No. 13-2233

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

SALVADOR SILVA,
Plaintiff-Appellant,

v.

METROPOLITAN LIFE INSURANCE CO;
SAVVIS COMMUNICATIONS CORP.,
Defendant-Appellee.

On Appeal from the United States District Court
for the Eastern District of Missouri at St. Louis

BRIEF OF THE SECRETARY OF LABOR, THOMAS E. PEREZ AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT

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STATEMENT OF THE ISSUES

1. Whether the district court erred in denying plaintiff's motion for leave to amend his complaint to add claims for "appropriate equitable relief" under section 502(a)(3) of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132(a)(3), on the grounds of futility.

2. Whether the district court erred in finding that plaintiff had been properly furnished a summary plan description (SPD), as required under section 104 of ERISA, 29 U.S.C. § 1024, and accompanying regulations.

STATEMENT OF INTEREST

The Secretary of Labor ("Secretary") has primary regulatory and enforcement authority for Title I of ERISA. See Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 692-93 (7th Cir. 1986) (en banc). This case presents an important remedial issue concerning the scope of equitable remedies available under ERISA section 502(a)(3). The Secretary has a strong interest in the proper resolution of this issue, an interest that is manifest both in private cases and in the Secretary's own litigation brought under a parallel provision of ERISA that allows the Secretary to sue for "appropriate equitable relief." 29 U.S.C. § 1132(a)(5). Likewise, the Secretary has an interest in the proper application of the statute and accompanying regulations regarding the distribution of SPDs. 29 U.S.C. § 1024; 29 C.F.R. § 2520.104b-1(b)(1), (b)(3) and (c).

The Secretary files this brief pursuant to Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

This case involves a claim for life insurance benefits under an ERISA-governed employee benefit plan by Salvador Silva ("Silva" or "Salvador Silva"), the father of Abel Silva ("Abel"). Appellant's Appendix (AA) 270-271. From September 2004 until the time of his death on June 27, 2010, Abel was an employee of Defendant Savvis Communications Corporation ("Savvis"). AA 271. Savvis offered and served as plan administrator for a life insurance plan sponsored by Savvis (the "Plan"), an ERISA-covered employee benefit plan. Id. at 273. Hartford Life Insurance originally insured the Plan, until January 2008, when Defendant Metropolitan Life Insurance Company ("MetLife") replaced Hartford Life Insurance. Id. at 271 n.7.

When Abel began his employment with Savvis, in the fall of 2004, he initially declined supplemental life insurance coverage. AA 271. At the time, the enrollment form stated that the Plan's insurer, Hartford Life Insurance, required "evidence of good health that is satisfactory to Hartford Life" if he later decided to enroll in Savvis' Group Supplemental Life Insurance plans. Id. Several years later, during an open enrollment period, Abel used an online enrollment form to request supplemental life insurance from the new insurer, MetLife, with a coverage level

of five times his salary, or $429,000 at the time of his death. Id. at 192, 274. Abel designated his father Salvador Silva as the sole beneficiary. Id. at 22, 274. As of January 1, 2010, when Savvis began deducting the cost of the supplemental life insurance premiums from Abel's paycheck and forwarding them to MetLife, id. at 276, Savvis' Benefits Election summary for Abel showed $429,000 in Supplemental Life Insurance. Id. at 331. Abel continued to pay premiums in this manner, which MetLife accepted, for the next six months until the time of his death. Id. at 276, 536, 542.

When Salvador Silva submitted a claim for the proceeds, however, MetLife denied his claim because it determined that Abel Silva had not submitted "evidence of insurability," in the form of a "Statement of Health," and thus had not been eligible for coverage. AA 274. In support of the denial of benefits, MetLife and Savvis relied on a certificate of insurance, which they say functioned both as the relevant Plan document and as the SPD, and which they contend, but have not produced any evidence to show, was distributed to all participants, including Abel. Id. at 367-462, 509, 520, 566, 576. However, although the certificate stated that an applicant had to submit "evidence of insurability," it did not define this term or explain how this was to be accomplished. Id. at 409, 427, 560. Nor did the certificate mention any health requirements for supplemental life insurance. Id. at

394-395. Instead, the certificate defined a similar term, "eligible classes," not in terms of health, but in terms of full time, active employment. Id. at 404, 406, 409.

