avoid both the *de novo* standard of review and preemption challenges for employer-sponsored coverage under such insurance policies, the policy should include a grant of discretionary authority to a person other than the insurer, for example, the employer.<sup>141</sup>

### ***B. Trust Agreements as Plan Documents***

The next document to be considered as a possible plan document is the trust agreement. ERISA Section 403 requires that the assets of an employee benefit plan be held in trust by

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<sup>136</sup> HEALTH INS. & MANAGED CARE (B) COMMITTEE, 2002 NAIC PROC. 1ST Qtr. p. 175, 180-181.

<sup>137</sup> HEALTH INS. & MANAGED CARE (B) COMMITTEE, 2004 NAIC PROC. 3RD Qtr. (Attachment 1) “Prohibition on the Use of Discretionary Clauses Model Act,” at 673, 677.

<sup>138</sup> See *e.g.*, CAL. INS. CODE §10110.6(a) (2012); COL. REV. STAT. § 10-3-1116(2) (2008); Conn. Ins. Dep’t Bull. HC-67 (Mar. 19, 2008); Haw. Commissioner’s Memo. 2004-13H (Dec. 8, 2004); IDAHO ADMIN. CODE § 18.01.29.011 (2011); 50 ILL. ADMIN. CODE tit. 50 § 2001.3 (2005); Ind. Dep’t of Ins., Bull. 103 (May 8, 2001); Ky. Dep’t of Ins., Adv. Op. 2010-01 (Mar. 9, 2010); ME. REV. STAT. ANN. tit. 24-A § 4303 (2011); MD. CODE ANN., INS. § 12-211 (2005); MICH. ADMIN. CODE r.500.2202 (2016); MONT. CODE ANN. § 33-1-502 (2011); N.J. ADMIN. CODE § 11:4-58.1 et seq. (2010); N.Y. Circular Letter No. 2006-14, NEW YORK INSURANCE BULLETINS AND RELATED MATERIALS (June 29, 2006); OR. REV. STAT. § 742.005 (2011); S.D. Admin. R. § 20:06:52:02 (2010); 28 TEX. ADMIN. CODE § 3.1202 et seq. (2010); UTAH ADMIN. CODE r.590-218 (2012); WASH. ADMIN. CODE §§ 284-44-015, 46-015, 96-012 (2012); WYO. STAT. ANN. § 26-13-304 (1977).

<sup>139</sup> American Council of Life Ins. v. Ross, 558 F.3d 600, 608-09 (6th Cir. 2009); Fontaine v. Metropolitan Life Ins. Co., 800 F.3d 883, 886-887 (7th Cir. 2015); and Standard Ins. Co. v. Morrison, 584 F.3d 837, 849 (9th Cir. 2009).

<sup>140</sup> Zaccone v. Standard Life Ins. Co., No.-10-CV 00033 (N.D. Ill. May 1, 2013).

<sup>141</sup> See Fontaine v. Metropolitan Life Ins. Co., 800 F.3d 883 (7th Cir. 2015).

one or more trustees “pursuant to a written trust instrument,” referred to as the “hold-in-trust” requirement.<sup>142</sup> It specifies that the trustee is to be named in either the trust instrument or plan instrument, but may be appointed by a person who is a named fiduciary.<sup>143</sup> “[T]he trustee or trustees . . . have [the] exclusive authority and discretion to manage and control the assets of the plan” (referred to as the exclusive control requirements).<sup>144</sup> The terms “trust,” “trustee,” and “trust instrument” are not found in ERISA’s “Definitions” section.<sup>145</sup> The existence of a trust is typically seen in the retirement plan context where employer and employee contributions are pre-funded and are thus in need of a tax-exempt trust and, consequently, a trust document.<sup>146</sup> It is not necessarily found in the insured welfare plan context, but may exist if the welfare plan is collectively bargained.<sup>147</sup>

ERISA Section 104(b)(4) enumerates the “trust agreement” separately from the plan document, and considers it a written instrument under which the plan is established or governed.<sup>148</sup> Under ERISA’s fiduciary standards, trustees as plan fiduciaries must comply with the terms of the trust agreement or face breach of fiduciary claim cases.<sup>149</sup> This raises the issue of whether the trust agreement needs to be a separate document from the plan document or whether it can be incorporated into

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<sup>142</sup> 29 U.S.C. § 1103(a).

<sup>143</sup> *Id.*

<sup>144</sup> *Id.* (unless the plan subjects the trustee or trustees to the direction of a named fiduciary who is not a trustee or allows the trustee or trustees to delegate powers to manage, acquire or dispose of plan assets to an investment manager). *Id.* at § 1103(a)(1).

<sup>145</sup> 29 C.F.R. § 2510.3 (2015).

<sup>146</sup> David A. Pratt, *The Past, Present and Future of Retiree Health Benefits*, 3 J. HEALTH & BIOMEDICAL L. 103, 128 (2007).

<sup>147</sup> *See, e.g.*, Peter J. Wiedenbeck, *ERISA’s Curious Coverage*, 76 WASH. U.L.Q. 311, 322 (1998).

<sup>148</sup> 29 U.S.C. § 1024(b)(4) (requiring furnishing of “a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.”).

<sup>149</sup> *Id.* at §§ 1104(a), 1109.



the base plan document. If the trust is a separate document from the foundational “plan document,” it is considered a written instrument under ERISA Section 104(b)(4) under which the plan is established or governed.<sup>150</sup>

The DOL regulations echo the statute, but further provide that “all assets of an employee benefit plan shall be held in trust by one or more trustees *pursuant to a written trust instrument.*”<sup>151</sup> In an amicus brief, the DOL takes the position that the language in ERISA Section 403, “all assets of an employee benefit plan shall be held in trust[,]” requires the execution of a separate trust document or separate written document governing the plan that clearly expresses an intent to create a trust.<sup>152</sup> Only then can a named or appointed trustee accept appointment and exclusively hold the plan assets for the benefit of the participants and beneficiaries.<sup>153</sup> The Department of Justice (DOJ) argues that because “[t]he statute clearly contemplates the formal execution of a trust instrument and the appointment of trustees,” and that DOJ regulations reflect that fact, it should be afforded deference.<sup>154</sup> The DOL rejects the argument that the plan document can serve as a written trust instrument because trust principles require the trustees, beneficiaries, and trust res to be clearly labeled, and the trustee must be appointed by express and unambiguous terms.<sup>155</sup>

Some courts have rejected the DOL’s position and have held that the trust need not be a separate stand-alone document, but instead could be incorporated in the base plan document.<sup>156</sup> In

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<sup>150</sup> *Id.* at § 1024(b)(4).

<sup>151</sup> 29 C.F.R. § 2550.403a-1(a) (2015) (emphasis added).

<sup>152</sup> See Brief Sec’y of Labor as amicus curiae in support of Appellant at 8-9, *Barboza v. Cal. Ass’n of Prof’l Firefighters*, 651 F.3d 1073 (9<sup>th</sup> Cir. 2011) (Nos. 11-15472, 11-16024, 11-16081, 11-16082).

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.* at 8 (“[T]he statute clearly contemplates the formal execution of a trust instrument and the appointment of trustees, as the Secretary’s regulations reflect.”).

the case of *Barboza v. Cal. Ass'n of Prof'l Firefighters*,<sup>157</sup> the Ninth Circuit rejected the DOL's interpretation and allowed the plan document to be the written instrument establishing the trust relationship, thus naming the defendant as trustee.<sup>158</sup> Relying on trust law, the terms "trust" and "trustee," which are not defined under ERISA, are defined by the legal relationship that exist either expressly or implicitly between a person or an entity who is "bound to deal with property over which he has control for the benefit of certain persons[,] and the beneficiaries have the ability to enforce that obligation."<sup>159</sup> The court expressly rejected the DOL's argument that the "hold-in-trust" requirement mandates the creation of a document that has the "express words of trust."<sup>160</sup> Under the facts of the case, the plan document created the trust relationship and named the trustee, which was sufficient for purposes of ERISA Section 403 and its related regulations.<sup>161</sup> The court concluded that it may be "better practice" to have used "express words of trust, and clearly label the trustees, beneficiaries, and the trust res," but Congress did not mandate such a requirement.<sup>162</sup>

### C. Investment Policy Statements as Plan Documents

The next document that may establish or govern the plan document is the plan's investment policy statement (IPS). The purpose of an IPS is to aid the investment committee of a plan in supervising, monitoring, and evaluating the management of the plan, including its investments.<sup>163</sup> This is certainly important

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<sup>157</sup> 782 F.3d 1072 (9th Cir. 2015).

<sup>158</sup> *Id.* at 1078 (quoting Walter G. Hart, *What is a Trust?*, 15 L.Q. REV. 294, 301 (1899)).

<sup>159</sup> *Id.* at 1079.

<sup>160</sup> *Id.*

<sup>161</sup> *Id.* at 1080.

<sup>162</sup> *Id.* at 1079.

<sup>163</sup> See 1 STUART D. ZIMRING ET AL., *Fundamentals of Special Needs Trusts*, § 7.02[3][D] (Matthew Bender 2016); see, e.g., *Hall v. Nat'l City Bank of Pa.*, 2010 WL 1405443 at \*2 ("The stated purpose of the IPS was 'to assist the Adviser [Chiampou] and Client [plaintiff] in effectively supervising, monitoring and evaluating the

when a plan appoints outside investment managers to invest some or all of the plan assets. The IPS generally provides criteria to select, monitor, evaluate, and compare the performance results of a plan's investment options, using rate-of-return and risk characteristics.<sup>164</sup>

While it is considered "best practice" for a retirement plan to have an IPS,<sup>165</sup> ERISA does not require that a plan adopt an IPS.<sup>166</sup> If a plan adopts an IPS, the DOL applies a rigid view that the IPS then becomes part of the binding plan document that is subject to the fiduciary requirements of ERISA Section 404(a)(1)(D).<sup>167</sup> Under a DOL Interpretative Bulletin, the organization defined a "statement of investment policy [as] a written statement that provides the fiduciaries who are responsible for plan investments with guidelines or general instructions concerning various types or categories of investment management decisions, which may include proxy voting decisions."<sup>168</sup> As a result, a statement of investment policy issued by a named fiduciary to appoint investment managers would be "part of the 'documents and instruments governing the plan' within the meaning of ERISA Sec[ti]on 404(a)(1)(D)."<sup>169</sup>

As noted earlier, the Fourth Circuit in its *Faircloth* decision held that the plan's funding policy and investment policies were

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investment of the Client's assets.'").

<sup>164</sup> See, e.g., *Americans for the Arts v. Ruth Lily Charitable Remainder Annuity Trust #1*, 855 N.E.2d 592, 595 (Ind. Ct. App. 2006) ("National City had formulated a draft Investment Policy Statement for the CRATs, the purpose of which was 'to identify and present the investment objectives, investment guidelines and performance measurement standards' for the CRATs' assets").

<sup>165</sup> See JAMES E. ANDERSON, ROBERT G. BAGNALL & MARIANNE K. SMYTHE, INVESTMENT ADVISERS: LAW & COMPLIANCE § 15.09[3][a] (Matthew Bender, Rev. Ed. 2016).

<sup>166</sup> See *id.*

<sup>167</sup> 29 C.F.R. § 2509.08-2 (2015) ("Statements of investment policy issued by a named fiduciary authorized to appoint investment managers would be part of the 'documents and instruments' governing the plan"). See also Brief for Sec'y of Labor as amicus curiae in Support of Appellant at 26, *Barboza v. Cal. Ass'n. of Prof'l. Firefighters*, 651 F.3d 1073 (9th Cir. 2011) (Nos. 11-15472, 11-16024, 11-16081, 11-16082).

<sup>168</sup> 29 C.F.R. § 2509.08-2 (2015).

