

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION**

WESCO, INC., WESCO, INC. CAFETERIA  
PLAN AND EMPLOYEE BENEFIT PLAN,  
FRANKENMUTH BAVARIAN INN, INC.,  
FRANKENMUTH BAVARIAN INN, INC.  
EMPLOYEE HEALTH BENEFIT PLAN &  
TRUST, OPUS PACKAGING GROUP INC.,  
and OPUS PACKAGING GROUP HEALTH  
INSURANCE PLAN, on  
behalf of themselves and a class of all others  
similarly situated,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF  
MICHIGAN,

Defendant.

Civil Action No.: 2:25-cv-11712

Judge: Hon. Susan K. DeClercq

Magistrate Judge: David R. Grand

**Oral Argument Requested**

**DEFENDANT'S REPLY BRIEF IN SUPPORT OF ITS MOTION TO  
DISMISS PLAINTIFFS' AMENDED COMPLAINT FOR  
FAILURE TO STATE A CLAIM**

**TABLE OF CONTENTS**

	<b>Page</b>
TABLE OF AUTHORITIES .....	ii
STATEMENT OF ISSUES PRESENTED.....	iii
CONTROLLING OR MOST APPROPRIATE AUTHORITY .....	iv
INTRODUCTION.....	1
ARGUMENT .....	1
I.    THE OPPOSITION CONFIRMS THE CLAIMS ARE UNTIMELY .....	1
II.   THE AMENDED COMPLAINT SHOULD BE DISMISSED FOR FAILURE TO PLEAD WITH PARTICULARITY .....	4
III.  THE WESCO PLAINTIFFS’ CLAIMS HAVE BEEN RELEASED.....	5
CONCLUSION .....	7

**TABLE OF AUTHORITIES**

	<b>Page</b>
<b>Cases</b>	
<i>Arnold v. Paredes</i> , 714 F. Supp. 3d 962 (M.D. Tenn. 2024).....	6
<i>Cataldo v. U.S. Steel Corp.</i> , 676 F.3d 542 (6th Cir. 2012).....	3, 4
<i>Fleming v. Kellogg Co.</i> , No. 23-1966, 2024 WL 4534677 (6th Cir. 2024) .....	6
<i>Grand Traverse Band of Ottawa &amp; Chippewa Indians v. Blue Cross Blue Shield of Mich.</i> , 146 F.4th 496 (6th Cir. 2025).....	v, 2, 3, 4
<i>Hall v. Small</i> , 705 N.W.2d 741 (Mich. Ct. App. 2005) .....	5
<i>Hawkins v. Cintas Corp.</i> , 32 F.4th 625 (6th Cir. 2022).....	6
<i>Parker v. Tenneco, Inc.</i> , 114 F.4th 786 (6th Cir. 2024).....	6
<i>Rosenbaum v. Davis Iron Works</i> , 871 F.2d 1088, 1989 WL 36897 (6th Cir. 1989) .....	6
<i>Taylor v. Visteon Corp.</i> , 149 F. App’x 422 (6th Cir. 2005) .....	v, 6, 7
<i>Tiara Yachts, Inc. v. Blue Cross Blue Shield of Mich.</i> , 138 F.4th 457 (6th Cir. 2025).....	3, 4, 5
<i>Wright v. Heyne</i> , 349 F.3d 321 (6th Cir. 2003).....	3
<b>Statutes</b>	
29 U.S.C. § 1110(a).....	6

**STATEMENT OF ISSUES PRESENTED**

1. Whether the Court should dismiss Plaintiffs’ Amended Complaint for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) because Plaintiffs’ claims are barred by the three-year statute of limitations applicable under the Employee Retirement Income Security Act of 1974 (“ERISA”) or, in the alternative, because Plaintiffs fail to plead facts sufficient to state a plausible claim.

Answer: Yes.

2. Whether the Court should, in the alternative, dismiss the Wesco Plaintiffs’ claims for lack of standing and subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1) because the Wesco Plaintiffs’ claims were released.

Answer: Yes.

**CONTROLLING OR MOST APPROPRIATE AUTHORITY**

*Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross Blue Shield of Mich.*, 146 F.4th 496 (6th Cir. 2025)

*Taylor v. Visteon Corp.*, 149 F. App'x 422 (6th Cir. 2005)

## **INTRODUCTION**

Plaintiffs' Response to BCBSM's Motion to Dismiss, ECF No. 32 ("Opposition"),<sup>1</sup> confirms that the Amended Complaint should be dismissed. Plaintiffs concede that BCBSM disclosed the SSP more than three years before they filed this case. That should end the matter. Yet Plaintiffs advance the futile argument that their claims are timely because they supposedly did not learn until 2025 that SSP fees were allegedly collected from Plan assets. But the Amended Complaint contradicts that argument, which depends on generalized allegations sounding in fraud that are not pled with the particularity that Rule 9(b) requires. Nor do those allegations even bear on the alleged ERISA violation Plaintiffs now contend makes their claims timely.

For these reasons and others discussed below and in the Motion, the Amended Complaint should be dismissed in its entirety and with prejudice.

## **ARGUMENT**

### **I. THE OPPOSITION CONFIRMS THE CLAIMS ARE UNTIMELY**

The Amended Complaint shows that Plaintiffs had "knowledge of the facts or transaction that constituted the alleged violation" more than three years before

---

<sup>1</sup> Capitalized terms have the meanings set forth in Defendant's Brief In Support Of Its Motion to Dismiss (ECF No. 31) ("Motion"). Solely for purposes of its Motion, BCBSM cites to and relies on the allegations in the Amended Complaint. BCBSM does not concede the accuracy, and specifically reserves its rights to contest the truth, of any such allegations.

the claims were asserted. *Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross Blue Shield of Mich.*, 146 F.4th 496, 508 (6th Cir. 2025) (internal quotations omitted).

Plaintiffs' Opposition does not show otherwise. Plaintiffs contend that BCBSM committed a "*per se*" ERISA violation "by paying itself SSP fees from Plan assets." ECF No. 32, PageID.788. But Plaintiffs do not deny that BCBSM disclosed the SSP to Wesco in 2018, to Bavarian Inn by at least 2019, and to Opus in February 2022. *See* ECF No. 31, PageID.600.<sup>2</sup> Nor can they deny that the ASCs, as of those dates, stated that, under the SSP, BCBSM will "retain as administrative compensation [a percent] of the recoveries or cost avoidance." ECF No. 31-4, PageID.654; ECF No. 31-7, PageID.671; ECF No. 31-10, PageID.720. Per the Amended Complaint, these recoveries necessarily came from Plan assets. *See* ECF No. 23, PageID.262 ¶¶ 62–63.

If the SSP was a *per se* violation of ERISA because it resulted in BCBSM "paying itself SSP fees from Plan assets," then the Amended Complaint and incorporated documents establish that Plaintiffs knew what was necessary to plead that claim more than three years ago. *See Grand Traverse*, 146 F.4th at 509; *see*

---

<sup>2</sup> Plaintiffs do not dispute that the Motion exhibits are properly before the Court. *See* ECF No. 32, PageID.794; ECF No. 31, PageID.592, n.4. Nor do they support the baseless claim that BCBSM "fabricated assertions." ECF No. 32, PageID.794.

*also Wright v. Heyne*, 349 F.3d 321, 331 (6th Cir. 2003) (requiring “only the plaintiff’s actual knowledge of the underlying conduct giving rise to the alleged violation”).

Indeed, the conduct Plaintiffs claim to have not discovered until 2025 is irrelevant to the claimed ERISA violation. ECF No. 32, PageID.795-796. For example, Plaintiffs assert they were missing “what the providers’ true charges were, what BCBSM’s payment rates were, how they compared, or what BCBSM kept for itself.” *Id.*, PageID.796. That information corresponds to specific provider charges, *not the accounts from which SSP fees were taken. Id.*

In *Grand Traverse*, the Sixth Circuit rejected the same argument Plaintiffs make here: that the existence of more than one non-discounted payment extended ERISA’s statutes of limitation or repose. 146 F.4th at 509 (starting limitations period when BCBSM disclosed the allegedly breaching approach to claims payment despite the approach existing over several years). In any event, Plaintiffs do not dispute that the Wesco and Bavarian Inn claims related to alleged payments made before June 9 and July 28, 2019 are barred under ERISA’s statute of repose.

Further, Plaintiffs have not alleged particularized facts to support applying the fraud or concealment exception. *See* ECF No. 31, PageID.602-603; *see also Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 551 (6th Cir. 2012); *Tiara Yachts, Inc. v. Blue Cross Blue Shield of Mich.*, 138 F.4th 457, 467 (6th Cir. 2025) (the exception

requires a plaintiff to “adequately plead fraud”). While Plaintiffs emphasize that, at an unidentified time, Wesco requested claims data, ECF No. 32, PageID.800, that neither meets Rule 9(b)’s requirements nor concerns their claimed *per se* ERISA violation. And the Amended Complaint and incorporated documents establish that Plaintiffs had actual knowledge, which undoes their concealment claims.

Tellingly, Plaintiffs resort to claiming that statutes of limitations arguments are “inappropriate” for motions to dismiss. This ignores that the Amended Complaint and incorporated documents establish that Plaintiffs had actual knowledge, rendering their claims ripe for dismissal. *See Grand Traverse*, 146 F.4th at 508–09; *Cataldo*, 676 F.3d at 547–48 (recognizing dismissal as appropriate if “allegations in the complaint affirmatively show that the claim is time-barred”).

## **II. THE AMENDED COMPLAINT SHOULD BE DISMISSED FOR FAILURE TO PLEAD WITH PARTICULARITY**

The Opposition refuses to address that the Amended Complaint fails to meet the demanding pleading requirements of Rule 9(b) and instead contends that Rule 9(b) does not apply. ECF No. 32, PageID.801-802. But it does.

Plaintiffs attempt to compare the Amended Complaint to the complaint in *Tiara Yachts*. *Id.* Unlike *Tiara Yachts*, however, allegations of fraudulent conduct

pervade the Amended Complaint.<sup>3</sup> *See, e.g.*, ECF No. 23, PageID.281, 294 ¶¶ 137, 182 (BCBSM allegedly “conceal[ed] its overpayments upon which SSP fees were based,” “misrepresent[ed] the SSP,” “engaged in systematic fraud,” and “engag[ed] in a pattern of conduct designed to mislead, confuse, deceive, and otherwise trick[.]”); *see also* ECF No. 31, PageID.598, 603-608. The litany of pleading failures highlighted in the Motion justify dismissal.

### **III. THE WESCO PLAINTIFFS’ CLAIMS HAVE BEEN RELEASED**

The Wesco Plaintiffs’ claims were validly released and their arguments to the contrary are unavailing. *First*, the Wesco Plaintiffs’ argument that the release lacks consideration is implausible. While the final refund payment was the trigger, the release was mutual and part of an extensive contract with obligations on both sides. *See Hall v. Small*, 705 N.W.2d 741, 744 (Mich. Ct. App. 2005) (“[W]hatever consideration is paid for all of the promises [in a contract] is consideration for each one.”) (internal quotations omitted).

*Second*, the release extends to the Wesco Plaintiffs’ ERISA claims because it covers “any and all claims . . . arising under” the ASC. ECF No.31-3, PageID.646. The Sixth Circuit has found that similar release language extends to ERISA claims.

---

<sup>3</sup> Accordingly, unlike here, Rule 9(b) did not apply to the *Tiara Yachts* complaint, ECF No. 1, 1:22-cv-00603-RJJ-RSK (W.D. Mich.), which BCBSM respectfully maintains should have been dismissed based on the statute of limitations.

*See Taylor v. Visteon Corp.*, 149 F. App'x 422, 423, 425–27 (6th Cir. 2005) (release of “any and all rights or claims” includes ERISA claims).

*Third*, the release extends to Wesco’s derivative claims because Wesco was the Plan’s sponsor. Plaintiffs’ cited cases are inapt because they concern derivative claims brought by individual plan participants, not plan sponsors. *See Hawkins v. Cintas Corp.*, 32 F.4th 625, 635 (6th Cir. 2022) (employment agreements’ arbitration provisions excluded derivative claims); *Arnold v. Paredes*, 714 F. Supp. 3d 962, 974 (M.D. Tenn. 2024) (similar).

*Fourth*, 29 U.S.C. § 1110(a) does not nullify the release, which only settled disputes against BCBSM that accrued at the time of the final payment—*i.e.*, past claims. *See Taylor*, 149 F. App'x at 427 (“a release of past breach-of-fiduciary-duty claims does not appear to implicate § 1110(a)”). Because the release only came into effect after Wesco terminated its ASC, it cannot violate Section 1110(a). *See Rosenbaum v. Davis Iron Works*, 871 F.2d 1088, 1989 WL 36897, at \*3–5 (6th Cir. 1989), *cert. denied*, 496 U.S. 890 (1989) (applying release to ERISA overpayment dispute); *Taylor*, 149 F. App'x at 426–27.

*Fifth*, enforcing the release does not violate the “effective vindication” doctrine, which is generally limited to arbitration clauses restricting individuals from pursuing statutory remedies, as in Plaintiffs’ cited caselaw. *See Parker v. Tenneco, Inc.*, 114 F.4th 786, 789, 792–93 (6th Cir. 2024); *Fleming v. Kellogg Co.*,

No. 23-1966, 2024 WL 4534677, at \*1, \*4 (6th Cir. 2024). Plaintiffs' formulation would prevent parties from ever agreeing to release statutory claims, but enforcing the release would promote public policy favoring non-judicial resolutions. *See Taylor*, 149 F. App'x at 427.

### **CONCLUSION**

For the foregoing reasons, the Court should dismiss the Amended Complaint in its entirety, with prejudice.

Dated: September 16, 2025

Respectfully submitted,

ZAUSMER, P.C.

ALLEN OVERY SHEARMAN  
STERLING US LLP

By: s/ Mark J. Zausmer  
Mark J. Zausmer (P31721)  
Michael A. Schwartz (P74361)  
Nathan S. Scherbarth (P75647)  
Jason M. Schneider (P79296)  
32255 Northwestern Hwy., Ste. 225  
Farmington Hills, MI 48334  
Telephone: +1.248.851.4111  
Facsimile: +1.248.851.0100  
[mzausmer@zausmer.com](mailto:mzausmer@zausmer.com)  
[mschwartz@zausmer.com](mailto:mschwartz@zausmer.com)  
[nscherbarth@zausmer.com](mailto:nscherbarth@zausmer.com)  
[jschneider@zausmer.com](mailto:jschneider@zausmer.com)

By: s/ Daniel Lewis  
Daniel Lewis (Adm. in E.D. MI,  
NY Reg. 4084810)  
Jeffrey D. Hoschander (Adm. in E.D. MI, NY  
4496337)  
599 Lexington Avenue  
New York, NY 10022  
Telephone: +1.212.848.4000  
Facsimile: +1.202.508.8100  
[daniel.lewis@aoshearman.com](mailto:daniel.lewis@aoshearman.com)  
[jeff.hoschander@aoshearman.com](mailto:jeff.hoschander@aoshearman.com)

Todd M. Stenerson (P51953)  
1101 New York Avenue, NW  
Washington, DC 20005  
Telephone: +1.202.508.8093  
Facsimile: +1.202.661.7484  
[todd.stenerson@aoshearman.com](mailto:todd.stenerson@aoshearman.com)

*Attorneys for Defendant*

# EXHIBIT 1

714 F.Supp.3d 962

United States District Court, M.D. Tennessee, Nashville Division.

