No. _____

# In The
# Supreme Court of the United States

SUSAN RENE JONES,

*Petitioner,*

v.

MERCK SHARP & DOHME, ET AL.,

*Respondents.*

**On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit**

## PETITION FOR A WRIT OF CERTIORARI

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April 24, 2018

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## QUESTIONS PRESENTED

1. Do three inconsistent disability determinations supplanted by five inconsistent plan interpretations negate deference or constitute abuse of discretion/bad faith under *Conkright*'s "one strike" rule?

2. Is deference to plan interpretations under *Conkright*'s undefined, "reasonable" safe harbor effectively unlimited? Does it extend to interpretations in litigation counsel's briefs or of summary plan descriptions (SPDs)?

3. After *Amara*, is an SPD evidence of plan meaning or is it meaningless? May an SPD also serve as the plan document? Does an umbrella plan's incorporation by reference of a long term disability plan's SPD repeal and replace the actual plan document?

4. Do 29 U.S.C. 1132(c) penalties apply to administrative record documents defined in 29 C.F.R. 2560.503-1, issued pursuant to express Congressional delegation in 29 U.S.C. 1133?

## PARTIES

Merck Sharp & Dohme Corp

The Merck & Co., Inc. Long Term Disability Plan for Non Union Employees

The MSD Medical Dental and Long Term Disability Plan for Non Union Employees

The Merck Medical, Dental, Life Insurance and Long Term Disability Plan

Life Insurance Company of North America

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## OPINIONS

The District Court Summary Judgment Order, App6, and Summary Judgment, App40, were entered June 14, 2016. App22. The Ninth Circuit's Memorandum was entered November 17, 2017. App1. The Order Denying Rehearing was entered January 9, 2018. App63. Justice Kennedy extended the time to file this petition to April 24, 2018.

## JURISDICTION

This Court's jurisdiction rests on 28 U.S.C. 1254(1).

## STATUTES AND REGULATIONS

ERISA 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B) allows participants to recover benefits, enforce rights, and clarify future rights under the terms of an ERISA plan.

ERISA 502(a)(3)(B), 29 U.S.C. 1132(a)(3)(B) allows participants "to obtain other appropriate relief" to redress violations or enforce provisions of the subchapter or terms of the plan.

"Every employee benefit plan shall be established and maintained pursuant to a written instrument", 29 U.S.C. 1102(a) so that "every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." H.R. Rep. No. 1280 at 297.

SPDs must detail the "circumstances which may result in . . . denial or loss of benefits". They must be written "to be understood by the average plan participant, . . . sufficiently accurate and comprehensive to reasonably apprise [participants] and beneficiaries of their rights and obligations under the plan." 29 U.S.C. 1022.

SPDs must be written in a "in format that must not have the effect of misleading, misinforming, or failing to inform participants. . . ." 29 C.F.R. 2520.102-2(b).

SPD provisions must clearly identify circumstances which may result in . . . offset . . . of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide. 29 C.F.R. 2520.102-3(l).

20 C.F.R. 404.1505(a); 404.315(a)(4), -(a)(3); and 404.321 provide that a disabled covered worker is entitled to Social Security Disability Benefits (SSDI).

20 C.F.R. 404.350 provides that the disabled worker's eligible dependent is entitled to Dependents Social Security Disability Benefits (DSSDI) upon application being made on his behalf after he is born.



## STATEMENT

Ms. Jones left work disabled from fibromyalgia on June 20, 2001. In December 2001, she became entitled to primary Social Security Disability Benefits (SSDI) and long term disability (LTD) benefits under the 1991 Merck & Co., Inc. Long Term Disability Plan for Non

Union Employees (LTD Plan). It restated 1980s LTD plans.

When Ms. Jones' first child was born in August 2003, he became entitled to dependents Social Security disability benefits (DSSDI). Claims administrator MetLife was informed of First Child's birth. It offset Ms. Jones' SSDI from monthly disability payments, but not First Child's DSSDI.

In April 2007, MetLife terminated Ms. Jones' benefits, eventually giving three inconsistent rationales for finding no disability. All were abuses of discretion in the Ninth Circuit.

MetLife's April 2007 termination letter, Doc59, p.14,[1] misrepresented an IME report and added requirements.[2] MetLife's 2008 appeal denial, Doc62, p.19, was based on a record review of its non-examining doctor.[3]

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[1] Citations to Docs are to ECF filings in Case 08-03971 in the Northern District of California.

[2] It said a 2005 doctor's report found she could work. In a contemporaneous phone call, MetLife said for the first time Independent Medical Exam Reports from four specialties were necessary and refused to let her provide them prior to termination. Doc59, pp.16, 17. Actually, the 2005 report said she could not work for at least six weeks after a possible future remission or cure. Doc54, pp.65, 63.

[3] He barely discussed the four IME reports Ms. Jones submitted and opined she was not disabled because she had no symptoms of heart disease or rheumatoid arthritis. Doc61, p.23. Ms. Jones submitted another of his reports from another case that states fibromyalgia is not disabling. Doc61, pp.3, 6-7.

**2009 District Court Proceedings.** In 2009, one month before summary judgment motions (MSJ) were due, Respondents conceded the disability issue but asserted a DSSDI offset that was retroactive to August 2003 under LTD Plan provisions. They told her to prepare to pay any overpayment of benefits, Doc278-19, p. 27 – leaving Ms. Jones owing the plan about $15,000. Respondents noticed a status conference requesting dismissal and mentioning benefit computation but not the offset. Docs34, 40.

In October 2009, Respondent Plan Administrator issued the 2010 SPD. It confirms the offset cutoff date is the last day of the LTD eligibility period. Respondents' January 2010 MSJ did not address the offset merits but argued that issue had not been exhausted.

After MSJs were filed in 2010, Respondents implemented the offset from August 2008 forward using information Ms. Jones provided it and paid some past due benefits. Doc77, p.7.

At oral argument, Respondents said Ms. Jones' offset arguments must relate to something they intended to pay after receiving additional information. App56, fn. 7. Ms. Jones fully briefed the offset and discussed it before and after Respondents' statement.

The District Court dismissed Ms. Jones' claim as moot and not exhausted. App56. The Ninth Circuit reversed and remanded for consideration of the offset. App46-47.

Respondents' offset assertions and implementation neither identified the offset provision nor gave an interpretation rationale. Respondents thereafter offered five conflicting plan interpretation rationales in three administrative interpretation letters and two briefs. Each rationale was abandoned when Ms. Jones refuted it. The only constant was benefit reduction.

After 1999, the LTD Plan provided:

> 3.1 *Entitlement To Benefits*. A Participant shall be entitled to benefits under the Plan upon:
>
> (a) completion of the Total Disability Eligibility Period; and,
>
> (b) satisfaction of the definition of Total Disability.