Defendants also relied on Savvis' online enrollment system, which Savvis says "prompted" employees who elect more than three times their base annual earnings (as Abel did) to fill out a Statement of Health in paper and submit it to the Human Resources department. AA 276, 280. Savvis also claimed that the Statement of Health forms were available in their Human Resources office, although MetLife found when it conducted an investigation that the Human Resources department regularly failed to ensure that applicants were properly enrolled. Id. at 275-276. MetLife also found that, due to problems with Savvis' enrollment system, Statement of Health forms for "around 200 other individuals . . . were never submitted." Id. at 275. It has since allowed these individuals to submit the required form. Id.

Silva appealed the denial of his claim for supplementary life insurance and submitted additional documentation to MetLife. AA 275. MetLife affirmed the denial because of the lack of evidence of insurability. Id. at 196-197, 559-560. In November 2011, MetLife issued a check to Savvis for $128.76, representing the refund of Abel's premiums for the supplemental life insurance. Id. at 276.

After exhausting the claims procedure, Silva brought suit against MetLife and Savvis for benefits under ERISA section 502(a)(1)(B), 29 U.S.C. §

1132(a)(1)(B), asserting that Abel had paid the premiums for and "satisfied all other conditions precedent" to obtaining supplemental life insurance in the amount of $429,000. AA 63. In this regard, Silva alleged that Savvis and MetLife failed to provide Abel with notice of the evidence of insurability requirement through an SPD or otherwise, and indeed asserted that Abel never received an SPD. Id. Silva further claimed that Savvis and MetLife waived any evidence of insurability requirement by continuing to collect premiums for six months without requesting such evidence and without notifying Abel of the requirement, which he would have satisfied if such a request had been made. Id. at 64.

Several months later, Silva moved to file a Third Amended Complaint, asserting, in addition to the claim for benefits, a claim for equitable relief in the form of "restitution or surcharges or damages in the amount of $429,000, " based on fiduciary breaches and other violations of ERISA relating to Savvis' failure to notify and advise Abel about the evidence of insurability requirement and adequately monitor the process of providing the evidence of insurability.[1] AA 122, 123. Silva argued that he had good cause for filing the Third Amended Complaint outside of the time limits set forth in an earlier order of the court, based on a document in which MetLife noted it had found about 200 individuals who should

[1] Plaintiff previously moved to file a Second Amended Complaint, which was superseded by his motion to file the Third Amended Complaint. AA 147.

have but did not submit Statements of Health due to Savvis' systematic problems in the enrollment process. Id. at 149. Defendants did not contest the good cause for filing the Third Amended Complaint outside the court-imposed deadlines, but instead argued that the motion should be denied on the grounds of futility because the appropriate avenue for relief was the Count I claim for benefits under section 502(a)(1), and because the relief sought in these two counts – a judgment in the amount of the benefits Abel elected under the policy – was not available as appropriate equitable relief under ERISA section 502(a)(3) to remedy a breach of fiduciary duty under ERISA. AA 149-150, 151-155.

The district court agreed and denied the motion to file a Third Amended Complaint on grounds of futility. AA 146-155. The court cited Pichoff v. QHG of Springdale, Inc., 556 F.3d 728 (8th Cir. 2009), in which the Eighth Circuit held that monetary compensation for benefits that would have been paid but for fiduciary breaches was not available as "appropriate equitable relief" under ERISA section 502(a)(3). AA 152, 155. The district court considered CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011), but distinguished it on the basis that, unlike the plaintiffs in Amara, Silva, in its view, did not seek plan reformation or an order compelling the defendant merely to pay benefits that it had promised. AA 154-155. Accordingly, the court denied Silva's motion for leave to file the Third

Amended Complaint because, under Pichoff, the relief sought by Silva was unavailable as "other appropriate equitable relief." Id. 155.

Defendants and plaintiff subsequently filed cross-motions for summary judgment on the counts in the First Amended Complaint. AA 270. On December 10, 2012, the court granted summary judgment to defendants on Silva's claims that they violated section 104(b)(1)(A), 29 U.S.C. § 1024(b)(1)(A), by failing to furnish Abel an SPD, and that Silva was entitled to relief under ERISA sections 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to recover benefits due under the terms of the plan. AA 293-294. With regard to the claim based on a failure to provide an SPD, the court concluded that "[in] the instant case, the SPD and Plan were distributed to employees and available on Savvis' intranet." Id. at 280. It further found that the online enrollment form for supplemental life insurance which was completed by Abel "prompted him to complete a statement of health form." Id. Therefore, applying an "abuse of discretion" standard of review, the court concluded that Silva was not entitled to benefits under the Plan because Abel failed to meet this eligibility requirement, which the court concluded MetLife had not waived. Id. at 283-289.