Lisa ARNOLD, Brandi Trout, and Sandra Golden-Woods, on behalf of the Churchill Holdings, Inc. Employee Stock Ownership Plan, and on behalf of a class of all other persons similarly situated, Plaintiffs,

v.

Miguel PAREDES, Prudent Fiduciary Services, LLC, Lawson H. Hardwick, III, Matthew C. Clarke, and Cecil O. Kemp, Jr., Defendants.

NO. 3:23-cv-00545

|

Filed January 31, 2024

### Synopsis

**Background:** Participants in employee stock ownership plan (ESOP) brought purported class action pursuant to Employee Retirement Income Security Act (ERISA) against fiduciary services company and its owner, and members of plan operator's board of directors challenging plan's purchase of chief executive officer's (CEO's) shares at \$145.90 per share, for a total of \$74,406,876, and alleging defendants improperly used annual dividends for corporate purposes and not for the benefit of the plan. Defendants moved to dismiss for failure to state a claim.

**Holdings:** The District Court, Waverly D. Crenshaw, Jr., Chief Judge, held that:

participants alleged derivative and not individual claims;

participants' releases of claims did not apply to their derivative claims;

plan's class action waiver prevented participants from effectively vindicating their rights under ERISA, and thus was invalid;

participants sufficiently alleged that fiduciary services company was plan's trustee;

participants failed to allege that fiduciary services company and its owner acted with motive to benefit themselves, thus precluding claim for breach of duty of loyalty under ERISA against company and owner;

participants stated claim for breach of duty of loyalty against plan operator's board of directors; and

participants requested equitable relief, specifically, disgorgement of traceable funds, was an available form of relief under ERISA.

Trustee's motion granted in part and denied in part; board members' motion denied.

**Procedural Posture(s):** Motion to Dismiss for Failure to State a Claim.

### Attorneys and Law Firms

\***965** Alyson S. Beridon, Herzfeld, Suetholz, Gastel, Leniski and Wall, PLLC, Cincinnati, OH, Benjamin A. Gastel, Herzfeld, Suetholz, Gastel, Leniski & Wall, PLLC, Nashville, TN, Christopher M. Barrett, Robert A. Izard, Jr., Izard, Kindall & Raabe,

LLP, West Hartford, CT, Douglas P. Needham, Motley Rice LLC, Hartford, CT, Gregory Y. Porter, Ryan T. Jenny, Bailey Glasser LLP, Washington, DC, Mark G. Boyko, Bailey Glasser LLP, Webster Groves, MO, for Plaintiffs.

Andrew D. Salek-Raham, Claire M. Lally, Lars C. Golumbic, Groom Law Group, Chartered, Washington, DC, Mark E. Stamelos, FordHarrison LLP, Nashville, TN, for Defendants Miguel Paredes, Prudent Fiduciary Services, LLC.

J. Christian Nemeth, Robert M. Kline, McDermott Will & Emery LLP, Miami, FL, Jonathan P. Farmer, Spencer Fane LLP, Nashville, TN, for Defendants Lawson H. Hardwick, III, Matthew C. Clarke, Cecil O. Kemp, Jr.

## **MEMORANDUM OPINION**

WAVERLY D. CRENSHAW, JR., CHIEF UNITED STATES DISTRICT JUDGE

**\*966** Pending before the Court are two motions to dismiss, filed by Lawson H. Hardwick, III (“Hardwick”), Matthew C. Clarke (“Clarke”), and Cecil O. Kemp, Jr. (“Kemp”) (collectively, the “Churchill Defendants”) and Miguel Paredes (“Paredes”) and Prudent Fiduciary Services, LLC (“PFS”) (collectively, the “Trustee Defendants”).

The Churchill Defendants filed a Motion to Dismiss (Doc. No. 37), to which Plaintiffs responded (Doc. No. 45), and the Churchill Defendants replied (Doc. No. 47). The Trustee Defendants filed a Motion to Dismiss (Doc. No. 40), to which Plaintiffs responded (Doc. No. 46), and the Trustee Defendants replied (Doc. No. 48). Additionally, the Defendants have filed two notices of supplemental authority (Doc. Nos. 56 and 58), and Plaintiffs have responded to both (Doc. Nos. 57 and 59). Plaintiffs have also filed a notice of supplemental authority. (Doc. No. 61).

The motions are ripe for review. For the reasons that follow, the Court will deny the Churchill Defendants’ motion and will grant in part and deny in part the Trustee Defendants’ motion.

## **BACKGROUND**

The following allegations are taken from the Complaint (Doc. No. 1) and the Churchill Holdings, Inc. Employee Stock Ownership Plan (Doc. No. 37-1), which the Court may consider because it is referenced throughout the Complaint. See Greenberg v. Life Ins. Co. of Virginia, 177 F.3d 507, 514 (6th Cir. 1999). The allegations in the Complaint are accepted as true to resolve the pending motions.

Churchill Holdings, Inc. (“Churchill”) is a privately owned company. (Doc. No. 1 ¶ 5). It operates an Employee Stock Ownership Plan (the “Plan”). (Id. ¶ 6). During the relevant period, Hardwick was the President, Chief Executive Officer of Churchill and a member of its Board of Directors. (Id. ¶ 31). Clarke was Churchill’s Secretary, Chief Financial Officer, and Chief Operations Officer, as well as a member of its Board of Directors. (Id. ¶ 33). Kemp was the third and final member of Churchill’s Board. (Id. ¶ 34). Michael Paredes and his employer, Prudent Fiduciary Services (“PFS”), were the trustees of the Plan. Plaintiffs are three former employees of Churchill. (Id. ¶ 23-25). They all participate in Churchill’s Plan. (Id. ¶ 1).

The Plan was formed by Churchill on October 31, 2013. (Id. ¶ 6). At the same time, Hardwick sold 49% of his 100% stake in Churchill to the Plan in the form of Preferred Shares of Churchill stock. (Id.). Those Preferred Shares entitled the Plan and its participants to annual dividends of \$2.4 million. (Id. ¶ 8).

At the core of Plaintiffs’ claims is a December 19, 2020 transaction, in which the Plan purchased the remaining 51% of Hardwick’s shares of Churchill stock at \$145.90 per share, or \$74,406,876 total (the “2020 Transaction”). (Id. ¶ 66). At year-end 2019, Churchill’s stock was valued at \$52.25 per share. (Id.). As Trustees of the **\*967** Plan, Michael Paredes and PFS had “the sole and exclusive authority to negotiate the terms of the 2020 Transaction and to authorize the Transaction on the Plan’s

behalf.” (Id. ¶ 13). The 2020 Transaction was financed through a note payable to Hardwick, which Churchill assumed from the Plan. (Id. ¶ 69). Churchill was then obligated to make payments on the note to Hardwick. (Id. ¶ 80). At the end of 2020, Churchill's Board of Directors approved a special \$43.4 million dividend, \$35 million of which was paid to Hardwick as an accelerated paydown of the note. (Id. ¶ 80). Plaintiffs allege that the Plan grossly overpaid for Hardwick's remaining shares in the 2020 Transaction.

Plaintiffs also allege that Hardwick, Clarke and Kemp, as Churchill's Board of Directors, controlled the distribution of the annual \$2.4 million dividend. (Id. ¶¶ 49, 114-15). Rather than using the dividends to benefit the Plan, Plaintiffs allege that the Churchill Defendants used the dividends “for corporate purposes and not for the benefit of the Plan. In particular, the excess dividend payments were used to offset Churchill's obligations to make contributions to the [Plan] as an employee benefit.” (Id. 60). Specifically, Plaintiffs allege that “[i]n 2017, \$1,290,744 in dividends were improperly used to offset employer contributions into the Plan;” (id. ¶ 61), “[i]n 2018, \$1.9 million in dividends were improperly used to offset employer contributions into the Plan;” (id. ¶ 62), and “[i]n 2019, \$249,450 was used to pay interest expenses on [the 2013 loan from Hardwick to the Plan], while the remainder of the \$2.4 million in dividends was used to offset corporate expenses.” (Id. ¶ 63).

### LEGAL STANDARD

To survive a motion to dismiss for failure to state a claim, a complaint must include “a short and plain statement of the claim showing that the pleader is entitled to relief.” Fed. R. Civ. P. 8(a)(2). In reviewing a motion to dismiss, the Court must “construe the complaint in the light most favorable to the plaintiff, accept all well-pleaded factual allegations in the complaint as true, and draw all reasonable inferences in favor of the plaintiff.” Courtright v. City of Battle Creek, 839 F.3d 513, 518 (6th Cir. 2016). However, the Court will “disregard bare legal conclusions and naked assertions” and “afford[ ] the presumption of truth only to genuine factual allegations.” Dakota Girls, LLC v. Philadelphia Indem. Ins. Co., 17 F.4th 645, 648 (6th Cir. 2021) (quoting Ashcroft v. Iqbal, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009)) (internal quotations omitted). Nor can the Court “credit a threadbare recital of the elements of a cause of action ... supported by mere conclusory statements.” Dakota Girls, 17 F.4th at 648 (citing Iqbal, 556 U.S. at 678, 129 S.Ct. 1937) (internal quotations omitted). The “factual allegations in the complaint need to be sufficient to give notice to the defendant as to what claims are alleged, and the plaintiff must plead ‘sufficient factual matter’ to render the legal claim plausible, i.e., more than merely possible.” Cabinets to Go, LLC v. Qingdao Haiyan Real Est. Grp. Co., 605 F. Supp. 3d 1051, 1057 (M.D. Tenn. 2022) (quoting Fritz v. Charter Twp. of Comstock, 592 F.3d 718, 722 (6th Cir. 2010)), *reconsideration denied sub nom.* 688 F.Supp.3d 617 (M.D. Tenn. 2023). “Ultimately, only a complaint that states a plausible claim for relief survives a motion to dismiss.” Dakota Girls, 17 F.4th at 648 (quoting Iqbal, 556 U.S. at 679, 129 S.Ct. 1937) (internal quotations omitted). To avoid dismissal under Rule 12(b)(6), a complaint must contain either direct or inferential allegations with respect to all material elements of each claim. Wittstock v. Mark A. Van Sile, Inc., 330 F.3d 899, 902 (6th Cir. 2003).

### \*968 DISCUSSION

Defendants make two types of arguments for dismissal. First, they allege that Plaintiffs’ claims are barred (1) because two of the Plaintiffs signed releases of their claims, (Doc. No. 38 at 19-20), and (2) because the Plan's governing documents contain a class action waiver that prevents them from bringing this action on behalf of a class and from requesting relief beyond their individual injuries. (Doc. No. 38 at 20-21; Doc. No. 41 at 6-8). Second, they make a slew of arguments that Plaintiffs have failed to state a claim, and the Complaint should be dismissed under Fed. R. Civ. P. 12(b)(6). (Doc. No. 38 at 8-19; Doc. No. 41 at 8-26). The Court will address the releases and class action waiver first, and then will address Defendants’ Rule 12(b)(6) arguments.

#### 1. Arnold and Golden-Woods Releases

Defendants argue that Plaintiffs Arnold and Golden-Woods released their claims against Hardwick, Clarke, and Kemp in their employment separation agreements, and thus lack Article III standing. (Doc. No. 38 at 19-20). Generally, “[a] release is valid if it was knowingly and voluntarily made under circumstances not indicating any overreaching or exploitation.” Halvorson v. Boy Scouts of America, 215 F.3d 1326, at \*3 (6th Cir. May 3, 2000). Plaintiffs argue that here, however, whether the releases apply hangs on whether their claims are individual in nature or are brought derivatively on behalf of the Plan. See Hawkins v. Cintas Corp., 32 F.4th 625, 636 (6th Cir. 2022). Plaintiffs argue that their claims are derivative and that, because of their derivative nature, the individual releases Arnold and Golden-Woods signed do not apply. (Doc. No. 46 at 12-13). Churchill Defendants counter that there is “no 6<sup>th</sup> Circuit authority that holds a release can be invalidated because it concerns ERISA claims.” (Doc. No. 47 at 5).

Arnold's and Golden-Woods's releases are identical. Both are included in their severance agreements with Churchill Mortgage Corporation; Arnold's is dated September 5, 2018 and Golden-Woods's is dated July 27, 2018. (Doc. No. 46 at 13; Doc. No. 37-3 at 5, 9). The relevant language in the releases states:

**Section 3. Waiver of Claims; Release.**

In exchange for Employer's agreement to pay the amounts provided in Section 2, Employee hereby irrevocably and unconditionally releases, acquits and forever discharges Employer and each of Employer's owners, stockholders, partners, members, predecessors, successors, assigns, agents, directors, officers, employees, representatives, attorneys, divisions, subsidiaries, affiliates (and agents, directors, officers, employees, representatives and attorneys of such divisions, subsidiaries and affiliates), and all persons acting by, through, under or in concert with any of them (collectively, “Releasees”), or any of them, from any and all charges, complaints, claims, liabilities, obligations, promises, agreements, controversies, damages, actions, causes of action, suits, rights, demands, costs, losses, debts and expenses (including attorney's fees and costs actually incurred), of any nature whatsoever pertaining to his [sic] employment with or separation from Employer, or arising from any action taken by Employer, known or unknown (hereafter referred to as “Claim” or “Claims”), which Employee now has, owns or holds, or claims to have, own or hold, or which Employee at any time hereafter may have, own or hold, or claim to have, own or hold, against each of any of the Releasees, except for Employer's duties and obligations pursuant to this Agreement.

Employee acknowledges and agrees that she is releasing and giving up any right or claims she may have under the Age **\*969** Discrimination in Employment Act ... Title VII of the Civil Rights Act of 1964 and the Tennessee Human Rights Act ... the Equal Pay Act ... the Americans with Disabilities Act ...42 U.S.C. 1981 and 1985; the Employee Retirement Income Security Acts of 1974; or any other federal, state or local laws or regulations prohibiting employment discrimination. This also includes a release by Employee of any claims for wrongful discharge.

EMPLOYEE REPRESENTS THAT SHE HAS THOROUGHLY CONSIDERED ALL ASPECTS OF THIS AGREEMENT, THAT EMPLOYEE HAS CAREFULLY READ AND FULLY UNDERSTANDS ALL OF THE PROVISIONS OF THIS AGREEMENT, THAT EMPLOYEE HAS HAD THE ASSISTANCE OF COUNSEL IN NEGOTIATING AND ENTERING INTO THIS AGREEMENT, AND THAT EMPLOYEE IS VOLUNTARILY ENTERING INTO THIS AGREEMENT. EMPLOYEE ACKNOWLEDGES THAT EMPLOYER IS RELYING ON THIS AND ALL OTHER REPRESENTATIONS SHE HAS MADE HEREIN.

It is understood that this Agreement does not constitute an admission by Employer of liability or any violation [of] applicable state or federal laws, including but not limited to those prohibiting employment discrimination, wrongful termination, or breach of contract.

(Doc. No. 37-3 at 3, 7) (emphasis in original).