ER 306.

> 3.5 *Benefit Reductions*. (a) Any benefit payable under the Plan shall be reduced by:
>
> (i) Social Security Benefits, effective at the time the Participant becomes entitled to benefits; . . . and provided further, that if a Participant does not apply for Social Security disability benefits, any benefit payable under this Plan shall be offset by an amount the Claims Administrator determines in its sole discretion;

ER 333.

The 2010, 2011, and 2012 SPDs had language essentially identical to this 1999/2002 provision:

> Your LTD benefits are offset by certain other sources of income, as follows:
>
> Social Security benefits (both primary and family disability or retirement benefits) that you and your eligible dependents are entitled to receive when you become eligible for LTD benefits. If you do not apply for Social Security disability benefits, your payments from the LTD Plan will be offset by an estimated Social Security amount. . . .

ER 353.

The 2010, 2011, and 2012 SPDs add specific details.

> The amount of offset for Social Security benefits shall be computed at the time you qualify for LTD. Subsequent increases in Social Security benefits shall not be used to reduce LTD benefits. SER1120, 1034, 1067, 944, respectively.
>
> * * *
>
> You are eligible to receive LTD benefits after you have been continuously Totally Disabled for 26 consecutive weeks. SER1120, 1034, 1067, 944, respectively.
>
> * * *
>
> If you are approved to receive LTD benefits, benefits will begin to accrue on the date following the day you complete your benefit

> Eligibility Period. SER1119, 1033, 1066, 943, respectively.
>
> The parties did not discuss the 2010 additional language in the district court. Ms. Jones argued that the basic SPD offset provision was clear. She raised the additional language in the Ninth Circuit.

Cal. Ins. Code § 10127.1(b), enacted in 1978, is now preempted but expresses policy interests similar to the LTD Plan's:

> (b) No self-insured employee welfare benefit plan providing loss of time benefits shall contain any provision for a reduction of such benefits during a benefit period because of an increase in benefits payable under the Federal Social Security Act, as amended. Cal. Ins. Code § 10127.1(b).

Social Security Cost of Living Adjustments (COLA) and DSSDI of children born after the participant becomes entitled to or eligible for LTD benefits are not offset. They are effective after the cutoff date.

Social Security regulations provide that the disabled claimant is entitled to SSDI, 20 C.F.R. §§ 404.1505(a); 404.315(a)(4), -(a)(3) and 404.321. Her eligible dependents are entitled to DSSDI upon application being made after they are born. 20 C.F.R. 404.350. The SPD's main provision and § 3.5 make the First Child's birth date the effective date for offsetting DSSDI, even if an application is not made.

**MetLife's July 2010 Letter.** MetLife's letter quoted the main SPD offset provision as actual plan language. To move First Child's DSSDI effective date back to Ms. Jones' December 2001 LTD entitlement, MetLife said Ms. Jones was entitled to receive it when she became entitled to primary SSDI – also December 2001.[4] (See footnotes for letter quotes.)

That renders nugatory the SPD language recognizing First Child's entitlement to DSSDI per § 404.350. It offsets "( . . . family disability . . . ) that . . . your eligible dependents are entitled to receive when you become eligible for LTD benefits." It renders nugatory a consistent reading of §§ 3.1 and 3.5, and the

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[4] "Under Social Security regulations, Ms. Jones became '*entitled to receive*' benefits for her dependents, when she became entitled to receive benefits for herself."

ER233.

* * *

> "a claimant who qualifies for SSDI necessarily also simultaneously become '*entitled to receive*' DSSD benefits with regard to her dependents, once she takes the necessary steps for submitting an application, notwithstanding that no DSSD benefits may in fact be payable at that date (in Ms. Jones' case, because her dependents were born later)."

ER234.

> "The Plan's consistent interpretation of the interplay of this part of Social Security regulations, and the Plan language regarding offsets for other Income Sources, is and has been that DSSDI is offset from Plan benefits, regardless of whether it is first received before or after Plan benefits become payable."

ER233.

2010 SPD's language confirming the main offset provision.

If Ms. Jones was entitled to First Child's DSSDI when she became entitled to SSDI, she certainly was entitled to her own COLA increases then. All COLA of all participants is offset under MetLife's rationale.

MetLife's letter claimed Respondents consistently interpreted the plan and regulations to offset DSSDI "whether it is first received before or after Plan benefits become payable." That is an admission of consistently interpreting the plan contrary and without regard to its plain language and Social Security Regulations.

MetLife had two other reasons why SPD language should not be interpreted as written. ER233-34. A participant could avoid the offset by delaying SSDI application until after LTD entitlement. Actually, § 3.5 and the SPD allow the administrator to offset DSSDI from the month an application could have been made.

SSDI would never be offset because LTD entitlement is 6 months after disability and SSDI entitlement 12 months. Actually, SSDI entitlement is the sixth month after disability begins whether the claimant is expected to be or is disabled for 12 months.

**LINA's July 2011 Letter.** LINA's Letter also quotes the SPD offset provision as the Plan, but its rationale is not based on SPD or plan language.[5] Neither

[5] "The benefit issued to the dependents was on Ms. Jones' behalf and issued under her social security

say DSSDI can be offset if "issued to the dependents" "on Ms. Jones' behalf" "under her social security number" or "because of the [same] disability". This renders nugatory "( . . . family disability . . . ) that . . . your eligible dependents are entitled to receive when you become eligible for LTD benefits."

LINA's letter substitutes "such" for "LTD" to give the SPD's main offset clause ("when you become eligible for LTD benefits") to obtain an opposite meaning. It claims the plan offsets social security benefits "when the claimant becomes eligible for *such* benefits", "whether a dependent was born before or after the claimant was declared disabled". (emphasis added) No plan or SPD language says this. LINA's rationales also would offset COLA.

**LINA's June 2012 Court Ordered Remand Determination.** LINA's 2012 Remand Letter moves Ms. Jones' LTD entitlement from December 2001 indefinitely out past First Child's August, 2003 DSSDI entitlement – opposite MetLife's approach and opposite its own plan explanation. LINA's Letter says the plan and SPD are not in conflict because the SPD's main offset clause means the same as the Plan's Social

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> number because of the disability which she qualifies for both under the Social Security Administration (SSA) and this plan. Regardless of whether a dependent was born before or after the claimant was declared disabled, the plan offsets both SSDI and dependent SSDI benefits when the claimant becomes eligible for such benefits."

ER247.

