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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 18-1539

[Filed July 3, 2019]

MBI Energy Services *Plaintiff - Appellee*	)
v.	)
Robert Hoch *Defendant - Appellant*	)
Charles Kannebecker, as a stakeholder; Law Office of Charles Kannebecker, LLC, as a stakeholder *Defendant*s	)

Appeal from United States District Court
for the District of North Dakota - Bismarck

Submitted: March 12, 2019
Filed: July 3, 2019

Before GRUENDER, BENTON, and GRASZ, Circuit Judges.

GRUENDER, Circuit Judge.

Robert Hoch appeals the district court[1] order granting summary judgment to MBI Energy Services, denying Hoch's motion for partial summary judgment, and dismissing his counterclaims. We affirm.

Hoch was a member and beneficiary of a self-funded employee benefit plan ("the Plan") sponsored and administered by MBI. The Plan provided Hoch $68,210.38 in medical benefits after he was injured in an accident. He also reached a settlement with the tortfeasor responsible for his injury and received compensation from the tortfeasor's insurer. Because Hoch was compensated twice for his injury, MBI brought suit seeking reimbursement of the benefits it paid him under the Plan. MBI eventually reduced its original claim of $68,210.38 by one-third to $45,473.59 to offset the attorneys' fees Hoch incurred in achieving his settlement.

Hoch denied that the Plan authorized reimbursement and also brought a counterclaim alleging that MBI acted improperly by initially seeking reimbursement of the full $68,210.38. The district court granted summary judgment to MBI, and it denied Hoch's motion for partial summary judgment and dismissed his counterclaim. Hoch appealed.

We first consider whether MBI was entitled to summary judgment on its reimbursement claim. We review a district court's grant of summary judgment *de novo* and may affirm on any ground supported by the record. *Moyle v. Anderson*, 571 F.3d 814, 817 (8th Cir.

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[1] The Honorable Daniel L. Hovland, Chief Judge, United States District Court for the District of North Dakota.

2009). Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a).

The Employee Retirement Income Security Act of 1974 ("ERISA") mandates that every employee benefit plan "be established and maintained pursuant to a written instrument" that "provide[s] for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan." 29 U.S.C. § 1102(a)(1). Each plan must also

> (1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of [ERISA],
>
> (2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan . . . ,
>
> (3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and
>
> (4) specify the basis on which payments are made to and from the plan.

Id. § 1102(b). ERISA further requires that participants and beneficiaries be given a "summary plan description." *Id.* § 1022(a). The summary plan description "shall 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." *Id.*

ERISA allows a fiduciary such as MBI to bring an action for equitable relief to enforce the terms of an employee benefit plan. *See id.* § 1132(a)(3). But Hoch argues that the Plan's terms do not authorize MBI to seek reimbursement of the benefits it paid him. We must therefore determine whether the Plan authorizes MBI to seek reimbursement following Hoch's settlement recovery.

As we have observed, "[I]dentifying 'the plan' is not always a clear-cut task." *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Gamboa*, 479 F.3d 538, 542 (8th Cir. 2007). "[O]ften the terms of an ERISA plan must be inferred from a series of documents none clearly labeled as 'the plan.'" *Id.* (alteration in original). Here, there is no written instrument clearly identifying itself as the Plan, but MBI entered an agreement authorizing Blue Cross Blue Shield of North Dakota ("BCBSND") to provide administrative services to the Plan. This Administrative Services Agreement ("ASA") states that the Plan "provides, among other things, various benefits to Members in the Plan, as set forth in the attached Exhibit 'A,'" and that "[r]equests for Plan benefits will be evaluated by [BCBSND] in accordance with the terms and conditions of the Plan, a copy of which is attached as Exhibit 'A.'" Exhibit A is entitled "Summary Plan Description" ("SPD") and includes the information required by § 1102(b), including comprehensive information concerning benefits.

The SPD also includes a provision entitled "Rights of Subrogation, Reimbursement and Assignment," which is the subject of this appeal. This provision requires a Plan member to "reimburse the Claims Administrator on behalf of the Group to the full extent of any benefits paid by the Claims Administrator, not to exceed the amount of the recovery," if the member "makes any recovery from a third party." Hoch maintains that this reimbursement provision is not binding because it is found only in the SPD, which he argues is distinct from and cannot constitute the Plan. *See* 29 U.S.C. § 1022(a) (requiring a summary plan description to "reasonably apprise such participants and beneficiaries of their rights and obligations *under the plan*" (emphasis added)). MBI counters that, despite its label, the terms of the SPD in fact comprise the Plan.

We previously addressed this question in *Gamboa*, which rejected the argument that a summary plan description cannot serve as a plan. In that case, as in this one, a beneficiary received benefits under an ERISA plan and also recovered a settlement with a third party. *Gamboa*, 479 F.3d at 540. The plan sought reimbursement, but the district court found that the reimbursement provision was not an enforceable part of the plan because it was contained only in a summary plan description that was not identified as a formal plan document. *Id.* at 540-41, 543. We reversed the district court's judgment because the summary plan description was the only document providing an identifiable source of plan benefits. *Id.* at 544. We rejected as "nonsensical . . . an interpretation that renders no plan at all under the terms of ERISA" and

concluded that "the label of summary plan description . . . is not dispositive. . . . Where no other source of benefits exists, the summary plan description *is* the formal plan document, regardless of its label." *Id.*

Hoch argues that our holding in *Gamboa* is contrary to the Supreme Court's subsequent decision in *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011). In *Amara*, the district court found that CIGNA Corporation's representations to beneficiaries regarding changes it made to its benefit plan violated ERISA, and the court reformed the plan's terms. *Id.* at 424-25. The Supreme Court held that ERISA did not authorize the district court to provide relief that altered a plan's terms in this manner. *Id.* at 436. The Solicitor General suggested that the altered terms were nonetheless enforceable because they were consistent with terms contained in the summary plan descriptions, and the Supreme Court addressed whether the summary plan descriptions were part of the plan. *Id.* at 437.

The Court concluded that the terms of the summary plan descriptions were not part of the plan. *Id.* It reasoned that summary plan descriptions "provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan." *Id.* at 438. Three factors drove the Court's analysis. First, the language of the statutory text mandating that summary plan descriptions apprise beneficiaries of their rights and obligations "under the plan" indicated that "the information *about* the plan provided by those disclosures is not itself *part of* the plan." *Id.* at 437. Second, ERISA's division of authority between a plan's sponsor (responsible for

creating a plan's terms) and the plan's administrator (responsible for managing the plan and providing the summary plan descriptions) meant that treating a summary plan description as part of the plan would give the administrator the power to set terms that should be set by the sponsor. *Id.* Third, construing summary plan descriptions as legally binding parts of a plan could lead administrators to favor legalese over "clear, simple communication," defeating the purpose of such summaries. *Id.* at 437-38.