<sup>169</sup> *Id.*

subject to disclosure under ERISA Section 104(b)(4) because they set forth the employer's obligations to fund the plan, which was an employee stock ownership plan (ESOP), and explained the responsibilities regarding investment of assets of the ESOP.<sup>170</sup> As such, they were "formal documents under which the ESOP [was] managed."<sup>171</sup>

While the Fifth Circuit recently ruled that an IPS was not an "instrument" for purposes of ERISA Section 104(b)(4) under the facts of that case, it did not rule out that investment guidelines could be such "instruments."<sup>172</sup> The Fifth Circuit agreed with the majority of the circuits in its construction of the catchall provision of ERISA Section 104(b)(4) with its narrow approach. However, the appellants in the case did not specifically plead that the guidelines in question were binding on the plans at issue, nor attached to the complaint portions of the plan; they also did not question if the guidelines had a mandatory effect.<sup>173</sup> The court emphasized that its holding was consistent with the Fourth Circuit's ruling in *Faircloth* regarding the investment policies in that case because "the plan contemplate[d] the establishment of funding and investment policies."<sup>174</sup> The Fifth Circuit also rejected the application of the DOL regulations stating that "[s]tatements of investment policy issued by a named fiduciary authorized to appoint investment managers would be part of the "documents and instruments governing the plan[.]" as those regulations were construing ERISA Section 404(a)(1)(D), and not ERISA Section 104(b)(4).<sup>175</sup> The Fifth Circuit concluded that disclosure under ERISA Section 404(a)(1)(D) is "broader" than ERISA Section 104(b)(4) as it "may not necessarily be limited to formal legal documents."<sup>176</sup>

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<sup>170</sup> *Fairecloth*, 91 F.3d at 656.

<sup>171</sup> *Id.*

<sup>172</sup> See *Murphy v. Verizon Commc'ns*, No. 13-11117, Appeal from U.S. Dis. Ct. for the N. Dis. Tex. (5th Cir. Dec. 3, 2014).

<sup>173</sup> *Id.* at 145.

<sup>174</sup> *Id.* (quoting *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 656 (4th Cir. 1996)).

<sup>175</sup> *Murphy*, No. 13-11117.

<sup>176</sup> *Id.* at 145-46 (referring to BLACK'S LAW DICTIONARY 587 (10th ed. 2014))

Whether an IPS can be a “document” governing the plan for purposes of ERISA Section 404(a)(1)(D) is an open issue, as the circuit courts are not uniform in their treatment of IPSs as plan documents for fiduciary purposes.<sup>177</sup> The Second Circuit in the case of *Dardaganis v. Grace Capital Inc.*<sup>178</sup> affirmed the district court’s finding of a breach of fiduciary duties to the Grace Capital, Inc. (GCI) fund because the registered investment advisor, president, chief executive officer, and principal shareholder of GCI deviated from the written agreement that governed GCI’s actions as the investment manager of the fund’s assets.<sup>179</sup> In the terms of the investment management agreement between the trustees and GCI, the latter “promised to manage the [Fund’s] Account in strict conformity with the investment guidelines promulgated by the Trustees from time to time and with all applicable Federal and State laws and regulations.”<sup>180</sup> The district court held that ERISA Section 404(a)(1)(D) required one to “abide by the plan documents together with the Agreement’s provision that GCI manage the account in strict conformity with the investment guidelines” and resulted in a holding that “[a]ny violation of the terms of [the] [a]greement constitutes a breach of . . . fiduciary duty[.]”<sup>181</sup> On appeal, the Second Circuit rejected the argument, at the summary judgment stage, that there was still a dispute as to whether GCI violated the guidelines set forth in the agreement, as it was apparent that GCI had not complied with the guidelines.<sup>182</sup> The court also rejected the claim that a fiduciary’s failure to abide by the plan documents was not necessarily a breach of duty because that liability required the conduct not to

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(defining “document” as “[s]omething tangible on which words, symbols, or marks are recorded”).

<sup>177</sup> See *infra* notes 178-207 and accompanying discussion.

<sup>178</sup> 889 F.2d 1237 (2d Cir. 1989).

<sup>179</sup> *Id.* at 1240.

<sup>180</sup> *Id.* at 1239 (with four sets of guidelines limiting GCI’s investment discretion).

<sup>181</sup> *Id.*

<sup>182</sup> *Id.* at 1240.

be prudent under the circumstances.<sup>183</sup>

The Ninth Circuit in its *Ca. Ironworkers Field Pension Trust v. Loomis Sayles & Co.*<sup>184</sup> case agreed with the Second Circuit's *Dardaganis* decision in holding that a plan's written statements of investment policy, to the extent the plan is consistent with the provisions of ERISA, could constitute a breach of fiduciary duty.<sup>185</sup> Under the facts of the case, the parties agreed that the trusts in question were ERISA employee benefit plans, and that Loomis' management of the trust funds was governed both by ERISA and the trusts' investment guidelines.<sup>186</sup> However, upon review of the actions of Loomis as an investment manager, the court affirmed the lower court's ruling that Loomis did not violate the actual terms of the written investment guidelines, and would not impose fiduciary liability even if Loomis had failed to comply with the "spirit" of those guidelines.<sup>187</sup>

In the 2007 district court opinion *Alco Industries, Inc. v. Wachovia Corp.*,<sup>188</sup> Alco sponsored two defined benefit pension plans and hired an investment manager, Wachovia, to manage some of the plans' assets.<sup>189</sup> Alco adopted a formal investment policy statement calling for a specific investment strategy.<sup>190</sup> In a suit by Alco against another plan fiduciary for breach of fiduciary duty, the court simply stated that investment strategy statements are "plan documents" for investment managers to follow when exercising their discretion, citing ERISA Section

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<sup>183</sup> *Id.* at 1241-42.

<sup>184</sup> 259 F.3d 1036 (9th Cir. 2001).

<sup>185</sup> *Id.* at 1042 (citing *Dardaganis v. Grace Capital, Inc.*, 889 F.2d 1237, 1241-42 (2d Cir. 1989)).

<sup>186</sup> *Id.* at 1041 (such "guidelines required that [the] investment managers inform the Trustees of significant changes in investment strategy, adhere to the 'prudence' rule, maintain sufficient liquidity to meet current cash needs, and obey the instructions of the Trustees.").

<sup>187</sup> *Id.* at 1043.

<sup>188</sup> 527 F. Supp. 2d 399 (E.D. Penn. 2007).

<sup>189</sup> *Id.* at 403.

<sup>190</sup> *Id.* at 404.

404(a)(1)(D).<sup>191</sup>

In contrast, a Fifth Circuit decision in *Kirschbaum v. Reliant Energy, Inc.*<sup>192</sup> appears to reject the premise that a statement of investment policy constitutes a plan document for ERISA fiduciary purposes.<sup>193</sup> The facts in that case involved an ESOP plan where the funds were to be invested almost exclusively in Reliant Energy, Inc. (REI) common stock.<sup>194</sup> REI, as the named fiduciary to the plan, directed the plan trustee through a statement of investment policy, detailing how the plan's investments would be managed.<sup>195</sup> The case involved a breach of fiduciary claim, as the participants' individual accounts were invested almost entirely in employer common stock while the value of the stock continued to decline.<sup>196</sup> In reference to details about a small, short-term cash component for the fund in the investment policy, the court remarked that the investment policy was "albeit not a constitutive Plan document[.]"<sup>197</sup> Later, the Fifth Circuit had another occasion to discuss the status of IPSs in the context of both ERISA Sections 104(b)(4) and 404(a)(1)(D).<sup>198</sup> As discussed earlier, the court held IPSs were not "instruments" for purposes of disclosure under ERISA Section 104(b)(4), but it failed to resolve whether they were "instruments" under ERISA Section 404(a)(1)(D), as the issue was moot under the facts of that case.<sup>199</sup>

More recently, the Eighth Circuit in *Tussey v. ABB, Inc.*<sup>200</sup> reserved judgment as to whether an IPS is a binding plan

<sup>191</sup> *Id.*

<sup>192</sup> 526 F.3d 243 (5th Cir. 2008).

<sup>193</sup> *Id.* at 252.

<sup>194</sup> *Id.* at 250.

<sup>195</sup> *Id.* at 251-52 (the investment policy outlined the investment objectives of the plan, the funding requirements, the target allocation of long-term assets, monitoring, and performance guidelines).

<sup>196</sup> *Id.* at 247.

<sup>197</sup> *Id.* at 250.

<sup>198</sup> *Murphy v. Verizon Commc'ns*, No. 13-11117, Appeal from U.S. Dis. Ct. for the N. Dis. Tex. at 2 (5th Cir. Dec. 3, 2014).

<sup>199</sup> *Id.* at 11.

<sup>200</sup> 746 F.3d 327 (8th Cir. 2014).

document for purposes of ERISA Section 404(a)(1)(D).<sup>201</sup> The lower court held that ABB breached its fiduciary duty to the plan by failing to monitor recordkeeping costs of the plan's assets and for failing to comply with the plan's IPS, which stated "at all times, [Alliance] rebates will be used to offset or reduce the cost of providing administrative services to plan participants."<sup>202</sup> The employer, AAB, had created an IPS for purposes of selecting, deselecting, and monitoring investments offered under the plan, which required a specific process to follow when deselecting a fund.<sup>203</sup> The district court held that the IPS was a governing plan document for purposes of ERISA Section 404(a)(1)(D), citing the DOL's Interpretive Bulletin Relating to Written Statements of Investment Policy.<sup>204</sup> Because "the IPS specifically require[d] that revenue sharing be used to offset or reduce the cost of providing administrative services to [p]lan participants[.]" ABB failed to comply and thereby did not act prudently in discharging its duties.<sup>205</sup> In vacating the district court's ruling, the Eighth Circuit cautioned that it did not wish to construe all IPSs as binding plan documents so as to discourage their use, but questioned whether the IPS at issue—"informally implemented to provide a framework for administering the Plan itself"—would be a binding plan document.<sup>206</sup> As the district court previously found breaches of the duties of loyalty and prudence independent of the IPS, the Eighth Circuit did not have to answer this question.<sup>207</sup>

Given the uncertainty under existing case law, the best approach from the plan sponsor's and fiduciary's perspective is to frame the IPS as a document that provides flexible guidance

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<sup>201</sup> *Id.* at 344 n. 5.

<sup>202</sup> *Tussey v. ABB, Inc.*, 52 EB Cases 2826 (W.D. Mo. Mar. 31, 2012).

<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

<sup>206</sup> *See Tussey*, 746 F.3d at 334 n.5.

<sup>207</sup> *Id.*



and that permits the fiduciaries to exercise their independent discretion and judgment based on the totality of the circumstances. An IPS that contains numerous specificities and requires rigid adherence to those specificities subjects the plan fiduciaries to potential liability to the terms of the plan document and related instruments.

#### ***D. Summary Plan Descriptions as Plan Documents***

The last document that may constitute a plan document is the Summary Plan Description (SPD). The Supreme Court in *CIGNA Corp. v. Amara*<sup>208</sup> confronted this issue in the context of a conversion from a traditional defined benefit plan to a cash balance plan with conflicting and misleading terms set forth in the plan's SPD.<sup>209</sup> CIGNA had created a separate plan document, as a prior plan had been terminated and a new plan created, as well as a separate SPD, each functioning on its own.<sup>210</sup> The district court held the SPDs and summary of material modifications (SMM) to have violated ERISA Sections 102(a), 104(b), and 204(h), and thus, used the misrepresentations to reform the terms of the new plan so as to authorize reformed benefits under ERISA Section 502(a)(1)(B).<sup>211</sup>

In its amicus brief, the Solicitor General argued that the plan terms as written included the SPD's terms, and thus the terms of these summaries were the terms of the plan.<sup>212</sup> The Supreme Court rejected this approach in interpreting ERISA Section 502(a)(1)(B), as they were “*enforc[ing]*” the ‘terms of the

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<sup>208</sup> 563 U.S. 421 (2011).

<sup>209</sup> *Id.*

<sup>210</sup> *Id.* at 421.

<sup>211</sup> See *Amara v. CIGNA Corp.*, 559 F. Supp. 2d 192 (D.Conn. 2008), *aff'd* 348 Fed. Appx. 627 (2d Cir. 2009) (unpub. opin.), *vacated* 563 U.S. 421 (2011).

<sup>212</sup> See Brief for the Sec'y of Lab. as Amicus Curiae Supporting Respondent-Appellee, *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), available at <https://www.dol.gov/sol/media/briefs/amara%28A%29-9-22-2011.htm> [<https://perma.cc/JL4K-WHXC>].

plan,” not *changing* them as the district court had.<sup>213</sup> The Court stated that it “cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a)(1)(B)) as the terms of the plan itself[,]” even if the lower court had viewed the summaries as plan terms, which the Court said it did not.<sup>214</sup>

In reaching its decision, the Court relied on three principles.<sup>215</sup> First, ERISA Section 102 requires plan administrators to furnish SPDs, which “suggest that the information *about* the plan provided by [the SPD] is not itself *part* of the plan.”<sup>216</sup> Second, if the SPD was regarded as part of the plan, it would then grant authority to the plan administrator to establish plan terms, which is a function that should be limited to the plan sponsor and is similar to a trust’s settlor.<sup>217</sup> The Court went on to say that ERISA distinguishes the roles of plan sponsor and plan administrator, and does not intend to provide the administrator with the power to alter the plan terms “indirectly” by including them in the SPD.<sup>218</sup> Finally, the court held that SPDs are intended to be a “clear, simple communication.”<sup>219</sup> Making them part of the plan document “could well lead plan administrators to sacrifice simplicity and comprehensibility in order to describe plan terms in the language of lawyers.”<sup>220</sup> Such result would lead to complexity and defeat the “fundamental purpose of the summaries.”<sup>221</sup>

The Court concluded by saying that the SPDs were “the summary documents . . . [that] provide communication with beneficiaries *about* the plan, but that their statements do not

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<sup>213</sup> See *CIGNA Corp.*, 563 U.S. at 436-37.