Security Benefits definition read consistently with § 3.5's offset clause.[6]

LINA's Letter says § 3.5's "entitled to" and the SPD's "eligible for" both refer to LTD benefits. Then it substitutes "continues to be" for "becomes" before "eligible for LTD benefits" and "entitled to benefits".[7]

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[6] The Plan and the SPD are not in conflict, as becomes clear when you add the Plan's Definition of 'Social Security Benefits' to its benefits reduction provision, *e.g.* In relevant part, the Plan states:

> (a) Any benefit payable under the plan shall be reduced by: (i) Social Security Benefits, effective at the time the Participant becomes entitled to benefits;
>
> Social Security Benefits shall mean the primary and family insurance benefit under the United States Social Security Act and any disability benefit provided by a non-U.S. governmentally established Social Security system or other such non-U.S. similar plan to which a participant is or would be entitled at the time of Total Disability.

Consistent with the Plan's Benefit Reduction provision and Definition of Social Security Benefits, the SPD states:

> Social Security Benefits (both primary and family disability or retirement benefits) that you and your eligible dependents are entitled to receive when you become eligible for LTD benefits.

ER260.

[7] "Under the Plan, a participant is *eligible for* and *entitled to receive* disability benefits for any period – following the Total Disability Eligibility Waiting Period during which s/he satisfies all the terms and conditions of the Plan. While a participant is initially

That rationale renders nugatory references to a specific computation date in the Plan and SPD offset provisions: § 3.1's "upon: (a) completion" of the eligibility period; § 3.5's "effective at the time . . . becomes"; and the SPD's "when you become." It is opposite SPD main offset clause's "when you become eligible for LTD benefits" and the more detailed explanations post 2009: Benefits begin to accrue the day after completing the eligibility period, participants are eligible to receive benefits the day after completing the eligibility period, and subsequent increases in Social Security may not be offset.

LINA's Remand Letter also says MetLife "[said] the plan has consistently applied the offset provision to defined offsets that tie to the disabling condition" and "appropriately applied [the offset] at the time she became entitled to receive both" DSSDI and LTD benefits. No Plan language allows offset based on the first. The second justifies offset if substitutions to plan language stretches LTD entitlement forward or DSSDI entitlement back.

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> *eligible* and initially *entitled to benefits* immediately following his/her satisfaction of the Waiting Period, neither the Plan nor the SPD specify that the Social Security Offset is limited to just that initial qualification period. As a practical matter, a participant continues to be *eligible* and *entitled to benefits* for each subsequent monthly or partial monthly period for which s/he is Totally Disabled." (emphasis added)

ER260.

If the Plan offsets any Social Security Benefit effective while the participant remains eligible for LTD benefits, it offsets COLA.

**Respondent's 2015 Motion for Summary Judgment (MSJ).** The MSJ said § 3.5's "entitled to benefits" referred to SSDI instead of LTD benefits so that all Social Security Benefits are offset whenever they are effective. For that result, § 3.5(a)(i) need say only "Social Security Benefits." The clause Respondents' MSJ interprets is nugatory. The SPD and three administrative determinations say "entitled to benefits" refers to LTD benefits.

This interpretation makes § 3.5(a)(i) nonsensical. It offsets benefits only when "the *Participant* becomes entitled to benefits." "Eligible dependents" are entitled to DSSDI. 20 C.F.R. 404.350. No DSSDI is offset, whether effective before or after LTD entitlement. Participant's COLA, however, is offset.

**The District Court's Interpretation.** The District Court adopted and gave deference to litigation counsel's new interpretation. App24-25. It found that Respondents' claims of consistently offsetting Social Security benefits regardless of when effective justified the new interpretation. App21. It took isolated sentences from each letter to support litigation counsel's interpretation.

The Court found: the SPD's conclusion that First Child's DSSDI could not be offset unless he was entitled to receive it when Ms. Jones became eligible for LTD benefits was inconsequential, App25-26, and the

administrative letters' interpretation rationales were not inconsistent. App22. It did not address the administrative letters' conclusion that "entitled to benefits" referred to LTD benefits. It looked for inconsistency between §§ 3.1 and 3.5 rather than consistency. App25. It treated 20 C.F.R. 404.350 as if it were a plan provision the administrator had discretion to interpret rather than a regulation. App26.

As a fallback, it accepted the Remand Letter's rationale that "entitled to benefits" refers to LTD benefits, but "becomes" means "continues to be". App26.

It found that the LTD Plan was merged into the umbrella plan, which incorporated the SPD by reference. It applied the 2011 SPD on the discretion issue, App14, but LTD Plan § 3.5 on the offset issue.

That both interpretations would offset COLA and the MSJ interpretation did not offset DSSDI was not addressed.

**Respondents' Ninth Circuit Answering Brief.** Respondents' Answering Brief said the general definition of Social Security Benefits defined offsettable Social Security Benefits instead.

**The Ninth Circuit's Affirmance.** The Ninth Circuit's Memorandum appears to have accepted Respondents' MSJ interpretation that § 3.5 offset "Jones' DSSDI benefits when she began receiving the DSSDI benefits in 2009" as a "reasonable interpretation of the plain language of the plan in effect at that time". App3. "Because LINA construed the plan provision

consistent with its plain language, . . . the district court properly upheld LINA's decision that Jones' LTD benefits were offset by her DSSDI benefits." App3.

Sections 3.1 and 3.5(a)(i) and the SPD's main offset clause did not change between 1999 and 2012. The details added to post 2009 SPDs were plan administrator interpretations of the plan sections issued contemporaneously with administrative letters that gave opposite interpretations.

The Ninth Circuit did not address why the MSJ rationale deserved deference and was reasonable. It did not address cases prohibiting consideration of rationales first raised in litigation. It did not consider that the SPD and three administrative letter rationales were premised on § 3.5's "entitled to benefits" referring to LTD benefits. It did not address the effect of eight different rationales for benefit reduction.

Any of the three inconsistent rationales in MetLife/LINA's three letters, however, could obtain respondents' desired result. The Court did not discuss which if any of the three opposite administrative letter rationales supported the conclusion or why it was reasonable.

The Ninth Circuit referred to "Jones' DSSDI benefits when she began receiving". 20 C.F.R. 404.350 provides First Child is entitled to DSSDI upon application after his birth, not Ms. Jones. The SPD's offset explanation incorporates § 404.350: "(both primary and family disability or retirement benefits) that you and your eligible dependents are entitled to receive when you become eligible for LTD benefits." Ms. Jones'

"receiving" DSSDI is from MetLife's July 2010 letter, which says the SPD's offset clause is the Plan.

The SPD certainly dictates that First Child's DSSDI is not offset, as does § 3.5(a)(i). "Receiving" is not a factor in § 3.5(a)(i); "effective at the time" is. 2009 is after December 2001.

The Court's response to Ms. Jones' argument that the California statute evidenced the context that gave rise to the offset provision was that it was preempted. App4.



## REASONS FOR GRANTING THE WRIT

Lower Courts applying *Conkright* and *Amara* have created several artificial dichotomies those cases do not require.

