No. 14-11678-CC

In The
United States Court of Appeals
For The Eleventh Circuit

BOARD OF TRUSTEES OF THE NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN,

Plaintiff-Appellee

v.

ROBERT MONTANILE,

Defendant-Appellant

On Appeal From The United States District Court For the Southern District of Florida

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BRIEF OF PLAINTIFF-APPELLEE

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No. 14-11678-CC
Board of Trustees Natl. Elev. v. Robert Montanile

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to F.R.A.P. 26.1 and 11th Cir. R. 26.1-3, the undersigned counsel of record for Appellees certifies that the following persons have an interest in the outcome of this case:

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JURISDICTIONAL STATEMENT

The Appellee filed the underlying action seeking enforcement of its employee benefit plan under 29 U.S.C. § 1132(a)(3). The district court had federal question jurisdiction under 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e)(1).

STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Whether the District Court correctly determined that a board of trustees, that serves as both the plan sponsor and plan administrator of a multiemployer employee welfare benefit plan, may create one document that satisfies the requirements of both a written instrument under ERISA Sec. 402(a)(1) and a summary plan description under ERISA Sec. 102.

2. Whether the District Court correctly held that an equitable lien by agreement may be enforced under ERISA Sec. 502(a)(3) regardless of whether the defendant dissipates the fund after the lien attaches.

STATEMENT OF THE CASE

Appellant was injured in a motor vehicle accident on December 1, 2008. Vol. 2, Dkt. No. 39-3, 1. At the time of the accident, the Appellant was a participant in the National Elevator Industry Health Benefit Plan (hereinafter "Plan" or "NEI Plan"), a self-funded multiemployer employee welfare benefit plan sponsored and maintained by the Appellee. The Plan's Other Party Liability Claims provision governs benefits related to an injury or illness caused, directly or indirectly, by another party. Pursuant to this provision, the Plan only pays accident related benefits "that exceed any amounts recovered from another party."

Although medical expenses caused by another party are excluded from the Plan, the Plan allows for an advance of benefits on certain conditions. By accepting these advanced benefits, the covered person agrees: (1) that the covered person will "file a claim for benefits" against any party who may be liable for the injury; (2) that "amounts that have been recovered by a covered person from another party are assets of the Plan"; and (3) that "any amounts recovered from another party by award, settlement or otherwise, and regardless of how the proceeds are characterized" will go to reimburse the Plan for the advanced benefits. Vol. 2, Dkt. No. 36-4, 71.

As a result of the accident, Appellant needed lumbar spinal fusion and other medical treatment. Vol. 2, Dkt. No. 39-3, 1. Prior to the surgery, the Appellant

signed an acknowledgement that he was aware of the Plan's Other Party Liability Claims provision and would abide by its terms. Vol. 2, Dkt. No. 36-5, 1. Based on Appellant's agreement, the Plan advanced $121,044.02 in benefits on behalf of Appellant related to the December 1, 2008 accident. Vol. 1, Dkt. No. 1, 2; Vol. 1, Dkt. No. 11, 1.

Appellant filed claims against the liable third party and his own automobile carrier for claims associated with the automobile accident. Vol. 2, Dkt. No. 39-3, 2. Appellant eventually settled these claims for $500,000. Despite signing an agreement prior to receiving advanced benefits, Appellant refused to reimburse the Plan for medical benefits it advanced on his behalf. Vol. 1, Dkt. No. 11, 2. Instead, Appellant hired ERISA counsel in an attempt to defeat the Plan's right of reimbursement.

After an extended period of settlement negotiations, the Plan filed this complaint seeking reimbursement of the $121,044.02 in medical benefits advanced to Appellant under ERISA Sec. 502(a)(3). During the course of the litigation, Appellant maintained that the Plan's Other Party Liability Claims provision was located only in the Plan's summary plan description, as opposed to a written instrument of the plan, and was therefore not enforceable under ERISA Sec. 502(a)(3). After a failed judicial settlement conference, the parties filed cross-motions for summary judgment. In the briefings on the motion, Appellant also

argued that Appellee's equitable lien by agreement was not enforceable because he had dissipated the proceeds of the settlement. In granting summary judgment to the Appellee, the district court rejected the Appellant's arguments. Vol. 2, Dkt. No. 45. Appellant filed a timely notice of appeal. Vol. 2, Dkt. No. 47, 1.

STATEMENT OF THE STANDARD OF REVIEW

Factual findings of the district court are review for clear error. *United States v. Bazemore*, 41 F.3d 1431 (11th Cir. 1994). "A finding of facts is clearly erroneous when, after reviewing the entirety of the evidence, the reviewing court is left with the definite and firm conviction that a mistake has been committed." *City of Tuscaloosa v. Harcos Chems.*, 158 F.3d 548 (11th Cir. 1998).

The district court's grant of summary judgment is reviewed de novo. Summary judgment is appropriate where, when viewing the evidence in a light most favorable to the non-moving parties, "there is no genuine issue of material fact and…the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c); *see Anderson v. Liberty Lobby, Inc.* 477 U.S. 242, 249-250 (1986). The moving party need only show "that there is an absence of evidence" to support the position of the non-moving parties. *Celotex Corp. v. Catrett,* 477 U.S. 317, 323-325 (1986). The burden then shifts to the non-moving parties to point to specific evidence – as opposed to mere allegations, general denials, or vague statements – establishing a genuine issue for trial. *Id.* at 324. If the non-moving parties fail to make such a showing, summary judgment must be entered against them. *Celotex* 477 U.S. at 322; *Anderson*, 477 U.S. at 249.