<sup>214</sup> *Id.* at 436.

<sup>215</sup> *Id.*

<sup>216</sup> *Id.*

<sup>217</sup> *Id.*

<sup>218</sup> *CIGNA Corp.*, 563 U.S. at 437 (citing *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 81-85 (1995)).

<sup>219</sup> *Id.*

<sup>220</sup> *Id.* at 437.

<sup>221</sup> *Id.*

themselves constitute the *terms* of the plan[.]”<sup>222</sup> Under the facts of the case, there were two documents—a separate retirement plan document and a separate summary plan description.<sup>223</sup>

*Amara* resolved the issue of whether the terms of the SPD could no longer trump the conflicting terms of the plan document, but left open the question of whether the terms of the SPD can ever constitute the terms of the plan.<sup>224</sup> Post-*Amara*, several circuit and district courts have wrestled with the issue as to whether the terms of the SPD are enforceable.<sup>225</sup> In cases where the governing plan documents explicitly incorporate the SPD or other plan-related documents into the plan, the SPD has been held to be enforceable.<sup>226</sup>

The First Circuit in *Tetreault v. Reliance Standard Life Ins. Co.*,<sup>227</sup> addressed the issue of the long-term disability plan, as the case expressly incorporated the terms of the SPD by reference, thereby including the SPD’s appeals deadline.<sup>228</sup> Thus, the “beneficiary’s failure to meet that deadline” could serve to bar her from challenging an adverse benefit decision.<sup>229</sup> The court did not find the *Amara* case applicable because *Amara* was silent on the issue of whether the terms of the SPD are enforceable under a fact pattern like this case.<sup>230</sup> While the SPD as a stand-alone document could not create rights and duties under the plan, the court held that “*Amara* pose[d] no automatic bar to a” plan incorporating the terms contained in the SPD.<sup>231</sup> The Eighth Circuit reached a similar conclusion in the case of

<sup>222</sup> *Id.* at 438.

<sup>223</sup> See *CIGNA Corp. v. Amara*, 534 F. Supp. 2d 288, 310 (D. Conn. 2008).

<sup>224</sup> See *CIGNA Corp.*, 563 U.S. at 421.

<sup>225</sup> See *infra* notes 227-267 and accompanying discussion.

<sup>226</sup> See *infra* notes 227-234 and accompanying discussion.

<sup>227</sup> 769 F.3d 49 (1st Cir. 2014).

<sup>228</sup> *Id.* at 54.

<sup>229</sup> *Id.* at 57.

<sup>230</sup> *Id.* at 56.

<sup>231</sup> *Id.* (citing *Eugene S. v. Horizon Blue Cross Blue Shield of N.J.*, 663 F.3d 1124, 1131 (10th Cir. 2011)); *Langlois v. Metro Life Ins. Co.*, 833 F. Supp. 2d 1182, 1185-86 (N.D. Cal. 2011); *Henderson v. Hartford Life & Accident Ins. Co.*, No. 2:11-CV-187, 2012 WL 2419961, at \*5 (D. Utah June 26, 2012).

*Johnson v. United of Omaha Life Ins. Co.*,<sup>232</sup> where the insurance policy incorporated the SPD and the Certificate of Insurance as part of the policy.<sup>233</sup> As the SPD contained the necessary language to confer discretionary authority to the plan administrator, discretion was thereby granted.<sup>234</sup>

Other cases go beyond this to enforce the terms of the SPD as long as they do not conflict with the plan.<sup>235</sup> In a case regarding whether the plan had ambiguous language that affected the plan administrator's discretionary authority, the Eighth Circuit reviewed the language of the SPD to clarify the plan's language.<sup>236</sup> As authority, the court cited the DOL regulations that required SPDs to describe "all claims procedures."<sup>237</sup> In an unpublished opinion, the Sixth Circuit held that the SPD can be a document or instrument governing the plan and that the statements are binding, even though its language did not constitute the terms of the plan.<sup>238</sup>

If there is no plan document and the SPD is the sole document, or if the plan serves as both the plan document and

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<sup>232</sup> 775 F.3d 983 (8th Cir. 2014).

<sup>233</sup> *Id.* at 988.

<sup>234</sup> *Id.* *But compare* *Bowers v. Life Ins. Co. of North America*, 21 F. Supp. 3d 993, 1000-01 (D. Minn. 2014) (where the SPD stated it was not a part of the insurance contract and would not "waive or alter" the terms of the policy, its discretion-granting language could not be used where the unambiguous plan did not have such discretionary language) and *Brown v. Life Insurance Co. of North America*, 7 F. Supp. 3d 1125, (D. Nev. 2014) (holding that the SPD's discretionary language did not apply where it was not part of the insurance contract and where it stated that it did not "alter or waive" the terms of the policy).

<sup>235</sup> See *infra* notes 236-238 and accompanying discussion.

<sup>236</sup> See *Prezioso v. Prudential Ins. Co. of America*, 748 F.3d 797, 804 (8th Cir. 2014).

<sup>237</sup> *Id.* (citing 29 C.F.R. § 2560.503-1(b)(2), cross-referencing § 2520.102-3).

<sup>238</sup> *Liss v. Fidelity Emp'r Servs. Co.*, 516 Fed. Appx. 468, 474 (6th Cir. 2013). *E.g.*, *L & W Associates. Welfare Ben. Plan v. Estate of Terance R. Wines*, (E.D. Mich. Jan. 13, 2014) (holding that the SPD is the plan document where no formal plan document exists) and *Board of Trustees v. Moore*, 800 F.3d 214, 219 (6th Cir. 2015) (holding that the SPD is a binding plan document that sets forth the enforceable subrogation terms). *But see* *Oldoerp v. Wells Fargo & Co. Long Term Disability Plan*, 500 Fed. Appx. 575, 576-77 (9th Cir. 2012) (refusing to enforce the grant of discretionary authority to the plan administrator in the SPD because the plan, which consisted of the group policy, the Certificate of Insurance, and amendments to the policy, did not confer such discretion).

the SPD, the courts thus far have enforced the terms of the SPD.<sup>239</sup> In the Tenth Circuit's case of *Eugene v. Horizon Blue Cross Blue Shield of New Jersey*,<sup>240</sup> the plaintiff appealed the lower court's use of the arbitrary and capricious standard of review in a benefits denial claim.<sup>241</sup> The plaintiff argued that under *Amara*, the SPD was simply a summary of the plan and could not itself be part of the plan.<sup>242</sup> The plaintiff made two arguments: (1) the record did not include documents governing the plan, and thus could not verify that the grant of discretion with the SPD was valid; and (2) the grant of discretionary authority solely from the SPD was insufficient.<sup>243</sup> The Tenth Circuit read *Amara* to apply in two different contexts: (1) the terms of the SPD are unenforceable as they conflict with the plan document, or (2) the SPD creates terms that are not authorized or reflected in the governing plan documents.<sup>244</sup> Neither of those situations existed in *Eugene* because the SPD was part of the plan.<sup>245</sup> The SPD stated in its introduction "that it "along with the individual 'Certificate of Coverage . . . form[s] [the] Group Insurance Certificate;' that it 'is made part of the Group Policy;' and that '[a]ll benefits are subject in every way to the entire Group Policy, which includes' the SPD."<sup>246</sup> Because the SPD unequivocally stated that it was part of the plan, the court could review its language to see if it granted discretion to the plan administrator in reviewing benefit claims.<sup>247</sup> Finding that it did, the court affirmed the lower court's ruling.<sup>248</sup>

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<sup>239</sup> See *infra* notes 240-267 and accompanying discussion.

<sup>240</sup> 663 F.3d 1124, 1128-29 (10th Cir. 2011).

<sup>241</sup> *Id.*

<sup>242</sup> *Id.* at 1131.

<sup>243</sup> *Id.*

<sup>244</sup> *Id.*

<sup>245</sup> *Id.*

<sup>246</sup> *Eugene*, 663 F.3d at 1132.

<sup>247</sup> *Id.*

<sup>248</sup> *Id.* at 1133.

Other district and circuit courts have affirmed this result.<sup>249</sup> The Sixth Circuit in *Board of Trustees of the National Elevator Industry Health Benefit Plan v. Moore*<sup>250</sup> upheld the SPD's subrogation provision when the SPD was held to be the binding plan document.<sup>251</sup> The case involved a trust agreement that authorized the trustees to adopt a written welfare benefits plan.<sup>252</sup> Instead of drafting a separate plan document, the trustees approved an SPD, which functioned as both the ERISA plan and the SPD under the terms provided.<sup>253</sup> The court noted two unreported cases in the Third and Eleventh Circuits that were called to review the same SPD at issue in this case and recognized that the SPD functioned as the plan in lieu of a separate plan document.<sup>254</sup>

A district court ruling in *Langlois v. Metropolitan Life Ins. Co.*<sup>255</sup> affirmed the use of the arbitrary and capricious standard of review in a benefits denial claim, even though it was found in the SPD.<sup>256</sup> While the plaintiff argued that language in the SPD was insufficient to grant a finding of discretionary authority because it was not the plan, the court declined to read *Amara* as precluding any reliance on the SPD in determining deference.<sup>257</sup> Instead, the court interpreted *Amara* to permit the enforcement of the terms of the SPD, provided they did not conflict with the terms of the plan.<sup>258</sup> As the defendant's counsel stated, there could be other documents "associated with the Plan," and the

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<sup>249</sup> See *infra* notes 250-267 and accompanying discussion.

<sup>250</sup> 800 F.3d 214, 219 (6th Cir. 2015)

<sup>251</sup> *Id.* at 219.

<sup>252</sup> *Id.*

<sup>253</sup> *Id.* at 220.

<sup>254</sup> *Id.* (citing Bd. of Trustees of the Nat'l Elevator Indus. Health Ben. Plan v. Montanile, 593 Fed. Appx. 154 (3d Cir. 2014), *cert. denied*, 135 S.Ct. 1405 (2015) and Bd. of Trustees of the Nat'l Elevator Inds. Health Ben. Plan v. Montanile, 593 Fed. Appx. 903, 910 (11th Cir. 2014), *cert. granted*, 135 S.Ct. 1700 (2015)).

<sup>255</sup> 833 F. Supp. 2d 1182 (N.D. Cal. 2011).

<sup>256</sup> *Id.* at 1186.

<sup>257</sup> *Id.* at 1185.

<sup>258</sup> *Id.* at 1185-86.

defendant accordingly treated the SPD as the plan.<sup>259</sup> Thus, the court affirmed the grant of discretionary authority to the plan administrator due to the terms of the SPD.<sup>260</sup>

The district court in the case of *L&W Associates Welfare Benefit Plan v. Estate of Terance R. Wines*<sup>261</sup> reached a similar conclusion, stating that “*Amara* does not support the broad proposition . . . that [a summary-document] can never serve as an ERISA plan document.”<sup>262</sup> The district court in *Jenkins v. Grant Thornton LLP*,<sup>263</sup> also affirmed that a Booklet-Certificate was a plan document because there was no separate long-term disability plan.<sup>264</sup> In contrast, the Eighth Circuit in *Silva v. Metropolitan Life Ins. Co.*<sup>265</sup> held that under the facts of its case the plan could not function as both the plan and the SPD because the length and complexity of the language of the plan could not be understood by “the average plan participant.”<sup>266</sup> As such, it did not constitute “clear” and “simple” communication as required under the statute for an SPD.<sup>267</sup>

Summary Plan Descriptions remain important documents for other reasons. The Eighth Circuit in the case of *Silva v. Metropolitan Life Ins. Co.*<sup>268</sup> held that there could be a breach of fiduciary duty claim if the plan administrator failed to distribute the correct SPD by withholding information regarding

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<sup>259</sup> *Id.* at 1186.