*Amara* states that Courts may look outside the plan to determine plan meaning. It does not except SPDs from that permission or restrict SPD use to interpreting ambiguous provisions. In many cases, as this one, the same entity with the same lawyers is the Plan Administrator and the Plan Sponsor. The SPD is the Administrator/Sponsor's contemporaneous interpretation of the plan. It should be consulted as the best evidence of plan meaning. If applying contract rules to the plan and its SPD separately obtain the same interpretation, what further evidence is needed?

The district court in this case and some Circuits take *Amara*'s statement that SPDs may not modify or

rewrite the plan to mean that SPDs may not be consulted to determine whether a plan interpretation is reasonable under *Conkright*. The Second Circuit requires that district courts determine 1132(a)(1)(B) benefit claims and 1132(a)(3)(B) equitable claims in separate stove pipes. It forbids consulting the SPD in the (a)(1)(B) claim even though it is determinative in a parallel (a)(3)(B) claim. One line in the D.C. Circuit looks to the SPD first in an (a)(1)(B) claim. The Fifth Circuit requires plans be interpreted as closely as possible to the SPDs meaning.

Lines of cases in some Circuits apply *Conkright*'s "reasonable" deference ruling in a manner approaching irrebuttable administrator correctness. They find interpretations reasonable, but do not explain why they are reasonable. The most consistent element of uniformity and predictability produced is decisions upholding the administrator. With no standard to determine reasonable, a claimant cannot predict whether a court will find the administrator's interpretation reasonable. Proving the negative – that it is unreasonable – without a standard to compare it to is impossible.

Other Circuits apply contract principles in the context of ERISA derived conditions to determine reasonableness. Plans are drafted conforming to rules of contract interpretation and to legal restrictions so they will be interpreted as intended. If the intended meaning can be predicted and determined, why is it not the reasonable interpretation? The only explanation is the one the administrator chose gave the result it wanted and expected it to be given deference. Making an

interpretation because deference allows it rather than by reasoned application of plan language is by definition an abuse of discretion. If deference upholds any administrative decisions as to any provision and any participant under such circumstances, the plan is illusory.

Perhaps the administrator and the court felt that Ms. Jones' circumstances gave her an unfair windfall other parents did not receive. Interpreting a plan to avoid an unwanted result is unreasonable and an abuse of discretion.

Drafters do not use the same clause in closely related sections to refer to different kinds of benefits. Read consistently, § 3.1's "entitled to benefits under the plan upon" and § 3.5's "entitled to benefits" both refer to LTD benefits. The plan offsets any Social Security benefit effective before the last day of the 26 week LTD eligibility period and none thereafter.

The district court looked for inconsistency to determine that presence of "under the plan" in § 3.1 but not in § 3.5 meant one referred to LTD benefits and the other Social Security benefits. Respondents' interpretation rationales lead to absurd results. One offsets no DSSDI; all offset all COLA. Since Respondents' interpretations offset all Social Security Benefits whenever effective, they render § 3.5's language after "Social Security Benefits" nugatory.

Looking outside the plan for its meaning and to the context that gave rise to the offset clause requires consulting the SPD and statutes and regulations

relevant to its purpose and drafting requirements. Social Security regulations say Ms. Jones is entitled to SSDI and her eligible dependents are entitled to DSSDI. SPDs must detail the "circumstances which may result in . . . denial or loss of benefits". 29 U.S.C. 1022. SPD provisions must clearly identify "circumstances which may result in . . . offset." 29 C.F.R. 2520.102-3(l). The offset clause was drafted to prevent LTD benefits from being reduced by post disability effective social security benefits. The California statute, preempted or not, is evidence of that pervasive policy choice.

Double conjunctives in the SPD offset clause reflect the participant is entitled to SSDI, the eligible dependent to DSSDI, and they are offset only if the respective person is entitled to receive them when the participant becomes eligible for LTD benefits. The administrative letters acknowledge this but substitute words to move entitlement to one or the other back and forth – unreasonable and an abuse of discretion. The SPD does not fail to disclose the offset. It accurately explains there is no offset.

Pre-*Conkright*, two shifting interpretations were often sufficient to allow de novo review or justify finding an abuse of discretion. Post *Conkright* Courts tend to grant deference indefinitely. To allow the administrator to exercise discretion, many courts remand rationales raised in litigation to the administrator.

Undefined reasonableness and indefinite limits on deferential review encourages plan administrators to

offer alternative interpretation rationales during the administrative process and litigation and to look for plan amendments to be applied later in the litigation. The *Harlick* result discussed below is rare. The practical limit on additional bites at the apple is the ability of disabled claimants to undergo continued administrative processes and litigation. Neither the district court nor Ninth Circuit addressed Ms. Jones' *Harlick* argument that new rationales in litigation are not permitted.

The absence of § 1132(c) penalties for failure to produce administrative records encourages administrators not to produce them, claim they don't exist or were lost, redact them or dribble out selective parts. Often new items are added at the last minute. Often administrators file the official administrative record, if any, with their motions for summary judgment. Respondents did not inform Ms. Jones of their MSJ plan interpretation or their contention that the 1991 LTD plan was merged into the 2011 umbrella plan until MSJs were filed in 2015. Respondents did not provide the administrative agreement they claimed granted discretion until November 2015. The last emails pertinent to the agreement and plan interpretation were provided two days before MSJs were filed. That Administrative Agreement, the 2011 Plan, and the 2010 SPD were not in the Administrative Record or mentioned in the administrative letters. The Administrative Agreement was defective. Neither the district court nor the Ninth Circuit addressed Ms. Jones' contention that the agreement was defective and no

authority or discretion was delegated, as required by both plans. This litigation would have ended years ago without the ensuing work had proper disclosures been made in 2009.

Many published (a)(3)(B) cases are class actions arising from failure to give accurate prior notice of plan changes. They involve well-funded classes and law firms, multiple appeals, and decade long litigation. Circuit holdings are all over the map on the most basic (a)(3)(B) elements. In some, a potential (a)(1)(B) claim bars an (a)(3)(B) claim. In others, they may be brought simultaneously so long as there is no double recovery. For reformation, reliance is required in the Ninth Circuit but not in the Second. The complexity and length of litigation has bled over into individual cases.

Ms. Jones was unaware of Respondents' final interpretation until their MSJ was filed. Her Opening Ninth Circuit Brief requested alternative (a)(3)(B) relief if she lost the (a)(1)(B) claim. Starting over is an impossible hurdle for disabled claimants. The only viable alternative is (a)(1)(B) claims that consider all circumstances. Given notice pleading and the Federal Rule of Civil Procedure rule directing any available relief be granted, stove piping 1132 claims and not allowing simultaneous claims appears to be an unnecessary dichotomy.

