APPENDIX

APPENDIX

TABLE OF CONTENTS

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

No. 23-5022
(D.C. No. 4:22-CV-00044-GKF-JFJ)
(N.D. Okla.)

[Filed December 20, 2023]

ROLAND HUFF, Plaintiff - Appellant,	)
v.	)
BP CORPORATION NORTH AMERICA, INC., Defendant - Appellee,	)
and	)
METROPOLITAN LIFE INSURANCE COMPANY, Defendant.	)

ORDER AND JUDGMENT*

* After examining the briefs and appellate record, this panel has determined unanimously to honor the parties' request for a decision on the briefs without oral argument. *See* Fed. R. App. P. 34(f); 10th Cir. R. 34.1(G). The case is therefore submitted

Before **PHILLIPS**, **McHUGH**, and **EID**, Circuit Judges.

Roland Huff appeals the dismissal of his claims related to his term life insurance policy brought under state law and under the Employee Retirement Income Security Act of 1974 (ERISA) against his former employer, BP Corporation North America, Inc. (BP). Exercising jurisdiction under 28 U.S.C. § 1291, we affirm.

BACKGROUND

Mr. Huff worked for BP until he retired in 1998. While employed with BP, he enrolled in the BP Group Universal Life Plan, which provides group universal term life insurance benefits to current and former BP employees. According to the summary plan description, Metropolitan Life Insurance Company (MetLife) served as the Plan claims administrator. Upon his retirement, Mr. Huff elected to maintain coverage under the Plan and pay the premiums directly to MetLife. He alleged that, until 2012, his monthly premiums were approximately $200 but that, by 2021, when he had reached the age of 78, his monthly premiums had risen to more than $1,900.

Mr. Huff sued MetLife in the Northern District of Oklahoma in *Huff v. Metropolitan Life Insurance*

---

without oral argument. This order and judgment is not binding precedent, except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

Company, No. 21-CV-284-CVE (*Huff I*), alleging state law causes of action including breach of contract and breach of the implied duty of good faith and fair dealing. His complaint against MetLife also sought an "Order to Produce Documentation." Supp. App. vol. 3 at 25. He alleged his "expert actuary need[ed] to review [the documentation] in order to determine whether MetLife's huge premium increases [were] justified." *Id.* at 15, ¶ 44. On motion by MetLife under Fed. R. Civ. P. 12(b)(6), the district court dismissed *Huff I*, concluding that ERISA preempted Mr. Huff's state law claims and that he did not state a claim under ERISA. The court stated it would "allow [Mr. Huff] to file an amended complaint if he wishe[d] to allege a claim under ERISA[] and name the correct defendant as to [his] employee benefit plan." Supp. App. vol. 3 at 213. But Mr. Huff did not file an amended complaint in *Huff I*, so the district court dismissed the case without prejudice under Fed. R. Civ. P. 41(b). Mr. Huff did not appeal the dismissal.

Instead, he brought a new complaint, in Oklahoma state court, against BP (*Huff II*). This complaint alleged similar causes of action under state law as the ones he brought against MetLife. BP removed the case to federal court and moved to dismiss under Fed. R. Civ. P. 12(b)(6) based on ERISA preemption. The district court granted the motion. Mr. Huff then filed an amended complaint including claims under ERISA. The amended complaint sought "answers to questions and documentation" regarding his premium increases and alleged that "[w]hen obtained, the information and documentation will be handed over for review and analysis by an expert life insurance actuary to

determine whether the increases were justified, reasonable and fair . . . .” Aplt. App. vol. 1 at 60. The amended complaint also named MetLife as a defendant, but Mr. Huff did not serve MetLife with a summons. Instead, he alleged “a summons . . . will not be issued to MetLife unless and until sufficient information showing MetLife’s responsibility for wrongdoing against Plaintiff is discovered as this action proceeds against BP.” *Id.* n.1.

BP moved to dismiss under Fed. R. Civ. P. 12(b)(6) once again, arguing the amended complaint failed to state a claim for relief under ERISA. The district court granted the motion. Mr. Huff twice moved for reconsideration, which the district court denied. He never served MetLife with a summons.[1] This appeal followed.

---

[1] Mr. Huff’s failure to serve MetLife with a summons does not affect the finality of the district court’s dismissal for purposes of our jurisdiction under § 1291. “In evaluating finality . . . we look to the *substance* and *objective intent* of the district court’s order, not just its terminology.” *Moya v. Schollenbarger*, 465 F.3d 444, 449 (10th Cir. 2006). The district court’s order of dismissal and subsequent judgment lack any indication of intent to permit a separate claim to go forward against MetLife. Indeed, Mr. Huff pleaded he would need to discover “sufficient information showing MetLife’s responsibility for wrongdoing against [him]” before he would serve MetLife. Aplt. App vol. 1 at 60 n.1. Because the district court dismissed the action before discovery, Mr. Huff obviously did not obtain such “sufficient information,” *id*. So, we have no trouble concluding the substance and objective intent of the district court’s order was to enter final judgment completely disposing of all of Mr. Huff’s claims.