**a. Plaintiffs' Claims are Derivative.**

Plaintiffs bring their claims pursuant to ERISA § 502(a)(2) and (a)(3), 29 U.S.C. § 1132(a)(2) and (a)(3), alleging that Defendants violated ERISA §§ 404, 406(a), and 409. (See Doc. No. 1 ¶¶ 100, 106, 121). The Supreme Court has twice addressed whether

ERISA claims alleging breach of fiduciary duties are individual or derivative. First, in a case brought by an employee who became disabled and received disability benefits through an ERISA-governed plan, the Court succinctly stated that § 502(a)(2) claims are “brought in a representative capacity on behalf of the plan as a whole.” Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 136, 142 n.9, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985). The Court relied in part on the text of ERISA § 409, which states that when a fiduciary violates his or her duties, “the potential personal liability of the fiduciary is ‘to make good *to such plan* any losses *to the plan* ... and to restore *to the plan* any profits of such fiduciary which have been made through use of assets of *the plan*.” Id. at 140, 105 S.Ct. 3085 (quoting ERISA § 409(a)) (emphasis in original). The Court rejected Russell's request for damages surrounding the plan's late payment of her disability benefits, holding that “the relevant text of ERISA, the structure of the entire statute, and its legislative history all support the conclusion that in § 409(a) Congress did not provide, and did not intend the judiciary to imply, a cause of action for extra-contractual damages caused by improper or untimely processing of benefit claims.” Id. at 148, 105 S.Ct. 3085.

In a later case, the Supreme Court explained that claims brought concerning defined contribution plans, where employees hold individual retirement accounts administered by their employer (such as 401(k) accounts), can be either individual in nature or derivative. Larue v. DeWolff, Boberg & Associates, Inc., 552 U.S. 248, 256, 128 S.Ct. 1020, 169 L.Ed.2d 847 (2008). The Court distinguished defined contribution plans from defined benefit plans like the plan at issue in Russell:

For defined contribution plans, ... fiduciary misconduct need not threaten the solvency of the entire plan to reduce \*970 benefits below the amount that participants would otherwise receive. Whether a fiduciary breach diminishes plan assets payable to all participants and beneficiaries, or only to person tied to particular individual accounts, it creates the kind of harms that concerned the draftsmen of [ERISA] § 409.

Id. at 255-56, 128 S.Ct. 1020. Larue did not hold that *all* ERISA fiduciary duty claims brought concerning defined contribution plans are individual in nature. See, e.g., Hawkins v. Cintas Corp., 32 F.4th 625, 631 (6th Cir. 2022); In re Schering Plough Corp. ERISA Litig., 589 F.3d 585, 595 n.9 (3d Cir. 2009). Rather, Larue held that it is *possible* to bring either individual or derivative claims concerning defined contribution plans. Id.

Here, the Plan is a defined contribution plan, so the Court must determine whether Plaintiffs have raised individual or derivative claims. To do so, the Court examines the description of the alleged wrongdoing and the nature of the requested relief. See, e.g., Harrison v. Envision Management Holding, Inc. Board of Directors, 59 F.4th 1090, 1101 (10th Cir. 2023).

The derivative nature of Plaintiffs' claims is evident from the Complaint's description of harm. The Complaint alleges that each year, “the Plan (and its participants) [were entitled] to annual dividends of approximately \$4.90 per share,” but “in most years a significant portion of the dividends were used to offset corporate obligations ... instead of being used for the benefit of the Plan and its participants.” (Doc. No. 1 ¶¶ 8-9). These allegations concerning Defendants' misuse of dividend payments affect the Plan as a whole and all of its participants, not just Plaintiffs' accounts. Additionally, the Complaint alleges that Hardwick sold his remaining shares in Churchill to the Plan for \$145.90 per share, despite that Churchill's shares were only valued at \$52.25 as of December 31, 2019, a year prior to the sale. (Id. ¶¶ 10-11). It further alleges that the Plan overpaid Hardwick for his remaining shares to the detriment of the Plan and all of its participants. (Id. ¶ 14). Again, this alleged overpayment injured the Plan as a whole, not the Plaintiffs individually. “Th[e]se alleged breaches do not impact the Plaintiffs specifically; the harm (and the recovery) is to the Plan.” Hawkins v. Cintas Corp., 32 F.4th 625, 634 (6th Cir. 2022).

The derivative nature of Plaintiffs' claims is further bolstered by their requested relief. They request, among other relief, (1) a declaration that the Trustee Defendants “caused the Plan to engage in prohibited transactions and thereby breached [their] duties under ERISA” (Doc. No. 1 at Prayer for Relief A.); (2) a declaration that the Churchill Defendants “breached their fiduciary duties under ERISA to the Plan and the class members” (id. at Prayer for Relief C.); (3) a “reformation of the 2020 Transaction

contracts to provide the Plan pays no more than fair market value for Churchill stock as of the date of the transaction” (*id.* at Prayer for Relief G.); and (4) that the Court “[r]emove the Trustee as Plan fiduciary” (*id.* at Prayer for Relief L.). This relief, by its nature, is relief to the Plan as a whole and not solely to Plaintiffs. See *Hawkins*, 32 F.4th at 634. See also *Smith v. Board of Directors of Triad Manufacturing, Inc.*, 13 F.4th 613, 621 (7th Cir. 2021) (“Removal of a fiduciary ... go[es] beyond just [the plaintiff] and extend[s] to the entire plan”).

Finally, claims brought pursuant to ERISA §§ 502(a)(2) and 502(a)(3) usually seek recovery for the plan itself, not an individual subject to the plan. *Stanley v. George Washington University*, 394 F. Supp. 3d 97, 103 (D.D.C. 2019). As one \*971 court has explained, “[s]uits under ERISA sections 502(a)(2) and (a)(3) are meaningfully distinct from those brought via section 502(a)(1)(B). Section 502(a)(2) and (a)(3) claims are generally brought in conjunction to enforce statutory ERISA rights, whereas section 502(a)(1)(B) claims are brought to enforce contractual rights created by the terms of a benefit plan.... [W]hile section 502(a)(2) suits are brought in a representative capacity, so that recovery runs to the plan, section 502(a)(1)(B) remedies run directly to the injury participant or beneficiary.” *Id.* Here, the fact that Plaintiffs have explicitly brought their claims under ERISA §§ 502(a)(2) and (a)(3) is another sign that they intended to bring their claims on behalf of the plan.

**b. Arnold's and Golden-Woods's Releases Are Not Enforceable Against Their Derivative Claims.**

As Arnold and Golden-Woods's claims are derivative, the Court must determine whether the releases in their severance agreements apply to derivative claims. The Court interprets the language in Arnold's and Golden-Woods's releases under federal common law. See *McClellan v. Midwest Machining, Inc.*, 900 F.3d 297, 302 (6th Cir. 2018) (“Federal law controls the validity of a release of a federal cause of action.”) (quoting *Street v. J.C. Bradford & Co.*, 886 F.2d 1472, 1481 (6th Cir. 1989)). Under federal common law, unambiguous agreements, including agreements to release or waive federal claims, are enforced according to their terms. See *Soltis v. J.C. Penney Corp.*, 635 Fed. App'x 245, 248 (6th Cir. 2015).

Arnold's and Golden-Woods's releases are broadly worded. They apply to “any and all charges, complaints, claims, liabilities, obligations, promises, agreements, controversies, damages, actions, causes of action, suits, rights, demands, costs, losses, debts and expenses (including attorney's fees and costs actually incurred), of any nature whatsoever pertaining to his [sic] employment with or separation from Employer, or arising from any action taken by Employer, known or unknown.” (Doc. No. 37-3 at 3, 7). They explicitly release any ERISA claims brought by Arnold or Golden-Woods. (*Id.* (“Employee acknowledges and agrees that she is releasing and giving up any right or claims she may have under ... the Employee Retirement Income Security Acts of 1974”). Moreover, they apply to claims “Employee now has, owns or holds, or claims to have, own or hold, or which Employee at any time hereafter may have, own or hold, or claim to have, own or hold.” (*Id.*). In other words, the releases explicitly apply to past, present, or future claims.

Not so fast; the Court cannot end its analysis there. Even though the plain language of the releases encompasses Plaintiffs' claims, Plaintiffs argue the releases are not enforceable because Plaintiffs cannot waive claims owned by the Plan. (See Doc. No. 46 at 12-13). Plaintiffs rely on *Hawkins v. Cintas Corp.*, which concerned an arbitration clause in an ERISA-governed plan, to support their argument. (See *id.*). In *Hawkins*, plaintiffs who had signed employment agreements to arbitrate employment-related claims sued their employer, Cintas, alleging that Cintas violated ERISA § 409 by failing to uphold its fiduciary duties to them in its administration of the company's retirement plan. *Hawkins*, 32 F.4th at 627-28. The plaintiffs, like Plaintiffs here, brought their lawsuit under ERISA § 502(a)(2). *Id.* The Sixth Circuit held that the arbitration provisions in the plaintiffs' employment agreements did not apply to their § 502(a)(2) claims. In doing so, the Court explained, as a matter of first impression, *id.* at 627:

Although § 502(a)(2) claims are brought by individual plaintiffs, it is the plan that takes legal claim to the recovery, suggesting that the claim really “belongs” \*972 to the Plan. And because § 502(a)(2) claims “belong” to the Plan, an arbitration agreement that binds only individual participants cannot bring such claims into arbitration.

Id. at 632-33. The Sixth Circuit further held that “[t]he weight of authority and the nature of § 502(a)(2) claims suggest that these claims belong to the plan, not to individual plaintiffs.” Id. at 627. In reaching this conclusion, the Court referenced the Supreme Court's decisions in Russell and Larue, both of which held that “any claims properly brought under § 502(a)(2) must be for injuries to the plan itself.” Id. at 631.

Defendants argue that because Hawkins concerned an arbitration agreement and not a release of claims, it is inapposite to this case. (See Doc. No. 47 at 5). They offer no argument, however, explaining why Hawkins' reasoning—that § 502(a)(2) claims belong to the Plan and not individual plaintiffs suing on its behalf—should not equally apply to releases of claims. (See id.). Nor do they explain what differences exist between arbitration agreements and releases of claims that would justify a different result in this case. (See id.). Most striking, Defendants ignore that the Sixth Circuit credited the Hawkins plaintiffs' comparison to cases holding that an individual plaintiff cannot release claims belonging to an ERISA plan. Hawkins, 32 F.4th at 636.

Instead, Defendants rely on one unpublished Sixth Circuit case, which predated Hawkins by 12 years, that enforced a release of ERISA claims. (See Doc. No. 38 at 19-20). In Dotson v. Arkema, former employees alleged that their company's retirement benefits plan breached its fiduciary duties when it did not pay them severance after they agreed to resign. 397 Fed. App'x 191, 192 (6th Cir. 2010). The severance agreements had been negotiated by the employees' union, which later released all claims relating to ERISA in an agreement with the company's buyer. Id. at 192. The Sixth Circuit held that the union's release applied to individual employees and was enforceable. Id. at 194. Like here, the Dotson plaintiffs' claims were derivative in nature.<sup>1</sup> Defendants are correct, then, that the Sixth Circuit has enforced individual releases against derivative claims on at least one occasion. But the Dotson opinion is not the ace-in-the-hole for Defendants. The Sixth Circuit explicitly declined to rule on the plaintiffs' argument that “a union contract may not waive ERISA claims as a matter of law” because they had not raised the argument below. Id. at 193. Here, Plaintiffs have raised the argument that, pursuant to Hawkins, their individual releases cannot waive derivative claims. (See Doc. No. 46 at 11-14). Because the Sixth Circuit did not address this issue in Dotson, it is of limited relevance here.

Another Sixth Circuit case relied upon by Defendants, Taylor v. Visteon, suggested without deciding that employees can waive ERISA fiduciary duty claims. 149 Fed. App'x 422, 426-27 (6th Cir. 2005). In that case, employees who were laid off sued their former employer, Visteon, alleging fiduciary duty violations under ERISA. Id. at 423. Specifically, the former employees alleged that Visteon had told them the benefits they received at termination were \*973 non-negotiable, but then Visteon negotiated additional benefits with other former employees. Id. In exchange for receiving the termination benefits, the employees all signed releases which “waive[d] and release[d] any and all rights or claims of any kind [they] may have ... against Visteon Corporation.” Id. at 423-24. The Sixth Circuit ultimately rejected Plaintiffs' argument that the releases did not apply to their lawsuit on grounds that are irrelevant here,<sup>2</sup> but it also addressed whether ERISA's prohibition of exculpatory agreements prohibits the enforcement of releases like the plaintiffs', finding that it likely does not. Id. at 426.<sup>3</sup> “[A] release of past breach-of-fiduciary-duty claims does not appear to implicate § 1110(a) because it does not relieve a fiduciary of any responsibility, obligation, or duty imposed by ERISA; instead, it merely settles a dispute that the fiduciary did not fulfill its responsibility or duty on a given occasion.” Id. at 427 (quoting Leavitt v. Northwestern Bell Telephone Co., 921 F.2d 160, 161-62 (8th Cir. 1990)) (internal quotation marks omitted). This reasoning, grounded in a provision of ERISA that prevents fiduciaries from contracting around their statutory fiduciary duties, is entirely different from the argument Plaintiffs make here—that individuals cannot waive claims that belong to the Plan. Like Dotson, the Court did not address the issue Plaintiffs raise here, so it, too, does not determine the outcome here.

The Court has identified two other instances where the Sixth Circuit has enforced releases of ERISA claims, both pre-dating Hawkins. These cases both concerned discrimination claims. See Halvorson v. Boy Scouts of America, 2000 WL 571933, at \*1, 215 F.3d 1326 (6th Cir. May 3, 2000); Samms v. Quanex, 1996 WL 599821, at \*1, 99 F.3d 1139 (6th Cir. 1996). Claims alleging discrimination under ERISA are brought pursuant to ERISA § 502(a)(1)(B), which allows “participant[s] or beneficiary[ies]” to bring civil actions “to recover benefits due to [them] under the terms of [their] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B). See, e.g., Lockett

v. Marsh USA, Inc., 354 Fed. App'x 984, 988 (6th Cir. 2009). These claims are individual in nature, see Stanley, 394 F. Supp. 3d at 103, and thus do not raise the relevant question here whether an individual release may waive derivative claims. Perhaps because these cases did not concern derivative claims, Defendants did not rely upon them.

Finally, Defendants rely on three out-of-circuit cases where district courts have upheld releases of derivative ERISA claims, again all pre-dating Hawkins. (See Doc. No. 38 at 20; Doc. No. 47 at 5). In Howell v. Motorola, Inc., the Seventh Circuit found a release to be valid that “waived the right to bring a lawsuit challenging the [ERISA] Plan as a whole.” 633 F.3d 552, 560-61 (7th Cir. 2011). Because Howell's release was valid, the Seventh Circuit held that “he cannot now claim that his [retirement] account would have been \*974 worth even more had the defendants not breached a fiduciary duty.” Id. at 561.

In Halldorson v. Wilmington Tr. Ret. & Institutional Servs. Co., the plaintiff brought ERISA claims similar to those in this case, alleging that the plan overpaid when it purchased another company's stock, as that stock's value plummeted over the seven months following the transaction. 182 F. Supp. 3d 531, 534 (E.D. Va. 2016). Like this case, the plaintiff filed his claims under ERISA § 502(a)(2) for violations of § 409. Id. at 535. The court enforced the plaintiff's release against his ERISA claims, rejecting the plaintiff's arguments that his claim was actually one for vested benefits, a type of claim he had not waived by signing the release. Id. at 539-41. The plaintiff did not argue that his release could not apply to his derivative claim, nor did the court address this issue. Id.