SUMMARY OF THE ARGUMENT

Based on undisputed evidence, the district court correctly found that the Board of Trustees created the document titled "National Elevator Industry Health Benefit Plan Summary Plan Description" to serve as the written plan of welfare benefits described in the Trust Agreement. This document meets both the statutory and regulatory requirements of a "written instrument" under ERISA Sec. 402 and a "summary plan description" under ERISA Sec. 102. It is the only document that specifies the basis on which payments are made from the plan as required under Sec. 402. Additionally, undisputed evidence shows that it was the intent of the Trustees for the document to serve both as a written instrument and the summary plan description.

Despite waiving the argument in the lower court, Appellant now argues that ERISA prohibits one document from serving as a written instrument and a summary plan description. In support of this argument, Appellant relies exclusively on the United States Supreme Court's ruling in *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011). Yet, in the three years since *Amara* was decided, no court has accepted the broad interpretation advanced by the Appellant. While *Amara* does hold that summary plan descriptions are not automatically enforceable plan documents, there is nothing in *Amara* that prohibits plan sponsors and administrators from using one document to serve both purposes.

In another effort to avoid his obligation to the plan, the Appellant argues that he spent "almost all" of the settlement funds before the plan filed suit. According to the defendant, the district court erred by issuing "legal relief" as opposed to "equitable relief" authorized under ERISA Sec. 502(a)(3) because the Appellee could not trace the settlement funds to an intact *res*.

Appellant's argument fails. First, there is no evidence in the record that supports the allegation that the settlement funds were spent prior to the filing of the Appellee's lawsuit. The Appellant's affidavit testimony conflicts with itself regarding the amount he received from the settlement and doesn't address the timing of his alleged dissipation of the funds in relation to the lawsuit.

More importantly, Appellant's argument fails because two separate United States Supreme Court cases, *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356; 126 S.Ct. 1869 (2006) and *U.S. Airways, Inc. v. McCutchen*, 133 S.Ct. 1537 (2013), have held that enforcement of an equitable lien by agreement constitutes equitable relief under ERISA Sec. 502(a)(3). In *Sereboff*, a unanimous Supreme Court explained that the strict tracing requirements that applied historically to "equitable liens *by restitution*" do not apply to "equitable liens *by agreement*." Six circuit courts have interpreted *Sereboff* as allowing ERISA plans to enforce reimbursement provisions through an equitable lien by agreement, even when the defendant asserts that the settlement funds have been dissipated. *See*

Cusson v. Liberty Life Assurance Co. of Boston, 592 F.3d 215 (1st Cir. 2010); *Thurber v. Aetna Life Inc. Co.*, 712 F.3d 654 (2d Cir. 2013); *Funk v. CIGNA Grp. Ins.*, 648 F.3d 182 (3d Cir. 2011); *ACS Recovery Servs., Inc. v. Griffin*, 723 F.3d 518 (5th Cir. 2013); *Longerberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009); *Gutta v. Std. Select Trust Ins. Plans*, 530 F.3d 614 (7th Cir. 2008).

The Ninth Circuit Court of Appeals stands alone in prohibiting the enforcement of an equitable lien by agreement when the settlement funds have been dissipated. *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012) *cert. denied*, 133 S.Ct. 1242 (2013). In that case, the Ninth Circuit incorrectly applied restitutionary requirements to equitable liens by agreement. This Circuit should join the majority of circuits and affirm the district court's ruling that dissipation of the settlement funds is immaterial to Appellee's claim.

ARGUMENT

I. THE DISTRICT COURT CORRECTLY DETERMINED THAT THE DOCUMENT TITLED "NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN SUMMARY PLAN DESCRIPTION" IS AN ENFORCEABLE PLAN DOCUMENT

A. Appellant's Argument That A Single Document Cannot Serve As Both Plan Document and Summary Plan Description Was Waived In the Lower Court Proceedings

The Appellant argues for the first time on appeal that a summary plan description cannot be a governing plan document. The Appellant's curious reading of *Amara* notwithstanding, we are unaware of any court or regulatory agency rulings that prohibit ERISA employee welfare benefit plan sponsors from designing plans so that the summary plan descriptions also serve as governing plan documents. By raising this issue, the Appellant urges this Court to establish precedent that will reach far beyond a dispute regarding this Plan's right to enforce an equitable lien. Should the Appellant prevail on this issue, the NEI Plan, its participants and beneficiaries would be left without a governing plan document and expose both the Plan and its administrator to extraordinary liabilities. Moreover, it would leave many other ERISA employee welfare benefit plans that for decades have been administered so that the plans' summary plan descriptions operate as governing plan documents in a similar predicament. Had the Appellant not waived this issue below, the Appellee would have vigorously challenged the

argument's legal underpinnings as both an evidentiary matter[1] and as a matter of law.