DISCUSSION

"We review de novo a district court's decision on a Rule 12(b)(6) motion for dismissal for failure to state a claim. Under this standard, we must accept all the well-pleaded allegations of the complaint as true and must construe them in the light most favorable to the plaintiff." *Waller v. City & Cnty. of Denver*, 932 F.3d 1277, 1282 (10th Cir. 2019) (italics, citation, and internal quotation marks omitted). "[A] complaint must contain sufficient factual matter . . . to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (internal quotation marks omitted). To meet this standard, the plaintiff must "plead[] factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* "The plausibility standard . . . asks for more than a sheer possibility that a defendant has acted unlawfully. Where a complaint pleads facts that are merely consistent with a defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief." *Id.* (citation and internal quotation marks omitted).

Mr. Huff argues the district court erred in concluding ERISA preempted his state law claims. But the express preemption language in ERISA, 29 U.S.C. § 1144(a), which provides that it "supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," is "conspicuous for its breadth," utilizing "deliberately expansive language [that] was designed to establish pension plan regulation as exclusively a federal concern." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990)

(internal quotation marks omitted). This preemption provision reaches state common law claims "if the factual basis of the cause of action involves an employee benefit plan." *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991).

Seeking to avoid this conclusion, Mr. Huff cites *Rutledge v. Pharmaceutical Care Management Association*, 141 S. Ct. 474, 481–82 (2020), for the proposition that "state law actions that are merely about money and affect costs are not preempted by ERISA." Aplt. Opening Br. at 15. But *Rutledge* does not set forth nearly so broad an exception to ERISA preemption. *Rutledge* concerned a state statute regulating cost lists by pharmacy benefit managers. *See* 141 S. Ct. at 478. Mr. Huff's claims challenge the increase in premiums under his company-furnished term life insurance plan. Their factual basis therefore clearly "involves an employee benefit plan," *Settles*, 927 F.2d at 509, so ERISA preempts his claims.

Mr. Huff alternatively asserts he converted his life insurance policy under the Plan from a company-sponsored employee benefit plan to an individual one between him and MetLife when he left BP's employment. This argument is flawed in three respects. First, the terms of the Plan expressly provided that an employee "cannot convert . . . coverage to individual coverage." Supp. App. vol 1 at 73. Second, ERISA reaches employee benefit plans "*established or* maintained" by employers. 29 U.S.C. § 1002(1) (emphasis added); *see also Peckham v. Gem State Mut. of Utah*, 964 F.2d 1043, 1049 (10th Cir. 1992) ("The 'established or maintained' requirement seeks to

ascertain whether the plan is part of an employment relationship by looking at the degree of participation by the employer in the *establishment or* maintenance of the plan." (emphasis added)); *id.* at 1049 (concluding ERISA plan existed where employer "purchased basic insurance . . . for its employees, and listed insurance in its company manual as an employment benefit."). So, even if BP no longer "maintains" the Plan, it still established it. And the Plan at issue—funded by group policy number 32900-G issued by MetLife to group number 95520—has not changed since Mr. Huff enrolled in it. Third, assuming without deciding that the only parties to the Plan at the time of this suit were Mr. Huff and MetLife, the district court did not err in dismissing the claims against BP.

Mr. Huff also argues the Plan falls under ERISA's regulatory "safe harbor exemption." *See* 29 C.F.R. § 2510.3-1(j). But the safe harbor exemption requires, inter alia, that "no contributions are made by an employer or employee organization." *Id.* § 2510.3-1(j)(1). This court has previously rejected attempts like Mr. Huff's "to sever . . . optional . . . coverage from the rest of the benefits [an employee] received through [an] employer's plan." *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 463 (10th Cir. 1997). We therefore affirm the district court's conclusion that ERISA preempted Mr. Huff's state law claims.

Mr. Huff also challenges the district court's conclusion that his amended complaint did not state a claim under ERISA. But we agree with the district court that the amended complaint violated Fed. R. Civ. P. 8's requirement that plaintiffs "state their claims

intelligibly so as to inform the defendants of the legal claims being asserted." *Mann v. Boatright*, 477 F.3d 1140, 1148 (10th Cir. 2007). Mr. Huff's amended complaint was "thirty-five (35) pages in length and attache[d] thirteen separate exhibits, totaling forty-eight (48) pages. In both its length and form, the document [was] difficult to interpret." Aplt. App. vol. 2 at 216. It was also "rife with legal exposition, both as to what the law is and [Mr. Huff's] counsel's opinions on what the law should be" including "questions regarding the numerous exhibits attached to [Mr. Huff's] Amended Complaint and discussions of what those exhibits may or may not show." *Id.* at 217. "For this reason alone," the district court concluded the amended complaint was subject to dismissal. *Id.* The district court further concluded the amended complaint did not state a claim for misrepresentation, breach of fiduciary duty, or equitable estoppel under ERISA because it did not allege any material misrepresentation by BP with respect to Mr. Huff's premiums under the Plan.