Like the plaintiff in Halldorson, the plaintiff in Stanley v. George Washington Univ. argued that her ERISA claim was for vested benefits. 394 F. Supp. 3d 97, 101 (D.D.C. 2019). The court rejected this argument, finding that “section 502(a)(2) suits are brought in a representative capacity.” Id. at 103. Finding that the plaintiff's release applied to her ERISA 502(a)(2) claim, the court enforced the release and dismissed her case. Id. at 111. Like the Halldorson and Howell courts, the court did not address whether Stanley had the power to waive claims brought derivatively on behalf of the plan. Id.

The Court does not find any of the cases relied upon by Defendants to be persuasive to answer the question whether Plaintiffs can release derivative claims. Instead, Hawkins is the most applicable case and is precedent that the Court must follow. Though Hawkins concerned an arbitration provision, its reasoning can be squarely applied to the release in this case. Moreover, the Sixth Circuit acknowledged several out-of-circuit cases in Hawkins that have held that a plaintiff cannot release derivative claims. See Hawkins, 32 F.4th at 636 (citing In re Schering Plough Corp. ERISA Litig., 589 F.3d 585, 594 (3d Cir. 2009); Bowles v. Reade, 198 F.3d 752, 760 (9th Cir. 1999); Leber v. Citigroup 401(k) Plan Inv. Comm., 323 F.R.D. 145, 161 (S.D.N.Y. 2017)). The Court finds that Hawkins is controlling and the reasoning of these out-of-circuit cases is persuasive. Therefore, even though Arnold's and Golden-Woods's releases unambiguously apply to future ERISA claims, Arnold and Golden-Woods did not have the power to individually waive claims owned by the Plan in their separation agreements.<sup>4</sup>

## 2. The Plan's Class Action Waiver

Arnold's and Golden-Woods's releases aside, Defendants argue that the Plan contains \*975 a class action waiver that prohibits all three Plaintiffs (and any other Plan participant) from “recovering monetary amounts [beyond] their individual accounts.” (Doc. No. 41 at 6; see also Doc. No. 40-3 § 11.09). The relevant Plan provision, which is included in Article XI, MISCELLANEOUS of the Plan and is titled “Consent to Jurisdiction; Service of Process; Legal Action; and Waiver of Class,” states in relevant part:

Actions shall not be brought as class or collective actions. A participant, beneficiary, or other claimant expressly waives, forfeits, and forever relinquishes the right to participate in a class or collective action and to any recovery as part of a class or collective action. With respect to Actions that, pursuant to applicable law, must be brought in a representative capacity of another, which include without limitation Actions brought for losses to the Plan pursuant to ERISA Section 502(a)(2) and ERISA Section 409, the claimant may not represent a class or bring a class or collective action, and any relief obtained shall be

limited to provide a remedy only to redress the claimant's individual losses. Any relief or remedy awarded must, to the extent possible, be pro-rated to provide relief or remedy solely to the individual claimant.

(Doc. No. 40-3 § 11.09).

Plaintiffs respond that to the extent the relevant provision of the Plan precludes them from seeking Plan-wide relief, it is void under the “effective vindication” doctrine because it bars a federal statutory remedy—the right to seek relief on behalf of the Plan as a whole. (Doc. No. 45 at 6-9). They further argue the provision is void because it is an unlawful exculpatory provision barred by ERISA § 410(a), 29 U.S.C. § 1110(a). (*Id.*). Defendants respond that the effective vindication doctrine only applies in the context of arbitration provisions, (Doc. No. 41 at 7 n.5), and the class waiver provision is not void under ERISA's exculpatory provision, § 410(a). (Doc. No. 45 at 10). The Court addresses each of these arguments below.

#### **a. Effective Vindication Doctrine**

Plaintiffs argue that because the Plan's class action waiver prevents them from seeking all but “monetary amounts [for their] individual accounts,” (Doc. No. 40-3 § 11.09), it is barred by the effective vindication doctrine. (Doc. No. 41 at 6). The effective vindication doctrine was first articulated in Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., when the Supreme Court determined that a Sherman Act antitrust claim could be arbitrated because “so long as the prospective litigant effectively may vindicate its statutory cause of action in the arbitral forum, the [federal] statute will continue to serve both its remedial and deterrent function.” 473 U.S. 614, 637, 105 S.Ct. 3346, 87 L.Ed.2d 444 (1985). The Supreme Court later explained that the doctrine “finds its origin in the desire to prevent prospective waiver of a party's right to pursue statutory remedies,” including “provision[s] in arbitration agreement[s] forbidding the assertion of certain statutory rights.” American Exp. Co. v. Italian Colors Restaurant, 570 U.S. 228, 236, 133 S.Ct. 2304, 186 L.Ed.2d 417 (2013). Though the Supreme Court has acknowledged the existence of the effective vindication doctrine on several occasions, it has never actually applied the doctrine to invalidate an arbitration provision. *Id.* at 235-36, 133 S.Ct. 2304. Multiple circuit courts, however, have done so. See Dorman v. Charles Schwab Corp., 780 Fed. App'x 510, 517 (9th Cir. 2019); Smith v. Board of Directors of Triad Manufacturing, Inc., 13 F.4th 613, 622 (7th Cir. 2021); Henry v. Wilmington Trust, N.A., 72 F.4th 499, 507 (3d Cir. 2023); \*976 Harrison v. Envision Management Holding, Inc. Board of Directors, 59 F.4th 1090, 1100-08 (10th Cir. 2023) *cert. denied* — U.S. —, 144 S.Ct. 280, 217 L.Ed.2d 128 (2023). See also Coleman v. Brozen, 2023 WL 4498506, at \*17 (N.D. Tex. Jul. 12, 2023). As explained below, while each of these circuit court opinions pertains to arbitration provisions, the courts' reasoning hinges on the class action waiver language within those arbitration provisions. While the class action waiver in this case is not encased in an arbitration provision, these decisions are persuasive and relevant to the Court's analysis in this case.

In the first-decided of these circuit court decisions, Dorman, the plaintiff alleged that his former employer breached its fiduciary duties in administering his retirement plan under ERISA § 409. 780 Fed. App'x at 512. The retirement plan's governing documents required arbitration of claims concerning the plan. *Id.* The district court found that the arbitration provision did not apply because “[a] plan document drafted by fiduciaries—the very people whose actions have been called into question by the lawsuit—should not prevent plan participants and beneficiaries from vindicating their rights in court.” 2018 WL 467357, at \*5 (N.D. Cal. Jan. 18, 2018). The Ninth Circuit reversed, holding that “an agreement to arbitrate ERISA claims is generally enforceable.” 780 Fed. App'x at 513-14. In reaching this holding, the Ninth Circuit did not address the effective vindication doctrine. See generally *id.*

In Smith, the plaintiff, Smith, also sued alleging financial misconduct by his former employer of his retirement plan. 13 F.4th at 615. Smith brought his action on behalf of a putative class of similarly situated individuals. *Id.* Smith's retirement plan was subject to an arbitration provision. *Id.* In addition to requiring plan participants to arbitrate their claims, the provision also precluded relief that “has the purpose or effect of providing additional benefits or monetary or other relief to any Eligible Employee, Participant or Beneficiary other than the Claimant.” *Id.* Like the Ninth Circuit held in Dorman, the court acknowledged that ERISA claims are generally arbitrable. *Id.* at 620. The court went on to hold, however, that the arbitration

provision did not apply to Smith's claims because “the plan's arbitration provision, which also contains a class action waiver, precludes a participant from seeking or receiving relief” on behalf of the plan. Id. at 621. In other words, the court found that that the invalid portion of the retirement plan's governing document was not the provision requiring arbitration of Smith's claims; instead, it was the class action waiver portion of that provision, which denied Smith the opportunity to seek damages on behalf of the retirement plan. Id.

In February 2023, the Tenth Circuit addressed a fact pattern similar to Dorman and Smith. Harrison, 59 F.4th at 1093-94. Like Smith, the Tenth Circuit declined to enforce an arbitration and class action waiver provision of a retirement plan that prohibited individuals from seeking plan-wide relief. Id. at 1096. After an extremely detailed analysis of the effective vindication doctrine, the class action waiver at issue, and ERISA, the Tenth Circuit held that “the effective vindication exception applies [because] it is not clear what remedies Harrison would be left with if [the class action waiver] is enforced as written. And, in fact, [the class action waiver] effectively prevents any claimant from pursuing the types of claims that Harrison asserts in his complaint.” Id. at 1107. The Tenth Circuit further explained:

[T]he Supreme Court's rulings regarding the effective vindication exception ... make clear that the exception is not implicated simply because an arbitration agreement changes, or even eliminates, the other applicable procedures that a \*977 claimant may use to seek relief. Instead, the effective vindication exception applies only where an arbitration agreement alters or effectively eliminates substantive forms of relief that are afforded to a claimant by statute ... It is not the Plan Document's requirement that a claimant engage in the procedural mechanism of individual arbitration that is the problem [the exception seeks to remedy]. Rather, it is the Plan's prohibition on an individual claimant seeking any form of relief that would benefit anyone other than the claimant.

Id. at 1111. The Supreme Court denied the defendants' petition for certiorari. Argent Trust Co. v. Harrison, — U.S. —, 144 S.Ct. 280, 217 L.Ed.2d 128 (2023).

In June 2023, the Third Circuit followed the reasoning of the Seventh and Tenth Circuits. Henry, 72 F.4th at 502. Like Smith and Harrison, the arbitration provision at issue in Henry contained a class action waiver that required claims to “be brought solely [in an] individual capacity and not in a representative capacity or on a class, collective, or group basis” and “prohibited a claimant from ‘seek[ing] or receiv[ing] any remedy which has the purpose or effect of providing additional benefits or monetary or other relief’ to anyone other than the claimant.” Id. at 503. The Third Circuit held that “the class action waiver purports to waive [ERISA] authorized remedies, the class action waiver and the statute cannot be reconciled.” Id. at 507.

The Smith, Harrison, and Henry opinions all invalidated class action waivers that prevented the plaintiff from seeking relief on behalf of the retirement plan. In this case, the class action waiver does the same thing—it prevents Plaintiffs from “represent[ing] a class or bring[ing] a class or collective action, and any relief obtained shall be limited to provide a remedy only to redress the claimant's individual losses. Any relief or remedy awarded must, to the extent possible, be pro-rated to provide relief or remedy solely to the individual claimant.” (Doc. No. 40-3 § 11.09). True, in this case, the class action waiver appears in the “MISCELLANEOUS” section of the Plan governing document, rather than within an arbitration provision. Id. In fact, the Plan does not contain an arbitration provision at all. Id. But as the three circuit court decisions all make clear, arbitration of ERISA claims is not, in itself, problematic. Harrison, 59 F.4th at 1111; Henry, 72 F.4th at 508; Smith, 13 F.4th at 620. The violative portions of the arbitration provisions in those cases are indistinguishable from the class action waiver in this case.

To be clear, the Court does not hold that a class action waiver alone violates the effective vindication doctrine. Indeed, the Supreme Court has declined to apply that doctrine to invalidate a class action waiver. American Express Co. v. Italian Colors Restaurant, 570 U.S. 228, 236-37, 133 S.Ct. 2304, 186 L.Ed.2d 417 (2013). (“[t]he class-action waiver merely limits arbitration to the two contracting parties. It no more eliminates those parties' right to pursue their statutory remedy than did federal law

before its adoption of the class action for legal relief in 1938 .... Or, to put it differently, the individual suit that was considered adequate to assure effective vindication of a federal right before adoption of class-action procedures did not suddenly become ineffective vindication upon their adoption.”) (internal quotation marks and citations omitted). What distinguishes the class action waiver here (as well as those in Smith, Henry, and Harrison) from the waiver in Italian Colors is the prohibition on seeking plan-wide relief. ERISA explicitly allows plaintiffs to seek plan-wide relief. See 29 U.S.C. §§ 1109(a), 1132(a)(2); see also Russell, 473 U.S. at 142 n.9, 105 S.Ct. 3085. Because the class action \*978 waiver in this case cannot be squared with that statutory remedy, it is barred by the effective vindication doctrine.

### **b. ERISA § 410(a) Exculpatory Provision**

Assuming arguendo that the effective vindication doctrine does not bar the enforcement of the class action waiver, Plaintiffs argue that the waiver is also prohibited by the ERISA's exculpatory provision, ERISA § 410(a), 29 U.S.C. § 1110(a). (Doc. No. 45 at 10). While courts have determined whether indemnification provisions and arbitration procedures are barred by this provision, the parties have not relied on—and the Court has not found any—cases concerning the application of this provision to a class action waiver.

In line with application of the effective vindication doctrine, courts hold that waivers that “diminish the statutory obligations of a fiduciary” are unlawful under ERISA's exculpatory provision. See Pfahler v. Nat'l Latex Products Co., 517 F.3d 816, 836-37 (6th Cir. 2007) (quoting Leavitt v. Nw. Bell Tel. Co., 921 F.2d 160, 161 (8th Cir. 1990)). See also Burnett v. Prudent Fiduciary Services LLC, 2023 WL 387586, at \*6 (D. Del. Jan. 25, 2023) (“[A]n arbitration provision that eliminates the right to pursue a remedy provided by ERISA is invalid as against public policy.”). Based on that reasoning, courts have found that indemnification provisions are not barred by § 410(a), because they “do not prevent a fiduciary from being held liable, but instead only provide that if the fiduciary is held liable, then someone else will compensate the fiduciary for that liability.” Pfahler, 517 F.3d at 837. Nor are arbitration procedures. Dorman v. Charles Schwab Corp., 780 Fed. App'x 510, 513 (9th Cir. 2019). In dicta, the Sixth Circuit has suggested that releases of ERISA claims also do not violate § 410(a). Taylor, 149 F. App'x at 427.<sup>5</sup> The Sixth Circuit explained that “[e]nforcing a waiver of this sort, for which plaintiffs received valuable consideration, does not *relieve* [a trustee] of any fiduciary duties; it merely *resolves* claims arising from those duties.” Id. (emphasis in original).

The Court finds that the portion of the class action waiver that bars relief on behalf of the plan is unlawful under ERISA § 410(a). Courts have held that provisions banning class actions—but not banning recovery of plan-wide relief—do not violate § 410(a) because these provisions do not prevent individual plaintiffs from pursuing statutory remedies; they simply prevent plaintiffs from aggregating their claims with similarly situated individuals. Burnett, 2023 WL 387586, at \*7-\*8 (citing Viking River Cruises, Inc. v. Moriana, 596 U.S. 639, 653, 142 S.Ct. 1906, 213 L.Ed.2d 179 (2022); Epic Systems Corp. v. Lewis, 584 U.S. 497, 505, 138 S.Ct. 1612, 200 L.Ed.2d 889 (2018); and Italian Colors, 570 U.S. at 236, 133 S.Ct. 2304). Here, Plaintiffs' requested relief is not limited to compensation for their individual losses. They also request reformation or rescission of the 2020 Transaction and for the Court to remove the Defendants as trustees and fiduciaries of the Plan. (Doc. No. 1, Prayers for Relief G, H, L and M). By the very nature of this relief, a court cannot isolate the individual's and the Plan's injunctive relief. See Smith v. Board of Directors of Triad Manufacturing, Inc., 13 F.4th 613, 622-23 (7th Cir. 2021) (“Just like the removal of a fiduciary, the appointment of a new [trustee] cannot have anything *but* a \*979 plan-wide effect.”) (emphasis in original). By forbidding claimants from seeking all but individual relief, the Plan bars several types of relief that ERISA guarantees. While every individual claimant could bring his or her own separate action seeking individual relief, none of these individuals would be able to seek injunctive relief. Therefore, the Court agrees with Plaintiffs that the portion of the class waiver provision that proscribes plan-wide relief violates ERISA § 410(a).