***Conkright* and Inconsistency.** Prior to *Conkright*, *Glenn*, and *Pacific Shores*, the Ninth Circuit held that inconsistency between the initial denial and the appeal determination justified either de novo review or finding an abuse of discretion. *Lang v. Long-Term*

*Disability Plan of Sponsor Applied Remote Technology, Inc.*, 125 F.3d 794, 799 (9th Cir. 1997) [used de novo review and reversed district court's affirmance of a benefit denial where inconsistent positions regarding the claim and reasons for denial indicated self-interested decision making]. *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868, 872 (9th Cir. 2008) remanded for determination whether deference was due [new reason suggests an "excuse to reject the claim rather than conducting an objective evaluation"].

*Conkright v. Frommert*, 559 U.S. 506, 513, 521 (2010) holds that deference to a plan administrator's interpretation is not negated by one honest mistake, but may be negated by multiple mistakes. *Conkright* does not state how many mistakes it takes.

*Conkright* deference requires acceptance of "reasonable" interpretations. *Conkright*, 521. This Court neither defines reasonable, nor subjects it to standards.

Post *Conkright*, the Second and Ninth Circuits remand to the administrator for a third or fourth bite at the apple. The Seventh and other Ninth Circuit panels enter judgment for the participant after two inconsistent rationales.

In the third appeal in *Frommert v. Conkright*, 738 F.3d 522, 534 (2d Cir. 2013), the Second Circuit remands with instructions to review a third, possibly fourth, administrator interpretation with deference. *Tapley v. Locals 302 and 612 of International Union of*

*Operating Engineers*, 728 F.3d 1134 (9th Cir. 2013), remands to the Trustees after finding two alternative interpretations they advance in the district court unreasonable.

*Harlick v. Blue Shield of California*, 686 F.3d 699 (9th Cir. 2012) rejects litigation counsel's attempt to offer an interpretation of medical necessity different than the shifting reasons provided in the administrative process, *id*., 719-21, and requires payment of benefits. *id*., 721. *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666 (9th Cir. 2011), finds an abuse of discretion and requires an award of benefits, *id*., 681, because the administrator gave a new reason for denial in the administrative appeal after the participant rebutted the reason for the initial denial. *id*., 678. In *Holstrom v. Metropolitan Life Insurance Company*, 615 F.3d 758 (7th Cir. 2010), the Seventh Circuit requires reinstatement of benefits because the administrator imposed shifting requirements which were then found insufficient for different reasons and selectively considered evidence.

**Defining "Reasonable" After *Conkright*.** The Ninth Circuit Memorandum in this case cites two cases for the proposition that "an administrator's decision must be upheld 'if it is based upon a reasonable interpretation of the plan's terms and if it was made in good faith' ". *Moyle v. Liberty Mutual Retirement Benefit Plan*, 823 F.3d 948, 957-58 (9th Cir. 2016); *Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1178 (9th Cir. 2005). App3. *Moyle* at 958 states that "The analysis is not based on 'whose

interpretation is most persuasive, but whether the [administrator's] interpretation is reasonable."

*Moyle* and *Boyd* in turn cite to a line of pre *Glenn*[8] cases going back to 1991 that say "an administrator's decision is not arbitrary unless it is not grounded on any reasonable basis."[9] This line, like similar lines in the Second, Seventh, Tenth, and D.C. Circuits, finds plan interpretations reasonable if they are consistent with the "plain meaning" of the plan, but provides no standard to determine whether interpretations accord with plain meaning or are reasonable. *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 443 (2d Cir. 1995) [If more than one interpretation is reasonable, the administrator's must be upheld.]; *Wagener v. SBC Pension Benefit Plan – Non Bargained Program*, 407 F.3d 395, 401 (D.C. Cir. 2005) ["The Court finds that the Committee's interpretation of the plan is reasonable, and since that is all that is required due to the substantial-deference owed to the Committee's decision, that is the end of the matter."]; *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990) [Discretionary administrator's interpretation can be overturned only if "they were not just clearly incorrect but downright unreasonable."]; *Eugene S. v. Horizon Blue Cross Blue Shield of New Jersey*, 663 F.3d 1124, 1133-34 (10th Cir. 2011) [The rationale relied upon need not be the only logical

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[8] *Metropolitan Life Insurance Company v. Glenn*, 554 U.S. 105 (2008).

[9] *E.g.*, *Sznewajs v. U.S. Bancorp Amended and Restated Supplemental Benefits Plan*, 572 F.3d 727, 734-35 (9th Cir. 2009); *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869 (9th Cir. 2004).

one or even the superlative one. The evidence need only be more than a scintilla, sufficient that a reasonable mind could accept as sufficient to support the conclusion.].

Under this line, the same language in the same circumstances can have opposite meanings depending upon whether review is de novo or which Circuit's "reasonable" deferential standard is applied.[10]

This line's methodology is similar to treatment of agency regulations issued pursuant to express or implied statutory delegation under *Chevron, U.S.A. v. Natural Resources Defense Council, Inc*., 467 U.S. 837, 841-45 (1984) and *National Cable & Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967, 980-86 (2005). A Court's construction of a statute may not trump an agency's regulation issued under express or implied delegation. If the agency made a reasonable policy choice, Courts must accept it. *Chevron*, 844-45; *National Cable*, 980-81, 983, 984, 986. Prior inconsistent regulations do not matter. *Chevron*, 857-58; *National Cable*, 981-82.

Another Ninth Circuit line of cases determines reasonableness by "apply[ing] contract principles derived from state law". *Gilliam v. Nevada Power Co*., 488 F.3d 1189, 1194 (9th Cir. 2007). "An ERISA plan is a contract we interpret 'in an ordinary and popular

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[10] *Cf. Blankenship v. Liberty Life Assurance Company of Boston*, 486 F.3d 620 (9th Cir. 2007); *Day v. AT&T Disability Income Plan*, 698 F.3d 1091 (9th Cir. 2012); and *Thomason v. Metropolitan Life Insurance Company*, *3, 2017 WL 3049528 (5th Cir. 2017).

sense as would a [person] of average intelligence and experience.' . . . We look first to the 'explicit language of the agreement to determine, if possible, the clear intent of the parties,' and then to extrinsic evidence." *Harlick v. Blue Shield of California*, 686 F.3d 699, 708 (9th Cir. 2012). A provision's meaning is best "understood in light of the context that gave rise to its inclusion." *Gilliam*, 1194. Courts "endeavor to interpret each provision consistent 'with the entire document such that no provision is rendered nugatory'." *id.*, 1194.

Under this line, courts "would reach the same conclusion under either standard of review." *Gilliam*, 1194.