<sup>260</sup> *Id.* at 1185-86.

<sup>261</sup> No. 12-CV-13524 (E.D. Mich. Jan. 13, 2014).

<sup>262</sup> *Id.* at \*6.

<sup>263</sup> No. 0:13-CV-60957 (S.D. Fla. Jan. 23, 2015).

<sup>264</sup> *Id.* (citing to an Eleventh Circuit unpublished opinion, *Bd. of Trustees of Nat'l Elevator Indus. Health Ben. Plan v. Montanile*, 593 Fed. Appx. 903, 910 (11th Cir. 2014), *vacated and remanded*, 644 Fed. Appx. 984 (11th Cir. 2016), which stated “*Amara* only precludes courts from enforcing summary plan descriptions, pursuant to § 1132(a)(1), where the terms of that summary *conflict* with the terms specified in other, governing documents. However, the *Amara* Court had no occasion to consider whether the terms of a summary plan description are enforceable where it is the *only* document . . .”).

<sup>265</sup> 762 F.3d 711 (8th Cir. 2014).

<sup>266</sup> *Id.* at 721.

<sup>267</sup> *Id.*

<sup>268</sup> 762 F.3d 711 (8th Cir. 2014).

enrollment in the plan.<sup>269</sup> In summary, the documents that govern a plan may be numerous and the terms of *each* instrument are important in determining how the plan is to be administered, and should themselves contain protective provisions as applicable. The case law also highlights the importance of consistency between the terms of the plan and the terms of the SPD.<sup>270</sup>

For a self-insured welfare plan, the plan sponsor could consider a combination SPD plan document, but he or she should state that the SPD serves as the official plan document. If the welfare plan “wraps” around a vendor’s booklet, for example, by incorporating all of a group insurance policies’ booklets that provide welfare benefits to employees, the wrap plan document should set forth those administrative provisions that rarely change. Additionally, the plan sponsor should incorporate by reference an SPD that is updated on a regular basis and the summary material modifications that have been provided since the last distributed SPD. Plan sponsors will need to engage the vendor in any changes made to the plan document that deviate from a vendor’s booklet.

#### IV. PROTECTIVE PLAN PROVISIONS TO CONSIDER FOR INSERTION

While ERISA Section 402 mandates that certain provisions must be included in a plan document, there are a number of optional provisions that can be inserted in the plan document that are enforced by the courts.<sup>271</sup> The provisions discussed in this Part include grants of discretionary powers to review benefit claims, interpret the terms of the plan, and make factual findings; subrogation and reimbursement provisions; standing

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<sup>269</sup> *Id.* See also *Thomas v. CIGNA Group Ins.*, No. 1:09-CV-05029 (E.D.N.Y. 2015) (stating that posting the SPD on a company’s website without prior notice is not an acceptable method of distribution under the DOL’s regulations as it is similar to placing materials in an area frequented by participants).

<sup>270</sup> See *supra* notes 236-267 and accompanying discussion.

<sup>271</sup> 29 U.S.C. § 1102.



for out-of-network providers; statute of limitations for benefit claims or non-fiduciary claims brought under ERISA Section 502(a)(3); arbitration clauses and class waivers; venue locations for a cause of action under Title I of ERISA; and the settlor rights to amend, terminate, or modify the terms of the plan.<sup>272</sup> As the courts have allowed plan sponsors to craft these provisions in favor of the plan sponsor to reduce the costs of litigation,<sup>273</sup> plan sponsors should consider modifying the terms of the plan to take advantage of this. As demonstrated by the case law, the plan sponsor is advised to craft SPD terms that are consistent with the plan.

### **A. *Judicial Standard of Review***

Courts must tackle the applicable judicial standard of review for a plan administrator's denial of benefits.<sup>274</sup> The Supreme Court resolved the issue back in 1989 with the *Firestone Tire & Rubber Co. v. Bruch*<sup>275</sup> decision. Under the facts of that case, the employer established a self-funded and self-administered severance plan for its employee and conditioned eligibility for benefits upon a reduction in work force or corporate change of control.<sup>276</sup> Upon spinning off one of its divisions, Firestone determined there was no "reduction in work force," and therefore, the affected participants were not entitled to severance benefits.<sup>277</sup> While the district court granted Firestone's motion for summary judgment because the denial of

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<sup>272</sup> See discussion *infra* Sections IV.A.-G.

<sup>273</sup> See Nancy G. Ross & Samuel P. Myler, *Five Provisions to Reduce ERISA Litigation Risk: Plan Sponsors Can Significantly Limit Threats, Cost of Claims by Ensuring Plans Include These*, THOMPSON'S HR COMPLIANCE EXPERT (May 2014), [https://www.mayerbrown.com/files/News/ef176777-7b56-4761-8b79-d54c1872df5a/Presentation/NewsAttachment/8c916fbb-77b5-4d65-a964-ad1102d8d246/MayerBrown\\_PDF\\_0515.pdf](https://www.mayerbrown.com/files/News/ef176777-7b56-4761-8b79-d54c1872df5a/Presentation/NewsAttachment/8c916fbb-77b5-4d65-a964-ad1102d8d246/MayerBrown_PDF_0515.pdf) [<https://perma.cc/54JW-GNPK>].

<sup>274</sup> *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

<sup>275</sup> *Id.*

<sup>276</sup> *Id.* at 105-06 (noting that *Firestone* established and maintained three pension and welfare benefit plans for its employees and was the sole source for funding those plans).

<sup>277</sup> *Id.* at 106.

benefits was not arbitrary or capricious, the Third Circuit reversed because the employer, as plan administrator, was a conflict of interest.<sup>278</sup> Relying on trust law, the Supreme Court reversed and permitted plans to grant discretionary authority to the plan administrator, entitling the plan administrator “to deference in exercising that discretion,” such as the abuse of discretion standard.<sup>279</sup> In the absence of a grant of discretionary authority, the standard of review would be *de novo*.<sup>280</sup>

Under the abuse of discretion standard, the plan administrator’s “interpretation will not be disturbed if reasonable.”<sup>281</sup> Its interpretation is not made “invalid merely because [a court] disagree[s] with it, but only if it is unreasonable.”<sup>282</sup> In its latest decision on the topic, the Supreme Court noted that the judicial standard of review was fashioned to preserve a ““careful balancing” between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.”<sup>283</sup> As a result, allowing the employer to grant interpretative authority over the plan to the plan administrator

- (1) encourages employers to offer ERISA plans by controlling administrative costs and litigation expenses;
- (2) creates administrative efficiency;
- (3) “promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from *de novo* judicial review”; and
- (4) “serves the interest of uniformity, helping to avoid a patchwork of

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<sup>278</sup> See *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144-45 (3d Cir. 1987) (believing that the *de novo* standard was more appropriate when the administrator was conflicted).

<sup>279</sup> See *Firestone*, 489 U.S. at 111.

<sup>280</sup> *Id.* at 112.

<sup>281</sup> *Id.*

<sup>282</sup> See *Hutchins v. Champion Int’l Corp.*, 110 F.3d 1341, 1344 (8th Cir. 1997).

<sup>283</sup> See *Conkright v. Frommert*, 559 U.S. 506, 517 (2010).

different interpretations of a plan.”<sup>284</sup>

The issue has also arisen as to whether the *Firestone* deference goes beyond plan interpretation and applies to findings of fact made by the plan administrator. Although the Fifth Circuit has held that a plan administrator’s fact finding decisions should always be reviewed under the abuse of discretion standard, other circuits have held to the contrary in the absence of plan language.<sup>285</sup>

Due to the highly deferential standard of review,<sup>286</sup> employers of non-insured employee benefit plans should confer discretionary powers to the plan administrator to provide deference to the plan administrator’s factual findings. Accordingly, this standard is “highly prized by benefit plans” and their administrators.<sup>287</sup>

Plan sponsors should consider conferring similar discretionary authority on plan trustees in exercising their powers. Most circuits that have addressed the issue apply the deferential standard to trustees’ decisions where there has been a grant of discretionary authority.<sup>288</sup> The Eighth Circuit more

<sup>284</sup> *Tussey v. ABB, Inc.*, 746 F.3d 327, 334-35 (8th Cir. 2014) (quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004)).

<sup>285</sup> *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1562 (5th Cir. 1993) (holding that the administrator’s decisions as to findings of fact should always be reviewed for an abuse of discretion); *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 395 (5th Cir. 1998). *But compare* *Torres v. Pittston Co.*, 346 F.1324, 1329 (11th Cir. 2003) (declining to follow the Fifth Circuit’s approach); *Riedl v. General Am. Life Ins. Co.*, 248 F.3d 753, 756 (8th Cir. 2001) (holding that absent language in the plan granting discretionary authority to the plan administrator to determine eligibility for benefits or to construe terms of the plan, findings of fact determinations should receive *de novo* review); *Walker v. American Home Shield Long Term Disability Plan*, 180 F.3d 1065, 1068-70 (9th Cir. 1999); *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 249-51 (2d Cir. 1999); *Rowan v. UNUM Life Ins. Co. of Am.*, 119 F.3d 433, 435 (6th Cir. 1997).

<sup>286</sup> *See supra* notes 274-285 and accompanying discussion.

<sup>287</sup> *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 (2002).

<sup>288</sup> *Armstrong v. LaSalle Bank Nat’l Ass’n*, 446 F.3d 728, 733 (7th Cir. 2006) (holding that the standard of judicial review of discretionary judgments is abuse of discretion); *Hunter v. Caliber Sys., Inc.*, 220 F.3d 702, 711 (6th Cir. 2000) (holding that there is “no barrier” in using the deferential standard to a case “not involving a typical review of denial of benefits”); *Moench v. Robertson*, 62 F.3d 553, 565 (3d Cir. 1995) (following trust law for claims under “29 U.S.C. § 1132(a)(2) based on violations of fiduciary duties set forth in section 1104(a)”); *Tussey*, 746 F.3d at 335.

recently found no compelling reason to limit the *Firestone* deference to benefit claims.<sup>289</sup> Similarly, the plan and trust documents should explicitly confer discretionary authority to the trustees in selecting plan asset investments and plan providers, including their related compensation.

### ***B. Subrogation and Reimbursement Provisions***

Healthcare plans usually contain subrogation and reimbursement clauses granting the plan the contractual right to recoup monies paid from the plan.<sup>290</sup> The most common example occurs when a healthcare plan pays for a participant's or beneficiary's medical expenses incurred during an accident, and then the participant or beneficiary sues the third party tortfeasor to recover health care and other expenses incurred in connection with the accident.<sup>291</sup> ERISA neither prohibits nor authorizes subrogation on the part of a healthcare plan,<sup>292</sup> but the Supreme Court has upheld a plan's subrogation rights as determined under the "catch-all" cause of action of ERISA Section 502(a)(3).<sup>293</sup>

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*But compare* John Blair Comm'ns, Inc. Profit Sharing Plan v. Telemundo Grp., Inc. Profit Sharing Plan, 26 F.3d 360, 369 (2d Cir. 1994) (declining to use the deferential standard beyond the "simple denial of benefits"); Bidwell v. Univ. Med. Ctr., Inc., 685 F.3d 613, 616 (6th Cir. 2012) (requiring no deference for claims for breaches of fiduciary duty); Futral v. Chastant, No. 13-30856 at 3, n.1 (5th Cir. 2014) (applying the *de novo* standard of review to a breach of fiduciary duty claim).

<sup>289</sup> *Tussey*, 746 F.3d at 335 (stating "[w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustees of his discretion").

<sup>290</sup> Dana Muir & Norman Stein, *Two Hats, One Head, No Heart: The Anatomy of the ERISA Settlor/fiduciary Distinction*, 93 N.C. L. Rev. 459, 505 (2015) ("Health care plans typically include provisions permitting the plan to recover the cost of health care benefits provided to a participant who is injured in an accident and subsequently receives an award or settlement from the tortfeasor that caused the accident or the tortfeasor's insurance company.").

<sup>291</sup> *Id.*

<sup>292</sup> *Providence Health Plan v. McDowell*, 361 F.3d 1243, 1247-48 (9th Cir. 2004) (finding that health care plan reimbursement and subrogation provisions were enforceable under state law and not barred by ERISA).