### **3. Rule 12(b)(6) Failure to State a Claim**

Defendants raise several arguments that the Complaint fails state a claim. It is black letter law that a complaint must plausibly allege each element of its claims, and plaintiffs cannot rest upon conclusory statements to sail through the motion to dismiss phase of a case. Dakota Girls, 17 F.4th at 648. Defendants argue that the Complaint is littered with conclusory statements, requiring dismissal of each of Plaintiff's claims. (Doc. No. 38 at 2-3; Doc. No. 41 at 2). They further argue that Plaintiffs have

failed to allege necessary elements of certain of their claims. (Doc. No. 38 at 8-19; Doc. No. 41 at 8-23). The Court addresses each of these so-called deficiencies in turn.

**a. Whether Plaintiffs have alleged that PFS was a trustee**

Defendants argue that Plaintiffs have not alleged that PFS was a trustee of the Plan, a necessary element of Plaintiffs' Counts I and II. (Doc. No. 41 at 25). In response, Plaintiffs argue that the Complaint's allegations and the engagement agreement between PFS and the Plan confirm that both Michael Paredes and PFS, his operating company, are trustees of the Plan. (Doc. No. 45 at 21). The Court agrees with Plaintiffs. The Complaint clearly alleges that "Miguel Paredes and his operating company Prudent Fiduciary Services, LLC ... [is] the fiduciary trustee for the Churchill Holdings, Inc. Employee Stock Ownership Plan." (Doc. No. 1 ¶ 1). It further alleges that PFS "provid[es] trustee services to privately held companies wishing to sponsor Employee Stock Ownership Plans," (*id.* ¶ 26), and that "PFS provides a team of approximately fifteen full-time individuals to execute ESOP transactions including an in-house business appraiser, a routine due diligence process, office space, and insurance," of which "Paredes was ... the sole member of PFS" responsible for making decisions regarding the Plan. (*Id.* ¶ 28). At this stage of the case, Plaintiffs have met their pleading burden. See *Ahrendsen v. Prudent Fiduciary Services, LLC*, 2022 WL 294394, at \*4 n.4 (E.D. Pa. Feb. 1, 2022).

Trustee Defendants argue that the Complaint incorporates the Plan's engagement agreement, and so the Court may look to the language of that agreement when deciding the motion to dismiss. (Doc. No. 41 at 25 (citing Doc. No. 1 ¶¶ 28-29)). Contrary to Trustee Defendants' arguments, the Complaint does not reference the engagement agreement; instead, it references the Plan's Summary Plan Description. (See Doc. No. 1 ¶¶ 28-29). Even if the Court were to consider the engagement agreement, however, the agreement only reinforces the Complaint's allegations that PFS "exercises ... discretionary authority of discretionary control respecting management of [the Plan] or exercises ... authority or control respecting management or disposition of its assets." 29 U.S.C. § 1002(21)(A).

**b. Whether Plaintiffs have alleged that the Trustee Defendants acted with the motive to benefit themselves**

Trustee Defendants argue that Plaintiffs have failed to allege that PFS \*980 and Paredes acted with the motive to benefit themselves, which they further argue is a requirement of Plaintiffs' second claim, that Trustee Defendants breached their duty of loyalty to the Plan. (Doc. No. 41 at 23-25). Plaintiffs respond that because they sue a "private company ESOP action," they are not required to plead self-dealing or motive to allege a breach of fiduciary duty, as all they need to allege is that the trustees did not act with only the interests of the Plan in mind and did not thoroughly investigate the 2020 Transaction. (Doc. No. 45 at 20-21).

The Sixth Circuit's recent decision in *Forman v. TriHealth, Inc.* decides this issue. There, the Sixth Circuit held that the duty of loyalty "claim fails because [the plaintiffs] do not make any allegations suggesting that the fiduciary's operative motive was to further its own interests, as required to show a breach of the fiduciary duty of loyalty." 40 F.4th 443, 450 (6th Cir. 2022). The Sixth Circuit specifically rejected the plaintiffs' allegations that the trustee violated its duty of loyalty by choosing investments that would benefit third parties, suggesting that even conduct designed to benefit third parties who are not plan beneficiaries may not be enough to state a claim for violation of the duty of loyalty. *Id.* Cf. *Cassell v. Vanderbilt Univ.*, 285 F. Supp. 3d 1056, 1062 (M.D. Tenn. 2018) (holding that "in order to show that Defendants breached the fiduciary duty of loyalty, Plaintiffs must allege that Defendants acted for the purpose of benefitting ... third parties or themselves") (internal quotation marks and emphasis omitted). Plaintiffs try to distinguish *Forman* from this case because *Forman* involved a public company's retirement plan rather than a private company's retirement plan, but they offer no explanation—and cite no case—supporting their argument that this case should be treated differently. (See Doc. No. 45 at 20-21).<sup>6</sup>

Plaintiffs also argue that Trustee Defendants "improperly attempt to slice-and-dice" their fiduciary duty breach claim, which purports to allege breaches of both the duty of loyalty and the duty of prudence under ERISA § 404(a). (Doc. No. 45 at 20-21). Courts acknowledge that ERISA § 404(a) creates fiduciary duties of prudence and loyalty. See *Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570-71, 105 S.Ct. 2833, 86 L.Ed.2d 447 (1985). These

duties closely mimic duties created under trust laws. *Id.* Courts analyze allegations concerning the two duties separately. *See, e.g., Cassell*, 285 F. Supp. 3d at 1062-63; *Beldock v. Microsoft Corp.*, 2023 WL 1798171, at \*6-\*7 (W.D. Wash. Feb. 7, 2023). There was nothing improper about Trustee Defendants' argument that Plaintiffs failed to allege a breach of the duty of loyalty. Because Plaintiffs have not alleged that the 2020 Transaction or the alleged misuse of dividend payments was an act of self-dealing on Paredes's or PFS's part, or that these transactions were completed to benefit Paredes or PFS, they have not sufficiently alleged the breach of duty of loyalty portion of their ERISA § 404(a) claim (Count II).

**\*981 c. Whether Plaintiffs have alleged that Trustee Defendants used a deficient process to evaluate the 2020 Transaction**

Trustee Defendants argue that Plaintiffs have failed to allege that they used a deficient process in evaluating the 2020 Transaction, so Count I (prohibited transaction under ERISA § 406) must be dismissed. (Doc. No. 41 at 8-23). Plaintiffs respond that they have provided circumstantial allegations that suggests an imprudent process. (Doc. No. 45 at 17-18).

The Complaint lays out several ways that Plaintiffs allege the Trustee Defendants' evaluation of the 2020 Transaction was deficient:

- “The Trustee valued Churchill stock on a control basis by using an industry capital structure instead of Churchill's actual capital structure in its income method, which yielded a control value.” (Doc. No. 14 ¶ 82). Since “the Plan did not obtain control of Churchill ... because Hardwick maintained control over the board of directors and, through the board, the company.” (*Id.*). Reading this allegation in the light most favorable to Plaintiffs, Plaintiffs allege that the Trustee Defendants used a deficient process by determining a control value but not discounting the stock for the Plan's lack of control (and Hardwick's continued control) following the 2020 Transaction.
- The Trustee Defendants relied on financial statements as well as cashflow and income projections provided by Churchill management to value Churchill's income. (*Id.* ¶ 83). Churchill management's projections were “unreasonably optimistic,” and the Trustee Defendants “did not adequately challenge” this information. (*Id.*).
- The Trustee Defendants' market valuation techniques were deficient because they were “based on supposedly comparable companies to Churchill” that were actually “too dissimilar to Churchill to provide a reliable indication of value.” (*Id.* ¶ 84).
- “The Trustee [Defendants] failed to apply a sufficient discount for lack of marketability (DLOM) to its valuation in the 2020 Transaction because it failed to account for the lack of marketability for the stock that was purchased by the [Plan].” (*Id.* ¶ 85).
- The Trustee Defendants' valuation did not account for the fact that “at or around the closing of the 2020 Transaction ... Hardwick [took on] synthetic equity ... which diluted the value of the Plan-owned stock.” (*Id.* ¶ 86).

(*See also* Doc. No. 45 at 18).

Trustee Defendants attack each of these allegations, arguing that Plaintiffs have not met their plausibility threshold. (Doc. No. 41 at 12-23). Those arguments are fruitless for now. At the motion to dismiss phase of a case, a plaintiff need only “plead ‘sufficient factual matter’ to render the legal claim plausible, i.e., more than merely possible.” *Cabinets to Go*, 605 F. Supp. 3d at 1057. Courts are particularly sensitive to the incongruities between the access to information that beneficiaries of an ERISA-governed retirement plan have versus the trustees of that plan. *See Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 594 (8th Cir. 2009); *Allen v. GreatBanc Trust Co.*, 835 F.3d 670, 678 (7th Cir. 2016); *Innova Hosp. San Antonio, L.P. v. Blue Cross & Blue Shield of Ga., Inc.*, 892 F.3d 719, 728–29 (5th Cir. 2018). Prior to discovery, Plaintiffs do not have access to many of the specifics Trustee Defendants argue should have been in the Complaint, \*982 such as the identity of the “comparable companies” used in the Trustees' market valuation and how those comparators were “too dissimilar,” (Doc. No. 41 at 12), the amount the Plan paid as a control premium, (*id.* at 16), the nature of the warrants issued, (*id.* at 20), and whether the Plan paid a grossly inflated price for Hardwick's shares of Churchill's stock in the 2020 Transaction (*id.* ¶ 66).

Trustee Defendants' arguments only emphasize the need for discovery to determine whether Plaintiffs will ultimately be able to prove their well-pleaded allegations. Indeed, they admit as much. (*Id.* at 16) (“discovery ... will show that the [Plan] did not, in fact, pay any control premium”); *id.* at 20 (“neither the 2013 transaction nor the 2020 Transaction actually involved an issuance of warrants ... and discovery ... will show it”). Viewing the complaint's allegations in their totality at this stage, the Court finds that Plaintiffs have plausibly alleged a deficient process.

**d. Whether Plaintiffs have alleged that Churchill Defendants breached their fiduciary duties concerning dividend payments**

Churchill Defendants argue that Plaintiffs have failed to allege that they breached their fiduciary duties concerning dividend payments under Count III. (Doc. No. 38 at 17-19). Relatedly, Defendants ask the Court to take judicial notice of documents “confirm[ing] that the \$2.4 million annual Dividend Payments were used for the very purposes that Plaintiffs claim they should have been used.” (Doc. No. 38 at 18-19). These documents include “audited financial statements that are attached to the [Plan's] annual Forms 5500 from as far back as 2015,” which “contain a specific paragraph that shows that each annual payment of \$2.4 million was used to service existing debt obligations.” (*Id.* at 18). Defendants attached a 219-page “composite exhibit” of these documents to their motion to dismiss. (Doc. No. 37-2). Plaintiffs respond that the Complaint plausibly alleges misuse of the dividend payments, and clarify that because “the dividends belong to the Plan and not Churchill,” they “cannot be used to defray [Churchill's] obligation to contribute to the plan.” (Doc. No. 46 at 10-11).

As a threshold matter, the Court will not take judicial notice of Churchill Defendants' composite exhibit of financial statements. “Importantly, Federal Rule of Evidence 201 allows a court to take notice of facts not subject to reasonable dispute.” *In re Omnicare, Inc. Securities Litigation*, 769 F.3d 455, 467 (6th Cir. 2014). The Court acknowledges that it may consider the financial statements, as Plaintiffs admit that the Complaint's allegations of misused dividend payments “come straight from the financial statements Defendants provide.” (Doc. No. 46 at 10). The Court need not credit allegations in the Complaint that are refuted by these financial statements, *id.* at 466, but the parties dispute how to interpret the financial statements. Churchill Defendants argue that the statements “confirm that the \$2.4 million annual Dividend Payments were used for the very purposes that Plaintiffs claim they should have been used,” (Doc. No. 38 at 18), while Plaintiffs argue the statements are “at best, ... internally inconsistent.” (Doc. No. 46 at 10).

Moreover, Churchill Defendants cite only one statement from the 219-page exhibit to their motion that they say refutes the Complaint: “[t]he Company paid a dividend to the [Plan] of \$4.90 per share of \$2,400,000 during the year ended December 31, 2019.” (*See* Doc. No. 38 at 18). Churchill Defendants ask the Court to accept this statement as true, which the Court cannot do at this stage of the case. Under the judicial notice doctrine, the Court “c[an] take notice only of the fact \*983 that [the defendant] filed the [documents] and what that filing said, but [the Court] c[an] not consider the statements contained in the document for the truth of the matter asserted, even at the motion-to-dismiss stage.” *Id.* In reality, Churchill Defendants' request is a thinly veiled attempt to have the Court weigh documents that will surely be produced in discovery and evaluate whether they disprove Plaintiffs' allegations. That is the work of summary judgment.

The Court now considers whether the Complaint plausibly alleges that the Churchill Defendants breached their fiduciary duties, specifically the duty of loyalty, concerning the use of dividend payments between 2013 and 2019. (*See* Doc. No. 1 ¶¶ 3, 118). To bring a breach of duty of loyalty claim under ERISA § 404(a), a plaintiff must first allege that the defendant is a fiduciary as defined by ERISA § 1002(21)(A). Here, Churchill Defendants do not dispute that they were fiduciaries of the Plan. (*See* Doc. No. 38 at 17-19).

Next, Plaintiffs must “allege facts that permit a plausible inference that the defendant engaged in transactions involving self-dealing or in transactions that otherwise involve or create a conflict between the trustee's fiduciary duties and personal interests.” *Cassell v. Vanderbilt Univ.*, 285 F. Supp. 3d 1056, 1062 (M.D. Tenn. 2018). Here, Plaintiffs allege that “each year the Plan received \$2.4 million in dividends from the Preferred Shares,” which were “used, in part, to pay principal and interest on the [2013 Note].” (Doc. No. 1 ¶¶ 58-59). The remaining portion of the dividends, the Churchill Defendants used the dividends

for corporate purposes, to benefit themselves and the company, not the Plan. (Doc. No. 1 ¶ 60). They further make specific allegations concerning the amount of the dividends that were siphoned for corporate purposes in 2017-2019. (*Id.* ¶¶ 61-63). These allegations are sufficient.

Defendants have only two responses to the allegations. First, they argue that Plaintiffs' allegations are not plausible because the dividend payments were used to pay down the 2013 Note early, and "paying off the debt quite obviously inures to the benefit of the Plan because reducing the debt releases shares to the Plan." (Doc. No. 38 at 19). This argument requires the Court to consider evidence outside of the pleadings, which it cannot do. Worse, it misstates the Complaint's allegations. The Complaint clearly alleges that the dividend payments were used not only to pay down the 2013 Note, but also "for corporate purposes and not for the benefit of the Plan," including "to offset Churchill's obligations to make contributions to the [Plan] as an employee benefit." (Doc. No. 1 ¶¶ 59-60). In fact, Plaintiffs do not appear to contest the 2013 Note payments. (*See id.* ¶ 59; Doc. No. 46 at 11 ("To be clear, Plaintiffs do not complain that it was improper to use dividends to make payments on the Plan's note to Churchill.")). Churchill Defendants' argument thus completely misses the mark.