Mr. Huff does not defend the intelligibility of the amended complaint in his opening brief. This alone constitutes sufficient grounds to affirm the dismissal. *See Rivero v. Bd. of Regents of Univ. of N.M.*, 950 F.3d 754, 763 (10th Cir. 2020) ("If the district court states multiple alternative grounds for its ruling and the appellant does not challenge all those grounds in the opening brief, then we may affirm the ruling."). And, to the extent Mr. Huff seeks to challenge the rate increases under the Plan, his admission that he needs an expert actuary to review certain information "to determine whether the huge premium increases are justified," Aplt. App. vol. 1 at 14, ¶ 44, establishes

that—as pled—the allegations in the amended complaint "are merely consistent with [BP's] liability" and therefore "stop[] short of the line between possibility and plausibility of entitlement to relief." *Iqbal*, 556 U.S. at 678 (internal quotation marks omitted).

Finally, Mr. Huff argues the district court unfairly left him without a remedy through its dual conclusions that (1) ERISA preempted his state law claims and (2) he failed to plausibly state claims under ERISA in his amended complaint. But this argument has no bearing on the preemption analysis because even if ERISA provides fewer remedies than would otherwise be available under state law, its preemption provision "evidences Congress's policy choices and intent to provide only the remedies it specified, and this court is not in a position to second-guess Congress simply because the facts of a particular case might be sympathetic." *Coldesina v. Estate of Simper*, 407 F.3d 1126, 1139 (10th Cir. 2005) (citation omitted). The argument also has no bearing on the dismissal of his amended complaint because the burden to plead an intelligible claim in compliance with Fed. R. Civ. P. 8 was his, *see In re ZAGG Inc.*, 826 F.3d 1222, 1231 (10th Cir. 2016), and he failed to meet it.[2]

---

[2] Because we affirm the district court on the grounds given in its dismissal orders, we need not and do not consider BP's alternative argument that res judicata from *Huff I* barred the instant action. And because we conclude the district court did not err in dismissing Mr. Huff's complaint and amended complaint, we likewise discern no error in its denial of his two motions for reconsideration.

CONCLUSION

We affirm the judgment of the district court.

Entered for the Court

Carolyn B. McHugh
Circuit Judge

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

Case No. 22-CV-00044-GKF-JFJ

[Filed February 27, 2023]

ROLAND HUFF,
Plaintiff,

v.

BP CORPORATION NORTH AMERICA, INC. and/or METROPOLITAN LIFE INSURANCE COMPANY,
Defendant(s).

ORDER

This matter comes before the court on the Motion to Dismiss Amended Complaint [Doc. 23] of defendant BP Corporation North America, Inc. For the reasons set forth below, the motion is granted.

Background/Procedural History

This matter has a lengthy procedural history, which the court the court has now twice summarized. *See* [Doc. 15; Doc. 36]. Relevant to this motion, on December 14, 2021, plaintiff Roland Huff filed a

Complaint in the District Court in and for Tulsa County against BP. [Doc. 2, pp. 7-19]. The Complaint included two state-law claims: breach of implied service contract and breach of the implied duty of good faith and fair dealing. [*Id.* at pp. 16-17]. On January 24, 2022, BP removed the case to this court and, on January 31, 2022, filed a motion to dismiss [Doc. 9].

In an Order dated May 26, 2022, this court granted BP's motion to dismiss. [Doc. 15]. Specifically, the court concluded that the BP Corporation North America Inc. Life and Accident Plan, group life insurance policy number 32900-G, is a qualifying "employee benefit plan" subject to ERISA. [*Id.* at p. 10]. Thus, Mr. Huff's state-law breach of contract and bad faith claim were pre-empted. [*Id.* at pp. 10-11]. The court further concluded that Mr. Huff failed to state a plausible ERISA claim as the pleading included no allegations from which the court could reasonably infer that Mr. Huff was seeking to recover benefits or to clarify his right to future benefits. [*Id.* at pp. 12-13]. Though the court granted BP's motion to dismiss, it granted Mr. Huff leave to file an Amended Complaint to allege a claim under ERISA. [*Id.* at p. 13].

On June 16, 2022, Mr. Huff filed the First Amended Complaint (Based on ERISA). [Doc. 19]. The Amended Complaint purports to assert claims under 29 U.S.C. §§ 1132(c), 1132(a)(1)(B), 1132(a)(3). [*Id.* at p. 30]. Mr. Huff generally alleges that BP has failed to provide information and documents he requested and breached its fiduciary duties by overcharging Mr. Huff for premiums. [*Id.*].