Moreover, relying on the Eighth Circuit's decision in Fink v. Union Cent. Life Ins. Co., 94 F.3d 489, 492 (8th Cir. 1996), the court concluded that the doctrine of equitable estoppel does not allow for an award of benefits, and

additionally noted that the mere withholding of premiums by MetLife was not enough to overcome the plan language concerning the eligibility requirement. AA 290-291. On May 16, 2013, the district court denied Silva's Motion to Alter or Amend Judgment under Federal Rule of Civil Procedure 59. Id. at 321-322.

SUMMARY OF ARGUMENT

I. The district court in this case relied on the same perceived obstacle to relief under section 502(a)(3) of ERISA that the Supreme Court rejected in Amara, 131 S. Ct. 1866, namely that the plaintiff is seeking make-whole monetary relief against the plan fiduciaries that is legal and not equitable in nature under the Supreme Court's analysis in Mertens v. Hewitt Assocs., 508 U.S. 24849 (1993). By correcting this misreading of Mertens and authorizing monetary relief to restore a plan participant or beneficiary to the position he would occupy absent a fiduciary's breach of duty, the Supreme Court in Amara explicitly authorized the equitable remedy sought by the plaintiff in this case: the payment of benefits which he would have received absent the fiduciary's breach. The Supreme Court distinguished the factual situation in Amara, which involved claims by plan participants against fiduciaries to remedy fiduciary breaches, from the situation at issue in Mertens, which involved claims against a non-fiduciary third party. The Court recognized that in the former context, courts have the equitable power to award make-whole monetary relief to plan participants and beneficiaries who are

harmed by fiduciary breaches. Thus, the district court's reliance on Pichoff to disallow Silva's claim for monetary relief is no longer justified, and the Third Amended Complaint plausibly alleges a breach of fiduciary duty which warrants equitable relief in the form of the payment of benefits to Silva.

II. The district court erroneously concluded that Savvis provided Plan participants and employees with an SPD, when the briefs below and parties' submissions of facts at best demonstrated a dispute regarding whether Abel had in fact received an SPD. Not only did defendants fail to produce evidence that they had distributed an SPD to Abel, but the document they claim to have provided to Plan participants is a nearly 100 page-long certificate of insurance written in technical terms, which does not qualify as an SPD. Distribution of a full plan policy in lieu of an SPD cannot be justified in light of the basic objective of SPDs to provide "clear, simple communication," and the Supreme Court's recent decision in Amara distinguishing the terms of the plan from the plan's SPD. Amara, 131 S. Ct. 1877-78. Nor does the availability of the certificate on the employer website meet the requirements of the Department's regulation even if the certificate could qualify as an SPD, inasmuch as the governing regulation requires plan administrators to furnish the SPD by a method or methods of delivery likely to result in full distribution to participants. 29 C.F.R. § 2520.104b-1(b)(1),(b)(3) and (c). Moreover, to the extent that the district court based its conclusion on Savvis'

disclosure of Hartford Life Insurance's "evidence of good health" requirement to Abel in 2004, the district court erred because the Plan subsequently changed insurers, and ERISA section 104(b)(1), 29 U.S.C. § 1024(b)(1), requires plan administrators to furnish an updated SPD to Plan participants every five years reflecting all of the amendments in the preceding years, as well as ongoing summaries of material modifications.

DISCUSSION

I. THE DISTRICT COURT ERRED IN DENYING PLAINTIFF'S REQUEST FOR LEAVE TO AMEND ON THE GROUNDS OF FUTILITY

ERISA was designed to protect the interests of participants and beneficiaries of employee benefit plans by establishing standards of conduct, responsibility, and obligations for fiduciaries, 29 U.S.C. § 1001(b), "invoking the common law of trusts to define the general scope of" these duties. Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp. Inc., 472 U.S. 559, 570 (1985) (citations omitted). At the core of ERISA's fiduciary obligations are the familiar trust-law duties of loyalty and prudence, which are among the "highest known to the law." Donovan v. Bierwirth, 680 F.2d 263, 272 n.8 (2d Cir. 1982).

ERISA provides for enforcement of its stringent fiduciary duties and other requirements through a number of "carefully integrated" remedial provisions. Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985). Among other things, this case concerns one of those provisions, ERISA section 502(a)(3),

which allows a participant, beneficiary, or fiduciary to sue "to enjoin any act or practice which violates" ERISA or "to obtain other appropriate equitable relief . . . to redress such violations." 29 U.S.C. § 1132(a)(3). That provision is designed as a "catchall" that "act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy." Varity Corp. v. Howe, 516 U.S. 489, 512 (1996). Moreover, as the Supreme Court explained in Mertens, "equitable relief" under section 502(a)(3) means relief that was "typically available in equity." 508 U.S. at 256-57.