Second, Defendants argue that Plaintiffs cannot "assert a breach of fiduciary duty claim for any action that predates 2017," citing ERISA's statute of limitations, 29 U.S.C. § 1113(1). (Doc. No. 38 at 17). That statute of limitations, which Churchill Defendants quote in their motion, states that "[n]o action may be commenced ... with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this party, after the earlier of – (1) six years after (A) the date of *the last action* which constituted a part of the breach or violation ... or (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation." 29 U.S.C. 1113(1) (emphasis added). Plaintiffs allege a continuing misuse of dividend payments, in violation of Churchill Defendants' fiduciary duties, \*984 from 2013-2019. (Doc. No. 1 ¶ 3). The date from which to apply the statute of limitation is the date of *the last action*—i.e., the date of the misuse of the 2019 dividend payment. *See* 29 U.S.C. 1113(1). Defendants have provided no support for their argument that the Court should ignore Plaintiffs' allegations prior to 2017 aside from the language of the statute, which contradicts their argument.

The Court finds that Plaintiffs have plausibly alleged the Churchill Defendants breached the duty of loyalty by misusing the annual dividend payments owed to the Plan between 2013 and 2019.

**e. Whether Plaintiffs have plausibly alleged that Churchill Defendants failed to monitor the trustees**

Churchill Defendants argue that they only have a limited fiduciary duty to monitor the Plan trustees, and Plaintiffs have not alleged that they failed to do so, requiring that the co-fiduciary duty claim against them must be dismissed. (Doc. No. 38 at 12-13). Plaintiffs respond that they have alleged several facts that should have alerted these Defendants to the problems with the 2020 Transaction and caused them to monitor the Trustee Defendants. (Doc. No. 46 at 7). The Court agrees with Plaintiffs. At this stage of the case, their allegations that the 2020 Transaction was for triple the last valuation of Churchill stock and that the Board adopted the special dividend that allowed Hardwick to collect \$35 million immediately after the transaction are enough to suggest circumstances that should have invoked Churchill Defendants' duty to monitor.

**f. Whether Plaintiffs have alleged that Hardwick "knowingly participated" in a transaction prohibited by ERISA when he entered into the 2020 Transaction**

Churchill Defendants argue that Plaintiffs have failed to allege that Hardwick "knowingly participated" in a prohibited transaction under ERISA because they have not alleged that he knew the 2020 Transaction was unlawful. (Doc. No. 38 at 13-15). Plaintiffs respond that they need only allege facts that Hardwick knew or should have known that he was transacting with an ERISA fiduciary and that he understood the factual circumstances underlying the transaction. (Doc. No. 46 at 8). They also argue that they need not allege facts rebutting an affirmative defense. (*Id.* at 7).

Churchill Defendants argue that Plaintiffs have not alleged that "Mr. Hardwick believed he was engaged in an unlawful prohibited transaction." (Doc. No. 38 at 13). This is a distortion of the knowledge element of the claim. Plaintiffs need only allege that Hardwick "knowingly participated" in the fiduciary's breach of ERISA § 406. Harris Trust and Sav. Bank v. Salomon Smith

Barney, Inc., 530 U.S. 238, 239, 120 S.Ct. 2180, 147 L.Ed.2d 187 (2000). See also id. at 251, 120 S.Ct. 2180 (a defendant “must be demonstrated to have had actual or constructive knowledge of the circumstances that rendered the transaction unlawful.”). It is not a defense that Hardwick may not have known what transactions are unlawful under ERISA § 406 when he entered into the 2020 Transaction. “Ignorance of the law is no excuse.” United States v. Fortner, 943 F.3d 1007, 1011 (6th Cir. 2019) (quoting United States v. Int’l Minerals & Chem. Corp., 402 U.S. 558, 563, 91 S.Ct. 1697, 29 L.Ed.2d 178 (1971)).

Defendants have offered no support from the Sixth Circuit that rebuts this “general rule.” Int’l Minerals, 402 U.S. at 563, 91 S.Ct. 1697. The one case they do cite, from the Northern District of California, does not support their argument. In that case, the plaintiff alleged that two fiduciary defendants had “actual or constructive knowledge” that nonfiduciary defendants violated ERISA “by engaging in, \*985 authorizing and permitting prohibited financial transactions.” Del Castillo v. Comm. Child Care Council of Santa Clara County, Inc., 2019 WL 6841222, at \*2 (N.D. Cal. Dec. 16, 2019). The court held that “mere knowledge that a transaction is (or might be) prohibited under ERISA 406(a)” because “ERISA 408(b) ... provides for a broad range of statutory and administrative exemptions for 406(a) prohibitions.” Id. at \*6. Therefore, the plaintiffs needed to plead that the defendants knew they were engaged in conduct that was not exempted by 408(b). The Court did not hold that plaintiffs were required to plead that the defendants believed they were engaged in an unlawful transaction.

Importantly, Plaintiffs raise that several courts disagree with the conclusion in Del Castillo by holding that a plaintiff need not plead the absence of a 408(b) exemption. (See Doc. No. 45 at 14, 14 n.6). The Seventh Circuit explained why:

An ERISA plaintiff need not plead the absence of exemptions to prohibited transactions. It is the defendant who bears the burden of proving a section 408 exemption, and the burden of pleading commonly precedes the burden of persuasion.... We now hold squarely that the section 408 exemptions are affirmative defenses for pleading purposes, and so the plaintiff has no duty to negate any or all of them.

Allen v. GreatBanc Trust Co., 835 F.3d 670, 676 (7th Cir. 2016).

With this in mind, this Court holds that Plaintiffs must allege that Hardwick knew the 2020 Transaction was between the Plan and a “party in interest” concerning the “lending of money or other extension of credit,” the “sale or exchange ... of any property,” the “transfer to, or use by or for the benefit of a party in interest.” 29 U.S.C. § 406(a).<sup>7</sup> They have done so. They allege:

- Hardwick sold his remaining shares of Churchill to the Plan. (Doc. No. 1 ¶ 66).
- He sold the shares for more than three times their value one year prior. (Id.).
- Hardwick and “his friends on the Board” appointed PFS and Paredes to serve as the trustee of the Plan with “sole and exclusive authority to negotiate and approve the 2020 Transaction.” (Id. ¶ 72).
- Hardwick was “involved in directing the preparation of financial statements and projections by [his] team of subordinate Churchill management for use in valuations in the 2020 Transaction.” (Id. ¶ 76).
- Those financial statements and projections overstated Churchill's value. (Id. ¶ 83).
- Hardwick “massively accelerate[d] the [Plan's] payments to him under the 2020 Note” by declaring a \$35 million dividend for debt service of that note at the end of 2020. (Id. ¶ 80).

These allegations fit the criteria for a transaction prohibited by 406(a). Moreover, while the Court finds that Plaintiffs were not obligated to plead the absence of a 408(b) exemption, the Court finds that the Complaint plausibly alleges that the 2020 Transaction did not have “adequate consideration.” 29 U.S.C. 1108(b)(17).

**g. Whether Plaintiffs request equitable relief as to their knowing participation claim against Hardwick.**

Churchill Defendants argue that Plaintiffs seek legal damages concerning \*986 their knowing participation claim against Hardwick (Count IV), yet they are only entitled to equitable relief. Since Plaintiffs do not seek equitable relief, their claim must be dismissed. (Doc. No. 38 at 15-17). Relatedly, Churchill Defendants also argue that Plaintiffs have failed to trace the funds for which they are seeking disgorgement. (*Id.* at 16). Plaintiffs respond that their request for disgorgement is a traceable equitable remedy. (Doc. No. 46 at 9-10).

The Supreme Court long ago decided that plaintiffs suing under ERISA § 502(a)(3) are only entitled to equitable relief, not money damages. See *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 248, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993) (“ERISA does not authorize suits for money damages against nonfiduciaries who knowingly participate in a fiduciary’s breach of fiduciary duty.”); *Harris*, 530 U.S. at 241, 120 S.Ct. 2180 (holding that § 502(a)(3) allows suits for equitable relief against nonfiduciaries). Plaintiffs’ knowing participation claim against Hardwick is brought under that provision. (See Doc. No. 1 ¶ 121). Defendants are correct, then, that Plaintiffs are limited to seeking equitable relief for their knowing participation claim against Hardwick.

Here, Plaintiffs request disgorgement of Hardwick’s ill-gotten gains from the 2020 Transaction, which is the difference between what Hardwick received for his shares and the fair market value of those shares. (Doc. No. 1 ¶¶ 131). That is an equitable remedy. *Harris*, 530 U.S. at 250, 120 S.Ct. 2180. Churchill Defendants argue that Plaintiffs’ disgorgement request “identif[ies] no specific property or traceable funds.” (Doc. No. 38 at 16). Churchill Defendants further argue that Plaintiffs actually seek money damages because “[t]hey seek to recover the [Plan’s] monetary losses—the amount of the alleged overpayment—from the Trustee” and the Board Defendants, but that argument does not win the day. (*Id.*). Plaintiffs seek money damages for their breach of fiduciary duty claims against the Trustee Defendants and Board Defendants, but their request for disgorgement from Hardwick under their knowing participation claim is separate. (See Doc. No. 1 ¶ 131). Ultimately, they will not be able to double collect from the Defendants, but that Plaintiffs request different types of relief for different claims is unobjectionable at this phase of the case.

Moreover, Plaintiffs have alleged that the funds requiring disgorgement can be traced. The Sixth Circuit recently described the level of detail required to plead traceability at the motion to dismiss phase of a case. In *Patterson v. United Healthcare Ins. Co.*, the Sixth Circuit held that “[a]lthough we have not so held, there is reason to believe the tracing requirement ... applies to disgorgement in ERISA cases between two private parties.” 76 F.4th 487, 497 (6th Cir. 2023). In *Patterson*, the defendants argued that “the complaint failed to identify a ‘specifically identified fund’ in their possession.” *Id.* at 498. The Sixth Circuit found that the plaintiff adequately pleaded this requirement by “request[ing] the return of the \$25,000 ... Patterson paid to [the defendant] and [the defendant] retained.” *Id.* Plaintiffs do the same here: they request “disgorgement of any ill-gotten gains [Hardwick] received in connection with the 2020 Transaction.” (Doc. No. 1 ¶ 131). Moreover, Plaintiffs specifically allege that a portion of that overpayment was made by the Plan to Hardwick in the form of a \$35 million paydown of the 2020 Note. As the Sixth Circuit noted in *Patterson*, “[i]f in the end [the defendant] spent the \$25,000 on nontraceable items or transferred it to the plan, as two examples, Patterson can no longer invoke disgorgement and equitable restitution.” *Patterson*, 76 F.4th at 498. \*987 Plaintiffs may ultimately not be able to trace Hardwick’s funds and as a result, be unable to disgorge his ill-gotten gains. “For now, though, [Plaintiffs] ha[ve] made out a colorable equitable claim.” *Id.*

An appropriate order will be entered.

**All Citations**

714 F.Supp.3d 962

---

**Footnotes**

- 1 Dotson concerned a defined benefits plan. Id. at 192; see also Larue, 552 U.S. at 255, 128 S.Ct. 1020 (a defined benefits plans “d[o] not have individual accounts,” rather, they “p[ay] a fixed benefit”). As the Supreme Court explained in Russell and Larue, when an employee brings an ERISA claim concerning a defined benefits plan such as the severance benefits at issue in Dotson, the claim is brought on behalf of the plan as a whole, not the individual claimant. Russell, 473 U.S. at 140, 105 S.Ct. 3085; Larue, 552 U.S. at 255, 128 S.Ct. 1020.
- 2 Plaintiffs argued that the releases were not applicable to their fiduciary duty claims because the releases only applied to claims arising before they signed the releases, and their fiduciary duty claim arose at the time of signing. Id. at 425. The Sixth Circuit rejected this argument. Id.
- 3 The plaintiffs’ argument that ERISA prohibited their releases was based on 29 U.S.C. § 1110(a): “Except as provided in sections 1105(b)(1) and 1105(d) of this title, any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy.”
- 4 Plaintiffs also argue that the releases cannot apply to claims that arose after they were entered into. (See Doc. No. 46 at 13). Both Arnold and Golden-Woods signed the releases in 2018, so their claims concerning the 2020 Transaction did not exist when they signed the releases. The Court has already determined that the language in the releases unambiguously applies to future claims. The Court need not reach Plaintiffs’ argument that future releases of federal claims are unenforceable because it has determined that the releases are unenforceable on other grounds. Moreover, it is not at all clear whether releases of future federal statutory claims are enforceable. Plaintiffs rely on Schumacher v. AK Steel Corp. Retirement Accumulation Pension Plan, 711 F.3d 675, 685 (6th Cir. 2013). Unlike this case, Schumacher concerned a general release that did not specifically mention ERISA claims. Id. at 684. The Sixth Circuit distinguished the case from two cases enforcing releases of future ERISA claims where ERISA was specifically mentioned in the releases. See id. at 684-85 (“Appellants also rely on cases where future ERISA claims were released. Those cases, however, involved an explicit reference to ‘ERISA’ in the agreement—a critical distinction from the present case.”).
- 5 In Taylor, the Court’s dicta only applied to claims that had already arisen at the time of the waiver, not to future claims. Taylor, 149 F. App’x at 427. An earlier Sixth Circuit case, Rosenbaum v. Davis Iron Works, held that waivers of future claims of fiduciary duty are unlawful under 410(a). 1989 WL 36897, at \*5, 871 F.2d 1088 (6th Cir. Apr. 19, 1989).
- 6 The cases Plaintiffs rely on are unhelpful. Brundle v. Wilmington Trust, 919 F.3d 763 (4th Cir. 2019), and Perez v. Bruister, 823 F.3d 250 (5th Cir. 2016) are not binding on this Court, and to the extent they conflict with Forman, the Court must follow Forman. Chao v. Johnston, 2007 WL 2847548 (E.D. Tenn. Jul. 9, 2007), which was decided by another district court within the Sixth Circuit, was decided before Forman and is also not binding on this Court. Finally, Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Michigan simply states that “ERISA’s duties of loyalty and care are undeniably broader than the prohibition on self-dealing.” 722 F.3d 861, 869 (6th Cir. 2013). This vague statement cannot trump Forman’s clear directive.
- 7 The Court has listed the types of transactions implicated in this case; § 406(a) prohibits other forms of transactions between a plan and a party in interest.

# EXHIBIT 2

676 F.3d 542

United States Court of Appeals, Sixth Circuit.

Dominic CATALDO, et al., Plaintiffs–Appellants,

v.

UNITED STATES STEEL CORPORATION; United States Steel and Carnegie Pension Fund; United Steelworkers of America, a.k.a. United Steelworkers; and USX Corporation, et al., Defendants–Appellees.

No. 10–3583

|

Argued: Oct. 6, 2011.

|

Decided and Filed: April 13, 2012.

|

Rehearing and Rehearing En Banc Denied June 11, 2012.