While *Amara* undermines parts of *Gamboa*'s reasoning, *see, e.g.*, 479 F.3d at 544 ("[W]e have held that the terms of a summary plan description prevail even if they conflict with the provisions of a formal plan . . . ."), it does not address the question we decided in *Gamboa*: whether, in the absence of any other plan document providing benefits, the summary plan description could constitute the plan. Thus, because *Amara* "rests in important part upon the circumstances present" in that case (namely that there was both a plan document and a summary plan description) that are not present here (where the SPD is the only benefit-providing Plan document), *Gamboa* remains binding law in this circuit. *See Amara*, 563 U.S. at 425. Indeed, several other circuit courts have considered this question and concluded that *Amara* does not prevent a summary plan description from functioning as the plan in the absence of a formal plan document. *Mull for Mull v. Motion Picture Indus. Health Plan*, 865 F.3d 1207, 1209-10 (9th Cir. 2017); *Rhea v. Alan Ritchey, Inc. Welfare Benefit Plan*, 858 F.3d 340, 344-45 (5th Cir. 2017); *Bd. of Trs. v. Moore*, 800 F.3d 214, 219-21 (6th Cir. 2015); *Eugene S. v. Horizon Blue Cross*

Blue Shield of N.J., 663 F.3d 1124, 1131-32 (10th Cir. 2011). Thus, applying *Gamboa*, we hold that the SPD is the Plan's written instrument because it is the only document providing benefits.

Hoch nevertheless contends that a pair of Eighth Circuit decisions decided after *Gamboa* prevents MBI from relying on the SPD's reimbursement provision. *See Jobe v. Med. Life Ins. Co.*, 598 F.3d 478 (8th Cir. 2010); *Ringwald v. Prudential Ins. Co. of Am.*, 609 F.3d 946 (8th Cir. 2010) (applying *Jobe*). In *Jobe*, the summary plan description granted discretionary authority to the plan administrator, but such a grant did not appear in the plan itself. 598 F.3d at 480. Recognizing a conflict between the two documents, we held that a provision appearing in the summary plan description alone was not sufficient to confer such discretionary authority. *Id. at* 483-84. But as *Jobe* recognized, in *Gamboa* there was no such conflict: "The summary plan description was the only plan document providing health benefits." *Id.* at 482. Hoch claims there is a conflict between the ASA and the SPD here and argues that the ASA should control. But the ASA is silent as to reimbursement and expressly incorporates the SPD, noting that it delineates "the terms and conditions of the Plan." Thus, there is no conflict between the two documents. *See Johnson v. United of Omaha Life Ins. Co.*, 775 F.3d 983, 988 (8th Cir. 2014) (concluding there was no conflict between two plan documents because the policy incorporated the summary plan description). As in *Gamboa*, the SPD must be the Plan because it is the only document that can plausibly serve this function.

To be sure, conflating a plan and a summary plan description risks undermining ERISA's goal that the summary plan description embody "clear, simple communication," *Amara*, 563 U.S. at 437, and we do not address whether this SPD meets all the requirements of § 1022. But the equities in this case buttress our conclusion that the reimbursement provision is enforceable. As we stated in *Gamboa*, "Having received medical benefits in accordance with the [summary plan description], we will not permit a participant to deny the corresponding responsibilities and obligations that are clearly imposed on the participant in the same document—what is good for the goose is good for the gander." 479 F.3d at 545. We likewise noted the importance of reimbursement in maintaining the "financial viability" of self-funded plans with limited resources. *Id.* at 545-46. Because the SPD is the Plan's written instrument and Hoch does not dispute that its reimbursement provision requires him to pay MBI if it is an enforceable part of the Plan, we affirm the district court's holding that MBI is entitled to reimbursement.

Hoch also appeals the district court's dismissal of his counterclaim. "We review *de novo* the district court's grant of a motion to dismiss, accepting as true all factual allegations in the complaint and drawing all reasonable inferences in favor of the nonmoving party." *Topchian v. JPMorgan Chase Bank, N.A.*, 760 F.3d 843, 848 (8th Cir. 2014).

On appeal, Hoch appears to argue that by initially asserting a claim for $68,210.38 rather than $45,473.59, MBI unlawfully deprived him of the use of

$22,736.79 and thus owes him interest and other relief. But in his brief in opposition to MBI's motion to dismiss before the district court, Hoch explained only how he was injured by being deprived of the $45,743.59. As we explained above, he was not entitled to this money. And because Hoch did not spell out his alternative theory and give the district court the opportunity to consider his arguments concerning the additional $22,736.79 initially claimed by MBI, we decline to take this issue up here. *See Mau v. Twin City Fire Ins. Co.*, 910 F.3d 388, 391 (8th Cir. 2018).

Finally, Hoch maintains in his reply brief that he is entitled to an array of equitable remedies for various ERISA violations committed by MBI. But he failed to meaningfully raise this issue in his opening brief, and we generally do not consider arguments made for the first time in a reply brief. *See Tension Envelope Corp. v. JBM Envelope Co.*, 876 F.3d 1112, 1120 (8th Cir. 2017).

For all these reasons, the district court's judgment is affirmed.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 18-1539

[Filed July 3, 2019]

MBI Energy Services Plaintiff - Appellee	)
v.	)
Robert Hoch Defendant - Appellant	)
Charles Kannebecker, as a stakeholder; Law Office of Charles Kannebecker, LLC, as a stakeholder Defendants	)

Appeal from U.S. District Court for the District of North Dakota - Bismarck
(1:16-cv-00329-DLH)

JUDGMENT

Before GRUENDER, BENTON and GRASZ, Circuit Judges.

This appeal from the United States District Court was submitted on the record of the district court, briefs of the parties and was argued by counsel.

After consideration, it is hereby ordered and adjudged that the judgment of the district court in this

cause is affirmed in accordance with the opinion of this Court.

July 03, 2019

Order Entered in Accordance with Opinion:
Clerk, U.S. Court of Appeals, Eighth Circuit.

_____

/s/ Michael E. Gans

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NORTH DAKOTA

Case No. 1:16-cv-329

[Filed February 28, 2018]

MBI Energy Services,)
Plaintiff,)
)
vs.)
)
Robert Hoch,)
Defendant.)

ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND MOTION TO DISMISS AND DENYING DEFENDANT'S MOTION FOR PARTIAL SUMMARY JUDGMENT

Before the Court are the parties cross motions for summary judgment, as well as the Plaintiff's motion to dismiss the Defendant's counterclaim. See Docket Nos. 25, 30, and 36. For the reasons set forth below, the Court grants the Plaintiff's motions and denies the Defendant's motion.