The basic legal question here governing the futility determination is whether, consistent with Amara but contrary to this Court's holding in Pichoff, the scope of "appropriate equitable relief" encompasses the type of make-whole monetary remedy that Silva is seeking if permitted to amend his complaint. In Pichoff, the defendant employer failed to notify an employee and plan participant of his right to extend his life insurance if he provided proof of disability after he was discharged for medical reasons, and failed to notify the insurance carrier or plan administrator of Pichoff's disability. Id. at 730-731. As a result, Pichoff's life insurance policy lapsed and, following Pichoff's death, the insurer denied benefits to his estate. Id. at 731. Pichoff's estate filed an action under section 502(a)(3) seeking relief in the form of the payment of benefits that it would have otherwise been paid absent defendant's alleged breach of fiduciary duty. Id. Citing to Mertens, however, this

Court denied the relief sought, 556 F.3d at 731-32, holding instead that "monetary relief in the form of restitution is generally available only if the action seeks 'not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession.'" Id. (quoting Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 213 (2002)).

This conclusion is no longer justified in light of Amara, the Supreme Court's most recent decision addressing the scope of equitable remedies under section 502(a)(3), which now makes clear that the kind of make-whole monetary relief from a breaching fiduciary that the plaintiff in Pichoff sought, and which Silva seeks, is available equitable relief under section 502(a)(3) of ERISA. In Amara, plan participants sought to be made whole for harm caused to them when they received misleading and false information with regard to the conversion of their defined benefit plan to a "cash balance" plan. Amara, 131 S. Ct. at 1872-74. The district court found that the disclosures violated CIGNA's duties as a fiduciary under ERISA, and that the plaintiffs were "likely harm[ed]" by these violations. Id. at 1871. Consequently, it ordered the plan reformed and benefits paid under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and declined to decide whether it could provide the same relief under section 502(a)(3). 131 S. Ct. at 1872-74. After the Second Circuit affirmed, the Supreme Court granted certiorari to decide "whether a showing of 'likely harm' is sufficient to entitle plaintiffs to

recover benefits based on faulty disclosures." Id. at 1876. Thus, the dispute in the case was about "the appropriate legal standard in determining whether members of the relevant employee class were injured." Id. at 1880.

The Supreme Court resolved this dispute in Amara by concluding that the provision upon which the district court relied, "namely, the provision for the recovery of plan benefits," section 502(a)(1)(B), did not provide any authority to impose this remedy, which essentially rewrote the plan. 131 S. Ct. at 1876. The Court instead found such authority in section 502(a)(3), observing that "[t]he district court strongly implied, but did not directly hold, that it would base its relief upon [section 502(a)(3)] were it not for (1) the fact that [section 502(a)(1)(B)] provided sufficient authority; and (2) certain cases from this Court that narrowed the application of the term 'appropriate equitable relief[.]'" 131 S. Ct. at 1878 (citing Mertens and Great-West). Having determined that section 502(a)(1)(B) did not provide the authority, thus resolving the first concern, the Court found the district court's concern about the limitations placed on 502(a)(3) remedies by Mertens and Great-West "misplaced." 131 S. Ct. at 1878.

Noting the maxim that "[e]quity suffers not a right to be without a remedy," Amara, 131 S. Ct. at 1879 (quoting R. Francis, Maxims of Equity 29 (1st Am. ed. 1823)), the Court held that section 502(a)(3) provides a broad range of equitable remedies for fiduciary misconduct, including make-whole monetary relief in the

form of surcharge, equitable estoppel, and plan reformation. 131 S. Ct. at 1879. In the Court's view, its previous cases denying a loss remedy under section 502(a)(3) were distinguishable because they involved non-fiduciaries, while CIGNA was a fiduciary. 131 S. Ct. at 1880 ("insofar as an award of make-whole relief is concerned, the fact that the defendant in this case, unlike the defendant in Mertens, is analogous to a trustee makes a critical difference"). Because Amara involved "a suit by a beneficiary against a plan fiduciary (whom ERISA typically treats as a trustee) about the terms of the trust[,] it was precisely the kind of lawsuit that, before the merger of law and equity, respondents could have brought only in a court of equity, not a court of law." Id. at 1880. The Court recognized that the remedies at issue in that case (reformation, estoppel, and surcharge) were the kinds of remedies that courts of equity typically granted under their exclusive jurisdiction. Id.