<sup>293</sup> *See* *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210-14 (2001) (denying equitable relief as the funds were not in Knudson's possession but in a trust required by state law); *Sereboff v. Mid Atlantic Medical Services, LLC*, 547

A subrogation clause allows the plan to “stand in the shoes of” the participant or beneficiary to pursue a right to recover from the tortfeasor to the extent of the plan’s payments.<sup>294</sup> In contrast, a reimbursement clause, standing alone, offers no such contractual right for the plan to pursue the tortfeasor directly, but instead allows the plan to recover its expenses from the plan participant or beneficiary.<sup>295</sup> Having both provisions in the healthcare plan permits the plan to choose how it wishes to proceed.<sup>296</sup> However, the plan must first pay healthcare benefits to the participant or beneficiary in order to trigger either subrogation or reimbursement.<sup>297</sup> A plan’s or insurer’s ability to enforce reimbursement or subrogation rights may depend on whether the action is governed by federal or state laws. Health plans that are fully insured are subject to both federal and state laws, and some states prohibit the insurer’s right to subrogate or reimburse.<sup>298</sup> ERISA generally preempts state law that would

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U.S. 356, 362-63 (2006) (providing equitable relief as the identifiable funds were in Sereboff’s possession and control); *U.S. Airways, Inc. v. McCutchen*, 133 S.Ct. 1537, 1546 (2013) (denying an equitable lien over funds due to the plan’s reimbursement provisions); *Montanile v. Bd. of Trustees of the Nat’l Elevator Indus. Health Benefit Plan*, 136 S.Ct. 651, 657-58 (2016) (denying an equitable lien over the funds as the defendant dissipated the settlement funds).

<sup>294</sup> Roger M. Baron & Anthony P. Lamb, *The Revictimization of Personal Injury Victims by ERISA Subrogation Claims*, 45 CREIGHTON L. REV. 325, 329 (2012).

<sup>295</sup> *New Orleans Assets, L.L.C. v. Woodward*, 363 F.3d 372, 376 (5th Cir. 2004) (“Even if a provision mentions both subrogation and reimbursement, if that provision gives the insurer the right to assert the actions and rights of the insured against the tortfeasor, then the clause is a subrogation clause. A true reimbursement clause does not allow the insurer to proceed against the tortfeasor.”) (internal citations omitted); see also *Brister v. Blue Cross & Blue Shield*, 562 So.2d 1040, 1045 (La. Ct. App. 1990) (differentiating between a subrogation clause and a reimbursement clause).

<sup>296</sup> See *McIntosh v. Pacific Holding Co.*, 992 F.2d 882, 884 (8th Cir. 1993) (nothing that a reimbursement clause “creates a contractual obligation for reimbursement” and that a subrogation clause “deals with a statutory or common-law right to subrogation.”).

<sup>297</sup> See *Helfrich v. Blue Cross & Blue Shield Ass’n*, 804 F.3d 1090, 1106 (10th Cir. 2015) (“the subrogation and reimbursement requirements in the Plan are tied directly to payments with respect to benefits. They are triggered when a third party injures an enrollee and the Plan pa[ys] benefits for that injury.”) (internal quotations omitted) (internal citations omitted).

<sup>298</sup> See *Med. Mut. Of Ohio v. deSoto*, 245 F.3d 561, 564 (6th Cir. 2001) (finding a California law prohibiting reimbursement of medical expenses was applicable to an ERISA insurer); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 280 (4th

prohibit a self-insured plan's ability to pursue its subrogation rights against the tortfeasor,<sup>299</sup> but the courts are split as to whether ERISA preempts state law claims by the plan against the participant or beneficiary for reimbursement or subrogation.<sup>300</sup>

The DOL regulations require that the SPD set forth the "circumstances which may result in . . . forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits . . . [.]"<sup>301</sup> Hence, the plan's subrogation and reimbursement clauses should be described in the SPD. The district court's decision in *U.S. Airways, Inc. v. McCutchen*<sup>302</sup> is illustrative of the problems that can develop if the plan and the SPD are not consistent.<sup>303</sup> Upon remand from the Supreme Court's decision,<sup>304</sup> the district court was confronted with inconsistent terms between the plan and the SPD.<sup>305</sup> The plan stated that if benefits were paid from the

Cir. 2003) (finding a Maryland law prohibiting subrogation was applicable to an ERISA HMO insurer); *Smith v. Life. Ins. Co. of N. Am.*, 466 F. Supp. 2d 1275, 1290 (N.D. Ga. 2006) (finding a Georgia anti-subrogation law was applicable to an insured ERISA plan).

<sup>299</sup> See, e.g., *United Food & Commercial Workers & Emp'rs Ariz. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (holding that a state anti-subrogation law did not apply to a self-funded plan even though it had catastrophic insurance). But compare *Horrell v. CEC Entm't Inc.*, No. 1:09-CV-951 at 6 (W.D. Mich. Oct. 18, 2011) (holding that Michigan's no-fault law which would have limited the right of the health plan to pursue a no-fault car insurer was saved under ERISA's preemption savings clause).

<sup>300</sup> See *Providence Health Plan v. Skyles*, No. 03:11-CV-06273-HU (D. Or. Apr. 9, 2012) (finding no preemption); *Bachman v. Genesis Invs., Inc. Health & Benefit Plan*, No. 09-1212-HU, (D. Or. Mar. 14, 2011) (finding no preemption). But compare *Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888, 897 (8th Cir. 2012), cert. denied, 133 S.Ct. 1644 (2013) (finding preemption of a state claim against the participant's attorney for conversion of settlement funds).

<sup>301</sup> 29 C.F.R § 2520.102-3(l) (2015).

<sup>302</sup> No. 2:08-CV-1593 (W.D. Penn. Mar. 16, 2016).

<sup>303</sup> *Id.* at 11.

<sup>304</sup> See *U.S. Airways*, 133 S.Ct. at 1551 (rejecting the defenses of unjust enrichment, the common fund doctrine or the make-whole doctrine as they cannot overrule the terms of the plan).

<sup>305</sup> See *U.S. Airways*, No. 2:08-CV-1593 at 2.

plan as a result of an action of a third party, the plan would “be subrogated to all rights of recovery of any [p]articipant under this [p]lan in respect to such action.”<sup>306</sup> The SPD stated

[i]f the [p]lan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the [p]lan will be subrogated to all your rights of recovery. You will be required to reimburse the [p]lan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise.<sup>307</sup>

Under the facts, McCutchen sustained injuries in an automobile accident.<sup>308</sup> The plan paid for the accident-related medical expenses, but McCutchen recouped amounts from the driver and from his auto insurance policy.<sup>309</sup> Pursuant to the terms of the SPD, the plan sought reimbursement of all monies recovered, including from McCutchen’s insurance company, but did not seek reimbursement under the plan document, as it contained no similar reimbursement language.<sup>310</sup> The court declined to use the terms of the SPD and instead relied on the terms of the plan to hold that the plan could not seek reimbursement.<sup>311</sup> Thus, this case is illustrative of the lesson that the terms of the SPD should be the same as the terms of the plan.

The subrogation and reimbursement clauses generally set forth the kind of benefit payments that are subject to recoupment, the type of legal interest created, and the type of funds that are subject to reimbursement.<sup>312</sup> This is attributed to

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<sup>306</sup> *See id.* at 4.

<sup>307</sup> *Id.* at 3.

<sup>308</sup> *Id.*

<sup>309</sup> *Id.*

<sup>310</sup> *Id.* at 5.

<sup>311</sup> *U.S. Airways*, No. 2:08-CV-1593 at 9.

<sup>312</sup> *See, e.g., Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006).

the Supreme Court's jurisprudence on the issue.<sup>313</sup>

The Supreme Court first addressed the issue in the *Great-West Life & Annuity Ins. Co. v. Knudson*.<sup>314</sup> While the Court did not reject the plan's recoupment provision, it denied the plan's claim to impose personal liability on the defendants for the payment of medical benefits, which was a claim for *legal* restitution, instead of pursuing a constructive trust or equitable lien.<sup>315</sup> The Court emphasized that the funds to which the plan claimed entitlement were no longer in Knudson's possession, but instead had been placed in a special needs trust under California law.<sup>316</sup>

The Supreme Court reached a similar conclusion in a recent case, *Montanile v. Bd. of Trustees of the Nat'l Elevator Indus. Health Benefit Plan*,<sup>317</sup> where the plan sought to enforce its reimbursement clause against a plan participant who recouped his medical claims both in an outside settlement and through his insurance.<sup>318</sup> The Court declined to enforce the plan's equitable lien by agreement, as Montanile had dissipated the funds, leaving the plan to recover out of his general assets, which is a legal remedy and not an equitable remedy.<sup>319</sup> The Court held that to pursue a claim under ERISA Section 502(a)(3), two elements must be present: (1) the claim alleged must be equitable in nature, and (2) the remedy sought must be equitable.<sup>320</sup> While the plan alleged to enforce its equitable lien by agreement through the terms of the plan against Montanile, the lien could not attach to separate and identifiable funds, as the plan administrator dissipated the funds in a way that could not be traced.<sup>321</sup> While the plan trustees could have enforced its

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<sup>313</sup> See *infra* notes 314-332 and accompanying discussion.

<sup>314</sup> 534 U.S. 204 (2002).

<sup>315</sup> See *id.* at 213.

<sup>316</sup> *Id.* at 214.

<sup>317</sup> 136 S.Ct. 651, 655 (2016).

<sup>318</sup> *Id.* at 655-56.

<sup>319</sup> *Id.* at 659.

<sup>320</sup> *Id.* at 657-58.

<sup>321</sup> *Id.* at 659.



equitable lien against the settlement funds once they were in the participant's possession, they did not at the time, and thus could not later pursue a claim to recover out of the participant's general assets.<sup>322</sup> The Court acknowledged that more than a decade had passed since the *Great-West* decision, affording time for plans to draft sufficient safeguards to protect their reimbursement rights and to enforce such rights on a timely basis.<sup>323</sup>

In the case of *Sereboff v. MidAtlantic Medical Services*,<sup>324</sup> the plan sued the Sereboffs for recoupment of medical expenses recovered from a third party in a tort action, pursuant to the plan's reimbursement clause.<sup>325</sup> The Court allowed relief under ERISA Section 502(a)(3) and enforced the terms of the plan, as the plan sought "specifically identifiable" funds that the Sereboffs possessed and controlled from the tort settlement.<sup>326</sup> While the plan alleged a breach of contract and requested money, it pursued recovery through a constructive trust or equitable lien on specifically identifiable funds, not from the Sereboff's assets generally.<sup>327</sup>

While the circuits had been split on the issue of whether common law equitable defenses asserted by the defendant, such as the common fund doctrine or make-whole doctrine, could prevail in light of plan language that renounces those defenses, the Supreme Court in *U.S. Airways, Inc. v. McCutchen*<sup>328</sup> settled

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<sup>322</sup> *Id.* at 659-660.

<sup>323</sup> *Montanile*, 136 S.Ct at 662 (the plan provisions required participants and beneficiaries to notify the plan if they began legal process against third parties and gave the plan the right of subrogation without reduction for attorneys' fees, costs, expenses or damages, but here the plan waited half a year to object to the disbursement of funds by Montanile's lawyer to Montanile).

<sup>324</sup> 547 U.S. 356 (2006).

<sup>325</sup> *Id.* at 359 (the plan's reimbursement provision "applies when [a beneficiary is] sick or injured as a result of the act or omission of another person or party,' and requires such person who 'receive[d] benefits' under the plan for such injuries to 'reimburse [Mid Atlantic] for those benefits from '[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise).'" ).

<sup>326</sup> *Id.* at 362-63.

<sup>327</sup> *Id.* at 363.

<sup>328</sup> 133 S.Ct. 1537 (2013).

the issue and allowed the plan language to prevail.<sup>329</sup> Under that decision, the terms of the SPD stated that if the plan paid for benefits for any claim incurred as a result of the negligence, willful misconduct, or other acts of a third party, the participant or beneficiary would be required to reimburse the plan from such recovery from the third party or any “insurance company as [a] result of a judgment, settlement or otherwise.”<sup>330</sup> As such, the agreement did not permit an attorney’s fees exception, such as allowing the common-fund rule, and the court held that the provisions of the agreement controlled and the plan was entitled to “first claim on the entire recovery.”<sup>331</sup> As the action was brought under ERISA Section 502(a)(3) “based on an equitable lien by agreement,” the terms of the plan prevailed and neither principles of unjust enrichment or specific defenses, “such as double-recovery or common-fund rules,” defeated the terms of the plan.<sup>332</sup>

These cases highlight that plan sponsors should have explicit subrogation and reimbursement rights and that a plan should clearly refute any common law equitable defenses that a court could consider in light of ambiguous disclaimer language.<sup>333</sup> Plan sponsors should also require that plan participants and beneficiaries acknowledge the plan’s rights through a reimbursement agreement and require notification to the plan if any legal action has commenced. Working with subrogation vendors, plan sponsors should make sure that potential claims are being tracked so they can act quickly before the participant or beneficiary dissipates the settlement funds.