I. BACKGROUND

Plaintiff MBI Energy Services ("MBI") is a sponsor and administrator of the Missouri Basin Health Plan ("Plan"). The Plan is a self-funded health benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). Defendant Robert Hoch ("Hoch") was a member and beneficiary of the plan. Hoch sustained injuries in an accident that occurred on December 20, 2012. MBI claims the plan paid $68,210.38 in health benefits related to Hoch's injuries. Hoch settled a tort claim with the individual who allegedly caused the accident for $320,000. See Docket No. 3-2, p. 4.

MBI filed a complaint against Hoch and his attorney, Charles Kannebecker ("Kannebecker"), and the Law Office of Charles Kannebecker, LLC ("Law Office") to recover the medical benefits MBI asserts the Plan paid on Hoch's behalf. MBI's complaint was accompanied by an itemized benefit statement showing the Plan paid a total of $68,210.38. See Docket No. 1-1. MBI asserts the Plan requires members to reimburse the Plan for benefits it pays if a member obtains a recovery from a tortfeasor. The Summary Plan Description ("SPD") contains a provision entitled "Rights of Subrogation, Reimbursement, and Assignment." It states, in part:

> If a member makes any recovery from a third party . . . whether by judgment settlement or otherwise, the Member must notify the Claims Administrator of said recovery and must reimburse the Claims Administrator on behalf of the Group to the full extent of any benefits paid

> by the Claims Administrator, not to exceed the amount of the recovery.

See Docket No. 1-2, p. 74. The Plan's claims administrator is Blue Cross Blue Shield of North Dakota ("BCBSND"). MBI entered into an Administrative Service Agreement ("ASC") with BCBSND that sets forth various provisions regarding claims administration. See Docket No. 28-2, p. 18. The SPD is attached to the ASC as an exhibit. See Docket No. 32-1, p. 33.

MBI, Hoch, and Kannebecker entered into a stipulation agreement on September 26, 2016. MBI agreed to dismiss its claim against Kannebecker and his Law Office without prejudice. In turn, Hoch and Kannebecker agreed to deposit $45,473.59 ("the Disputed Funds") with the Court pending resolution of MBI's claim. See Docket No. 7. Kannebecker deposited the Disputed Funds with the Registry of the Court on September 29, 2016. Hoch then reduced its reimbursement claim by one-third (for a total claim amount of $45,473.59) to account for costs Hoch incurred due to his tort recovery efforts. See Docket No. 25, p. 2.

MBI moved for summary judgment on March 29, 2017. Hoch brought a counter motion for partial summary judgment on April 13, 2017. On the same date, Hoch also brought a counterclaim. MBI moved to dismiss Hoch's counterclaim on April 27, 2017.

II. LEGAL DISCUSSION

MBI's summary judgment motion asserts the SPD's reimbursement language gives the Plan an equitable

lien on Hoch's recovery proceeds. Hoch's counter motion for summary judgment argues the SPD is not a valid plan document and thus MBI has no right to reimbursement. Hoch's counterclaim asserts MBI breached fiduciary duties it owed to himself and other plan members. MBI, as fiduciary for the Plan, asserts it has a right to reimbursement pursuant to the SPD's reimbursement provision. MBI claims the SPD creates an equitable lien on a portion[1] of the proceeds Hoch recovered from the alleged tortfeasor. Hoch contends MBI is not entitled to reimbursement because the SPD is only a summary of the plan, and it conflicts with the ASC, which is the controlling plan document. Hoch also argues there are issues of material fact that preclude a grant of summary judgment in MBI's favor.

A. STANDARD OF REVIEW

Summary judgment is appropriate when the evidence, viewed in a light most favorable to the non-moving party, indicates no genuine issues of material fact exist and the moving party is entitled to judgment as a matter of law. Davison v. City of Minneapolis, 490 F.3d 648, 654 (8th Cir. 2007); see also Fed. R. Civ. P. 56(a). Summary judgment is not appropriate if there are factual disputes that may affect the outcome of the case under the applicable substantive law. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). A genuine issue of material fact is not the "mere

[1] MBI's original claim was for the full amount of benefits the Plan paid. See Docket No. 1. MBI later reduced its claim for costs Hoch incurred while negotiating a settlement with the alleged tortfeasor. See Docket No. 25, p. 2.

existence of some alleged factual dispute between the parties." State Auto Ins. Co. v. Lawrence, 358 F.3d 982, 985 (8th Cir. 2004). Rather, an issue of material fact is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." Anderson, 477 U.S. at 248. The moving party always bears the burden of demonstrating the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986). The non-moving party may not rely merely on allegations or denials; it must set out specific facts showing a genuine issue for trial. Forrest v. Kraft Foods, Inc., 285 F.3d 688, 691 (8th Cir. 2002). The court must view the facts in the light most favorable to the non-moving party. Adickes v. S.H. Kress & Co., 398 U.S. 144, 157 (1970).

B. MBI IS ENTITLED TO REIMBURSEMENT

MBI brings its claim under 29 U.S.C. § 1132(a)(3), which allows a plan fiduciary to bring a civil action to obtain "appropriate" equitable relief to redress violations and enforce provisions of the plan. The United States Supreme Court has held "the enforcement of a lien created by an agreement to convey a particular fund to another party" constitutes appropriate equitable relief under Section 1132(a)(3). Montanile v. Brd. of Tr. of the Nat'l Elevator Indus., 136 S.Ct. 651, 654 (2016).

ERISA requires plans "be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). "Courts often refer to written instruments as 'plan documents.'" Rhea v. Alan Ritchey, Inc. Welfare Benefit Plan, 858 F.3d 340, 344

(5th Cir. 2017). "[E]mployers have large leeway to design disability plans and other welfare plans as they see fit." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 838 (2003). However, ERISA mandates plan documents contain certain features, including specifying "the basis on which payments are made to and from the plan." 29 U.S.C. § 1102(b). ERISA also requires plan administrators provide a summary plan description ("SPD") to plan members. See id. § 1024(b)(1). The SPD must "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." Id. § 1022.

It is often unclear which document or documents constitute the plan. Admin. Comm. of Wal-Mart Stores, Inc. v. Gamboa, 479 F.3d 538, 542 (8th Cir. 2007). "Often the terms of an ERISA plan must be inferred from a series of documents none clearly labeled as 'the plan.'" Id. "A formal plan document is one which a plan participant could read to determine his or her rights or obligations under the plan." United Food & Commercial Workers Union v. Campbell Soup Co., 898 F. Supp. 1118, 1136 (D.N.J. 1995) (citing Curtis-Wright Corp. v. Schoonejongen, 514 U.S. 73, 84 (1995)). "Summary plan descriptions are considered part of ERISA plan documents." Barker v. Ceridian Corp., 122 F.3d 628, 633 (8th Cir. 1997). See also Hughs v. 3M Retiree Med. Plan, 281 F.3d 786, 790 (8th Cir. 2002); Jensen v. SIPCO, Inc., 38 F.3d 945, 949 (8th Cir. 1994). "Where no other source of benefits exists, the summary plan description *is* the formal plan document,

regardless of its label." Gamboa, 479 F.3d at 544 (emphasis in original).