On July 7, 2022, BP filed the Motion to Dismiss the Amended Complaint. [Doc. 23]. Mr. Huff responded in opposition, [Doc. 28; Doc. 29], and BP filed a reply [Doc. 31].

After having responded to the motion to dismiss, Mr. Huff filed a motion to reconsider [Doc. 30]. Therein, Mr. Huff asked the court to reconsider its conclusion in the May 26, 2022 Order that the BP Corporation North America Inc. Life and Accident Plan, group life insurance policy number 32900-G, is a qualifying "employee benefit plan" subject to ERISA. [*Id.*].

In a February 1, 2023 Opinion and Order, the court denied Mr. Huff's motion to reconsider and reiterated its conclusion that group life insurance policy number 32900-G constitutes an "employee welfare benefit plan" under ERISA (referred to herein as "the Plan"). [Doc. 36]. The court now considers BP's motion to dismiss.

Legal Standard

Federal Rule of Civil Procedure 12(b)(6) permits a court to dismiss a claim that "fail[s] to state a claim upon which relief can be granted." "To survive a motion to dismiss under Rule 12(b)(6), a plaintiff must plead sufficient factual allegations 'to state a claim to relief that is plausible on its face.'" *Brokers' Choice of Am., Inc. v. NBC Universal, Inc.,* 861 F.3d 1081, 1104 (10th Cir. 2017) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim is facially plausible 'when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.'" *Id.*

(quoting *Ashcroft v. Iqbal,* 556 U.S. 662, 678 (2009)). "Mere 'labels and conclusions' and 'a formulaic recitation of the elements of a cause of action' are insufficient." *Estate of Lockett ex rel. Lockett v. Fallin*, 841 F.3d 1098, 1107 (10th Cir. 2016) (quoting *Twombly,* 550 U.S. at 555). The court accepts as true all factual allegations, but the tenet is inapplicable to legal conclusions. *Iqbal*, 556 U.S. at 678. "Accordingly, in examining a complaint under Rule 12(b)(6), [the court] will disregard conclusory statements and look only to whether the remaining, factual allegations plausibly suggest the defendant is liable." *Waller v. City & Cnty. of Denver*, 932 F.3d 1277, 1282 (10th Cir. 2019) (quoting *Khalik v. United Air Lines*, 671 F.3d 1188, 1191 (10th Cir. 2012)). The court "must determine whether the complaint sufficiently alleges facts supporting all the elements necessary to establish an entitlement to relief under the legal theory proposed." *Lane v. Simon*, 495 F.3d 1182, 1186 (10th Cir. 2007) (quoting *Forest Guardians v. Forsgren*, 478 F.3d 1149, 1160 (10th Cir. 2007)).

Analysis

As previously stated, the First Amended Complaint (Based on ERISA) purports to assert claims under 29 U.S.C. §§ 1132(c), 1132(a)(1)(B), 1132(a)(3), for failure to provide information and documents requested and breach of fiduciary duties by premium overcharging. BP seeks dismissal of the Amended Complaint for three general reasons: (1) Mr. Huff has no ERISA claim or Plan right premised on the failure to provide information; (2) Mr. Huff has no ERISA claim for the alleged overcharge; and (3) Mr. Huff has no claim for

court-sponsored relief. [Doc. 23]. The court separately considers each argument.

A. Failure to Provide Documents and Information

Mr. Huff alleges that he, through his attorney, requested information and documents from BP regarding the increase in insurance premiums, but that BP has failed to provide the requested information. *See* [Doc. 19, pp. 9, 26, 30, ¶¶ 27, 101, 108]. Further, Mr. Huff attached to his Amended Complaint a letter, dated August 18, 2021, from plaintiff's counsel to "Tonya ??" in the BP Plan Administrator's Office requesting responses to six questions related to the Plan and Mr. Huff's premiums. [Doc. 19-5].[1] Mr. Huff seeks statutory penalties for the failure to provide the requested documents. [Doc. 19, p. 31].

Pursuant to 29 U.S.C. § 1024, "[t]he administrator shall, upon written request of any participant or beneficiary, furnish 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." 29 U.S.C. § 1024(b)(4) (internal footnote omitted). Any administrator who fails to provide the requested information within thirty (30) days "may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the

[1] "A written document that is attached to the complaint as an exhibit is considered part of the complaint and may be considered in a Rule 12(b)(6) dismissal." *Hall v. Bellmon,* 935 F.2d 1106, 1112 (10th Cir. 1991).

date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper." 29 U.S.C. § 1132(c)(1).[2] "The penalty only applies, however, if a plan administrator fails to provide information that it is required to provide by the provisions of Subchapter I of ERISA, 29 U.S.C. §§ 1001-1145." *Galman v. Sysco Food Servs. of Metro New York, LLC*, 674 F. App'x 211, 213 (3d Cir. 2016) (unpublished).