### ***C. Anti-Assignment Clause***

The ERISA causes of action specifically identify the parties

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<sup>329</sup> *Id.* at 1543.

<sup>330</sup> *Id.*

<sup>331</sup> *Id.* at 1549.

<sup>332</sup> *Id.* at 1541.

<sup>333</sup> *Id.* at 1546-47.

that have standing to bring such cause under Title I—namely, the plan participants, beneficiaries, plan fiduciaries, and the Secretary of Labor.<sup>334</sup>

There is an emerging growth in litigation where out-of-network (OON) providers have alleged that self-funded healthcare plans have systemically underpaid OON providers through the use of networks, as OON providers are typically paid at a lower rate than in-network providers, or not paid at all because the services provided were not covered.<sup>335</sup> In order to allege standing in a cause of action for benefits, on behalf of the participant or beneficiary, or for a breach of fiduciary cause, the OON provider must have the participant or beneficiary assign their rights under the plan such that the provider can “stand in their shoes” and have standing in the cause of action.<sup>336</sup> As ERISA does not include medical providers on the list of individuals who may bring an ERISA claim,<sup>337</sup> the OON provider must argue that the assignment of benefits signed by the

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<sup>334</sup> 29 U.S.C. § 1132(a)(1)-(6).

<sup>335</sup> See *Patient Care Assocs., L.L.C. v. N.J. Carpenters Health Fund*, No. 10-1669 (SRC) (D.N.J. Apr. 16, 2012) (concerning allegedly improper underpayment of benefits under a self-funded welfare benefit plan governed by ERISA because the provider was not part of the plan’s preferred provider network); *Montvale Surgical Ctr., LLC v. Horizon Blue Cross Blue Shield of N.J., Inc.*, No. 12-3685 (SRC) (D.N.J. Feb. 5, 2013) (concerning allegedly improper underpayment of benefits under a self-funded welfare benefit plan governed by ERISA because the involved outpatient ambulatory surgery center was an “out of network” provider); *Crescent City Surgical Ctr. Operating Co., LLC v. Humana Ins. Co.*, No. 16-3314 (E.D. La. June 22, 2016) (concerning the underpayment of an insurance claim by a self-funded health insurance plan to an acute care hospital that was out-of-network).

<sup>336</sup> See *Biohealth Med. Lab., Inc. v. Conn. Gen. Life Ins. Co.*, No. 1:15-CV-23075-KMM (S.D. Fla. 2016)

(I hereby irrevocably assign to [the Laboratories] . . . all benefits under any policy of insurance, indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action, including legal suit, if for any reason my insurance company fails to make payment of benefits due. This assignment also includes all rights to recover attorney’s fees and costs for such action brought by the provider as my assignee.).

<sup>337</sup> 29 U.S.C. § 1132(a).

participant confers standing to sue on the participant's behalf.<sup>338</sup>

ERISA Section 206(d) prohibits assignment of benefits by a participant in the retirement plan context,<sup>339</sup> but does not have a similar rule in the welfare plan context.<sup>340</sup> Thus, in the latter context, whether the participant may assign his or her rights to an OON provider is a matter of plan design.<sup>341</sup> Therefore, plan sponsors have begun inserting anti-assignment clauses to prevent the participant's ability to assign his or her rights under the plan.<sup>342</sup> The courts have consistently held that such anti-assignment provisions in ERISA healthcare plans are enforceable.<sup>343</sup> In *Griffin v. Verizon Communications, Inc.*,<sup>344</sup> Dr. Griffin sued Verizon's health plan for ERISA claims of unpaid benefits, breach of fiduciary duty, and failure to provide plan documents, asserting standing under the participant's

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<sup>338</sup> See, e.g., *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1128 (C.D. Cal. 2015) ("A health care provider may have derivative standing to pursue ERISA benefits if he or she was assigned the right to reimbursement by an ERISA plan beneficiary.").

<sup>339</sup> 29 U.S.C. § 1056(d).

<sup>340</sup> *Id.* at § 1056.

<sup>341</sup> See *Lesser v. Hartford*, No. 05 CIV. 3380 (MHD) at 7 (S.D.N.Y. June 13, 2006) ("welfare benefit plans are typically designed to ensure the ability of plan participants to obtain adequate health care or related benefits . . . [a]ssignment of such benefits . . . is thus fully consistent with [this] goal.").

<sup>342</sup> See *Torpey v. Blue Cross Blue Shield of Texas*, No. 12-CV-7618 (JAP) (D.N.J. Jan. 30, 2014) (where the plan's anti-assignment clause stated that "[r]ights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided").

<sup>343</sup> See *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1294-96 (11th Cir. 2004) (holding that unambiguous anti-assignment provisions in an ERISA governed welfare plan was valid and enforceable); *City of Hope Nat'l Med Ctr. v. Health Plus Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) (holding non-assignment of health care benefits under an ERISA welfare plan as valid "consistent with the other circuits which have addressed this issue"); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1464-65 (10th Cir. 1995) (upholding an anti-assignment provision as that issue is subject "to the agreement of the contracting parties"); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1478 (9th Cir. 1991) (enforcing an anti-assignment clause where the parties' intent was clear); *Washington Hosp. Ctr. Corp. v. Grp. Hospitalization & Med. Servs., Inc.*, 758 F. Supp. 750, 755 (D.D.C. 1991) (upholding anti-assignment clause as it was not contrary to public policy). *But compare* *North Jersey Brain & Spine Center v. Aetna, Inc.*, 801 F.3d 369, 373 (3d Cir. 2015) (granting standing to the provider pursuant to a patient's assignment of benefits).

<sup>344</sup> No. 15-13525 (11th Cir. 2016).

assignment of benefits.<sup>345</sup> While the court noted that ERISA does not prohibit a participant or beneficiary from assigning benefits to the provider, an anti-assignment provision in the plan that limited such assignments was valid and enforceable, thereby denying the healthcare provider standing to pursue an ERISA Section 502(a) cause of action.<sup>346</sup>

Case law has also ruled against OON providers on the grounds that even if they had standing to pursue an ERISA cause of action, they did not exhaust the administrative claims process under ERISA.<sup>347</sup>

These cases highlight that plan sponsors should insert anti-assignment clauses in their ERISA welfare plans to prohibit a medical provider from asserting benefit claims and fiduciary breach claims against the plan. Plan sponsors should also provide similar language in the SPD to alert participants of the plan's anti-assignment provisions. In the *Griffin* case discussed above, Dr. Griffin argued that Verizon could not rely on the anti-assignment provision because it failed to notify her of the plan's provision; Verizon was thus equitably estopped from relying on the provision or having waived it.<sup>348</sup> While the court rejected that argument, explicit language in the SPD should prevent such an argument in the future.<sup>349</sup>

#### ***D. Statute of Limitations Provision***

Recent Supreme Court case law is instructive for drafting

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<sup>345</sup> *Id.* at 3 (where the plan's summary of coverage's anti-assignment provision stated, "You cannot assign your right to receive payment to anyone else, except as required by a 'Qualified Medical Child Support Order' as defined by ERISA or any applicable state or federal law . . . The coverage and any benefits under the plan are not assignable by any covered member without the written consent of the plan . . .").

<sup>346</sup> *Id.* at 4-5.

<sup>347</sup> See *Biohealth Med. Lab. v. Conn.*, No. 1: 15-CV-23075-KMMM at 8 (S.D. Fla. 2016); *Riverview Health Inst. v. United Health Group, Inc.*, No. 15-CV-3604 at 8 (D. Minn. 2015).

<sup>348</sup> See *Griffin*, No. 15-13525 at 10.

<sup>349</sup> *Id.*

statute of limitations provisions within an ERISA plan.<sup>350</sup> A statute of limitations sets forth a period of time for bringing certain types of causes of action.<sup>351</sup> Under ERISA's "Fiduciary Responsibility" section, the law sets forth a statute of limitations only for fiduciary breaches, prohibited transactions, and other provisions under Part Four of Title I of ERISA, including those brought under ERISA Section 502(a)(3).<sup>352</sup> That limitation concludes "six years after [either] the date of the last action [that] constituted a part of the breach or violation, . . . or in the case of an omission[,] the latest date on which the fiduciary could have cured the breach of violation, or . . . three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation[.]" whichever is earlier.<sup>353</sup> A recent Supreme Court decision addressed the statute of limitations in the context of a breach of fiduciary duty claim involving a plan trustee's continued holding of an imprudent investment.<sup>354</sup>

There is no comparable statute of limitations period set forth under Part 5 of Title I relating to enforcement, namely the time period applicable for the filing of a cause of action for benefit claims under ERISA Section 502(a)(1)(B) or non-fiduciary claims brought under ERISA Section 502(a)(3).<sup>355</sup>

Most courts have applied the statute of limitations from analogous state laws in non-fiduciary claims. The Eleventh Circuit borrowed a statute of limitations from the most analogous state law in the context of a plan pursuing reimbursement from a plan participant who had recovered

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<sup>350</sup> See *infra* notes 369-379 and accompanying discussion.

<sup>351</sup> See *Grell v. Laci Le Beau Corp.*, 73 Cal. App. 4th 1300, 1304-05 (1999).

<sup>352</sup> 29 U.S.C. § 1113 (referring to actions with respect to a fiduciary's breach of any responsibility, duty or obligation or with respect to a violation under Part 4 of ERISA).

<sup>353</sup> *Id.* (but cases of fraud or concealment result in a limitation period not later than six years after the discovery of the date of discovery of such breach or violation).

<sup>354</sup> *Tibble v. Edison Int'l*, 135 S.Ct. 1823, 1824 (2015) (reversing the Ninth Circuit's holding that the statute of limitations began with in the trustee's initial selection of the funds as ERISA requires the fiduciary to prudently monitor funds and remove those that become imprudent).

<sup>355</sup> 29 U.S.C. §§ 1131-1151.

monies from a third party tortfeasor for injuries.<sup>356</sup> The Eighth Circuit did the same in a similar ERISA Section 502(a)(3) context.<sup>357</sup> The Third, Sixth, and Tenth Circuits, as well as other lower courts, have used state law statute of limitations for non-fiduciary claims.<sup>358</sup> The courts have also affirmed the use of an alternative period of time under the terms of the plan, provided such period is reasonable.<sup>359</sup>

In non-fiduciary claims, the issue arises as to when the cause of action accrues for statute of limitations purposes. Normally, case law affirmed that a claim for benefit payments would accrue after the claim was submitted and formally denied because the plan requires the claimant to exhaust the claims procedures prior to initiating a lawsuit.<sup>360</sup> The Supreme Court recently addressed this issue in the case of *Heimeshoff v. Hartford Life & Accident Ins. Co.*,<sup>361</sup> which was a unanimous decision upholding the plan's statute of limitations for benefit claims, including its claim accrual date, as long as it was

<sup>356</sup> See *Blue Cross Blue Shield of Ala. v. Sanders*, 138 F.3d 1347, 1356-57 (11th Cir. 1998).

<sup>357</sup> See *Administrative Comm. of Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Soles*, 336 F.3d 780, 781 (8th Cir. 2003).

<sup>358</sup> *Michigan United Food & Commercial Workers Unions v. Muir Co.*, 2 F.2d 594, 598 (6th Cir. 1993) (a cause of action for delinquent employer contributions); *Vernau v. Vic's Mkt.*, 896 F.2d 43, 44-45 (3d Cir. 1990) (same); *Wyo. Laborers Health & Welfare Plan Trs. v. Morgen & Oswood Constr. Co.*, 850 F.2d 613, 615 (10th Cir. 1988) (same); *Campanella v. Mason Tenders Dist. Council Pension Plan*, 299 F. Supp. 2d 274, 277 (S.D. N.Y. 2004) (a cause of action alleging plan violations of the participation and vesting requirements of ERISA); *Gashlin v. Prudential Ins. Co. of Am. Ret. Sys. For U.S. Emps. & Special Agents*, 286 F. Supp. 2d 407, 419 (D.N.J. 2003) (a claim for equitable estoppel under ERISA § 502(a)(3)); *Miele v. Pension Plan of N.Y. State Teamsters*, 72 F. Supp. 2d 88, 93 (E.D.N.Y. 1999) (a cause of action for declaratory and injunctive relief alleging the benefit formula violated the terms of the plan and ERISA); *DeVito v. Pension Plan of Local 819 Teamsters Pension Fund*, 975 F. Supp. 258, 264 (S.D. N.Y. 1997) (a cause of action alleging the Social Security offset to the plan formula violated ERISA), *abrogated on other grounds* by *Dunnigan v. Metropolitan Life Ins. Co.*, 277 F.3d 223, 225 (2d Cir. 2002); *Carollo v. Cement & Concrete Workers Dist. Council Pension Plan*, 964 F. Supp. 677, 688 (E.D.N.Y. 1997) (a cause of action alleging the plan's accrual formula violated ERISA).