Hoch asserts the SPD is merely a summary of the plan, and thus it is a "legally insufficient document to confer subrogation and repayment rights." See Docket No. 28, p. 11. In *Board of Trustees v. Moore*, the plaintiff similarly argued a subrogation provision was unenforceable because it appeared only in the SPD and not in the trust agreement that established and funded the plan. 800 F.3d 214, 218 (6th Cir. 2015). The trial court found the SPD was the controlling plan document because there was no other provision establishing the rights and obligations of members under the plan. Id. at 220. On appeal, the plaintiff relied—as does Hoch—on the United States Supreme Court's observation in *Cigna Corp. v. Amara*, "that 'summary documents, important as they are, provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan.'" Id. (emphasis in original) (quoting Cigna Corp v. Amara, 563 U.S. 421, 438 (2011)). The Sixth Circuit Court of Appeals upheld the district court's enforcement of the SPD's subrogation provision. It explained that *Amara* does not stand for the proposition that an SPD cannot be a plan document:

> In *Amara*, however, it was clear that one document functioned as the plan itself, that a different document functions as the summary plan description, and that the two documents contained conflicting terms. Nothing in *Amara* prevents a document from functioning both as

> the ERISA plan *and* as an SPD, if the terms of the plan so provide.

Id. (emphasis in original). The Court agrees with the analysis in *Moore*; there is no prohibition on SPDs serving as plan documents. As in *Moore*, the SPD is the only document that sets forth member benefit rights and obligations. Hoch was paid benefits pursuant to the SPD. If the SPD were not a plan document, there would effectively be no plan.

Hoch alternatively asserts that even if the SPD is a plan document, it conflicts with the ASC, which controls. Because the ASC has no reimbursement language, Hoch argues the Plan has no right to reimbursement. The ASC is an agreement between the Plan and its claims administrator, BCBSND. The ASC contains terms concerning the handling of claims. On the other hand, the SPD contains terms regarding member benefits and obligations. Given this scheme, inclusion of language in the ASC regarding a member's reimbursement obligation would be unexpected. See Campbell Soup Co., 898 F. Supp. at 1136 (finding ASC between welfare plan and plan administer was as a contract for services and did not contain provisions regarding member health benefits). The Court concludes that, despite its label, the SPD is a plan document and there is no conflict between it and the ASC. The Plan's reimbursement provision creates an equitable lien on Hoch's recovery, and thus MBI is entitled to the Disputed Funds as a fiduciary of the Plan.

C. THERE ARE NO ISSUES OF MATERIAL FACT

Hoch asserts summary judgment is not appropriate at this stage because there are material issues of fact.[2] Hoch first claims there is a factual dispute regarding the payment of benefits; he "denies that the plan actually paid all the money alleged." See Docket No. 29-1, pgs. 11-12. The moving party bears the initial burden of showing there is no genuine issue of material fact. Celotex Corp., 477 U.S. at 323. MBI supported its motion with (1) an itemized benefit statement showing dates and amounts paid; (2) correspondence between Hoch's attorney and a BCBSND representative discussing the Plan's lien amount; and (3) an email from the tortfeasor's insurer indicating Hoch renegotiated the settlement amount based on an increase in the Plan's lien amount. See Docket Nos. 1, 32, 33, and 36. "[A] nonmoving party may not rest upon mere denials or allegations, but must instead set forth specific facts sufficient to raise a genuine issue for trial." Forrest, 285 F.3d 691. Hoch has not alleged a single fact in support of his assertion that the Plan did not pay him the full amount of benefits MBI claims.

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[2] In his response to MBI's motion for summary judgment, Hoch states, in a footnote, that he "incorporates herein by reference the averments and facts set forth in Defendant's Rule 56(d) Declaration" and he asks the Court to defer ruling on MBI's summary judgment motion until he has had an opportunity for further discovery. See Docket No. 29-1, p. 12. Hoch has not submitted any declaration or other document, as required by the rule, setting forth the basis for why he is entitled to Rule 56(d) relief as to MBI's motion for summary judgment. The Court will not address his informal request.

Hoch simply rests on his one sentence denial without further explanation. Hoch has not raised a factual dispute regarding the amount of benefits the Plan paid.

Second, Hoch contends summary judgment is not appropriate because the benefits the Plan paid were not for treatment related to the fall for which he obtained a recovery. Hoch supports this allegation with one sentence in a declaration by his attorney: "Robert Hoch had already had injury to his shoulder prior to his fall on December 20, 2012." See Docket No. 31-1, p. 1. There are no other details in the record regarding this prior fall, what type of injuries resulted, whether the injuries necessitated medical care, or what amount the Plan paid for his injury. Moreover, Hoch has not met his burden of showing how this fact, even if true, is material under the substantive law of the case. The reimbursement language in the SPD appears to require members to reimburse the Plan for any benefits paid after a recovery, regardless of whether the benefits paid were on account of the specific injury for which the member obtained a recovery:

> If a member makes *any* recovery from a third party . . . the Member must . . . reimburse [the Plan] . . . to the full extent of any benefits paid . . . . This right of reimbursement shall apply to *any* such recovery . . . . *Any* recovery the member may obtain is conclusively presumed to be for the reimbursement of benefits paid . . . .

See Docket No. 1, p. 3 (emphasis added). Hoch has not provided a legal basis for his suggestion that his alleged prior fall relieves him of his reimbursement obligation under the SPD.

Last, Hoch asserts there are factual issues concerning whether "the purported subrogation terms were properly placed into the Plaintiff's documents . . . . In order to be operative, the terms of any SPD agreement or plan must be properly and legally incorporated into the document." See Docket No. 29-1, p. 12. Hoch provides no legal basis for what steps would be required for "proper and legal incorporation," nor does he articulate how MBI may have failed to follow these steps. Regardless, as the Court has explained, the SPD *is* the controlling plan document. The Court concludes there are no genuine issues of material fact, and MBI is entitled to judgment as a matter of law. Further, because the Court concludes MBI is entitled to reimbursement, the Court finds Hoch's counterclaims against MBI necessarily fail.