In the court below, the Appellant "acknowledge[d] that ERISA plan fiduciaries may draft a document that operates both as the governing plan document and the SPD mandated by ERISA." Vol. 2, 39, 4. Now, the Appellant takes the exact opposite position, arguing that one document can never serve as both a "written instrument" and "summary plan description." Brief of Appellant, p. 17. This Court should not consider an argument that was not advanced (and in fact conceded) in the court below. *Eagle Hosp. Physicians, LLC v. SRG Consulting, Inc.*, 561 F.3d 1298, 1307 (11th Cir. 2009). *See also,* 19 James Wm. Moore *et al.*, *Moore's Federal Practice* § 205.05[1] ("The reason for such a rule is

[1] For example, Appellant asserts for the first time on appeal that the Summary Plan Description does not comply with Department of Labor summary plan description regulations. Brief of Appellant, p. 25 n. 8. To help rebut that claim, the Appellee would have submitted correspondence between the Department of Labor and the NEI Plan relating to the Department of Labor's random examination of the Plan initiated on February 4, 2013. Among other things, this correspondence would have shown that the Department of Labor—the agency charged with enforcing and regulating ERISA Secs. 102 and 402—after reviewing the Summary Plan Description, did not question its accuracy or its comprehensiveness and did not in any way suggest that it was not written in a manner calculated to be understood by the average plan participant. Moreover, the manner in which the Department of Labor requested documents from the Plan in the agency's February 4 letter would have indicated that the agency recognizes that many ERISA welfare benefit plans are governed by multiple documents. In fact, the Appellee may have requested the Department of Labor provide an opinion as to whether an administrator of an ERISA welfare benefit plan may have its summary plan description serve as an ERISA Sec. 402(a)(1) governing plan instrument.

obvious: '[analyzing] the facts of a particular [issue] without the benefit of a full record or lower court determination is not a sensible exercise.'" (quoting *Yee v. City of Escondido*, 503 U.S. 519, 538 (1992) (internal quotations omitted))).

B. *Amara* Does Not Alter This Circuit's Prior Holdings That Summary Plan Descriptions May Qualify As Enforceable Plan Documents

If this Court does consider Appellant's argument, it should be rejected. The issue of whether a summary plan description may serve as an enforceable plan document should be considered in the context of the fundamental purpose of ERISA Sec. 402. Section 402 ensures that ERISA plans are established and maintained pursuant to a written plan document, and "[a] written plan is to be required in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan. Also, a written plan is required so the employees may know who is responsible for operating the plan." *See* H.R. Rep. No. 93-1280, 2d Sess., at 297 (1974), *reprinted in* U.S.C.C.A.N. 5038, 5075. In *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995), the Court explained:

> ERISA gives effect to this "written plan documents" scheme through a comprehensive set of "reporting and disclosure" requirements, see [ERISA Secs. 101-111]. . . One provision, for example, requires that plan administrators periodically furnish beneficiaries with a Summary Plan Description. . . , the purpose being to communicate to beneficiaries the essential information about the plan.

The NEI Plan is governed by several "written plan documents" including the collective bargaining agreement between signatory employers and the union, the Trust Agreement and the Summary Plan Description. It is only the latter of these three written plan documents that satisfies the statutory requirement that the basis on which payments are made from the Plan be specified in writing. *See* ERISA Sec. 402(b)(4). The fact that the Summary Plan Description also satisfies the requirements of ERISA Section 102 and the complex set of Department of Labor regulations that govern the content of summary plan descriptions is merely a matter of plan design that is subject to ERISA's comprehensive disclosure requirements (*i.e.*, does the Summary Plan Description meet Department of Labor requirements set forth in 29 C.F.R. § 2520.102-1 *et seq.*[2]).

The fact that more than one document collectively can comprise the ERISA Sec. 402 written instrument has been well-established. *See Myron v. Trust Co. Bank Long-Term Disability Benefit Plan*, 522 F. Supp. 511, 519 (N.D. Ga. 1980), *aff'd*, 691 F.2d 510 (11th Cir. 1982), *cert. denied*, 462 U.S. 1119 (1983) (". . . the Court has found no authority that states that [the 402(a)(1)] written instrument must be one all-inclusive document. Indeed, the legislative history indicates that

[2] For example, the Summary Plan Description regulations require that an SPD provide "a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., *by exercise of subrogation or reimbursement rights*) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide. . ." 29 C.F.R. § 2520.102-3(l) (emphasis added).

Congress contemplated the possibility of more than one writing constituting an ERISA plan."); *Eardman v. Bethlehem Steel Corp. Emp. Welfare Benefit Plan*, 607 F. Supp. 196, 207 (W.D.N.Y. 1984); *Gonzales v. Unum Life Ins. Co. of Am.*, 861 F. Supp.2d 1099, 1107 (S.D. Cal. 2012).

This Circuit has previously recognized that a summary plan description may serve as a plan document. *Alday v. Container Corp. of America*, 906 F.2d 660, 666 (11th Cir. 1990) ("Here…there was an SPD that clearly functioned as the plan document required by ERISA."). *See also*, *Ross v. Rail Car Am. Group Disability Income Plan*, 285 F.3d 735, 738-39 (8th Cir. 2002) (finding that as a matter of law the district court was correct that an ERISA welfare plan's disability income insurance policy and its SPD were the plan's Sec. 402(a)(1) "written instrument").

The United States Supreme Court's decision in *CIGNA v. Amara,* 131 S.Ct. 1866 (2011) does not command a different result. In *Amara*, employees commenced a lawsuit against their employer and pension plan challenging their employer's conversion of the pension plan from a traditional defined benefit pension plan to a cash balance retirement plan. They contended that they were entitled to certain equitable relief arguing, among other things, that the notice they received from their employer, was misleading and incomplete in violation of

ERISA Secs. 102(a), 104(b) and 204(h).[3] The trial court reformed the terms of the plan to match those found in the communications and awarded benefits under the reformed plan pursuant to ERISA Sec. 502(a)(1)(B). Upon certiorari, the Court held that the remedy of reformation was not available under ERISA Sec. 502(a)(1)(B), because 502(a)(1)(B) allows only the enforcement of an employee benefit plan as written.