The Amended Complaint includes no allegations that Mr. Huff requested a copy of the latest updated summary, plan description, latest annual report, a terminal report, a bargaining agreement, a trust agreement, or a contract. *See* 29 U.S.C. § 1024(b)(4). Thus, Mr. Huff states a plausible ERISA claim only if the requested information regarding increased premiums qualifies as an "other instruments under which the plan is established or operated." 29 U.S.C. § 1024(b)(4). Courts have interpreted "other instruments" to mean "the formal legal documents that govern or confine a plan's operations, rather than the routine documents with which or by means of which a plan conducts its operations." *Bd. of Trs. of the CWA/ITU Negotiated Pension Plan v. Weinstein*, 107 F.3d 139, 142 (2d Cir. 1997); *see also Williamson v. Travelport, LP,* 953 F.3d 1278, 1294 (11th Cir. 2020) (emphasis in original) ("[M]ost circuits interpret 'other instruments' narrowly, explaining that they must be 'formal legal documents' and not merely any documents *related to* a plan."); *Trs. of Colo. Laborers Health &*

[2] The maximum penalty has subsequently been increased to $110 per day. 29 C.F.R. § 2575.502c-1.

Welfare Tr. Fund v. Am. Benefit Plan Adm'rs, Inc., No. 04-CV-02630-EWN-MEH, 2006 WL 2632308 (D. Colo. Sept. 13, 2006). A generalized request for documents related to an increase in premiums, as alleged in the Amended Complaint, does not satisfy the standard. *See Corby v. UNUM Life Ins. Co. of Am.*, No. C-09-5890-WHA, 2010 WL 3768040, at **8-9 (N.D. Cal. Sept. 21, 2010); *Green v. AT&T, Inc.*, No. 07-CV-1537-DDN, 2009 WL 1161576, at **7-8 (E.D. Mo. Apr. 29, 2009).

Insofar as Mr. Huff relies on the August 18, 2021 correspondence from Mr. Martin, the Tenth Circuit has recognized that "[a]n attorney . . . is entitled to request plan information on behalf of the participant if the request is clear and puts the administrator on notice of the information sought." *Moothart v. Bell,* 21 F.3d 1499, 1503 (10th Cir. 1994). The August 18, 2021 correspondence does not specifically request copies of any documents, nor can it be reasonably construed to put BP on notice that Mr. Huff was requesting documents.

Nor does Mr. Huff assert a claim for failure to provide documents as required by the Plan. Pursuant to the Plan, participants have the right to production of governing Plan documents, a copy of the latest annual report, and a summary of the Plan's annual financial report. [Doc. 26-2, p. 34]. Mr. Huff has not plausibly alleged that he requested any of these documents.

Because Mr. Huff has not asserted that he requested a document required to be provided by ERISA or the Plan, he has failed to plausibly allege an ERISA claim premised on the failure to provide documents and BP cannot be subject to § 1132(c)'s

statutory penalty. Thus, Mr. Huff's Amended Complaint is dismissed in this regard.

B. Claims Related to Overcharge

BP argues that dismissal of Mr. Huff's claim for breach of fiduciary duty by premium overcharging is warranted for three reasons: (1) Mr. Huff states no violation of ERISA or the Plan; (2) Mr. Huff's claim is barred by acquiescence; and (3) Mr. Huff's claim is barred by the statute of limitations. [Doc. 23, pp. 17-22]. Because the court concludes that the first argument is dispositive, it does not consider BP's arguments related to acquiescence or the statute of limitations.

As an initial matter, the court concludes that the pleading runs afoul of Federal Rule of Civil Procedure 8. Federal Rule of Civil Procedure 8 provides that "[a] pleading that states a claim for relief must contain . . . a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). "Rule 8 serves the important purpose of requiring plaintiffs to state their claims intelligibly so as to inform the defendants of the legal claims being asserted." *Mann v. Boatright,* 477 F.3d 1140, 1148 (10th Cir. 2007). The Rule "requires parties to make their pleadings straightforward, so that judges and adverse parties need not try to fish a gold coin from a bucket of mud." *United States ex rel. Garst v. Lockheed-Martin Corp.,* 328 F.3d 374, 378 (7th Cir. 2003).

Mr. Huff's First Amended Complaint is thirty-five (35) pages in length and attaches thirteen separate exhibits, totaling forty-eight (48) pages. In both its

length and form, the document is difficult to interpret. And the court's task of determining whether Mr. Huff has stated a plausible claim is rendered more difficult by the seemingly incompatible allegations contained therein.