III. CONCLUSION

The Court has carefully reviewed the entire record, the parties' filings, and the relevant law. For the reasons set forth above, the Court **GRANTS** the Plaintiff's Motion for Summary Judgment (Docket No. 25) and **DENIES** the Defendant's Motion for Partial Summary Judgment (Docket No. 30). The Court also **GRANTS** the Plaintiff's Motion to Dismiss the Counterclaims (Docket No. 36) and **DISMISSES** Hoch's counterclaims against MBI. The Court directs the Clerk of Court to enter judgment in favor of MBI Energy Services in the amount of $45,473.59.

IT IS SO ORDERED

Dated this 28th day of February, 2018.

/s/ Daniel L. Hovland
Daniel L. Hovland, Chief Judge
United States District Court

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA

Case No.: _____

[Filed September 9, 2016]

MBI ENERGY SERVICES, Plaintiff, v. ROBERT HOCH; CHARLES KANNEBECKER, as a stakeholder; LAW OFFICE OF CHARLES KANNEBECKER, LLC, as a stakeholder, Defendants.	)

VERIFIED COMPLAINT

Plaintiff, MBI Energy Services ("MBI"), pleads as follows:

1. This action is to enforce the terms of the Missouri Basin Health Plan ("Plan") and for equitable relief, arising under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001–1461.

PARTIES

2. MBI is the Plan Sponsor and Plan Administrator of the Plan, which is self-funded and covered by ERISA. MBI is therefore a Plan fiduciary entitled to bring this action pursuant to 29 U.S.C. § 1132(a)(3).

3. Defendant, Robert Hoch ("Hoch"), is a citizen and resident of Greentown, Pennsylvania.

4. Upon information and belief, Defendant, Charles Kannebecker, Esq. ("Kannebecker"), is a citizen and resident of Milford, Pennsylvania.

5. Defendant, Law Office of Charles Kannebecker, LLC ("Law Firm"), is a law firm operating in Milford, Pennsylvania.

JURISDICTION AND VENUE

6. This Court has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132, because this action is to enforce provisions of the Plan, arising under ERISA.

7. Jurisdiction is also based on 29 U.S.C. §1132(e)(1), which grants United States District Courts exclusive jurisdiction over all civil actions arising under 29 U.S.C. § 1132(a)(3).

8. Pursuant to 29 U.S.C. §1132(e)(2), venue in this Court is proper because MBI administers the Plan in this District.

9. Pursuant to 29 U.S.C. §1132(e)(2), personal jurisdiction is proper because the Defendants all "reside or may be found" within the United States.

FACTUAL ALLEGATIONS

10. At all times relevant to this action, Hoch was a Member and beneficiary of the Plan.

11. On or about December 20, 2012, Hoch was injured in a personal-injury accident ("Accident").

12. In connection with the injuries suffered by Hoch, the Plan paid medical benefits on his behalf in the amount of $68,210.38. A redacted copy of the Itemization of Benefits is attached hereto as Exhibit 1.

13. The Plan's Summary Plan Description ("SPD") contains a section entitled, "Rights of Subrogation, Reimbursement, and Assignment," which sets forth the Plan's rights of subrogation and reimbursement. That provision states:

> 7.4 **RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT**
>
> If the Claims Administrator on behalf of the Group pays benefits for Covered Services to or for a Member for any injury or condition caused or contributed to by the act or omission of any third party, the Claims Administrator on behalf of the Group shall have certain rights of assignment, subrogation and/or reimbursement as set forth below. The Claims Administrator has full discretionary authority to determine whether to exercise any or all of said rights.

A Member must notify the Claims Administrator of the circumstances of the injury or condition, cooperate with the Claims Administrator in doing whatever is necessary to enable the Claims Administrator to assert these rights, and do nothing to prejudice them. The rights stated herein apply automatically in any applicable situation. The Claims Administrator has no obligation to notify a Member of the Claims Administrator's intent to exercise one or more of these rights and the Claims Administrator's failure to provide such a notice shall not constitute a waiver of these rights.

If a Member does not comply with these provisions or otherwise prejudices the rights of the Claims Administrator on behalf of the Group to assignment, subrogation or reimbursement, the Claims Administrator shall have full discretion to withhold payment of any future benefits to or for the Member and to off set the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition. The Claims Administrator shall have full discretion to interpret these provisions and to determine their application in each and every situation. Any decisions by the Claims Administrator regarding the application of the above provisions shall be final, conclusive and binding upon all parties.

A. Right of Assignment and/or Subrogation: If a Member fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), the Claims Administrator on behalf of the Group has the right to bring said claim as the assignee and/or subrogee of the Member and to recover any benefits paid under this Benefit Plan.

B. Right of Reimbursement: If a Member makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Member must notify the Claims Administrator of said recovery and must reimburse the Claims Administrator on behalf of the Group to the full extent of any benefits paid by the Claims Administrator, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Member has not received full compensation for the injury or condition. Any recovery the Member may obtain is conclusively presumed to be for the reimbursement of benefits paid by the Claims Administrator on behalf of the Group until the Claims Administrator has been fully reimbursed.

The Member agrees to not transfer any right to any recovery to a third party or otherwise attempt to avoid the rights of the Claims

> Administrator on behalf of the Group under this Benefit Plan. The Member agrees that any recovery shall be held in trust for the Claims Administrator on behalf of the Group until the Claims Administrator on behalf of the Group has been fully reimbursed and/or that the Claims Administrator on behalf of the Group shall have a lien on any recovery to the full extent of any benefits paid under this Benefit Plan. The Member agrees that to enforce its rights under this section, the Claims Administrator on behalf of the Group may pursue any and all remedies, legal or equitable, available under state or federal law, Including subrogation, breach of contract, constructive trust, equitable lien, injunction, restitution and any other remedies.
>
> SPD, at 58–59 (emphasis in original). A true and correct copy of the reimbursement provision is attached hereto as Exhibit 2.

14. In or around November of 2015, Hoch settled his claims arising out of the Accident for at least $320,000.

15. MBI, on behalf of the Plan, has asserted the Plan's right of reimbursement as to benefits the Plan paid. Defendants have not reimbursed the Plan, and continue to refuse to reimburse the Plan pursuant to its terms.

16. MBI brings this action to seek enforcement—under ERISA—of the Plan's right of reimbursement in the amount of $68,210.38 ("Disputed Funds").

17. Upon information and belief, Defendants, individually or collectively, have actual or constructive possession of the Disputed Funds.

18. Although the Plan has requested that Kannebecker hold the Disputed Funds in Law Firm's IOLTA trust account pending resolution of the Plan's equitable lien by agreement, Kannebecker has refused to confirm that he will hold the Disputed Funds in trust.

19. Kannebecker may have disbursed the some or all of the Disputed Funds to Hoch.

20. Kannebecker and Law Firm are named as stakeholders because they may currently be in possession of some or all of the Disputed Funds.