In an amicus brief, the Solicitor General argued reformation was not necessary because the plan's communications about the amendments constituted a summary plan description which could be enforced as a plan document. The Supreme Court rejected this argument holding: "we cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced…as terms of the plan itself." *Id.* at 1877 (emphasis added). The Court explained that the Solicitor General's view ignored the division of authority between the plan sponsor and the plan administrator. The plan sponsor is responsible for establishing the plan and executing a written document containing its terms. On the other hand, the plan administrator manages the plan according to its terms and provides summary documents to participants and beneficiaries. To hold that summaries automatically constitute terms of the plan

[3] ERISA Sec. 204(h) requires that a pension plan administrator provide notice of significant reduction in benefit accruals. Sec. 204(h) does not apply to ERISA welfare benefit plans.

itself would be to vest the plan administrator with the power to amend the plan by changing the summary. *Id.*

The Supreme Court's logic in *Amara* presumes that there is summary plan description and a separate written plan document. While this is typically the case in the context of an ERISA pension plan, it frequently is not the case in the context of a welfare benefit plan where the administrator adopts the summary plan description to also function as the detailed plan of benefits. Where "summaries" of the written plan's terms merely summarize a separate detailed plan document, such summaries will not automatically be considered enforceable "terms of the plan" for purposes of ERISA Sec. 502(a)(1)(B). In fact, Justice Breyer's use of the word "necessarily" presumes that there may be times when the summary plan description either constitutes, or is part of, the written plan.

No court interpreting *Amara* has applied it as broadly as the Appellant requests this Court to do. In fact, several courts have acknowledged that a summary plan description may be incorporated into, and enforced as, the written plan in accordance with *Amara*. *See Eugene S. v. Horizon Blue Cross Blue Shield of N. J.*, 663 F.3d 1124 (10th Cir. 2011)("[T]he SPD does not conflict with the Plan or present terms unsupported by the Plan; rather, it *is* the Plan."); *L&W Assoc. Welfare Benefit Plan v. Estate of Wines*, 2014 U.S. Dist. LEXIS 3512 (E.D. Mich. 2014)("*Amara* does not support the broad position urged by the Estate, *i.e.* that an

SPD can never serve as an ERISA plan document."); *Shaffer v. Rawlings Co.,* 424 Fed. Appx. 422 (6th Cir. 2011).

This case is distinguishable from the facts in *Amara*. Here, there is only one document that describes the nature and extent of plan benefits. As such, this case more closely resembles that of *Administrative Committee of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Gamboa*, 479 F.3d 538 (8th Cir. 2007). In *Gamboa,* the only document describing the nature and extent of benefits was titled "Associate Benefits Book." Due to an administrative error, the benefit book was not listed in the wrap document as an official plan document although it was the only document which outlined the benefits available to participants and beneficiaries. The question before the Eighth Circuit was whether the terms of the benefit book constituted plan terms enforceable under ERISA Sec. 502(a)(3). In finding the benefit book enforceable, the Eighth Circuit stated: "It would be nonsensical to conclude that the plain language of the Plan requires an interpretation that renders no plan at all under the terms of ERISA." *Id.* at 544. The Second Circuit reached a similar conclusion in *Feifer v. Prudential Insurance Co. of America*, 306 F.3d 1202 (2d Cir. 2002) ("We reject the notion that this disclaimer renders the [plan summary] as a non-plan during the period it was the only written document describing benefits."). If accepted, Appellant's argument

would create the same "nonsensical" result rejected by the *Gamboa* and *Feifer* courts.

Although both the *Gamboa* and *Feifer* decisions pre-date *Amara*, the United States District Court for the Western District of Missouri applied the same rationale to its post-*Amara* ruling in *Ozarks Coca-Cola v. Ritter*, 2011 U.S. Dist. LEXIS 66686 (W. D. Mo. 2011). With facts almost identical to those at the bar, *Ritter* involved a self-funded employee benefit plan seeking to enforce its recovery provision under ERISA Sec. 502(a)(3). The only document defining the benefits was titled "Summary Plan Description" and the defendant argued that it was not enforceable under *Amara*. The district court ruled in favor of the plan, holding "*CIGNA* is distinguishable because the SPD [is] the only document establishing the terms of the plan. *CIGNA* assumes the existence of both an instrument establishing the terms of the plan and a summary plan description."

This case is further distinguishable from *Amara* because it does not possess the same policy concerns. For the NEI Plan, the Board of Trustees serves as both the plan sponsor and plan administrator.[4] In accordance with its discretionary

[4] We note that the Appellant is mistaken when he claims that the NEI Plan was established by its Trustees and the Union. Appellant's brief, p. 22. The Board of Trustees had no role in the establishment of the NEI Plan. In fact, the settlors of the NEI Plan were an employer bargaining association, National Elevator Industry, Inc., and the Union. As set forth in the Trust Agreement, these two trust settlors delegated to the Board of Trustees the exclusive authority to operate and administer the NEI Plan and adopt, and from time to time modify and amend, a

authority, the Board of Trustees adopted a single document that serves both as the formal written plan document describing benefits and the summary plan description. Any amendment to this document must be adopted by the Board of Trustees in its dual role as *sponsor* and *administrator*.[5]