First, the Amended Complaint includes allegations and argument against MetLife, despite the fact that Judges in this court had twice previously concluded that no plausible claim could be asserted against MetLife because the Plan was subject to ERISA and MetLife was not the Plan Administrator. *Ronald Huff v. Metropolitan Life Insurance Company*, 21-CV-00284-CVE-CDL (N.D. Okla. July 14, 2021), [Doc. 14, pp. 4-5]; [Doc. 12].[3] Likewise, Mr. Huff continues to posit that this matter is not governed by ERISA. [Doc. 19, pp. 3, 11-13, 27-29]. It is. ERISA applies. Mr. Huff's allegations to the contrary serve only to confuse the issues and put more mud in the proverbial bucket. *See Garst,* 328 F.3d at 378.

Nor does the Amended Complaint otherwise state Mr. Huff's "claims intelligibly so as to inform the defendants of the legal claims being asserted." *Mann,* 477 F.3d at 1148. Confusingly, the pleading includes argument and allegations directed to claims *not asserted* in this case because Mr. Huff "might then have evidence enough to add" future claims and requests for remedies for "fraudulent, unjustified, price gouging, and unjust self-enriching insurance rate increases." *See* [Doc. 19, p. 3]; *see also* [Doc. 19, p. 27 ("Plaintiff has

[3] Since the filing of the Amended Complaint, the court has again affirmed that ERISA applies. *See* [Doc. 36].

reason to believe . . . BP . . . has violated The Plan [and] ERISA . . . by raising his life insurance rates and insurance premiums without justification. . . . However, more information and documentation are needed before the . . . allegation[] of wrongdoing will be made. Plaintiff reserves the right to make these allegations later."). In contrast, Mr. Huff also states that *he does* "allege[] a breach of his ERISA rights and of express contract terms by BP, fraudulent representations by BP, and Fraudulent Price Gouging and Unjust Enrichment increases and overcharges in premiums by BP." [Doc. 19, p. 25]. Neither the court nor BP should be required to guess as to which claims Mr. Huff presently asserts.

Further, compounding the problems in Mr. Huff's pleading, the Amended Complaint is rife with legal exposition, both as to what the law is and plaintiff's counsel's opinions on what the law should be. *See, e.g,* [Doc. 19, p. 26 n.22]. Mr. Huff also includes questions regarding the numerous exhibits attached to his Amended Complaint and discussions of what those exhibits may or may not show. *See, e.g.,* [Doc. 19, p. 28]. "The complaint is not the proper document for the plaintiff to adduce all of the evidence or to argue fully the claims." *Gen. Steel. Domestic Sales, LLC v. Steelwise, LLC*, No. 07-CV-01145-DME-KMT, 2008 WL 2520423, at *2 (D. Colo. June 20, 2008).

The lack of clarity in Mr. Huff's pleading has frustrated the court's determination of whether the Amended Complaint sets forth a plausible claim for overcharging under ERISA. For this reason alone, Mr. Huff's claim in this regard is subject to dismissal.

Mr. Huff's overcharging claim is also subject to dismissal as it fails to state a plausible claim for breach of fiduciary duty based on overcharging under ERISA. Mr. Huff invokes 29 U.S.C. § 1132(a)(3).[4] [Doc. 19, pp. 30-31]. Pursuant to that subsection, "[a] civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the Plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3).

Mr. Huff contends he was fraudulently overcharged based on representations made to him in a October 24, 2013 letter from MetLife regarding his monthly premiums for calendar years 2014 and 2015. *See* [Doc. 19, pp. 22-26; Doc. 19-7; Doc. 19-10]. However, Mr. Huff's contention fails to state a plausible claim for two reasons.

First, with respect to calendar years 2014 and 2015, the court has reviewed the Group Universal Life Billing Statements issued to Mr. Huff on January 1, 2014 and January 1, 2015, both of which were attached to the Amended Complaint. *See Hall,* 935 F.2d at 1112 ("A written document that is attached to the complaint as an exhibit is considered part of the complaint and may be considered in a Rule 12(b)(6) dismissal."). The premiums charged are consistent with the premium

---

[4] Sections 1101 through 1112 include other statutory fiduciary duties. *See* 29 U.S.C. §§ 1101 to 1112. Mr. Huff includes no allegations directed to these sections.

calculations set forth in the October 24, 2013 correspondence.[5] Thus, Mr. Huff fails to state a plausible claim with respect to the years 2014 and 2015. *See Hardy v. Midland Enters., Inc.*, 66 F. App'x 535 (6th Cir. 2003) (no breach of fiduciary duty claim for misrepresentation when the statements were true).

Second, the October 24, 2013 correspondence includes no representations regarding the premiums to be charged for any period thereafter. [Doc. 19-7]. Nor has Mr. Huff included any allegations regarding any representations as to the premium to be charged in the years 2016 to present.

"The Tenth Circuit has not adopted a test for breach of fiduciary duty claims premised on material misrepresentations." *Kerber v. Qwest Group Life Ins. Plan*, 647 F.3d 950, 968 (10th Cir. 2011). However, the Circuit has recognized that "[u]nder any test, the Plaintiff[] would be required to allege a material misrepresentation." *Id.* Here, Mr. Huff has alleged no material misrepresentation by BP with respect to his premiums. Thus, Mr. Huff fails to state a plausible claim.