Post *Glenn*, "any reasonable basis" was overruled. *Pacific Shores Hosp. v. United Behavioral Health*, 764 F.3d 1030, 1042-43 (9th Cir. 2014); *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 673-74 (9th Cir. 2011). "[I]n reviewing for abuse of discretion, we consider all of the relevant circumstances in evaluating the decision of the plan administrator." *Pacific Shores*, 1041.

Nevertheless, both lines continue. They seldom cite each other. Which line is applied depends upon the Judge or Panel drawn.

As in most Circuits with standards for reasonableness, contract rules are applied as part of Federal

Common Law subject to ERISA and other Federal statutes and regulations.[11]

This Court applies contract rules to interpret ERISA plans and related contracts. *M & G Polymers USA, LTD v. Tackett*, 135 S.Ct. 926, 933-34 (2015) recognizes that ERISA plans are interpreted consistent with traditional rules of contract interpretation. *Heimeshoff v. Hartford Life & Accident Insurance Co*., ___ U.S. ___, 134 S.Ct. 604, 610-12 (2013) treats an ERISA plan as a contract in a contractual limitations case. *id*., 611. *Heimeshoff* focuses on the written terms of the plan, *id*., 612; recognizes the particular importance of enforcing plan terms as written, *id*.; and finds rights and duties are built around reliance on the face of written plan documents. *id*.

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[11] "[A] court will not allow an ERISA plan administrator to assert a reason for denial of benefits that it had not given during the administrative process." *Harlick v. Blue Shield of California*, 686 F.3d 699, 719, 719-20 (9th Cir. 2012). Rendering a decision without "any explanation", referring to the "specific plan provision", or explaining the "specific reasons for such denial" is an abuse of discretion. *Pacific Shores*, 1042; *Harlick*, 719.

Courts cannot defer to an administrator's construction of law. *McDaniel v. Chevron*, 203 F.3d 1099, 1108 (9th Cir. 2000). Administrator conclusions contrary to law are abuses of discretion. *Bergt v. Retirement Plan for Employees Employed by MarkAir, Inc*., 293 F.3d 1139, 1145 (9th Cir. 2002); *Koehler v. Aetna Health, Inc*., 683 F.3d 182, 189 (5th Cir. 2012). If language complies with a statutory requirement, "it is interpreted consistent with the statute absent evidence of intent 'to do anything other than incorporate the statute's requirements' ". *United States v. City of Fulton*, 475 U.S. 657, 672, 671-72, 106 S.Ct. 1422, 89 L.Ed.2d 661 (1986).

Other Circuits apply contract rules. The D.C. and Seventh Circuits also have dual lines. The D.C. Circuit's *Foster v. Sedgwick Claims Service*, 842 F.3d 721 (D.C. Cir. 2016) "look[s] first to the Summary Plan Description" to assess LTD plan terms, *id.*, 731; then "appl[ies] ordinary principles of contractual interpretation in assessing the terms of an ERISA plan." *id.*, 734.

The Fifth Circuit requires that "(1) ambiguous plan language be given a meaning as close as possible to what is said in the plan summary, and (2) plan summaries be interpreted in light of the applicable statutes and regulations". *Koehler v. Aetna Health, Inc.*, 683 F.3d 182, 189 (5th Cir. 2012).

[If the plan incorporates the SPD or is the same document, deference does not extend to the SPD. *Koehler*, 188-89. In the Second Circuit, this question is open where notice is the issue. *Frommert v. Conkright*, 738 F.3d 522, 531 (2d Cir. 2013)].

The Fifth Circuit applies a two-step, six-factor test, as modified for *Amara* in *Koehler*. *Gosselink v. Am. Tel. & Tel., Inc.*, 272 F.3d 722, 726 (5th Cir. 2001). Both steps use contract interpretation rules to thoroughly analyze the administrator's interpretation and plan language. The language is given a fair reading in its ordinary and popular sense. The plan is interpreted as a whole to achieve internal consistency and avoid unanticipated results. *Gosselink*, 727-28; *Chacko v. Sabre, Inc.*, 473 F.3d 604, 612 (5th Cir. 2006). The first step considers three factors to determine whether the

interpretation is legally correct.[12] *Gosselink*, 726. If so, the interpretation is approved. If not, three other factors determine whether it is an abuse of discretion.[13] *Gosselink*, 726; *Chacko*, 611.

The Sixth Circuit applies general rules of contract law as part of the federal common law to interpret ERISA plans. *Cassidy v. Akzo Nobel Salt, Inc.*, 308 F.3d 613, 615 (6th Cir. 2002). Even if an administrator establishes rational justifications for an interpretations conclusion, it is not reasonable unless it is "based on the language of the Plan." *Shelby County Healthcare Corporation v. Southern Counsil of Industria Workers Health and Welfare Fund*, 203 F.3d 926, 934 (6th Cir. 2000). Plan language subject to more than one reasonable interpretation is ambiguous. *id.*, 934. Even if a plan term is ambiguous, the administrator's interpretation is unreasonable if "the requirement cannot be found in the language of the Plan." *id.*, 935.

The Seventh Circuit applies "federal common law principles of contract interpretation" to plans whether the administrator has discretion or not. *Frye v. Thompson Steel Co*., 657 F.3d 488, 493 (7th Cir. 2011)

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[12] "(1) the administrator has given the plan a uniform construction; (2) the interpretation is consistent with a fair reading of the plan; and, (3) there are any unanticipated costs resulting from different interpretations of the plan."

[13] "(1) the internal consistency of the plan under the administrator's interpretation; (2) any relevant regulations formulated by the appropriate administrative agencies; and, (3) the factual background of the determination and any inferences of lack of good faith."

[discretion]; *Shultz v. Aviall, Inc. Long Term Disability Plan*, 670 F.3d 834, 837, 838 (7th Cir. 2012) [de novo]. In discretion cases, the administrator "is not free . . . to disregard unambiguous language in the plan." It must use "interpretive tools to disambiguate ambiguous language". If interpretation of ambiguous language does not "rewrite or modify the plan", it is entitled to deference. The interpretation must be "compatible with the language and the structure of the plan document." *Frye*, 493. Seventh Circuit cases thoroughly analyze plan provisions.

The First Circuit has not adopted specific standards defining reasonable but determines reasonableness by thoroughly comparing plan provisions and the administrator's interpretation for consistency, using rules similar to Federal Common Law contract interpretation rules. *D.H. Therapy Associates, LLC v. Boston Mutual Life Insurance Company*, 640 F.3d 27, 37-38 (1st Cir. 2011).