21. The disbursement of the Disputed Funds to Defendant Hoch by Kannebecker and Law Firm puts the Disputed Funds at imminent risk of dissipation and being placed beyond the Court's ERISA jurisdiction.

COUNT I

TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

22. MBI hereby re-alleges and incorporates by reference the allegations set forth in Paragraphs 1 through 21 of the Complaint, as through fully restated herein verbatim.

23. Pursuant to Federal Rule of Civil Procedure 65, MBI is entitled to a temporary restraining order, and, upon notice and hearing, a

preliminary injunction against Defendant Hoch, and all those acting in concert or participation with him, from disposing of the settlement proceeds, or whatever portion of those funds has not been dissipated, and requiring them to either preserve the Disputed Funds as is or to pay the remaining Disputed Funds into the Registry of this Court pending a final determination of the parties' rights. If Defendant Hoch is able to dissipate the Disputed Funds, then he may deprive the Court of the ability to impose an equitable remedy under ERISA.

COUNT II

ENFORCEMENT OF THE TERMS OF THE PLAN

24. MBI hereby re-alleges and incorporates by reference the allegations set forth in Paragraphs 1 through 23 of the Complaint, as through fully restated herein verbatim.

25. Pursuant to 29 U.S.C. § 1132(a)(3), MBI seeks equitable relief, including, but not limited to, equitable lien by agreement, equitable lien to enforce ERISA and the terms of the Plan, restitution, and imposition of a constructive trust with respect to the Disputed Funds.

26. Because Hoch is obligated, under the terms of the Plan, to reimburse the Plan for benefits paid, Defendants are in possession of funds which belong in good conscience to the Plan.

27. Defendants have violated the terms of the Plan by refusing to cooperate with the Plan to protect

its rights and refusing to reimburse the Plan to the extent of benefits paid out of the amount that Hoch recovered.

28. Because Defendants' acts and practices violate the Plan terms, this Court should enter an Order enforcing the terms of the Plan and requiring Defendants to reimburse the Plan in the amount of the Disputed Funds, $68,210.38.

PRAYER FOR RELIEF

WHEREFORE, MBI requests that the Court enter an Order granting it a temporary restraining order, and upon notice and hearing, a preliminary injunction, a declaratory judgment, injunction, equitable lien by agreement, constructive trust, and restitution against Defendants, requiring Defendants to turn over to MBI $68,210.38, including appropriate pre-judgment and post-judgment interest, and any other relief to which the Plan is entitled, including any declaratory and injunctive relief necessary to enable it to obtain the relief sought. MBI further requests that the Court award it reasonable attorney's fees and costs pursuant to 29 U.S.C. § 1132(g).

Dated: September 8, 2016.

Respectfully submitted,

/s/ J. Gordon Howard
J. Gordon Howard
Thomas H. Lawrence*
J. Matthew Stephens*
Jodi Bishop Runger*
LAWRENCE & RUSSELL, PLC
5178 Wheelis Drive
Memphis, Tennessee 38117
Phone: (901) 844-4449
Facsimile:(901) 844-4435
E-Mail: gordonh@lawrencerussell.com
toml@lawrencerussell.com
matts@lawrencerussell.com
jodir@lawrencerussell.com

**Application for admission* pro hac vice *to be filed.*

VERIFICATION

I, Sarah Boltz, a competent person of the full age of majority, do hereby make oath as follows:

I am employed as Director of Benefits and Administration at MBI Energy Services. I have personal knowledge of the facts and exhibits set forth in the Verified Complaint, and if called as a witness in this matter, I could and would testify competently thereto under oath. I verify under penalty of perjury that the foregoing is true and correct.

Date: September 7, 2016

By: /s/ Sarah Boltz
Sarah Boltz
Director of Benefits and Administration
MBI Energy Services

EXHIBIT 2 TO
VERIFIED COMPLAINT

Summary Plan Description

MBI
Energy Rentals

CompChoice

Health Care Coverage

This is a grandfathered Benefit Plan under the Patient Protection and Affordable Care Act (PPACA).

BlueCross BlueShield of North Dakota
An independent licensee of the Blue Cross & Blue Shield Association

This health plan is that of your employer. Blue Cross Blue Shield of North Dakota is serving only as the Claims Administrator and does not assume any financial risk except for stop-loss coverage.

Noridian Mutual Insurance Company

MEMBER SERVICES

Questions?

Our Member Services staff is available to answer questions about your coverage –

Call Member Services:

Monday through Friday
7:30 a.m. - 5:00 p.m. CST

(701) 277-2227

or

1-800-342-4718

Office Address and Hours:

You may visit our Home Office during normal business hours –

Monday through Friday
8:00 a.m. - 4:30 p.m. CST

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Mailing Address:

You may write to us at the following address –

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Internet Address:

www.BCBSND.com

District Offices:

We invite you to contact our District Office closest to you –

Fargo District Office
4510 13th Avenue South
(701) 282-1149

Jamestown Office
300 2nd Avenue Northeast
Suite 132
(701) 251-3180

Bismarck District Office
1415 Mapleton Avenue
(701) 223-6348

Dickinson Office
150 West Villard, Suite 2
(701) 225-8092

Grand Forks District Office
American Office Park
2810 19th Avenue South
(701) 795-5340

Devils Lake Office
425 College Drive South, Suite 13
(701) 662-8613

Minot District Office
1308 20th Avenue Southwest
(701) 858-5000

Williston Office
1137 2nd Avenue West, Suite 105
(701) 572-4535

Your employer has established a self-funded employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description is provided to you in accordance with the Employee Retirement Income Security Act of 1974. Every attempt has been made to provide concise and accurate information. This Summary Plan Description and the Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Summary Plan Description and the Service Agreement, the provisions of the Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the self-funded employee welfare benefit plan for an indefinite period of time, the Plan Administrator reserves the right, whether in an individual case or in general, to eliminate the Benefit Plan.

The Claims Administrator shall have full, final and complete discretion to construe and interpret the provisions of the Service Agreement, the Summary Plan Description and related documents, including doubtful or disputed terms and to determine all questions of eligibility; and to conduct any and all reviews of claims denied in whole or in part. The decision of the Claims Administrator shall be final, conclusive and binding upon all parties.