<sup>359</sup> See *Harris v. The Epoch Grp., L.C.*, 357 F.3d 822, 826 (8th Cir. 2004) (permitting the plan's use of a three-year statute of limitations or longer period of time under applicable law as valid).

<sup>360</sup> *Amato v. Bernard*, 618 F.2d 559, 566-67 (9th Cir. 1980).

<sup>361</sup> 134 S.Ct. 604, 610 (2013).

reasonable and there was no controlling state statute to the contrary.<sup>362</sup> The disability plan in question required participants to bring suit within three years after “proof of loss” was due to the plan, which was defined as ninety days after the elimination period, the start of the period for which the insurer would owe payment.<sup>363</sup> After being denied her claim, the plaintiff filed suit almost three years after the appeal denial, “but more than three years after ‘proof of loss’ was due.”<sup>364</sup> The district court granted a motion to dismiss, relying on the statute of limitations provided by the closest state statute.<sup>365</sup> Connecticut law permitted the plan to specify a limitations period “as long as that period is not less than one year[.]” even if such period began to run before the claimant could bring legal action; thus, the court held the plan’s three-year limitations period was enforceable and Heimeshoff’s claim was untimely.<sup>366</sup> The Second Circuit affirmed.<sup>367</sup> The Supreme Court “granted *certiorari* to resolve a split among the [circuits] [as to] the enforceability of this common contractual limitations provision.”<sup>368</sup>

The Supreme Court affirmed the Second Circuit.<sup>369</sup> While statute of limitations normally begin to run when the cause of action “accrues” (i.e., when the plaintiff can file suit for a claim for benefits, which in the context of ERISA cases is when the plan issued a final denial), the Court rejected that such a rule should apply in the context of ERISA benefit claims.<sup>370</sup> “Absent a controlling [state] statute to the contrary, a participant and a

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<sup>362</sup> *Id.* at 608.

<sup>363</sup> *Id.*

<sup>364</sup> *Id.* at 609.

<sup>365</sup> Heimeshoff v. Hartford Life & Accident Ins. Co., No. 3:10-CV-1813 (D. Conn. Jan. 16, 2012).

<sup>366</sup> *Id.* at 7.

<sup>367</sup> Heimeshoff v. Hartford Life & Accident Ins. Co., No. 12-651-CV at 5 (2d Cir. 2012).

<sup>368</sup> Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S.Ct. 604, 610 (2013).

<sup>369</sup> *Id.*

<sup>370</sup> *Id.*



plan may [contractually agree] to a particular limitations period, even [if it begins] to run before the cause of action accrues, [provided] the time period is reasonable.”<sup>371</sup> Quoting from its decision in *U.S. Airways, Inc. v. McCutchen*,<sup>372</sup> the Court stated that “[t]he plan, in short, is at the center of ERISA” such that employers may draft the written terms of the plan so as to avoid the complexity of administrative or litigation costs.<sup>373</sup> Hence, the parties may agree to the length of the limitations period, as well as its commencement.<sup>374</sup>

The Court rejected the DOL’s argument in its amicus brief that a limitations period should not begin before the internal review is complete due to the potential of preventing judicial review.<sup>375</sup> It held that its ruling did not undermine ERISA, as the parties both had an interest in participating in the administrative process, and if the parties acted in bad faith or delayed the process to avoid judicial review, the courts would have various means at their disposal, like waiver, estoppel, or tolling, to allow participants to proceed.<sup>376</sup> The Court also rejected the argument that ERISA regulations require tolling of the limitations period during internal review.<sup>377</sup> The only circumstance in which a plan must toll the limitations period is when the plan offers voluntary internal appeals beyond what is required under the regulations.<sup>378</sup> Thus, the Court upheld the limitations period in question, as it was found to be reasonable and not in conflict with a controlling state statute.<sup>379</sup>

Due to the flexibility provided by the Supreme Court, a plan sponsor should consider adopting a reasonable statute of

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<sup>371</sup> *Id.*

<sup>372</sup> 133 S.Ct. 1537 (2013).

<sup>373</sup> *Heimeshoff*, 134 S.Ct. at 611-12 (quoting *U.S. Airways, Inc. v. McCutchen*, 133 S.Ct. 1537, 1548 (2013)).

<sup>374</sup> *See id.*

<sup>375</sup> *Id.* at 613-14.

<sup>376</sup> *Id.* at 615.

<sup>377</sup> *Id.*

<sup>378</sup> *Id.*

<sup>379</sup> *Heimeshoff*, 134 S.Ct. at 612.

limitations within its plan, including when the claim accrues. Having the limitations period begin before the participant's cause of action accrues can be a powerful tool that the plan sponsor may utilize. However, sponsors should consider having the period begin with a specific date rather than the plan's final denial of the claim. As a suggestion, if the statute of limitations period is not generous, it should be disclosed on the claims denial notice that is usually found within the "explanation of benefits" form.

### ***E. Arbitration Clauses and Class Waivers***

ERISA Section 502(e)-(f) vests exclusive jurisdiction for ERISA causes of action in the federal courts.<sup>380</sup> Such exclusive jurisdiction does not preclude the employer sponsor's use of arbitration to resolve claims.<sup>381</sup> The Supreme Court has routinely upheld the enforceability of arbitration clauses, despite the disparities in bargaining power, as such clauses are viewed as a matter of contract.<sup>382</sup> While these cases were not in the context of ERISA plans, the Supreme Court's holding in *Heimeshoff* would support a similar ruling, as it upheld a plan's statute of limitations period as long as it was reasonable and not contrary to controlling state law.<sup>383</sup> Lower courts in the ERISA context have upheld arbitration clauses in ERISA plans that involve benefit claims and statutory claims.<sup>384</sup> They have also

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<sup>380</sup> 29 U.S.C. § 1132(e)-(f) (with two exceptions for causes of action for benefit claims and for QMCSO compliance, in which state courts have concurrent jurisdiction).

<sup>381</sup> See *Jillian Mech. Corp. v. United Serv. Workers Union Local 355*, 882 F. Supp. 2d 358, 363 (E.D.N.Y. 2012) (discussing arbitration as an alternative to litigation in the ERISA context); see also *Coker v. Transworld Airlines Inc.*, 957 F. Supp. 158, 163 (N.D. Ill. 1997) ("ERISA was not intended to preempt the mandatory arbitration provisions of [other statutes].").

<sup>382</sup> *AT&T Mobility LLC v. Concepcion*, 131 S.Ct. 1740, 1756 (2011); *Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220, 226 (1987) (holding that "[t]he duty to enforce arbitration agreements is not diminished when a party bound by an agreement raises a claim founded on statutory rights.").

<sup>383</sup> See *supra* Section IV.D. discussion and accompanying notes.

<sup>384</sup> See *Comer v. Micor*, 436 F.3d 1098, 1101 (9th Cir. 2006) (noting that the parties agreed that ERISA claims were arbitrable); *Arnulfo P. Sulit v. Dean Witter*

upheld the enforceability of an arbitration agreement's prohibition on class arbitration or joinder of claims.<sup>385</sup>

Plan sponsors should consider use of arbitration clauses in a plan document to expedite and reduce claim's litigation costs. However, they may choose to make the plan's arbitration provision discretionary on the part of the plan sponsor to limit judicial review of the arbitrator's ruling. The best practice would be to include mandatory arbitration provisions and prohibitions on class arbitrations or joinder of claims in both the plan document and the terms of the SPD.

### ***F. Venue Provisions***

ERISA Section 502(e)(2) sets forth the applicable rules to determine the proper venue for a cause of action: (1) where the plan is administered; (2) where the breach occurred; or (3) where at least one defendant resides or is found.<sup>386</sup> It is regarded as a liberal venue provision designed to provide easy and ready access to the federal courts.<sup>387</sup> As such, it provides plaintiffs with options that could lead to "forum shopping" depending on the facts of the case and any split of authority with respect to a

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Reynolds, Inc., 847 F.2d 475, 477-78 (8th Cir. 1988) (enforcing an arbitration agreement between a customer and securities broker, hired to manage its pension and profit sharing account, in any dispute arising under ERISA); *Bird v. Shearson Lehman/Am. Express, Inc.*, 926 F.2d 116, 119-20 (2d Cir. 1991), *cert. denied*, 111 S.Ct. 289 (1991) (holding that ERISA was not intended to preclude arbitration of claims); *Kramer v. Smith Barney*, 80 F.3d 1080, 1084 (5th Cir. 1996) (holding the plan's arbitration clause binding with respect to ERISA benefit claims); and *Pritzker v. Merrill Lynch, Pierce, Fenner & Smith*, 7 F.3d 1110, 1119 (3d Cir. 1993) (holding arbitration clauses binding on fiduciary breach claims under ERISA).

<sup>385</sup> See *Jasso v. Money Mart Exp., Inc.*, 879 F. Supp. 2d 1038, 1049 (N.D. Cal. 2012); *Sanders v. Swift Tramp Co. of Ariz., LLC*, 843 F. Supp. 2d 1033, 1037 (N.D. Cal. 2012); *Luchini v. Carmax*, No. CV F 12-0417 LJO DLB at 13 (E.D. Ca. July 23, 2012); *Tenet HealthSystem Phil., Inc. v. Rooney*, No. 12-mc-58 at 5 (E.D. Pa. Aug. 17, 2012); *Hornsby v. Macon County Greyhound Park, Inc.*, No. 3:10-CV-680-MHt at 5 (M.D. Ala. June 13, 2012).

<sup>386</sup> 29 U.S.C. § 1132(e)(2).

<sup>387</sup> *Gulf Life Ins. Co. v. Arnold*, 809 F.2d 1520, 1522 (11th Cir. 1987) (discussing invocation of "ERISA's liberal venue provision [which] was enacted to benefit plan participants/beneficiaries").

given legal issue.<sup>388</sup> An issue was raised as to whether the terms of the plan could dictate the venue that participants and beneficiaries would have to use in any cause of action against the plan.<sup>389</sup> If possible, this could mitigate the plan sponsor's costs of litigation.<sup>390</sup>

The Sixth Circuit in the case of *Smith v. Aegon Cos. Pension Plan*<sup>391</sup> upheld the enforcement of the plan's venue provision, despite the DOL's arguments in its amicus brief to the contrary.<sup>392</sup> In a claim for benefits, the plaintiff filed his cause of action in the U.S. District Court for the Western District of Kentucky.<sup>393</sup> The district court dismissed the complaint, as the plan's venue provision required a participant or beneficiary to bring any action in connection with the plan in the federal district court in Cedar Rapids, Iowa, where the plan was administered.<sup>394</sup> The Sixth Circuit held that the DOL's argument in its amicus brief that such venue selection clauses were "incompatible with ERISA" was not entitled to deference, as it was expressed solely in this amicus brief and another circuit-court amicus brief.<sup>395</sup> As a result, the court found the plan's venue selection clause to be "presumptively valid and

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<sup>388</sup> Kathryn J. Kennedy, *The Perilous and Ever-Changing Procedural Rules of Pursuing an ERISA Claims Case*, 70 UMKC L. REV. 329, 356 (2001) (discussing forum shopping resulting from ERISA section 502) (citing *Wallace v. Am. Petrofina, Inc.*, 659 F. Supp. 829, 832 (E.D. Tex. 1987); *Foster G. McGaw Hosp. of Loyola Univ. of Chicago v. Pension Trust Dist. #9 Welfare Trust I.A. of M.A.W.*, No. 92 C 4361, (N.D. Ill. Oct. 22, 1992); *Doe v. Connors*, 796 F. Supp. 214, 222 (W.D. Va. 1992)).