Surcharge in particular was a "traditional equitable remed[y]" falling within the category of "traditionally equitable relief" that Mertens previously held to be authorized by section 502(a)(3). 131 S. Ct. at 1880. "The surcharge remedy extended to a breach of trust committed by a fiduciary encompassing any violation of a duty imposed upon that fiduciary." Id. Thus, contrary to this Court's holding in Pichoff, the Supreme Court did not limit plaintiffs to seeking the restoration of their funds or property in the fiduciary-defendant's possession. Rather, surcharge

awards "make-whole relief," to a trust or beneficiary or recovery of unjust enrichment following a trustee's breach of trust, so long as the plaintiff has made a showing of actual harm by a preponderance of evidence. Id. at 1880-82.

For this reason, the district court erred in denying Silva's motion for leave to amend his complaint.[2] AA 152-153. Although it considered Amara, the district court erroneously held that Amara did not alter this Court's precedent in Pichoff, and on that basis concluded that Silva could not seek the payment of benefits that he would have received if Defendant Savvis had not breached its fiduciary duties. Id. at 155. Because the Supreme Court's holding in Amara concerning the availability of a surcharge remedy abrogates this Court's conclusion to the contrary in Pichoff, this Court should reverse the district court's decision, which was expressly based on Pichoff.[3] If this Court affirms the district court's decision, it

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[2] As the district court correctly stated, the standard of review to deny leave to amend on the ground of futility is whether the amended complaint could withstand a Rule 12(b)(6) motion to dismiss for failure to state a claim upon which relief can be granted. In re Senior Cottages of Am., LLC, 482 F.3d 997, 1001 (8th Cir. 2007). This Court's review of that legal conclusion is de novo. Id. In determining whether a complaint states a claim, this Court must accept as true all factual allegations of the complaint. Id.

[3] Because the Supreme Court's discussion of surcharge under section 502(a)(3) was essential to answer the question on which it granted certiorari – the applicable standard in determining whether the members of the class had been harmed – it is not dicta but rather a holding of the case. However, even if it could be characterized as dicta, the Eighth Circuit has held that the "federal courts are bound by the Supreme Court's considered dicta almost as firmly as by the Court's outright

will create a split with the Fourth, Fifth, Seventh, and Ninth Circuits, which have already applied Amara to recognize the availability of make-whole relief for participants in the form of monetary damages under section 502(a)(3). See Kenseth v. Dean Health Plan, Inc., No. 11-1560, 2013 WL 2991466 (7th Cir. June 13, 2013), Gearlds v. Entergy Servs., Inc., 709 F.3d 448, 452 (5th Cir. 2013), Skinner v. Northrop Grumman Ret. Plan B, 673 F.3d 1162 (9th Cir. 2012), McCravy v. Metro. Life, 690 F.3d 176 (4th Cir. 2011).

The circumstances in this case are analogous to McCravy, where the Fourth Circuit recognized the availability of surcharge to a plaintiff whose claim for death benefits for her daughter was denied because her daughter did not qualify for coverage under the plan's "eligible dependent children" at the time of her death. McCravy, 690 F.3d at 178. MetLife allegedly misled McCravy about whether her daughter had this coverage at the time of her death, and had accepted many years' worth of premiums for such coverage. Id. Following Amara, the Fourth Circuit, on panel rehearing, overturned prior precedent on the issue and held that estoppel

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holdings." Fond du Lac Band of Lake Superior Chippewa v. Frans, 649 F.3d 849, 852 (8th Cir. 2011) (quotation marks and citations omitted). See also McCravy v. Metro. Life, 690 F.3d 176, 181 n.2 (4th Cir. 2011) (even if Amara's discussion of section 502(a)(3) remedies is dictum (as Justice Scalia stated in his concurring opinion) "we cannot simply override a legal pronouncement endorsed just last year by a majority of the Supreme Court"); Gearlds v. Entergy Servs, Inc., 709 F.3d 448, 452 (5th Cir. 2013) (same); accord, Kenseth v. Dean Health Plan, Inc., No. 11-1560, 2013 WL 2991466, at *13 (7th Cir. June 13, 2013).

and surcharge are available remedies under section 502(a)(3) and consequentially, McCravy's potential recovery was not limited to a premium refund, as the district court and panel had previously held. Id. at 181. It noted that holding otherwise would encourage abuse by fiduciaries:

> Indeed, fiduciaries would have every incentive to wrongfully accept premiums, even if they had no idea as to whether coverage existed – or even if they affirmatively knew that it did not. The biggest risk fiduciaries would face would be the return of their ill-gotten gains, and even this risk would only materialize in the (likely small) subset of circumstances where plan participants actually needed the benefits for which they had paid.