Also absent in this case is the *Amara* court's concern that unequivocally defining SPDs as enforceable plan documents would encourage ERISA plan administrators to "sacrifice simplicity and comprehensibility in order to describe the plan terms in the language of lawyers." *Amara* at 1877-78. In this case, the document titled "National Elevator Industry Health Benefit Plan Summary Plan Description" is not the only "written instrument" by which the NEI Plan is established and maintained. The Trust Agreement accomplishes many of ERISA Sec. 402's "written instrument" requirements, in that it: (1) provides a procedure for establishing and carrying out a funding policy; (2) describes the plan's procedures for its operation and administration; and (3) provides a procedure for amending the plan, and for identifying the plan. The Trust Agreement is written in sufficiently technical terms to ensure the proper administration of the plan and is full of the "language of lawyers." The Trust Agreement does not, however, "specify the basis of the payments…from the plan" by detailing the type, amount,

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Plan of Welfare Benefits (*i.e.*, a program of welfare benefits). Vol. 1, Dkt. No. 36-2, 2, 8 and 34-38.

[5] *See* ERISA Sec. 3(16)(B)(iii).

and duration of benefits. For this requirement of Sec. 402, the Trust Agreement contemplated a separate written plan of benefits, which the Trustees produced in the document titled "National Elevator Industry Health Benefit Plan Summary Plan Description." In meeting the requirement of a summary plan description, this document must be "sufficiently accurate and comprehensive as to reasonably apprise participants of their rights and obligations under the plan" and "must be written in a manner calculated to be understood by the average plan participant." ERISA Sec. 102(a). It also must include the information described in 26 C.F.R. § 2520.102-3.[6]

Finally, this case is distinguishable from *Amara* because the plan sponsor in *Amara* did not produce the summaries with the purpose of having them operate as

[6] Appellant characterizes the Summary Plan Description as nothing more than a "poorly drafted" summary plan description and a "cumbersome 95-page document." This characterization of the Summary Plan Description suggests a lack of understanding regarding the comprehensive scope of benefits the Plan offers, the Appellee's obligation to comply with the requirements 26 C.F.R. § 2520.102-3.6, as well as the federal laws enacted after ERISA that impact the rights of the Plan's participants and beneficiaries including, but not limited to, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272; the Family and Medical Leave Act of 1993 (FMLA), Pub. L. No. 103-3; The Child Support Performance and Incentive Act of 1996, Pub. L. No. 105-200; the Women's Health and Cancer Rights Act, Pub. L. No. 105-277, Title IX; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191; 45 C.F.R. parts 160 and 164, 65 Fed. Reg. 82,462 (Dec. 28, 2000); the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), Pub. L. No. 104-204; Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204; the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 11-343; Michelle's Law, Pub. L. No. 110-381; and the Patient Protection and Affordable Care Act (PPACA) Pub. L. No. 111-148.

written plan documents or amendments to such documents. To the contrary, the trial court concluded that the summaries were intended to mislead employees about how amendments to the underlying plan document would impact employees' future benefit accruals. *See Amara v. CIGNA Corp.*, 534 F. Supp.2d 288, 350-51 (D. Conn. 2008) *aff'd*, 348 Fed.Appx. 627 (2d Cir. 2009), *vacated and remanded* 131 S.Ct. 1866 (2011). Here, the Board of Trustees, as plan sponsor and administrator, states that the Summary Plan Description is *the* written plan of benefits of the NEI Plan. In short, the Court in *Amara* did not consider whether a document the administrator establishes as the written plan of benefits of a welfare benefit plan can also serve as that plan's summary plan description.

C. If This Court Accepts Appellant's Interpretation of *Amara*, All Other Participants and Beneficiaries of the NEI Plan Will Be Harmed

If the document titled "National Elevator Industry Health Benefit Plan Summary Plan Description" is not considered an enforceable plan document, then there would be no enforceable document that describes what type of treatment is covered, the level of coverage, or the process by which to obtain that coverage. While such a result may benefit the Appellant by allowing him to obtain benefits without honoring his obligation to reimburse the NEI Plan from his $500,000 settlement, it would be to the serious detriment of all others covered by the NEI Plan. Participants and beneficiaries would no longer be able to enforce their right to benefits under the straight-forward provisions of ERISA Sec. 502(a)(1)(B).

Instead, they would be limited to "appropriate equitable relief" under ERISA Sec. 502(a)(3). Ironically, the participants would be asking the courts, through the equitable remedies of reformation or surcharge, to provide the same level of benefits specified in the National Elevator Industry Employee Benefit Plan Summary Plan Description. This is the very same document that the Appellant seeks to avoid.

D. The District Court Correctly Issued a Finding of Fact That the Document Titled The National Elevator Industry Summary Plan Description is the Written Plan of Benefits Contemplated in Article VII of the Trust Agreement

Appellee presented the district court with affidavit testimony that the document titled "National Elevator Industry Health Benefit Plan Summary Plan Description" is the written "Plan of Welfare Benefits" required by Article VII of the Trust Agreement. Vol. 1, 36-1, Par. 7. Appellant offered no evidence to dispute the affidavit testimony, nor did he challenge its admissibility or credibility. Instead, the Appellant merely noted that the affidavit testimony was not supported by "minutes, notes or other documents" demonstrating that the document had been formally approved by the Trustees. In response, Appellee presented an additional affidavit with the minutes of the meeting where the Trustees approved the document attached as an exhibit.