*D.H. Therapy*'s analysis follows general contract rules although it states that deferential review "must reflect the relevant principles of trust law, rather than the law of contracts." *id.*, 37. If the plan's language prescribes the same treatment of two items, the administrator's interpretations cannot prescribe inconsistent results. *id.*, 38. If the interpretation renders some plan provisions meaningless, it is unreasonable. *id.*, 40. Although, the court need not determine the best reading of the plan or how it would read it de novo, *id.*, 35, for an interpretation to be reasonable as to a specific result, the sponsor must "have drafted a plan that made

this clear." *id.*, 41. "[T]he plain language of an ERISA plan must be enforced in accordance with its literal and natural meaning". *Colby v. Union Security Insurance Company*, 705 F.3d 58, 65 (1st Cir. 2013). Whether an interpretation is reasonable if only as persuasive or less persuasive than others is still open. *id*., 36. *Coffin v. Bowater Inc.*, 501 F.3d 80, 96 (1st Cir. 2007) upholds an administrator's interpretation because it is "significantly more persuasive" than that offered by the plaintiffs.

The Third, Fourth, and Eighth Circuits apply a five-point test to determine reasonableness. It includes contract interpretation rules requiring that plan provisions be read consistently and in a manner that renders no provision meaningless.[14] *Manning v. American Republic Insurance Co*., 604 F.3d 1030, 1041-42 (8th Cir. 2010); *Howley v. Mellon Fin. Corp*., 625 F.3d 788, 795 (3d Cir. 2010); *Carden v. Aetna Life Ins. Co*., 559 F.3d 256, 261 (4th Cir. 2009). The Fourth Circuit adds four factors.[15] *Carden*, 261. These Circuits thoroughly

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[14] (1) whether the administrator's language is contrary to the clear language of the plan; (2) whether the interpretation conflicts with the substantive or procedural requirements of ERISA; (3) whether the interpretation renders any language in the plan meaningless or internally inconsistent; (4) whether the interpretation is consistent with the goals of the plan; and, (5) whether the administrator has consistently followed the interpretation.

[15] 1) whether the decisionmaking process was reasoned and principled; 2) the fiduciary's motives and conflict of interest; 3) any relevant external standard; and, 4) the adequacy of the materials considered to make the decision and the degree to which they support it.

compare plan language and the administrator's interpretation. *Carden*, 261-62; *Howley*, 795-98 [Administering benefits in a way that controverts a plan's stated purpose, renders plan language meaningless, and creates benefits that can exist only on paper, is unreasonable. In these circumstances, ERISA requires that we provide a remedy. *Howley*, 798.].

In the Eighth Circuit, the administrator's interpretation is reasonable "if a reasonable person *could* have reached a similar decision" even if a reasonable person would not have reached that decision or the court would interpret the language differently. *Manning v. American Republic Insurance Co*., 604 F.3d 1030, 1038 (8th Cir. 2010).

***Amara* and Treatment of SPDs.** Prior to *Amara*, Courts used summary plan descriptions in § 1132(a)(1)(B) plan interpretation cases as extrinsic evidence of ERISA plan meaning, *Fuller v. CBT Corp.*, 905 F.2d 1055, 1060 (7th Cir. 1990); *Pettaway v. Teachers Ins. & Annuity Ass'n of Am.*, 644 F.3d 427, 434 (D.C. Cir. 2011); and to resolve conflicts between the plan and SPD, binding administrators to the more employee-favorable of the two conflicting documents, *Koehler*, 188-89; *Edwards v. State Farm Mutual Automobile Ins. Co*., 851 F.2d 134, 136 (6th Cir. 1988) – even if one was erroneous. *Banuelos v. Construction Laborers Trust Fund of Southern California*, 382 F.3d 897, 904 (9th Cir. 2004); *Bergt v. Retirement Plan for Employees Employed by MarkAir, Inc*., 293 F.3d 1139, 1143, 1145 (9th Cir. 2002). "[W]hen it is the employee relying on the

handbook, . . . it is hardly realistic to expect him to read further." *Edwards*, 136; *Fuller*, 1060.

*Cigna Corp. v. Amara*, 563 U.S. 421, 436-38 (2011), holds that under 29 U.S.C. 1132(a)(1)(B), Courts enforce the terms of the plan and may look outside the plan to determine its meaning. *id.*, 436; but SPDs are not actual plan documents and may not indirectly amend plan terms.[16] *id*., 438. ERISA requires a plan document and an SPD. *id*., 436-38 and 445-46 (Scalia, J., concurring). Participants may, however, seek to hold the administrator to a conflicting SPD provision under section 1132(a)(3)(B), even if the plan unambiguously supports the administrator's interpretation. *Amara*, 438-45.

Despite *Amara*'s permission to look outside the plan, some lower courts decline to treat SPDs as extrinsic evidence of plan meaning because it is not a "plan document". Others look to the SPD first.

The Second Circuit prohibits consideration of SPD/notice circumstances when determining a reasonable interpretation under 1132(a)(1)(B) – even though the SPD is determinative of an alternative (a)(3)(B) misrepresentation claim. *Frommert v. Conkright*, 738 F.3d 522, 534 (2d Cir. 2013). The Fifth Circuit requires

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[16] Plan Administrators draft SPDs, which must give participants complete and accurate explanations of the plan's meaning in readily understandable form. *id.*, 437-38. Plan sponsors draft and amend plans, which must provide claimant rights with specificity. *id*., 437. Plan administrators may not perform plan sponsor functions. *id*., 437.

comparison with SPD language to determine reasonableness. *Koehler v. Aetna Health, Inc*., 683 F.3d 182, 188-89 (5th Cir. 2012). The D.C. Circuit's *Foster v. Sedgwick Claims Service*, 842 F.3d 721 (D.C. Cir. 2016) "looks first to the Summary Plan Description", *id.*, 731, then "appl[ies] ordinary principles of contractual interpretation in assessing the terms of an ERISA plan." *id.*, 734.

When an SPD is at issue, the Fifth Circuit first looks to see if the SPD is ambiguous. *Koehler v. Aetna Health, Inc*., 683 F.3d 182, 188-89 (5th Cir. 2012). *Thomason v. Metropolitan Life Insurance Company*, *3, 2017 WL 3049528 (5th Cir. 2017). Deference to discretionary administrator interpretations of the plan does not extend to SPD interpretations. SPD ambiguities "are resolved in favor of the beneficiary." *Koehler*, 188; *Thomason*, *3, 2017 WL 3049528. *Koehler* requires that "(1) ambiguous plan language be given a meaning as close as possible to what is said in the plan summary, and (2) plan summaries be interpreted in light of the applicable statutes and regulations". *Koehler*, 189.

The Second Circuit leaves open whether deference applies to the SPD where § 1132(a)(3) notice is the issue. *Frommert*, 738 F.3d at 528, fn. 6, 531; but "an SPD must explain the full import of a plan term." *id*., 522.

In *Koehler*, Aetna's certificate of coverage constitutes the plan and a document with identical language constitutes the SPD. The language of both documents grant the administrator discretion. *Koehler*, 187, 188.