Id. at 183.

Similarly, in this case, the Third Amended Complaint alleges that Savvis breached its duties as a fiduciary by accepting the premiums for supplemental life insurance while failing to disclose to Abel, either through actual notice or through the SPD, that he was required to submit a Statement of Health. AA 121, 123-124. The Third Amended Complaint further alleges that Savvis was responsible for administering a system to solicit, create, and transmit the evidence of insurability required by the Plan, but failed to monitor the process, or provide guidance to participants on how, when, or where the evidence of insurability was to be forwarded to the insurer. Id. at 122-123. As MetLife's own investigation uncovered, at least 200 employees failed to submit a Statement of Health because

of defects in Savvis' online enrollment process.[4] Id. at 117. Finally, the Third Amended Complaint alleges that Abel Silva would have submitted the required evidence of insurability and "satisfied all other conditions precedent of the policy" if he had been informed of the Statement of Health requirement. Id. at 120-121. Assuming all of these facts to be true, the Third Amended Complaint plausibly alleges a breach of fiduciary duty that caused Silva to lose benefits which he otherwise would have received. See Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997) (citing Varity Corp. v. Howe, 516 U.S. 489, 506 (1996)), for the proposition that fiduciaries have the "obligation to deal fairly and honestly with all plan members" and to inform plan participants and beneficiaries when it knows that silence may be harmful). As a result, the surcharge remedy should have been available based on these facts, but the district court failed even to discuss surcharge when it denied Silva's motion to amend his complaint. AA 153.

Moreover, the allegations here also plausibly allege sufficient facts to support requests for equitable estoppel and may also be enough to support reformation as alternative remedies to surcharge. Amara, 131 S. Ct. at 1879

[4] This allegation appears in MetLife's own document, which is attached to Silva's Memorandum in Support of Motion to File Third Amended Complaint along with the Third Amended Complaint. On a motion to dismiss, the Court may consider exhibits attached to the complaint and documents that are necessarily embraced by the pleadings. Mattes v. ABC Plastics, Inc., 323 F.3d 695, 697 n. 4 (8th Cir. 2003).

(recognizing the potential availability of both remedies under section 502(a)(3)). Although the district court in its decision to deny Silva's motion to amend concluded that Silva was not asking for relief in the form of estoppel or reformation, Silva disputes this (and in fact the court addressed estoppel in its decision on summary judgment). See also Gearlds, 709 F.3d at 452 (recognizing, as the Secretary argued, that "courts must focus on the substance of the relief sought and allegations pleaded, and not on the label used").

With regard to estoppel, Silva alleges that Savvis misrepresented Abel's enrollment status when it withdrew his premium payments from his paycheck and confirmed his election of coverage in its Benefits Summary, without providing any notice of the evidence of insurability requirement. AA 121. Likewise, according to Silva, MetLife misled Abel when it accepted the premiums without any hint of any other requirement for enrollment. Id. Silva also asserts that Abel would have satisfied any evidence of insurability requirement if he had known about this requirement, and defendants do not point to any disqualifying medical condition. Id. at 121. This ought to be enough to plausibly assert a claim that Abel reasonably and detrimentally relied on Savvis' and MetLife's misrepresentations and omissions. See Farley v. Benefit Life Ins. Co., 979 F.2d 653, 659 (8th Cir. 1992) ("The principle of estoppel declares that a party who makes a representation that misleads another person, who then reasonably relies on that representation,

may not deny that representation."). To the extent that the district court viewed this Court's opinion in Fink as a general rejection of equitable estoppel, the opinion has been abrogated by the Supreme Court's decision in Amara, which recognized estoppel as an available equitable remedy under section 502(a)(3) so long as the requirements of equity are met.[5] 131 S. Ct. at 1881.

These same allegations – Savvis' withholding of premiums for six months and confirmation of Abel's election for supplementary life insurance in its Benefits Summary, and MetLife's acceptance of premiums for six months without informing him of the "Statement of Health" requirement – may also be enough to establish both the mistake on Silva's part and the inequitable conduct on the defendants' part that are the prerequisites to a reformation claim. See Simmons Creek Coal Co. v. Doran, 142 U.S. 417, 435 (1892) (noting equity court's power to reform a written instrument where there is clear evidence either of mutual mistake or mistake on one side and fraud or inequitable conduct on the other); 3 John N.