After reviewing the evidence as a whole, the district court issued a finding of fact that "the Summary Plan Description is clearly contemplated by the [Trust

Agreement and CBA] and is the only document containing the requisite information about the eligibility requirements, type, amount and duration of benefits for Plan participants." Vol. 2, Dkt. No. 45, 7-8. This finding of fact can only be reversed if this Court determines it is clearly erroneous. *General Trading v. Yale Material Handling Corp.*, 119 F.3d 1485, 1495 (11th Cir. 1997) ("With respect to proceedings in the district court, this court reviews factual findings for clear error, and reviews applications of law to those facts de novo.")

Because he has no evidence to refute the district court's finding, the Appellant proposes a new theory: rather than create a written plan of benefits as directed in Article VII of the Trust Agreement, the Trustees relied on contracts of insurance and administrative service agreements to serve along with the Trust Agreement as the "written instrument" requirement of ERISA Sec. 402. According to this theory, the Trustees then summarized these various contracts and agreements in the document titled "National Elevator Industry Health Benefit Plan Summary Plan Description."

Appellant's unfounded conjecture should be disregarded. First, not one of these contracts or agreements is in the record. The Appellant offers no evidence that these documents address eligibility requirements, or the type, amount and duration of benefits as required by the Trust Agreement. Second, this theory is contrary to the argument that Appellant advanced in the district court – that the

Trust Agreement and the CBA are the only two governing documents of the NEI Plan. Vol. 1, Dkt. No. 35, 5. Finally, Appellant's theory is in direct conflict with the only evidence in the record regarding the plan documents, the affidavit testimony of John McGowan. Vol. 2, Dkt. No. 36-1, 7.

As a final argument, the Appellant points out that the document titled "National Elevator Industry Health Benefit Plan Summary Plan Description" does not identify itself as the written Plan of Benefits described in the Trust Agreement, or as a written instrument under ERISA Sec. 402. But, Sec. 402 does not require that an ERISA plan's written instruments be titled as such. *Horn v. Berdon*, *Inc. Defined Ben. Pension Plan,* 938 F.2d 125, 127 (9th Cir. 1991)("[T]here is no requirement that documents claimed to collectively form an employee benefit plan be formally labeled as such.") Whether a document is a "written instrument" of an ERISA plan, is determined by its content and the intent of its drafters, not its title.

II. THE DISTRICT COURT CORRECTLY DETERMINED THAT ENFORCEMENT OF THE NEI PLAN'S EQUITABLE LIEN BY AGREEMENT CONSTITUTES "APPROPRIATE EQUITABLE RELIEF" UNDER ERISA 502(a)(3)

A. The Other Party Liability Claim Provision Creates A Valid, Enforceable Equitable Lien By Agreement

Appellee filed the underlying action seeking "appropriate equitable relief" to enforce the NEI Plan's Other Party Liability Claims provision under ERISA Sec. 502(a)(3). In *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356; 126

S.Ct. 1869 (2006), the United States Supreme Court held that the remedy of "equitable lien by agreement" constitutes equitable relief authorized by ERISA Sec. 502(a)(3). To create an equitable lien by agreement, an ERISA plan must meet two requirements: (1) identify a particular fund distinct from the defendant's general assets; and (2) identify a particular share of the fund to which it is entitled. *Sereboff* at 364. The Other Party Liability Claims provision satisfies both of these requirements. First, it identifies "any amounts recovered from a third party by award, settlement, judgment, or otherwise" as a fund distinct from Appellant's general assets. Second, the provision specifies the amount necessary to "reimburse the Plan in full for benefits advanced" as a particular share of the fund to which it is entitled. Vol. 2, Dkt. No. 36-4, 82.

The United States Supreme Court again examined the scope of equitable liens by agreement in *U.S. Airways, Inc. v. McCutchen*, 133 S.Ct. 1537 (2013). Like *Sereboff*, *McCutchen* involved an employee benefit plan asserting an equitable lien by agreement on the proceeds of a participant's liability settlement. The district court granted summary judgment to the plan. On appeal, the Third Circuit reversed, holding that to qualify as "appropriate equitable relief" under ERISA the plan's claim was subject to equitable defenses, such as unjust enrichment. The plan's petition for certiorari was granted by the United States Supreme Court.

Upon vacating the Third Circuit's decision, the Supreme Court held that the plan sought to enforce the modern-day equivalent of an equitable lien by agreement. "And that kind of lien—as its name announces—both arises from and serves to carry out a contract's provision." *Id.* at 1546. "Even in equity, when a party sought to enforce an equitable lien by agreement, all provisions of that agreement controlled." *Id.* at 1549. In *McCutchen*, the Supreme Court reiterated the principle set forth in *Sereboff*, that enforcement of an equitable lien by agreement constitutes "appropriate equitable relief" under ERISA Sec. 502(a)(3).