*Koehler* finds the language as an SPD ambiguous, *id*., 187-88, so that Aetna's reliance on ambiguous plan language is "legally incorrect", and the same language as an SPD violates ERISA regulations requiring clarity and notice of plan terms. *id*., 191. It remands for a determination of abuse of discretion if Aetna's determination benefited plan fiduciaries at the beneficiary's expense unless it provided a greater benefit to plan participants as a class. *id*., 191.

The *Thomason* long term disability plan grants discretion and incorporates the SPD by reference. *Thomason* dispenses with the Fifth Circuit's legally correct test because construing the SPD in Thomason's favor resolves the abuse of discretion issue in Thomason's favor. *Thomason*, *4, 2017 WL 3049528.

The Tenth Circuit treats health SPDs as the plan if the Certificate of insurance and SPD say the SPD is part of the plan. It extends deference to interpretations of the SPD. *Eugene S. v. Horizon Blue Cross Blue Shield of New Jersey*, 663 F.3d 1124, 1131-32 (10th Cir. 2011).

The Eleventh Circuit treats the application for insurance as the Plan even though the SPD says the SPD is the plan. *Heffner v. Blue Cross & Blue Shield of Ala., Inc.*, 443 F.3d 1330, 1342-43 (11th Cir. 2006).

In the Ninth Circuit, where there is a Certificate of Insurance and an SPD that do not say the SPD is part of the plan (and do say that the plan controls), the Certificate is the plan and the SPD is the SPD. Terms of the SPD may not enlarge the plan. *Prichard v.*

*Metropolitan Life Insurance Company*, 783 F.3d 1166 (9th Cir. 2015). *Mull v. Motion Picture Industry Health Plan*, 865 F.3d 1207 (9th Cir. 2017) holds an SPD and trust Agreement comprise the plan where the SPD refers to master insurance contracts but provides it is both plan and SPD.

Ms. Jones can find no cases that allow an umbrella plan to repeal and replace individual welfare plan documents by incorporating all welfare plan SPDs by reference.

**Section 1132(a)(3) Claims After *Amara*.** In some Circuits, a claimant with a potential 1132(a)(1)(B) claim cannot proceed with an 1132(a)(3) equitable misrepresentation claim. *Korotynska v. Metropolitan Life Insurance Company*, 474 F.3d 101, 106 (4th Cir. 2006) [collecting cases]; *Swenson v. United of Omaha Life Insurance Company*, 876 F.3d 809 (5th Cir. 2017). In the 11th Circuit, an 1132(a)(3) claim is not available if the participant had an 1132(a)(1)(B) claim, even if the (a)(1)(B) claim is barred or was lost. *Ogden v. Blue Bell Creameries U.S.A., Inc.*, 348 F.3d 1284 (11th Cir. 2003).

In the Second and Ninth Circuits, having a 1132(a)(1)(B) claim does not foreclose bringing a 1132(a)(3) claim for reformation or surcharge based on SPD terms. *Frommert v. Conkright*, 433 F.3d 254, 272 (2d Cir. 2006); *Frommert v. Conkright*, 738 F.3d 522, 534 (2d Cir. 2013); *Moyle v. Liberty Mutual Retirement Benefit Plan*, 823 F.3d 948, 961-62 (2016). Equitable reformation is governed by contract principles, and a plan may be reformed "to reflect the representations

that the defendants made to the plaintiffs." *Osberg v. Foot Locker, Inc.*, 862 F.3d 198, 204, 214-15 (2d Cir. 2017).

Detrimental reliance is not required for reformation in the Seventh Circuit. *Osberg*, 212. Detrimental reliance and harm are required for reformation and surcharge in the Ninth and Eleventh Circuits. *Moyle*, 963; *Pettaway v. Teachers Ins. & Annuity Ass'n of Am.*, 644 F.3d 427, 434 (D.C. Cir. 2011).

In the Eighth and Sixth Circuits, a plaintiff cannot obtain a remedy under 1132(a)(3) that is available or has been obtained under 1132(a)(1)(B), *Antolik v. Sak's Inc*., 463 F.3d 796, 803 (8th Cir. 2006); *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 372-73 (6th Cir. 2015) (en banc). She can obtain relief under -(a)(3) not available under -(a)(1)(B), even if she has received -(a)(1)(B) relief. *Hall v. Lhaco, Inc*., 140 F.3d 1190, 1197 (8th Cir. 1998); so long as -(a)(3) relief "is based on an injury separate and distinct from the denial of benefits" or where the (a)(1)(B) remedy is otherwise shown to be inadequate [to make the claimant whole].

**1132(c) Penalties.** 29 U.S.C. 1132(c)(1)(B) imposes penalties on any administrator 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 . . . within 30 days". 29 U.S.C. 1133 is part of the subchapter. It requires "employee benefit plans" to "provide adequate notice in writing" of "the specific reasons for such denial" and to afford the participant "a reasonable

opportunity . . . for a full and fair review" "in accordance with regulations of the Secretary". The Secretary's regulations, 29 C.F.R. 2560.503-1, say the notice and review includes all documents and information of the administrator relevant to the claim. That includes the claim file/administrative record. Courts have adopted this definition.

Some Circuits, reading penalty statutes narrowly, hold that 1) the regulations are not the statute and so not a part of the subchapter, 2) section 1133 requires the plan to produce required documents – not the administrator, and 3) Congress did not authorize the Secretary of Labor to impose penalties. *Groves v. Modified Retirement Plan for Hourly Paid Employees of Johns Manville Corporation*, 803 F.2d 109, 111 (3d Cir. 1986); *Wilczynski v. Lumbermens Mutual Casualty Company*, 93 F.3d 397, 405-408 (7th Cir. 1996).

In 1132(c), Congress imposes the penalty for failure to make disclosures required by 1133. It expressly delegates to the Secretary the authority to determine what items must be disclosed. Under *Chevron*, 841-45 and *National Cable*, 980-86, Courts generally may not question an agency's regulations issued pursuant to such authorization. They effectively have the force of statutes. Plans do not act for themselves. Plan actions are carried out by the Plan Administrators. The Secretary's regulations require the plan administrator to make the required disclosures, 29 C.F.R. 2560.503-1(g), -(i), -(j), -(m)(8).

The Ninth Circuit, citing *National Cable*, holds that § 1132(c)(1)(B) penalties apply to the administrative record required by § 1133 and the 2560.503-1 regulations. *Sgro v. Danone Waters of North America, Inc.*, 532 F.3d 940, 942, 944-45 (9th Cir. 2008).

In this case, the district court declined to apply *Sgro*. App32-35. The Ninth Circuit did not address *Sgro* or *National Cable*. It held that § 1132(c) applies only to § 1024 plan documents. App4-5.

## CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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