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[5] Fink is distinguishable because it appears to have rejected the use of estoppel in support of a claim for benefits from the plan, rather than as a separately asserted claim for equitable relief from a breaching fiduciary pursuant to section 502(a)(3). See Fink, 94 F.3d at 492 (holding that "common law estoppel principles cannot be used to obtain benefits that are not payable under the terms of the ERISA plan" before going on to "also reject the Finks' claim that Union Central breached its fiduciary duties" in various respects). In any event, the Supreme Court's opinion in Amara makes clear that equitable estoppel is an available remedy when the participant – as both here and in Amara – alleges that he was misled about the benefits payable under the terms of the plan and, accordingly, seeks relief that departs from the literal terms of the plan.

Pomeroy, A Treatise on Equity Jurisdiction § 873 at 421 (5th ed. 1941) (in equity "fraud" or "inequitable conduct" mean "obtaining an undue advantage by means of some intentional act or omission which is unconscientious or a violation of good faith"). See also Cascades Dev. of Minn., LLC v. Nat'l Specialty Ins., 675 F.3d 1095, 1099 (8th Cir. 2012) (noting that under Minnesota law, an insurance policy may be reformed by the courts where there is mutual mistake or where there is a "unilateral mistake accompanied by fraud or inequitable conduct by the other party"); Brant v. Geico Gen. Ins. Co., 3 F.3d 1172, 1174 (8th Cir.1974) (same under Iowa law).

II. THE DISTRICT COURT ERRED IN GRANTING SUMMARY JUDGMENT ON THE CLAIM THAT METLIFE AND SAVVIS FAILED TO PROVIDE SILVA WITH AN SPD

One of ERISA's primary purposes is to protect participants' interests by requiring the disclosure of information about their plans. 29 U.S.C. § 1001(b). To achieve this purpose, ERISA requires a plan administrator to furnish each plan participant a copy of the SPD and modifications to the SPD within specified time limits, free of charge. 29 U.S.C. § 1024(b). The SPD's purpose is to communicate "the essential information about the plan." Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83 (1995). The SPD must be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants

and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a); see also 29 C.F.R. § 2520.102-2(a).

In granting summary judgment to the defendants on the ERISA section 104 violation, the court below, without elaboration or record citation, concluded that Savvis provided Plan participants and employees with an SPD. AA 280-281. The district court also found that the online enrollment process prompted Abel to complete a Statement of Health, and determined that "[i]t would be unfair to hold the employer liable when a claimant fails to adhere to a known plan requirement through 'procrastination,' 'indecision,' or the like." AA 280 (quoting Weinreb v. Hosp. for Joint Diseases Orthopaedic Inst., 404 F.3d 167, 172 (2d Cir. 2005)).

The Court's standard of review for a grant of summary judgment is de novo. Owners Ins. Co. v. European Auto Works, Inc., 695 F.3d 814, 818 (8th Cir. 2012). As correctly stated by the district court in this case, the court may award summary judgment "only if 'the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law.'" Torgerson v. City of Rochester, 643 F.3d 1031, 1042 (8th Cir. 2011) (en banc) (quoting Fed. R. Civ. P. 5(c)(2)). It is clear from the briefs below as well as the parties' submissions of facts that, at a minimum, a dispute exists regarding whether Abel had in fact received an SPD.

As an initial matter, although defendants claim that the certificate is the SPD, and the district court apparently accepted this assertion, as a document that is nearly 100 pages long and written in fairly technical terms, the certificate certainly does not qualify as a summary plan description. AA 367-462, 520. The Supreme Court in Amara described the "basic summary plan description objective" to be "clear, simple communication," and thus distinguished the plan's summary documents from the terms of the plan. Amara, 131 S. Ct. 1877-78 (citing 29 U.S.C. § 1001(a), 1022(a) referring to a "summary" "written in a manner reasonably calculated to be understood by the average plan participant"); 29 C.F.R. § 2520.102-2(a) (same and noting that this "will usually require the limitation or elimination of technical jargon and of long, complex sentences"). The Supreme Court expressed concern that conflating the plan summaries with the terms of the plan would result in plan administrators sacrificing "simplicity and comprehensibility" in order to "describe plan terms in the language of lawyers." Id. Allowing a full certificate of insurance to serve in the place of the SPD would have this very effect. As the Fifth Circuit correctly noted in rejecting a similar argument:

> The certificate of insurance, which sets out the full terms of the policy, is no[t] part of the summary plan description. Continental confounds the policy with a summary of the policy, collapsing two distinct documents into one. By definition, a summary description of the policy does not reproduce each and every term, word for word, of the policy. Indeed, the very purpose of having a summary description

> of the policy is to enable the average participant in the plan to understand readily the general features of the policy, precisely so that the average participant need not become expert in each and every one of the requirements, provisos, conditions, and qualifications of the policy and its legal terminology.