PLAN NAME

Missouri Basin Health Plan

NAME AND ADDRESS OF EMPLOYER (PLAN SPONSOR)

MBI Energy Rentals, Inc.
PO Box 458
Belfield, North Dakota 58622

PLAN SPONSOR'S IRS EMPLOYER IDENTIFICATION NUMBER

90-0762487

PLAN NUMBER ASSIGNED BY THE PLAN SPONSOR

501

TYPE OF WELFARE PLAN

Health

TYPE OF ADMINISTRATION

This is a self-funded employee welfare benefit plan with an individual stop-loss of $100,000 and an aggregate stop-loss of 125%. This plan is funded by MBI Energy Services. The Claims Administrator does not underwrite, insure or assume liability for payment of Covered Services available under the Benefit Plan up to the stop-loss points. The Claims Administrator does not assume any obligation to pay claims except from funds contributed up to the stop-loss points.

NAME AND ADDRESS OF CLAIMS ADMINISTRATOR

Blue Cross Blue Shield of North Dakota (BCBSND)
4510 13th Avenue South
Fargo, North Dakota 58121

PLAN ADMINISTRATOR'S NAME, BUSINESS ADDRESS AND BUSINESS TELEPHONE NUMBER

MBI Energy Services
PO Box 458
12980 35th Street South West
Belfield, North Dakota 58622
701-575-8242

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator:

Tony Hauck
PO Box 458
12980 35th Street South West
Belfield, North Dakota 58622

Claims Administrator:

Daniel E. Schwandt
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Service of legal process may be made upon a Plan trustee or the Plan Administrator.

TITLE OF EMPLOYEES AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION

Human Resources Manager

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business. These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

STATEMENT OF ELIGIBILITY TO RECEIVE BENEFITS

Full-time employees working 40 hours a week are eligible after 30 days probation.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. The Claims Administrator may review this initial determination and has full discretion to determine eligibility for benefits. The Claims Administrator's decision shall be final, conclusive and binding upon all parties.

DESCRIPTION OF BENEFITS

See the Schedule of Benefits and the Covered Services Sections. Refer to the Table of Contents for page numbers.

SOURCES OF PREMIUM CONTRIBUTIONS TO THE PLAN AND THE METHOD BY WHICH THE AMOUNT OF CONTRIBUTION IS CALCULATED

Health premium - 100% of the health premium is paid by the employer.

END OF THE YEAR DATE FOR PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS

December 31

* * *

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RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to administer this coordination of benefits provision and to determine benefits payable under this Benefit Plan and other plans. The Claims Administrator may obtain the facts it needs from or give them to other organizations or persons for the purpose of administering this provision. The Claims Administrator need not tell, or obtain the consent of, any person to do this. Each Member claiming benefits under this Benefit Plan must provide the Claims Administrator with any facts it needs to administer this provision and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Benefit Plan. If it does, the Claims Administrator may pay that amount to the organization that made the payment. The amount will then be treated as though it were a benefit paid under this Benefit Plan. The Claims Administrator will not have to pay that amount again.

RIGHT OF RECOVERY

If payments have been made by the Claims Administrator for Covered Services in excess of the amount payable under this Benefit Plan, the Claims Administrator may recover the excess from any persons to or for whom such payments were made, including any Member, provider or other organization. The

Member agrees to execute and deliver any documentation requested by the Claims Administrator to recover excess payments.

7.2 **AUTOMOBILE NO-FAULT OR MEDICAL PAYMENT BENEFIT COORDINATION**

If a Member is eligible for basic automobile no-fault benefits or other automobile medical payment benefits as the result of accidental bodily injury arising out of the operation, maintenance or use of a motor vehicle, the benefits available under this Benefit Plan will be reduced by and coordinated with the basic automobile no-fault benefits or other automobile medical payment benefits.

7.3 **MEDICAL PAYMENT BENEFIT COORDINATION**

If a Member is eligible for medical payment benefits provided by any other collectible insurance as a result of an injury, the benefits available under this Benefit Plan will be reduced by and coordinated with the medical payment benefits provided by any other collectible insurance not prohibited from coordination of benefits.

7.4 **RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT**

If the Claims Administrator on behalf of the Group pays benefits for Covered Services to or for a Member for any injury or condition caused or contributed to by the act or omission of any third party, the Claims Administrator on behalf of the Group shall have certain rights of assignment, subrogation and/or

reimbursement as set forth below. The Claims Administrator has full discretionary authority to determine whether to exercise any or all of said rights.

A Member must notify the Claims Administrator of the circumstances of the injury or condition, cooperate with the Claims Administrator in doing whatever is necessary to enable the Claims Administrator to assert these rights, and do nothing to prejudice them. The rights stated herein apply automatically in any applicable situation. The Claims Administrator has no obligation to notify a Member of the Claims Administrator's intent to exercise one or more of these rights and the Claims Administrator's failure to provide such a notice shall not constitute a waiver of these rights.

If a Member does not comply with these provisions or otherwise prejudices the rights of the Claims Administrator on behalf of the Group to assignment, subrogation or reimbursement, the Claims Administrator shall have full discretion to withhold payment of any future benefits to or for the Member and to off set the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition. The Claims Administrator shall have full discretion to interpret these provisions and to determine their application in each and every situation. Any decisions by the Claims Administrator regarding the application of the above provisions shall be final, conclusive and binding upon all parties.

A. Right of Assignment and/or Subrogation: If a Member fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), the Claims Administrator on behalf of the Group has the right to bring said claim as the assignee and/or subrogee of the Member and to recover any benefits paid under this Benefit Plan.

B. Right of Reimbursement: If a Member makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Member must notify the Claims Administrator of said recovery and must reimburse the Claims Administrator on behalf of the Group to the full extent of any benefits paid by the Claims Administrator, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Member has not received full compensation for the injury or condition. Any recovery the Member may obtain is conclusively presumed to be for the reimbursement of benefits paid by the Claims Administrator on behalf of the Group until the Claims Administrator has been fully reimbursed.

The Member agrees to not transfer any right to any recovery to a third party or otherwise attempt to avoid the rights of the Claims Administrator on behalf of the Group under this Benefit Plan. The Member agrees that any recovery shall be held in trust for the Claims Administrator on behalf of the Group until the Claims

Administrator on behalf of the Group has been fully reimbursed and/or that the Claims Administrator on behalf of the Group shall have a lien on any recovery to the full extent of any benefits paid under this Benefit Plan. The Member agrees that to enforce its rights under this section, the Claims Administrator on behalf of the Group may pursue any and all remedies, legal or equitable, available under state or federal law, Including subrogation, breach of contract, constructive trust, equitable lien, injunction, restitution and any other remedies.

7.5 **WORKERS' COMPENSATION**

If benefits or compensation are available, in whole or in part, under provisions of a state workers' compensation act, laws of the United States or any state or political subdivision thereof, the benefits under this Benefit Plan will be reduced by and coordinated with such other benefits or compensation available to a Member.