### Synopsis

**Background:** Current and former steel mill employees brought action against their employer, union, pension plan of which they were participants, and plan administrator, alleging that defendants violated the Employee Retirement Income Security Act (ERISA) and Ohio's common law by intentionally misleading them regarding how pension benefits would be calculated, inducing some of them to retire early. The United States District Court for the Northern District of Ohio, Dan A. Polster, J., 2010 WL 1254862, dismissed the complaint. Employees appealed.

**Holdings:** The Court of Appeals, Griffin, Circuit Judge, held that:

employees' claims for breach of ERISA fiduciary duty were time-barred;

union was not an ERISA fiduciary, as would support employees' breach of fiduciary duty claim against it;

plan was not liable on claim under ERISA for equitable estoppel;

plan's response to request for plan documents was sufficient to satisfy its disclosure obligation under ERISA; and

employees were not entitled to any equitable relief under ERISA.

Affirmed.

**Procedural Posture(s):** On Appeal; Motion to Dismiss; Motion to Dismiss for Failure to State a Claim.

### Attorneys and Law Firms

\*545 ARGUED: Mark W. Biggerman, Pepper Pike, Ohio, for Appellants. Rodney M. Torbic, United States Steel Corporation, Pittsburgh, Pennsylvania, David M. Fusco, Schwarzwald, McNair & Fusco, Cleveland, Ohio, for Appellees. ON BRIEF: Mark W. Biggerman, Pepper Pike, Ohio, William A. Carlin, Carlin & Carlin, Pepper Pike, Ohio, for Appellants. Rodney M. Torbic, United States Steel Corporation, Pittsburgh, Pennsylvania, David M. Fusco, Schwarzwald, McNair & Fusco, Cleveland, Ohio, Stanley Weiner, Johanna Fabrizio Parker, Michael M. Michetti, Jones Day, Cleveland, Ohio, Sasha Shapiro, United Steelworkers International Union, Pittsburgh, Pennsylvania, for Appellees.

Before: MARTIN and GRIFFIN, Circuit Judges; ANDERSON, District Judge.\*

## OPINION

GRIFFIN, Circuit Judge.

Plaintiffs are 225 individuals currently or formerly employed at steel mills located in Lorain, Ohio. They claim that their union, employer, and plan administrator violated provisions of the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. §§ 1001–1461, and Ohio's common law by intentionally misleading them regarding how pension benefits would be calculated, inducing some to retire early. The district court dismissed the claims, concluding that certain of the ERISA claims were time-barred, that the others failed to state a claim for relief, and that the common-law claims were preempted by federal law. We affirm.

### \*546 I.

The following facts are accepted as true for purposes of this appeal. *See Bennett v. MIS Corp.*, 607 F.3d 1076, 1091 (6th Cir.2010).

Plaintiffs work or used to work at steel mills located in Lorain, Ohio (the “mills” or the “Lorain Works”). At all times relevant here, they were represented in their collective bargaining efforts by the United Steelworkers of America (“USW”). They are eligible participants in an employer-sponsored pension plan governed by ERISA.

The mills have changed ownership many times in the last two decades. Before 1989, defendant U.S. Steel Corporation (“U.S. Steel”) owned them, and plaintiffs' pension plan was administered by defendant United States Steel & Carnegie Pension Fund (the “Fund”). U.S. Steel sold the mills in 1989 to Kobe Steel, Ltd., at which time Kobe Pension Fund began administering the plan. The mills were sold again in 1999, this time to Lorain Tubular Company, LLC, and the Fund resumed administration of plaintiffs' pension plan.

While U.S. Steel and (later) Kobe Steel owned the mills, plaintiffs' pension benefits were determined in the same way benefits were determined for employees working at other U.S. Steel-owned mills. Specifically, benefits were calculated based in part on a percentage of total wages earned during the five years in which the plan participant earned the highest annual income, without regard to whether the years were consecutive to one another (the “best five years method”). In 1999, however, when Lorain Tubular bought the mills and the Fund became the plan's administrator again, a cut-off date was established so that the best five years could include only those years up to and including 1999. Thus, income earned in 2000 and beyond—which for many employees was higher than in past years—could not be considered in the benefit calculations.

In 2001, Lorain Tubular merged into U.S. Steel, and plaintiffs once again became employees of U.S. Steel. Based upon promises made in 2003 by persons or entities plaintiffs do not specifically identify in the complaint, plaintiffs became “hopeful” that, as employees again of U.S. Steel, they would be treated like all other U.S. Steel employees with respect to their pension benefits, meaning that their “best five years” would no longer be limited to the years before 2000. Plaintiffs were later told, however, that the current formula for calculating pension benefits would remain in place. At no time was the pension plan amended to reflect the alleged promises.

Around this time, U.S. Steel offered its employees the opportunity for early retirement through its “USS Transition Assistance Program for [USW] Represented Employees,” or “TAP.” Employees who chose to participate in TAP would receive a lump sum payment and “a significantly more favorable pension calculation” than under the then-current regime. Plaintiffs sought

assurances from U.S. Steel, the Fund, and USW that Lorain Works employees who chose to participate would receive the same TAP benefits as U.S. Steel employees in other mills who retired under TAP. “[O]ne or more” defendants promised they would.

In reliance on defendants' assurances, some of the plaintiffs chose to retire under TAP. But after doing so, they immediately began to receive significantly less than they expected and less than TAP retirees from other steel mills were receiving. Meanwhile, plaintiffs who retired after 2003 (not under TAP) have continued to receive pension benefits calculated using only years before 2000.

**\*547** Plaintiffs who are still employed at the Lorain Works have inquired with defendants regarding the benefits they are to receive upon retirement and have asked for assurances that there is adequate capital in the plan to “ensure proper benefits upon retirement.” “Yet, they consistently receive incorrect benefit determinations and vague and inadequate responses.”

Plaintiffs filed the instant action on June 1, 2009, and asserted the following claims: (1) breach of ERISA fiduciary duty; (2) ERISA equitable accounting, restitution, and other equitable relief; (3) equitable estoppel; (4) failure to furnish requested plan documents; (5) common-law fraud; (6) common-law negligence; (7) common-law breach of fiduciary duty; and (8) common-law promissory estoppel. Defendants moved to dismiss plaintiffs' claims for failure to state a claim. *See Fed.R.Civ.P. 12(b)(6)*. The district court granted the motions and dismissed all of plaintiffs' claims. Plaintiffs timely appealed.

## II.

“We give fresh review to a district court's order to dismiss a claim under *Civil Rule 12(b)(6)*. In doing so, we accept all allegations in the complaint as true and determine whether the allegations plausibly state a claim for relief.” *Roberts ex rel. Wipfel v. Hamer*, 655 F.3d 578, 581 (6th Cir.2011) (internal citation and quotation marks omitted).

## III.

The district court concluded that plaintiffs' claims against U.S. Steel and the Fund for breach of ERISA fiduciary duty were time-barred. We review that conclusion de novo. *Friends of Tims Ford v. Tenn. Valley Auth.*, 585 F.3d 955, 964 (6th Cir.2009).

The statute of limitations is an affirmative defense, *see Fed.R.Civ.P. 8(c)*, and a plaintiff generally need not plead the lack of affirmative defenses to state a valid claim, *see Fed.R.Civ.P. 8(a)* (requiring “a short and plain statement of the claim” (emphasis added)); *Jones v. Bock*, 549 U.S. 199, 216, 127 S.Ct. 910, 166 L.Ed.2d 798 (2007). For this reason, a motion under *Rule 12(b)(6)*, which considers only the allegations in the complaint, is generally an inappropriate vehicle for dismissing a claim based upon the statute of limitations. But, sometimes the allegations in the complaint affirmatively show that the claim is time-barred. When that is the case, as it is here, dismissing the claim under *Rule 12(b)(6)* is appropriate. *See Jones*, 549 U.S. at 215, 127 S.Ct. 910 (“If the allegations ... show that relief is barred by the applicable statute of limitations, the complaint is subject to dismissal for failure to state a claim[.]”).

ERISA contains a statute of limitations that governs “action [s] ... with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part [29 U.S.C. §§ 1101–1114], or with respect to a violation of this part[.]” 29 U.S.C. § 1113.<sup>1</sup> The parties agree that this provision **\*548** applies to plaintiffs' fiduciary-duty claims.<sup>2</sup> Simplified somewhat, the statute requires that a claim be brought within three years of the date the plaintiff first obtained “actual knowledge” of the breach or violation forming the basis for the claim, but in no event later than six years after the breach or violation. *Id.* “Actual knowledge” means “knowledge of the underlying conduct giving rise to the alleged violation,” rather than “knowledge that the underlying conduct violates ERISA.” *Wright v. Heyne*, 349 F.3d 321, 331 (6th Cir.2003). Pointing to plaintiffs' allegation that they learned in 2003 that they would not receive the benefits they were allegedly promised, the district court concluded that plaintiffs had to file

within three years of that time, or in 2006. Because they filed in 2009, three years after the limitations period expired, the district court found the claims time-barred and dismissed them for failure to state a claim.

Plaintiffs contend that the district court applied the wrong limitations period—that it should have applied a six-year period instead of a three-year period because they assert fraud in count one. The final clause of the statute of limitations provides: “except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.” 29 U.S.C. § 1113. If plaintiffs’ fiduciary-duty claims fall within this clause, they were permitted to file no later than “six years after the date of discovery of [the] breach or violation.” *Id.* There is no serious dispute that plaintiffs’ claims are timely if a six-year limitations period is used.<sup>3</sup> The question, then, is whether this is a “case of fraud or concealment.”

The parties’ disagreement concerns a question of statutory interpretation. U.S. Steel and the Fund contend that the fraud-or-concealment exception applies *only* in situations where the fiduciary has attempted to hide its breach from the injured party, *i.e.*, only where there has been “fraudulent concealment,” and not simply where the underlying breach sounds in fraud. Plaintiffs, by contrast, take a literal approach and read the exception to apply exactly when it says so: in cases of fraud *or* concealment, meaning that a six-year period applies to claims of fiduciary fraud even absent later acts of concealment.<sup>4</sup>

\*549 We have not squarely considered this issue before. The parties say otherwise, but we disagree with their characterization of our precedent. Plaintiffs, for their part, rely primarily on our statement in *Tassinare v. American National Insurance Co.*, 32 F.3d 220 (6th Cir.1994), repeated in *Wright*, 349 F.3d at 327, that a “plaintiff with actual knowledge of a *non-fraudulent* breach of ERISA fiduciary duties must file suit within three years.” *Tassinare*, 32 F.3d at 223 (emphasis added). By implication, plaintiffs reason, a *fraudulent* breach would be subject to a six-year limitations period. Although we agree with the logic of that position, we cannot agree that this one statement in *Tassinare*, a case that involved no allegations of fraud or concealment, represents our considered view on the matter. Nor did we address the issue in *Rogers v. Millan*, 902 F.2d 34, 1990 WL 61120 (6th Cir. May 8, 1990) (per curiam) (unpublished table decision), when we said “the six-year period can be reduced to three years if there is no fraud or concealment and the defendant can show that the plaintiff had actual knowledge of the breach or violation.” *Id.* at \*2. That statement merely summarizes the statute; it provides no analysis of the fraud-or-concealment clause.

For their part, U.S. Steel and the Fund cite *Browning v. Levy*, 283 F.3d 761 (6th Cir.2002), as directly supporting their proposition that “the three-year limitations period is not circumvented by allegations of fraud that support a breach of fiduciary duty claim ... but rather by allegations that the fiduciary has attempted to *hide the alleged breach* from the party bringing the action.” The citation is completely off the mark and slightly misleading. The relevant line from *Browning* is: “In order to invoke the doctrine of fraudulent concealment, affirmative concealment must be shown; mere silence or unwillingness to divulge wrongful activities is not sufficient.” *Id.* at 770 (citation, internal quotation marks, and alterations omitted). By citing *Browning* for the proposition they do, U.S. Steel and the Fund have merely assumed the point they must prove: that the clause applies *only* in cases of fraudulent concealment. The citation to *Browning* is particularly inapposite given that we never even mentioned in that case the statute we are interpreting here.

One week after briefing in this case was complete, we issued *Brown v. Owens Corning Investment Review Committee*, 622 F.3d 564 (6th Cir.2010). U.S. Steel and the Fund promptly brought the case to our attention, claiming that it definitively answers the question we consider today. In their Rule 28(j) response letter, plaintiffs agree that *Brown* answers the question, but ask us not to follow it because it conflicts with our earlier decisions in *Tassinare*, *Wright*, and *Rogers*. See 6th Cir. R. 206(c).

We disagree with the parties’ reading of *Brown*. U.S. Steel and the Fund seize upon the following line in *Brown*: “ERISA’s fraud exception to the statute of limitations ‘requires the plaintiffs to show (1) that defendants engaged in a course of conduct designed to conceal evidence of their alleged wrong-doing and that (2) [the plaintiffs] were not on actual or constructive notice of that evidence, (3) despite their exercise of diligence.’ ” 622 F.3d at 573 (quoting *Larson v. Northrop Corp.*, 21 F.3d 1164, 1172 (D.C.Cir.1994)) (alteration in original).

Insofar as this line purports to set forth the entire set of circumstances in which the clause can apply, it is dictum because doing so was not necessary to our holding in *Brown*. Cf. *United States v. Stevenson*, 676 F.3d 557, 561–62 (6th Cir.2012) (concluding that a passage in an earlier published decision unequivocally answering \*550 the issue presented was dictum because it was unnecessary to the holding). The precise issue considered in *Brown* was when the plaintiffs obtained actual knowledge of the facts that gave rise to the fiduciary's alleged breach of duty. We agreed with the district court that the plaintiffs learned of the facts more than three years prior to filing suit, rendering their claim time-barred. *Brown*, 622 F.3d at 570–73. We further agreed that the plaintiffs' request to amend their complaint to allege that the fiduciary took steps to hide or conceal their earlier breach was futile. *Id.* at 573–74. It was during this discussion that we articulated the above test for the fraud-or-concealment clause. We found the proposed allegations foreclosed a claim of fraudulent concealment because most of the alleged actions taken by the fiduciary to cover up the wrongdoing occurred after the plaintiffs received actual knowledge of it. *Id.* at 574. And the fiduciary's alleged conduct pre-dating the plaintiffs' actual knowledge did not rise to the level of concealment. *Id.* We had no occasion in *Brown* to consider whether a claim of fraud, by itself, would be subject to the six-year period because the plaintiffs never pressed such a claim; they claimed that the defendant fiduciary failed to divest the plaintiffs' retirement plans of company stock before it became worthless, a non-fraudulent breach of fiduciary duty. *Id.* at 568, 574. *Brown's* discussion does not bind us.

Nor do we agree with the conclusion other circuits have ascribed to our earlier cases, indicating that we have interpreted the statute in the way U.S. Steel and the Fund would have us do. Specifically, our decision in *Farrell v. Automobile Club of Michigan*, 870 F.2d 1129 (6th Cir.1989), has been cited by both the District of Columbia and Seventh Circuits as indicating that we have taken sides on a circuit split on the issue and favor the position taken by U.S. Steel and the Fund. See *Larson*, 21 F.3d at 1172 n. 15; *Radiology Ctr., S.C. v. Stifel, Nicolaus & Co.*, 919 F.2d 1216, 1220 (7th Cir.1990). It is unclear which passage in *Farrell* these courts rely upon. Regardless, *Farrell* does not answer the question here.<sup>5</sup> The plaintiffs there did not assert that the six-year period applied, even though their claim sounded in fraud. See *id.* at 1130–31. They instead argued that they obtained actual knowledge of the violation within three years of filing. We found that the evidence showed the contrary—that the plaintiffs learned of the breach more than three years before filing. *Id.* at 1131–32. Yet we held that, because plaintiffs had filed an identical claim in state court within three years of learning of the alleged violation, the limitations period was equitably tolled while the state claim remained pending. *Id.* at 1134 (applying *Burnett v. New York Cent. R.R. Co.*, 380 U.S. 424, 85 S.Ct. 1050, 13 L.Ed.2d 941 (1965)). *Farrell*, too, does not bind us here.