B. Appellant's Alleged Dissipation Of The Settlement Proceeds Does Not Preclude Enforcement of the Appellee's Equitable Lien By Agreement

Appellant alleges that a third United States Supreme Court, *Great-West Life & Annuity Co.*, 534 U.S. 204 (2002), precludes enforcement of Appellee's equitable lien by agreement because he had dissipated "a substantial portion" of the settlement funds prior to Appellee filing this action.[7] If the settlement funds

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7 Appellant's factual statements in his brief regarding dissipation of the settlement funds and the evidence in the record are replete with inconsistencies. For instance, the record includes a settlement disbursement sheet attached to a sworn declaration signed by Appellant. The disbursement sheet shows $60,513.28 in past disbursements to the Appellant, $28,296.00 in available funds, plus $108,607.07 for the Appellee's "Health Care Lien". Vol. 2, Dkt. No. 39-3, 5. The record indicates that the remaining $108,000 was disbursed to Appellant on February 2, 2012. Vol. 1, Dkt. No. 35-2, 3. Therefore, the record reflects that Appellant received at least $197,416.35 from the proceeds of the $500,000 settlement. Yet, in the same sworn declaration, Appellant claims that he only received approximately $90,000 from the settlement. Vol. 2, Dkt. No. 39-3, 2. The

are no longer in his possession, Appellant argues the summary judgment granted by the district court constitutes legal relief against his personal assets not authorized by ERISA Sec. 502(a)(3).

Appellant's argument misses the crucial distinction between equitable liens imposed by restitution (discussed in *Knudson*) and equitable liens imposed by agreement (discussed in *Serebof* and *McCutchen*). Much like this case, *Knudson* involved an employee benefit plan that paid accident related benefits on behalf of a beneficiary who was severely injured in an automobile accident. A liability claim was filed on behalf of the beneficiary against the manufacturer of her vehicle. The terms of the plan imposed a "first lien upon any recovery" obtained by the beneficiary. *Id.* at 207. The liability claim settled and the proceeds were placed in a special needs trust. The trustee refused to reimburse the plan, and the plan's

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Appellant's brief relies on the same declaration to support Appellant's claim that "most" or a "substantial portion" of the settlement funds had been spent by the time that Appellee filed its lawsuit. Appellant's Brief, pp. 3, 7 and 30. But, the declaration does not indicate that the funds had been spent at the time Appellee's lawsuit was filed on July 11, 2012. It merely alleges that most of the $90,000 (not the $197,416.35) had been spent when the declaration was signed on September 24, 2013. No evidence in the record supports the Appellant's unfounded statement that most of the settlement funds had been dissipated prior to the filling of Appellee's lawsuit. In fact, the Appellant admitted the allegation in Appellee's complaint that "all or part" of the settlement proceeds were in his actual or constructive possession when he filed his answer. Vol. 1, Dkt. No. 1, 3, Par. 14; Vol.1, Dkt. No. 11, 2, Par. 14.

assignee filed suit solely against the beneficiary seeking "restitution" of the benefits paid by the plan.

In examining whether the "restitution" sought by the plan constituted "equitable relief" under ERISA Sec. 502(a)(3), the Court noted that restitution was available both in cases at law and cases in equity. *Id.* at 212. Restitution can be obtained in equity through creation of a constructive trust or equitable lien where "property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession." *Id.* at 213. The Court determined that the plan in *Knudson* was not entitled to restitution in the form of an equitable lien because the defendant beneficiary was not in possession of the settlement proceeds. The Court specifically left open whether the plan could have obtained relief against the trustee of the special needs trust. *Id.* at 220.

In the current action, Appellee does not rely on restitution to create an equitable lien[8]. Instead, the equitable lien asserted by Appellee derives from an agreement, *i.e.* the NEI Plan document. As such, the relief sought by Appellee is identical to the equitable relief allowed in *Sereboff*. In authoring the opinion of the unanimous court, Chief Justice Roberts recognized that "an equitable lien sought as a matter of restitution and an equitable lien 'by agreement'…were different species of relief" and that it was inaccurate to apply "all of the restitutionary

[8] The word "restitution" does not appear in the Appellee's Complaint. Vol. 1, Dkt. No. 1

conditions…to every action for equitable lien under Section 502(a)(3)." *Sereboff* at 364, 365. Chief Justice Roberts further explained the dicta in *Knudson*:

> *Knudson* simply described in general terms the conditions under which a fiduciary might recover when it was seeking equitable restitution under a provision like that at issue in [*Sereboff*]. There was no need in *Knudson* to catalog all circumstances in which equitable liens were available in equity; Great-West claimed a right to recover in restitution, and the Court concluded only that equitable restitution was unavailable because the funds sought were not in Knudson's possession.

Id. at 365.

Contrary to Appellant's assertions, the fact that Appellee's equitable lien is created by agreement rather than through restitution does not make the remedy any less equitable. Like the claim in *Sereboff*, the Appellee's "action to enforce the [Other Party Liability Claims] provision qualifies as an equitable remedy because it is indistinguishable from an action to enforce an equitable lien established by agreement, of the sort epitomized by [the Supreme Court's] decision[s] in *Barnes"* and *Sereboff*. *Id.* at 368. Pursuant to *Sereboff*, restitutionary conditions such as strict tracing rules simply do not apply to equitable liens by agreement.

Dobbs Law of Remedies § 4.3(3) sheds further light on the difference between equitable liens by agreement and equitable liens by restitution. Equitable liens by restitution are imposed to prevent unjust enrichment. The measure of the claim is not the loss to the plaintiff, but of the unjust enrichment to the defendant.

If the defendant is no longer in possession of the property creating the unjust enrichment (or a fund or asset into which it had been converted), then he is no longer enriched and the restitution claim fails.