If a Member is injured or suffers any condition caused or contributed to by the Member's employment, the Member must notify the Claims Administrator of the circumstances of the injury and condition, cooperate with the Claims Administrator and the United States or any state or political subdivision thereof in doing whatever is necessary to determine the availability of such benefits or compensation, and do nothing to prejudice them.

In the event of the failure of a Member to comply with this provision or if a Member prejudices that Member's right or entitlement to benefits or compensation available under such a program, the Claims

Administrator shall have full discretion to withhold payment of any future benefits to or for the Member and to off set the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition.

* * *

APPENDIX D

No. 18-1539

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

[Filed May 22, 2018]

MBI ENERGY SERVICES,
Plaintiff-Counterclaim Defendant-Appellee

v.

ROBERT HOCH,
Defendant-Counterclaim Plaintiff-Appellant

Appeal from the United States District Court
for the District of North Dakota
Case No. 1:16-cv-00329-DLH-CSM
Honorable Daniel L. Hovland, Presiding

ANSWERING BRIEF OF APPELLEE
MBI ENERGY SERVICES

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* * *

[p.14]

documents under the de novo standard of review.[53] Hoch also appeals the grant of MBI's Motion to Dismiss Hoch's Counterclaim.

The District Court determined that Hoch's counterclaims failed to state a claim upon which relief could be granted.[54] This Court reviews a Rule 12(b)(6) dismissal of a claim de novo.[55] In resolving the motion to dismiss, the Court is required to accept all well-

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[53] *Johnson*, 775 F.3d at 987; *Shaw*, 566 Fed. App'x at 538.

[54] A288.

[55] *Smithrud v. City of St. Paul*, 746 F.3d 391, 397 (8th Cir. 2014).

pleaded factual allegations as true. However, this tenet is not applicable to labels, legal conclusions, and formulaic recitations of a cause of action. To avoid dismissal, the complaint must state a claim that is "plausible on its face."[56] In evaluating the motion to dismiss, pursuant to Rule 12(b)(6), the court should evaluate the complaint in its entirety, as well as documents and "materials that are necessarily embraced by the pleadings."[57]

ARGUMENT AND AUTHORITIES

I. A summary plan description can serve as an employee welfare benefit plan's governing document.

In his Opening Brief, Hoch asks this Court to split from all other circuit courts of appeals—and its own prior precedent—and hold that a summary plan description can never serve as an employee welfare benefit plan's governing document. If this Court were to adopt Hoch's argument, it would not only create a circuit split, but it would also undermine the design of the majority of employer health plans and put thousands—if not millions—of ERISA participants' benefits at risk.[58] These ERISA participants would be

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[56] *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)(quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)).

[57] *Smithrud*, 746 F.3d at 397

[58] *Montanile*, 593 F. App'x at 910 (citing *Gamboa*, 479 F.3d at 544 ("it would be nonsensical to conclude that the plain language of the Plan requires an interpretation that renders no plan at all under the terms of ERISA.")); *Berumen*, 2016 U.S. Dist. LEXIS 146814

left without a Plan document to rely on in support of their claims for benefits under 29 U.S.C. § 1132(a)(1), and their benefit plans would cease to exist.[59]

Welfare benefit plans must be established and maintained pursuant to a written instrument. Under ERISA, a plan's written instrument must: (1) state the method of funding, (2) allocate responsibility for administration and operation of the Plan, (3) provide a procedure to amend the plan, and (4) specify how benefits are paid from the plan.[60]

The Supreme Court has long held that employers and plan sponsors "are given large leeway to design [employee welfare benefit plans] as they see fit."[61] Employers and plan sponsors are generally free to adopt, modify, or terminate

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*6 (quoting 3 ERISA Practice and Litigation § 12:38 (stating that health plans frequently take a consolidated approach to drafting plan documents)).

[59] *Id*.

[60] 29 U.S.C. § 1102(b); *Rhea*, 858 F.3d at 343.

[61] 29 U.S.C. § 1102(a)(1); *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 933 (2015) (citing *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003) and *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995)).

[p.18]

BCBSND will evaluate benefit claims in accordance with the rights and obligations set forth in the SPD.[73] Consequently, Hoch's attempts to undermine the SPD fail.

1. The SPD.

As noted above, an ERISA plan document must set forth the method of funding, allocate responsibility for administration and operation of the Plan, provide a procedure to amend the plan, and specify how benefits are paid from the plan.[74] The SPD should be enforced because it is indisputably a written document and clearly meets all of these criteria.

First, the SPD states how benefits are funded and describes how premium contributions are collected and calculated.[75] Second, the SPD allocates responsibility for the operation and administration of the Plan. It describes the roles of the Plan Administrator, Claims Administrator, and identifies agents for service of

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[73] A161 (the Plan provides benefits as set forth in the SPD); A165 at ¶ III.P ("Plan benefits will be evaluated by [BCBSND] in accordance with the terms and conditions of the Plan, a copy of which is attached as Exhibit 'A'[the SPD]."); A179 at ¶ XIII.H. (the Summary Plan Description, attached as Exhibit "A", is the controlling Plan document.).

[74] 29 U.S.C. § 1102(b).

[75] A022, A192 (the Plan is a self-funded by MBI and has an individual stop-loss of $100,000.00); A024, A194 (health premiums are paid by the employer).

process.[76] Third, the SPD provides information regarding how the Plan can be amended and identifies who is authorized to amend the Plan.[77] Finally, and most importantly, the SPD provides exhaustive details about the benefits and obligations of Plan participants including information about deductibles, coinsurance, out-of-pocket maximums, waiting periods, in-network versus out-of-network providers, accessing the Blue Card Network, services that are covered by the Plan, services that are excluded by the Plan, how benefits are coordinated with other plans, the claims and appeal process, and also provides the Plan's right of reimbursement and subrogation.[78]

The SPD is *the document* that describes how benefits are paid by the Plan, thus, it is the operative Plan document.[79]

2. The ASC.

The ASC is a contract between MBI and BCBSND that authorizes BCBSND to provide third-party administrative services on behalf of the Plan.[80] The terms of the ASC demonstrate that the ASC cannot be a standalone ERISA plan document, but that the Plan

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[76] A022–A024, A030; A192–A194, A200.

[77] A076, A246.

[78] A022–A024, A26–29; A032–A102; A192–A194; A196–A197; A202–A272.

[79] *Gamboa*, 479 F.3d at 544.

[80] A148 at ¶ 5; *see also* A161.

terms are found in another document, the SPD—identified as Exhibit "A" to the ASC.[81] Moreover, the ASC identifies itself as an

* * *

[81] A161 (the Plan provides benefits as set forth in the SPD); A165 at ¶ III.P ("Plan benefits will be evaluated by [BCBSND] in accordance with the terms and conditions of the Plan, a copy of which is attached as Exhibit 'A'[the SPD].");