<sup>389</sup> *Smith v. Aegon Cos. Pension Plan*, 769 F.3d 922, 929 (6th Cir. 2014), *cert. denied*, 136 S.Ct. 791 (2016).

<sup>390</sup> *Smith*, 769 F.3d at 932.

<sup>391</sup> *Id.*

<sup>392</sup> *Id.*

<sup>393</sup> *Id.* at 926.

<sup>394</sup> See *Smith v. Aegon Cos. Pension Plan*, No. 3-120-CV-0697-H at 3 (W.D. Ky. Jan. 28, 2013).

<sup>395</sup> See *Smith*, 769 F.3d at 926-28 (stating that "the Secretary is no more expert than this Court is in determining whether a statute proscribes venue selection") (referencing the DOL's amicus brief in this case, Brief of the Sec'y of Lab. as Amicus Curiae Supporting Plaintiff-Appellant, *Smith v. Aegon Cos. Pension Plan*, 769 F.3d 922 (6th Cir. 2014) (13-5492), and its prior amicus brief, see Brief of the Sec'y of Lab. as Amicus Curiae Supporting Appellant, *Mozingo v. Trend Personnel Services*, 504 Fed. Appx. 753 (10th Cir. 2012)).

enforceable.”<sup>396</sup> The court rejected the argument that its holding imposed an excessive burden on ERISA litigants by forcing them to exotic venues, as the “party may always challenge the reasonableness of a forum selection clause.”<sup>397</sup>

Plan sponsors who opt to incorporate a specific venue selection clause should select a forum that best minimizes litigation over the question.

### ***G. Reservation of Rights Clauses***

ERISA case law distinguishes a plan sponsor’s action as a settlor, as opposed to a fiduciary, for purposes of the fiduciary rules of ERISA Section 404(a)(1).<sup>398</sup> When a plan sponsor acts as a settlor, its actions are not judged under the fiduciary standards and a plan sponsor can thus wear “two hats” with respect to a plan.<sup>399</sup> In acting in its settlor capacity, a plan

<sup>396</sup> *Id.* at 930 (unless the enforcement of that clause would be unreasonable or unjust or the clause was invalid due to fraud or overreaching).

<sup>397</sup> *Id.* at 930 (citing its case in *Wong v. Partygaming Ltd.*, 589 F.3d 821, 828 (6th Cir. 2009), that set forth a three-part test to judge the enforceability of a forum selection clause). The court states that the majority of courts have upheld the validity of venue selection clauses in ERISA plans, citing *Bernikow v. Xerox Corp. Long-Term Disability Income Plan*, CV 06-2612 RGK(SHx), (C.D. Cal. Aug. 29, 2006); *Gipson v. Wells Fargo & Co.*, 563 F. Supp. 2d 149 (D.D.C. 2008); *Klotz v. Xerox Corp.*, 519 F. Supp. 2d 430 (S.D. N.Y. 2007); *Rodriguez v. PepsiCo Long Term Disability Plan*, 716 F. Supp. 2d 855 (N.D. Cal. 2010); *Rogal v. Skilstaf, Inc.*, 446 F. Supp. 2d 334 (E.D. Pa 2006); *Schoemann ex rel. Schoemann v. Excellus Health Plan, Inc.*, 447 F. Supp. 2d 1000 (D. Minn. 2006); *Smith v. Aegon USA, LLC*, 770 F. Supp. 2d 809 (W.D. Va. 2011); *Sneed v. Wellmark Blue Cross & Blue Shield of Iowa*, No. 1:07-CV-292, (E.D. Tenn. Apr. 30, 2008); *Williams v. CIGNA Corp.*, No. 5:10-CV-00155, (W.D. Ky. Dec. 13, 2010), but see *Coleman v. Supervalu, Inc. Short Term Disability Program* 920 F. Supp. 2d 901 (N.D. Ill 2013); *Nicolas v. MCI Health & Welfare Plan* No. 501, 453 F. Supp. 2d 972 (E.D. Tex. 2006).

<sup>398</sup> See, e.g., *Bennett v. Conrail Matched Sav. Plan Admin. Comm.*, 168 F.3d 671, 679 (3d Cir. 1999) (“ERISA permits employers to ‘wear two hats,’” as plan administrator and as plan sponsor).

<sup>399</sup> *Sonoco Prods. Co. v. Physicians Health Plan, Inc.*, 338 F.3d 366, 373 (4th Cir. 2003) (“Accordingly, a plan sponsor is entitled to wear different hats: it may perform some functions as a fiduciary to the plan, while it may perform other functions on its own behalf, i.e., in a non-fiduciary capacity”); *Hunter v. Caliber Sys., Inc.* 220 F.3d 702, 718 (6th Cir. 2000) (“We have recognized that employers who are also plan sponsors wear two hats: one as fiduciary . . . and the other as employer performing settlor functions . . . .”); *Akers v. Palmer*, 71 F.3d 226, 231 (6th Cir. 1995) (“[i]t is therefore perfectly consistent for an employer to wear ‘two hats’ and act both as a

sponsor is wearing its “sponsor hat,” and not acting as a fiduciary even though its actions affect the interests of the participants and beneficiaries.<sup>400</sup> However, when the sponsor wears its “fiduciary hat,” it is subject to the fiduciary standards of ERISA.<sup>401</sup> Thus, it becomes critical to determine the nature of the action taken by the plan sponsor to ascertain whether the action gives rise to fiduciary obligations.

This distinction has been drawn in a trio of Supreme Court cases—*Curtiss-Wright Corp. v. Schoonejongen*,<sup>402</sup> *Lockheed Corp. v. Spink*,<sup>403</sup> and *Hughes Aircraft Co. v. Jacobson*.<sup>404</sup> In these cases, the Court affirmed the right of plan sponsors to terminate retiree welfare benefits,<sup>405</sup> to amend a retirement plan to add early retirement benefits,<sup>406</sup> and to use surplus assets under a defined benefit plan to fund benefits for a recently added group of participants.<sup>407</sup> This may or may not include the sponsor’s decision regarding actual amendments or termination processes.<sup>408</sup> However, the Court in the case of *Varity Corp. v. Howe*<sup>409</sup> held that an employer’s misrepresentations to plan participants about the future of plan benefits was not protected as a settlor action, but instead was a fiduciary action.<sup>410</sup>

The lower courts have applied the Supreme Court settlor rulings in a number of different contexts: where the employer

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fiduciary and as an employer without breaching fiduciary duties.”).

<sup>400</sup> *Bennet*, 168 F.3d at 679.

<sup>401</sup> *Id.*

<sup>402</sup> 514 U.S. 73, 78 (1995).

<sup>403</sup> 517 U.S. 882, 890 (1996).

<sup>404</sup> 525 U.S. 432, 442-43 (1999).

<sup>405</sup> 514 U.S. 73, 78 (1995) (referencing *Adams v. Avondale Industries, Inc.*, 905 F.2d 943, 947 (6th Cir. 1990), which stated “[A] company does not act in a fiduciary capacity when deciding to amend or terminate a welfare benefits plan.”).

<sup>406</sup> 517 U.S. 882, 890 (1996).

<sup>407</sup> 525 U.S. 432, 442 (1999).

<sup>408</sup> See *Amato v. W. Union Int’l, Inc.*, 773 F.2d 1402, 1417 (2d Cir. 1985) (deciding that an employer’s decision to recapture plan assets could be a fiduciary decision). Dana M. Muir, *Changing the Rules of the Game: Pension Plan Terminations and Early Retirement Benefits*, 87 MICH. L. REV. 1034, 1036 (1989).

<sup>409</sup> 516 U.S. 489 (1996).

<sup>410</sup> *Id.* at 503.

amended the plan to eliminate or create benefits for different groups of employees;<sup>411</sup> to set participant contributions or co-pay clauses under a health plan;<sup>412</sup> to amend the plan to provide greater benefits for a limited group of participants;<sup>413</sup> and to amend a pension plan to cause severed employees to be ineligible to receive unreduced early retirement benefits.<sup>414</sup>

Plan sponsors can become fiduciaries when their responsibilities or actions make them a fiduciary. In the Second Circuit's decision in *In re Citigroup ERISA Litig.*,<sup>415</sup> a plan sponsor of an Internal Revenue Code (IRC) Section 401(k) plan was not held to be a fiduciary for purposes of determining whether and how the company stock would be an investment option, because such authority had been delegated to the plan's Investment and Administrative Committee, and there was no evidence that the sponsor retained or exercised such control.<sup>416</sup> However, a district court invalidated a plan sponsor's amendment, eliminating Nabisco stock funds as an investment option under the plan on the grounds that a sponsor failed to follow the terms of the plan.<sup>417</sup>

The lessons learned from previous litigation emphasize that the plan sponsor should make its settlor rights to amend,

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<sup>411</sup> *Campbell v. BankBoston, N.A.*, 327 F.3d 1, 6-8 (1st Cir. 2003); *Anderson v. Consolidated Rail Corp.*, 297 F.3d 242, 252 (3d Cir. 2002).

<sup>412</sup> *Voyk v. Brotherhood of Locomotive Eng'rs*, 198 F.3d 599, 604-06 (6th Cir. 1999). *But see* *Abbot v. Pipefitters Local 522*, 94 F.3d 236, 240 (6th Cir. 1996) (holding that trustees of a multiemployer welfare plan did act as fiduciaries in setting different contribution rates for different unions without amending the plan).

<sup>413</sup> *See* *Bennett v. Conrail Matched Sav. Plan Admin. Comm.*, 168 F.3d 671, 678-79 (3d Cir. 1999) (upholding the employer's amendment to the plan to allocate surplus to a given group of employees); *Fletcher v. Kroger Co.*, 942 F.2d 1137, 1139-40 (7th Cir. 1991) (upholding an employer's decision to provide early retirement benefits to a given group of employees); *Belade v. ITT Corp.*, 909 F.2d 736, 737-38 (2d Cir. 1990) (upholding the exclusion of a given group of participants from early retirement benefits).

<sup>414</sup> *See* *Schultz v. Windstream Commc'ns, Inc.*, 600 F.3d 948, 951-52 (8th Cir. 2010).

<sup>415</sup> 662 F.3d 128 (2d Cir. 2011).

<sup>416</sup> *In re Citigroup ERISA Litig.*, 662 F.3d 128, 135-36 (2d Cir. 2011), *cert. denied sub nom.* *Gray v. Citigroup, Inc.*, 133 S.Ct. 475 (2012).

<sup>417</sup> *Tatum v. R.J. Reynolds Tobacco Co.*, No. 1:02-CV-00373 (M.D.N.C. June 1, 2011).

modify, or terminate the plan explicit, along with the processes associated with making those actions. Plan sponsors should also refrain from using gratuitous recitals in the plan document because an adherence to ERISA's fiduciary standards will avoid unfavorable court outcomes.<sup>418</sup>

## V. CONCLUSION

The case law makes it clear that plan documents contain numerous instruments that govern the plan. Each instrument should have protective provisions within the plan document to better protect the plan sponsor and other fiduciaries. ERISA Section 102(a) requires the SPD to be “written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”<sup>419</sup> This assumes that there are two documents—the plan document and the SPD.<sup>420</sup> This may not be the case in the health and welfare context if a vendor-drafted booklet, rather than an SPD, explains the “terms of the plan.” As noted in the case law discussed above, the courts contemplate that a document can serve as both the ERISA plan document and the SPD, if the terms of the plan so provide.<sup>421</sup>

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<sup>418</sup> See *Boesel v. Chase Manhattan*, 962 F. Supp. 2d 1015, 1032-34 (W.D.N.Y. 1999) (where the court was inclined to favor the defendant's plan interpretation to “all of the plan provisions”).

<sup>419</sup> 29 U.S.C. § 1022(a).

<sup>420</sup> *Tuttle*, 15 F. Supp. 3d at 949 (discussing plan documents as a separate conceptual entity which may be comprised of portions of other documents); *Frazier*, 725 F.3d at 566 (discussing plan documents as separate from plan assets before acknowledging that a single document may qualify as both).

<sup>421</sup> *Liss v. Fidelity Employer Services Co.*, No. 11-2125 at 8 (6th Cir. 2013). See also *L & W Associates Welfare Ben. Plan v. Estate of Terance R. Wines*, No. 12-CV-13524 at 17 (E.D. Mich. Jan. 13, 2014) (holding that the SPD is the plan document where no formal plan document exists) and *Board of Trustees v. Moore*, 800 F.3d 214, 219 (6th Cir. 2015) (holding that the SPD is a binding plan document that sets forth the enforceable subrogation terms).