Insofar as Mr. Huff contends that BP was required to justify the increased rates, the claim fails. The Plan

---

[5] The court notes that Mr. Huff alleges he was fraudulently billed in both 2014 and 2015. *See* [Doc. 19, p. 25, 25 n.20]; *see also* [Doc. 19-10]. Based on the court's calculations, respectfully, the court declines to accept as true Mr. Huff's allegations. *See GFF Corp. v. Associated Wholesale Grocers, Inc.*, 130 F.3d 1381, 1385 (10th Cir. 1997) ("Mere legal conclusions and factual allegations that contradict such a properly considered document are not well-pleaded facts that the court must accept as true.").

provides the Administrator the authority to determine the "amount and frequency of contributions required from a Participant in order to participate in the Plan." [Doc. 23-1, p. 5, § 3.4]. To that end, the Summary Plan Document provides that the cost of coverage is based on the participant's age, level of coverage, and use of tobacco products. *See* [Doc. 23-2, pp. 8-9]. Further, the Summary Plan Document states that "[t]he company reserves the right to change or end a plan at any time without advance notice." [Doc. 23-2, p. 33]. Mr. Huff points to no statute or other authority requiring BP to justify rate increases. Thus, Mr. Huff fails to state a plausible claim. *See Frahm v. Equitable Life Assur. Soc'y of the United States*, 137 F.3d 955 (7th Cir. 1998).

Finally, the Tenth Circuit has held that 29 U.S.C. § 1132(a)(3) establishes a claim for equitable estoppel. *See Lebahn v. Nat'l Farmers Union Unif. Pension Plan*, 828 F.3d 1180, 1187 (10th Cir. 2016). However, Mr. Huff includes no allegations directed to equitable estoppel and has not satisfied the elements of ERISA equitable estoppel.[6] *Id.* at 1187 n.7. Specifically, for the same reasons discussed above, Mr. Huff has failed to

---

[6] The Tenth Circuit has indicated that the five elements of an ERISA claim for equitable estoppel are: "1) conduct or language amounting to a representation of material fact; 2) awareness of the true facts by the party to be estopped; 3) an intention on the part of the party to be estopped that the representation be acted on, or conduct toward the party asserting the estoppel such that the latter has a right to believe that the former's conduct is so intended; 4) unawareness of the true facts by the party asserting the estoppel; and 5) detrimental and justifiable reliance by the party asserting estoppel on the representation." *Lebahn*, 828 F.3d at 1187 n.7.

alleged conduct or language by BP amounting to a representation of material fact. Nor has he alleged that BP was aware he was relying on any such representation. Finally, Mr. Huff attaches to his Amended Complaint the Group Universal Life Billing Statements, which indicate that he was aware of the true facts—that is, the amount of premiums charged. For all of these reasons, Mr. Huff's Amended Complaint fails to plausibly assert a claim for equitable estoppel.

For all of the foregoing reasons, Mr. Huff fails to state a plausible ERISA breach of fiduciary duty claim pursuant to 29 U.S.C. § 1132(a)(3) and the claim must be dismissed.[7]

C. Claim for Court-Sponsored Belief

Finally, BP seeks to dismiss Mr. Huff's request for "other appropriate equitable relief." [Doc. 23, p. 22]. As an initial matter, the Tenth Circuit has held that "the prayer for relief is no part of the cause of action." *Coll v. First American Title Ins. Co.*, 642 F.3d 876, 901 (10th Cir. 2011). Thus, a motion to dismiss is generally not a proper vehicle for addressing a prayer for relief. *See Reininger v. Oklahoma,* 292 F. Supp. 3d 1254, 1266 (W.D. Okla. 2017).

---

[7] Insofar as Mr. Huff seeks to assert state-law claims for breach of contract or fraud, the claims are dismissed, as the court's grant of leave to amend was limited to assertion of a claim under ERISA. *See* [Doc. 15, p. 13].

Regardless, for the reasons discussed above, Mr. Huff has failed to plausibly allege an ERISA violation and therefore other equitable relief is inappropriate.

Conclusion

WHEREFORE, the Motion to Dismiss Amended Complaint [Doc. 23] of defendant BP Corporation North America, Inc. is granted.

DATED this 27th day of February, 2023.

/s/ Gregory K. Frizzell
Gregory K. Frizzell
United States District Judge
Northern District of Oklahoma

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

Case No. 22-CV-00044-GKF-JFJ

[Filed February 27, 2023]

ROLAND HUFF, Plaintiff,	)
v.	)
BP CORPORATION NORTH AMERICA, INC. and/or METROPOLITAN LIFE INSURANCE COMPANY, Defendant(s).	)

JUDGMENT OF DISMISSAL

Pursuant to the court's Order dated February 27, 2023, and the court having determined plaintiff Roland Huff's Amended Complaint does not state a plausible claim pursuant to the Employee Retirement Income Security Act of 1974, it is hereby ordered, adjudged, and decreed that this case is dismissed with prejudice.