As the district court recognized in its opinion, The First, Second, Third, Fifth, Sixth and Seventh Circuits have all correctly acknowledged that equitable liens by agreement can be enforced despite dissipation of the property or funds subject to the lien. *See Cusson v. Liberty Life Assurance Co. of Boston*, 592 F.3d 215 (1st Cir. 2010); *Thurber v. Aetna Life Inc. Co.*, 712 F.3d 654 (2d Cir. 2013); *Funk v. CIGNA Grp. Ins.*, 648 F.3d 182 (3d Cir. 2011); *ACS Recovery Servs., Inc. v. Griffin*, F.3d. 518 (5th Cir. 2013); *Longerberger Co. v. Kolt*, 586 F.3d 459 (6th Cir. 2009); *Gutta v. Std. Select Trust Ins. Plans*, 530 F.3d 614 (7th Cir. 2008).

Very recently, the Fifth Circuit once again explained its take on the dissipation issue in *Cent. States, Southeast & Southwest Areas Health & Welfare Fund v. Health Special Risk, Inc.*, __ F.3d.__; 2014 U.S. App. LEXIS 11904 (5th Cir. June 23, 2014). In that case, an ERISA plan sought an equitable lien by restitution against third party insurers it claimed were primary for a participant's medical expenses. In evaluating the plan's claim, the Fifth Circuit advised that *Sereboff* "distinguished between equitable liens by agreement–which do not require tracing–and equitable liens by restitution—which do." *Id.* at 16. Because

the basis of the plan's claim was in restitution, as opposed to agreement, "the requirement that the res be traceable is still very much intact." *Id.*

Meanwhile, the Ninth Circuit stands alone in applying strict restitutionary tracing requirements to equitable liens by agreement.[9] *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083 (9th Cir. 2012) *cert. denied*, 133 S.Ct. 1242 (2013). *Bilyeu* was decided in a 2-1 decision by a sharply divided panel. The majority opinion determined that *Sereboff's* discussion of tracing rules applied only to "tracing a particular fund back to the plaintiff's own possession." *Id.* at 1096, ft. 6. In support of this narrow interpretation, the majority relied extensively on the Restatement (First) of Restitution (1937) and Restatement (Third) of Restitution and Unjust Enrichment (2011). As their titles imply, these treatises discuss equitable liens by restitution rather than equitable liens by agreement. Judge Rawinson wrote a dissenting opinion wherein she explained: "I would adhere to the reasoning of the Supreme Court in *Sereboff* as interpreted by our sister circuits, and conclude that strict tracing of overpaid funds is not required to enforce an equitable lien by agreement." *Id.* at 1102.

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9 Appellee contends that the Eighth Circuit joined with the Ninth Circuit in *Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Trust v. Goding*, 692 F.3d 888 (8th Cir. 2012), *cert denied,* 133 S.Ct. 1644 (2013). Nevertheless, the plan in *Goding* was seeking to impose an equitable lien by restitution against an attorney who was not covered by the plan. As such, equitable lien by agreement was not available. The Eighth Circuit correctly held that possession was required for enforcement of the equitable lien by restitution.

The Appellant invites this Court to adopt the reasoning of the divided Ninth Circuit panel in *Bilyeu* over that of the First, Second, Third, Fifth, Sixth and Seventh Circuits. This Court should deny that invitation. The approach taken by the majority of circuits is not only the correct application of Supreme Court precedent, it is better policy.

The Ninth Circuit's approach rewards bad action. It will encourage plan participants to dissipate settlement funds as quickly as possible to avoid the bargain they agreed to when they accepted benefits. Dishonest plan participants and their counsel will be incentivized to mislead plans about the timing or amount of their settlements. *See AirTran Airways, Inc. v. Elem*, 771 F.Supp.2d 1344 (N.D. Ga. 2011)(Attorney and participant attempted to hide $475,000 of a $500,000 settlement by executing two releases and lying to the plan representative). Some may simply refuse to preserve and turn over funds despite orders from the court that they do so. *See Cent. States, Southeast & Southwest Areas Health & Welfare Fund v. Lewis*, 745 F.3d 283 (7th Cir. 2014). Why not? The more of the settlement they can spend, the less they will personally have to pay back to the plan. Of course, such actions would be at a great cost to the other participant and beneficiaries in their self-funded plans.

The majority approach is better policy because it protects and preserves the assets of self-funded plans. Subrogation and reimbursement provisions are crucial

to the financial viability of self-funded plans. *Administrative Committee of the Wal-Mart Stores, Inc. Assoc. Health and Welfare Plan v. Shank*, 500 F.3d 834, 838 (8th Cir. 2007). Allowing plan members to avoid reimbursement obligations by merely spending the money "would harm other plan members and beneficiaries by reducing funds available to pay their claims." *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232, 1238 (11th Cir. 2010) *cert. denied*, 131 S. Ct. 943 (2011). As a result, the cost of medical treatment caused by third parties would be absorbed by all plan members and beneficiaries through higher contributions and premiums. *Schwade v. Total Plastics, Inc.*, 837 F.Supp.2d 1255, 1278 (M.D. Fla. 2012). Worse yet, it would dissuade employers from sponsoring and maintaining employee benefit plans in the first place. *See O'Hara* at 1237.

CONCLUSION

The order and judgment of the district court should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(c), the undersigned hereby certifies that this brief, in Times New Roman 14-point type face, contains 7,576 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and therefore complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B)(i).

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CERTIFICATE OF SERVICE

I hereby certify that on June 30, 2014 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

I further certify that an original and 6 copies of the foregoing was sent via Next Day Air to the Clerk of the Court.

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