Hansen v. Cont'l Ins. Co., 940 F.2d 971, 981 (5th Cir. 1997), abrogated on other grounds by Amara, 131 S. Ct. at 1877-78.

Moreover, in addition to giving Silva an SPD when he first became a participant in the Plan, the defendants should also have furnished him with an updated SPD every five years reflecting all of the amendments in the preceding years, as well as ongoing summaries of material modifications. 29 U.S.C. § 1024(b)(1). Compliance with these provisions was particularly important here because MetLife had replaced Hartford Life Insurance in January 2008. AA 271, n.7. Accordingly, the district court also erred by citing language regarding "evidence of good health satisfactory to Hartford Life" that was purportedly in Savvis' initial 2004 disclosures to Abel. Id. at 271. The 2004 disclosure, even if it had been part of a compliant SPD, would not have told him whether MetLife required evidence of insurability, since the language related to a different claims administrator and insurer under a different policy.

In any event, defendants did not produce any evidence confirming how or when an SPD or material modification was distributed, and Salvador Silva disputed that it was ever distributed to his son. AA 63-64. As reflected in

MetLife's administrative record in this case, the defendants acknowledge that "Savvis does not have employees sign a document stating that they received a copy of the SPD." Id. at 520. Instead, the defendants rely at least in part, as did the district court, on the fact that "[a] copy of the SPD can be requested and it can be reviewed on Savvis' intranet. Employees are notified whenever there is a change to the document." Id. at 278-279, 520. Thus, the record reflects, at best, that plan participants can request a copy of an SPD or seek to review their SPD on the web. Even if they take these actions, however, they would not see an SPD, but rather the 100-page certificate of insurance, replete with all the technical "requirements, provisos, conditions, and qualifications of the policy and its legal terminology." Hansen, 940 F.2d at 981.

Nor is it enough under ERISA for the plan administrator merely to tell plan participants how an SPD might be found, without actually furnishing the participant with the SPD. The district court cited the Department's regulation requiring the administrator of an employee benefit plan to make required disclosures, including SPDs, using "measures reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals." 29 C.F.R. § 2520.104b-1(b)(1). The same regulation, however, also states that "[m]aterial which is required to be furnished to all participants covered under the plan . . . must be sent by a method or methods of delivery likely to result

in full distribution," such as in-hand delivery. Cf. Leyda v. AlliedSignal, Inc., 322 F.3d 199 (2d Cir. 2003) (affirming district court's ruling that administrator failed to use measures reasonably calculated to ensure actual receipt when it unreasonably relied on employees' attendance at meetings to achieve full distribution but did not record names of those who attended).

The Department has also separately authorized electronic transmission of required disclosures in specific regulatory provisions not cited by the district court, but the defendants have failed to offer any evidence that they complied with the regulation's specific requirements (or that they ever transmitted the SPD to the participant through electronic or any other means). See 29 C.F.R. § 2520.104b-1(c) (limiting the class of participants and beneficiaries for whom electronic disclosure is permissible and requiring that the administrator take "appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents" results in actual receipt of the transmitted information, prepare the electronically delivered document in accordance with the applicable "style, format, and content requirements" for the particular document, apprise the participant of the significance of the disclosure if it is not otherwise reasonably evident, and disclose that the recipient can elect paper disclosure). There is no evidence that any of the regulations' requirements were satisfied with respect to Abel Silva and

for this and the other reasons stated above, the grant of summary judgment on this claims should be reversed.[6]

[6] Silva's brief on appeal also argues that MetLife abused its discretion in denying his claim for benefits. The Secretary, however, does not express a view on the merits of this argument, except to note that Silva may assert a claim for benefits under section 502(a)(1)(B) in tandem with claims for equitable relief under section 502(a)(3). See Amara, 131 S. Ct at 1879-82 (allowing plaintiff to go forward with their claim for equitable relief under section 502(a)(3) where they could not obtain the requested relief under section 502(a)(1)(B)).

CONCLUSION

For the reasons stated above, the district court's denial of Silva's request for leave to amend the complaint and the district court's grant of summary judgment to defendants should be reversed.

Respectfully submitted,

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Attorney for U.S. Department of Labor, Plan Benefits Security Division
Dated: August 14, 2013

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I hereby certify that on 13th day of August, 2013, I electronically filed the Brief for Amicus Curiae, Hilda L. Solis, Secretary of Labor, with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to all registered counsel of record.

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