ENTERED in Tulsa, Oklahoma this 27th day of February, 2023.

/s/ Gregory K. Frizzell
Gregory K. Frizzell
United States District Judge
Northern District of Oklahoma

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

No. 23-5022
(D.C. No. 4:22-CV-00044-GKF-JFJ)
(N.D. Okla.)

[Filed January 22, 2024]

ROLAND HUFF, Plaintiff - Appellant,	)
v.	)
BP CORPORATION NORTH AMERICA, INC., Defendant - Appellee,	)
and	)
METROPOLITAN LIFE INSURANCE COMPANY, Defendant.	)

ORDER

Before **PHILLIPS**, **McHUGH**, and **EID**, Circuit Judges.

Appellant's petition for rehearing is denied.

Entered for the Court
/s/ Christopher M. Wolpert
CHRISTOPHER M. WOLPERT, Clerk

APPENDIX E

Relevant Statutory Provisions

29 U.S.C. § 1001

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made

and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing

for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

29 U.S.C. § 1024(b)(4)

* * *

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan

Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

* * *

(4) The administrator shall, upon written request of any participant or beneficiary, furnish 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. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

29 U.S.C. § 1132

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) 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;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of section 1025(c) or 1032(a) of this title;

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if

necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts;

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 1085 of this title, if the plan sponsor—

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan; or

(11) in the case of a multiemployer plan, by an employee representative, or any employer that has an obligation to contribute to the plan, (A) to enjoin any act or practice which violates subsection (k) of section 1021 of this title (or, in the case of an employer, subsection (l) of such section), or (B) to obtain

appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) Except as provided in subsections (c)(9) and (a)(6) (with respect to collecting civil penalties under subsection (c)(9)), the Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health

insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title, section 1021(e)(1) of this title, section 1021(f) of this title, section 1025(a), or section 1032(a) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(1) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person or who fails to meet the requirements of section 1082(d)(12)(E) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 a day for each violation by any person of subsection (j), (k), or (l) of section 1021 of this title or section 1144(e)(3) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with subsection (i) or (m) of section 1021 of this title. For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary may assess against any plan sponsor of a multiemployer plan a civil penalty of not more than $1,100 per day—

(A) for each violation by such sponsor of the requirement under section 1085 of this title to adopt by the deadline established in that section a funding improvement plan or rehabilitation plan with respect to a multiemployer plan which is in endangered or critical status, or

(B) in the case of a plan in endangered status which is not in seriously endangered status, for failure by the plan to meet the applicable benchmarks under section

1085 of this title by the end of the funding improvement period with respect to the plan.

(9)

(A) The Secretary may assess a civil penalty against any employer of up to $100 a day from the date of the employer's failure to meet the notice requirement of section 1181(f)(3)(B)(i)(I) of this title. For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

(B) The Secretary may assess a civil penalty against any plan administrator of up to $100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 1181(f)(3)(B)(ii) of this title. For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(10) Secretarial enforcement authority relating to use of genetic information.—

(A) General rule.—

The Secretary may impose a penalty against any plan sponsor of a group health plan, or any health insurance issuer offering health insurance coverage in connection with the plan, for any failure by such sponsor or issuer to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 1182 of this title or section 1181 or 1182(b)(1) of this title with respect to genetic information, in connection with the plan.

(B) Amount.—

(i) In general.—

The amount of the penalty imposed by subparagraph (A) shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) Noncompliance period.—For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period—

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) Minimum penalties where failure discovered.—Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) In general.—In the case of 1 or more failures with respect to a participant or beneficiary—

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such participant or beneficiary shall not be less than $2,500.

(ii) Higher minimum penalty where violations are more than de minimis.—

To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting "$15,000" for "$2,500" with respect to such person.

(D) Limitations.—

(i) Penalty not to apply where failure not discovered exercising reasonable diligence.—

No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) Penalty not to apply to failures corrected within certain periods.—No penalty shall be imposed by subparagraph (A) on any failure if—

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) Overall limitation for unintentional failures.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the plan sponsor (or predecessor plan sponsor)

during the preceding taxable year for group health plans; or

(II) $500,000.

(E) Waiver by secretary.—

In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

(F) Definitions.—

Terms used in this paragraph which are defined in section 1191b of this title shall have the meanings provided such terms in such section.

(11) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b–14(c)(8) of title 42.

(12) The Secretary may assess a civil penalty against any sponsor of a CSEC plan of up to $100 a day from the date of the plan sponsor's failure to comply with the requirements of section 1085a(j)(3) of this title to establish or update a funding restoration plan.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan

in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in

any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the

amount involved in each such transaction (as defined in section 4975(f)(4) of title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan

(or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.