Therefore, whether a six-year limitations period applies in instances where the claim is based upon fraud and there are no allegations of separate conduct undertaken by the fiduciary to hide the fraud is an open question in this circuit. Although some other circuits have concluded that it does not apply in such situations, see, e.g., *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 242 F.3d 497, 503 (3d Cir.2001); *Radiology Ctr.*, 919 F.2d at 1220–21, the Second Circuit has provided a persuasive contrary interpretation. See *Caputo v. Pfizer, Inc.*, 267 F.3d 181, 188–90 (2d Cir.2001).

We need not take sides on the split at this time, however, for even were \*551 we to conclude that the exception applies in such situations, plaintiffs have failed to sufficiently plead fraud in this case. Any discussion on the matter therefore would be dictum, and we decline to opine unnecessarily. See *United States v. Hardin*, 539 F.3d 404, 415 (6th Cir.2008) (noting that “when the facts of the instant case do not require resolution of the question[,] any statement regarding the issue is simply dicta” (citation and internal quotation marks omitted)); cf. *Souter v. Jones*, 395 F.3d 577, 589 (6th Cir.2005) (reserving the determination of whether an actual innocence exception to the federal habeas statute of limitations exists until finding that the petitioner could satisfy the exception if it did). Abstaining is particularly prudent here because the allegations of fraud are woefully inadequate (as we discuss below), the briefing on the question was minimal, the issue was not litigated vigorously below, and the question is a rather complicated one. Therefore, we assume, but do not decide, that a claim of fiduciary fraud not involving separate acts of concealment is subject to a six-year limitations period that begins to run when the plaintiff discovered or with due diligence should have discovered the fraud.

Plaintiffs have not adequately alleged any underlying fraud. To be sure, the primary theory of liability contained in plaintiffs' fiduciary-duty claims does sound in fraud.<sup>6</sup> Specifically, plaintiffs allege that those who retired under the TAP program did so in reliance upon defendants' false representations that plaintiffs' retirement benefits would be calculated the way other U.S.

Steel employees' benefits were calculated.<sup>7</sup> See *Caputo*, 267 F.3d at 191 (listing the elements of common-law fraud). The problem for these plaintiffs, however, is that they have not pleaded the fraud with even the slightest amount of particularity. See *Fed.R.Civ.P. 9(b)*.

“We interpret ‘Rule 9(b) as requiring plaintiffs to allege the time, place, and content of the alleged misrepresentation on which he or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud.’” See *Bennett*, 607 F.3d at 1100 (quoting *Yuhasz v. Brush Wellman, Inc.*, 341 F.3d 559, 563 (6th Cir.2003)). Plaintiffs' allegations fall well short of this pleading requirement.

The complaint avers in relevant part that “[n]umerous Plaintiffs specifically asked (orally and in writing) [defendants] for assurances that they would receive the same T.A.P. benefits as all other ... U.S. Steel employees. In response, one or more of [defendants] promised the Plaintiffs that they would receive the same such benefits, made representations, and provided false, inaccurate, and/or misleading information to the Plaintiffs.” This allegation omits entirely the time and place of the alleged statements. It also fails to allege the speaker of the alleged statements, instead referring vaguely only to “defendants,” of which there are many in this case.<sup>8</sup> See *Heinrich v. Waiting Angels Adoption Servs., Inc.*, 668 F.3d 393, 404 (6th Cir.2012) (noting that Rule 9(b)'s heightened pleading requirements require a plaintiff who pleads fraud to identify the speaker of the statement); *Luce v. Edelstein*, 802 F.2d 49, 54 (2d Cir.1986) (holding that the plaintiff's failure to connect allegations of fraudulent representations to \*552 particular defendants, attributing representations simply to the “defendants,” could not satisfy Rule 9(b)'s particularity requirement); see also *United States ex rel. Branhan v. Mercy Health Sys. of Sw. Ohio*, 188 F.3d 510, 1999 WL 618018, at \*9 (6th Cir. Aug. 5, 1999) (unpublished table decision) (Clay, J., concurring in part and dissenting in part) (noting that “Rule 9(b) does not permit a plaintiff to allege fraud by indiscriminately grouping all of the individual defendants into one wrongdoing monolith” (citation and internal quotation marks omitted)).

For these reasons, plaintiffs' claims for breach of ERISA fiduciary duty against U.S. Steel and the Fund are time-barred, and the district court properly dismissed them for failure to state a claim for relief.

#### IV.

Even though the above analysis applies with equal force to plaintiffs' ERISA fiduciary-duty claim against USW, USW never argued below that the claim was time-barred. It has therefore forfeited that basis for dismissal for purposes of this appeal. See *Poplar Creek Dev. Co. v. Chesapeake Appalachia, L.L.C.*, 636 F.3d 235, 242 n. 5 (6th Cir.2011). Nevertheless, plaintiffs' claim against USW fails because plaintiffs have not plausibly alleged that USW is an ERISA fiduciary.

The threshold question in all cases charging breach of ERISA fiduciary duty is whether the defendant was “acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint.” *Pegram v. Herdrich*, 530 U.S. 211, 226, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000). “[F]or purposes of ERISA, a ‘fiduciary’ not only includes persons specifically named as fiduciaries by the benefit plan, but also anyone else who exercises discretionary control or authority over a plan's management, administration, or assets.” *Moore v. Lafayette Ins. Co.*, 458 F.3d 416, 438 (6th Cir.2006); see 29 U.S.C. § 1002(21) (A); see also *Wright v. Or. Metallurgical Corp.*, 360 F.3d 1090, 1101–02 (9th Cir.2004) (noting “that an individual or entity can still be found liable as a ‘de facto’ fiduciary if it lacks formal power to control or manage a plan yet exercises informally the requisite ‘discretionary control’ over plan management and administration”).

The complaint fails to plausibly allege that USW is an ERISA fiduciary. First of all, USW is not named in plan documents as a fiduciary. Plan documents demonstrate, rather, that U.S. Steel has delegated to *the Fund* the fiduciary function of administering plan benefits to participants. Moreover, the complaint contains only the most conclusory of allegations that USW exercises discretionary control or authority over plan administration, management, or assets, so it cannot be considered a de facto fiduciary under ERISA.

Seemingly recognizing the inadequacy of their allegations, plaintiffs seek to affix a fiduciary status to USW on the un-pleaded theory that USW explained plan benefits and business decisions regarding plan benefits to plaintiffs and made assurances to those considering retirement. They cite *Bouboulis v. Transport Workers Union of America*, 442 F.3d 55 (2d Cir.2006), for support. *Bouboulis* involved imposing a fiduciary status on an employer who made assurances regarding plan benefits to its employees. *Id.* at 65. The court did so because the employer was also the plan's administrator, and employees could have reasonably believed that their employer was communicating to them in both capacities (employer and administrator). *See id.* (citing *Varity Corp. v. Howe*, 516 U.S. 489, 503, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996)). Here, however, USW was plaintiffs' *collective bargaining representative*, \*553 not their employer. And there is no basis for plaintiffs to have reasonably believed that USW was acting in the capacity of a plan administrator when it allegedly made assurances. Indeed, plaintiffs were specifically informed in 1999 that *the Fund* would again be administering their pension plan. USW is not an ERISA fiduciary. The district court correctly dismissed this claim.

## V.

In count three of their complaint, plaintiffs assert a claim for equitable estoppel. The district court dismissed this claim on the ground that this court had yet to recognize such a theory of liability in the context of a pension plan (as opposed to a welfare benefit plan). After the district court entered judgment, however, we recognized a claim for equitable estoppel in the context of a pension plan. *See Bloemker v. Laborers' Local 265 Pension Fund*, 605 F.3d 436 (6th Cir.2010). Unfortunately for plaintiffs, the special facts that gave rise to liability in *Bloemker* are absent here.

In *Bloemker*, the plaintiff decided to retire early after he was told by the plan administrator in a certified letter that he would receive a certain amount in pension benefits each month during retirement. *Id.* at 439. After receiving benefits for more than a year in an amount consistent with what he was initially told, the plaintiff was advised that, due to a computer programming error, the administrator had been overpaying him approximately \$500 per month. The administrator asked the plaintiff to return more than \$11,000 in overpayments. *Id.* The plaintiff sued the plan administrator under ERISA and asserted a claim of equitable estoppel, but the district court dismissed the claim. Reversing, we held that a plaintiff can invoke equitable estoppel in the pension-plan context if the plaintiff can demonstrate the traditional elements of estoppel plus (1) a written representation; (2) plan provisions which, although unambiguous, do not allow for individual benefit calculation; and (3) extraordinary circumstances in which the balance of equities strongly favors the application of estoppel. *Id.* at 444. We found that the plaintiff had met each of these requirements.

The only plaintiffs in any position to assert a claim of equitable estoppel here are those who participated in the TAP retirement program, because it is only they who allegedly relied to their detriment on the alleged representations by the Fund. *See id.* at 442 (stating that reliance is an element of traditional estoppel). Moreover, only the Fund can potentially be estopped from doing anything, because it is the only defendant that pays pension benefits in accordance with plan documents. *See generally Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1299 (6th Cir.1991) (“Equitable estoppel ... precludes a party from exercising contractual rights because of his own inequitable conduct toward the party asserting the estoppel.”).

These plaintiffs cannot state a claim for equitable estoppel against the Fund for two reasons. First, plaintiffs have not adequately pleaded a claim of traditional equitable estoppel, which requires that the defendant's actions “contain an element of fraud, either intended deception or such gross negligence as to amount to constructive fraud.” *Bloemker*, 605 F.3d at 443 (citation, internal quotation marks, and alteration omitted). As explained above, plaintiffs have not satisfied their burden to plead fraud with particularity.

Second, plaintiffs cannot satisfy the justifiable-reliance requirement of an estoppel claim. A reason we initially hesitated to recognize an estoppel theory when the terms of the plan are unambiguous is \*554 because a participant's reliance on a representation regarding the plan “can seldom, if ever, be reasonable or justifiable if it is inconsistent with the clear and unambiguous terms of plan documents.” *Id.* at 443 (quoting *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 404 (6th Cir.1998)

(en banc)). We found this reason inapplicable in *Bloemker*, however, because it was impossible for the plaintiff to determine his correct pension benefit due to the complexity of the actuarial calculations and his lack of knowledge about the relevant actuarial assumptions used. *Id.* It was not a situation where a clear answer to the plaintiff's question about his plan was easily answered by reference to plan documents, and the information provided by the plan administrator—how much the plaintiff would receive each month in benefits—could not be contradicted by the plan documents. Therefore, it was justifiable for the plaintiff to rely on the letter calculating the monthly amount. *Id.*

Here, by contrast, plaintiffs do not allege that the plan documents are ambiguous on the point at issue here—which years can be included under the best five years method. Nor do they allege that the documents prevent them from calculating their own benefits. Indeed, plaintiffs were admittedly aware of *precisely how* their benefits would be calculated under the plan: by using the annual income from the participant's best five years up to and including 1999. They simply contend that pension benefits should be calculated in a way different from what is called for in plan documents. Such allegations cannot form a basis for an ERISA estoppel claim. Therefore, plaintiffs' reliance on alleged statements that contradict plan documents (which are unambiguous on the point) was not justifiable as a matter of law. Plaintiffs have failed to state a claim for equitable estoppel.

## VI.

In count four, plaintiffs claim that the Fund failed to furnish plan documents upon request. The district court concluded, based upon a review of letters attached to the Fund's motion to dismiss, that this claim was baseless.

ERISA provides that an “administrator shall, upon written request of any participant or beneficiary, furnish a copy [of certain specific plan documents] or other instruments under which the plan is established or operated.” 29 U.S.C. § 1024(b)(4). An administrator who fails or refuses to comply with a request may be held personally liable for the failure. *Id.* § 1132(c)(1)(B).

The relevant allegation in this count states as follows:

On or about March 11, 2009, the Plaintiffs sent written requests to all of the Defendants<sup>9</sup> for several Plan and Fund-related Documents including, but not limited to, Summary annual reports, Summary Plan descriptions, Form 5500s, Trust Agreement, Rules and Regulations of the Pension Fund, individual Participant benefit calculations, and 204(h) notices. However, as of the date this complaint was filed, each Defendant has either failed to respond or provided inadequate responses to those requests.

**\*555** Attached to the Fund's motion to dismiss was plaintiffs' letter request, as well as the Fund's response. In their opposition brief in the district court, plaintiffs only argued that the letters could not be considered without converting the motion into one for summary judgment. It recognized that matters referenced in the complaint and central to a plaintiff's claim can generally be considered on a motion to dismiss, but argued that they never referenced the letters in their complaint and that the genuineness and admissibility of the letters were issues of fact not appropriate for resolution under Rule 12(b)(6). Plaintiffs never argued that the Fund's response to their request was legally inadequate under ERISA or that the response was untimely.

The district court correctly concluded that both letters were sufficiently referenced in the complaint and central to plaintiffs' claim so as to be properly considered on a motion to dismiss. See *Weiner v. Klais & Co., Inc.*, 108 F.3d 86, 89 (6th Cir.1997). As noted above, paragraph 85 of the complaint expressly mentions plaintiffs' March 11 request and alleges that “each Defendant has either failed to respond or provided *inadequate responses* to those requests.” (Emphasis added.) That is a sufficient reference to the response, we believe, and the adequacy of the response *is the entire claim*, let alone central to it.

Plaintiffs now argue (for the first time on appeal) that the Fund's response was legally inadequate because it did not include documents that fall within section 1024(b)(4)'s residual clause. See 29 U.S.C. § 1024(b)(4) (administrator must produce, upon request, “other instruments under which the plan is established or operated”). The Fund's response demonstrates that it furnished all the requested documents, except for regulatory filings and other documents provided to various governmental agencies, regarding the plan. It also withheld requested “minutes, notes, and reports of all meetings of the Board of Trustees and negotiating committees since January 1, 1969 [.]” because the request was overly broad. Plaintiffs do not challenge these withholdings. Rather, they contend that the Fund failed to furnish: (1) actuarial valuation reports; (2) “procedures”; and (3) “calculations.” Because this argument was not raised below, it is forfeited on appeal. See Poplar Creek Dev., 636 F.3d at 242 n. 5. Nevertheless, the argument is meritless.

With respect to the actuarial valuation reports, plaintiffs concede that they never specifically requested them. Accordingly, the Fund had no legal duty to produce them. See 29 U.S.C. § 1024(b)(4) (noting that duty to furnish plan documents arises “upon written request of any participant or beneficiary”). But plaintiffs say their lack of a request poses no problem because these reports so obviously fall within the residual clause that the Fund had a duty to produce them pursuant to a general request for “plan documents.”

To be sure, we have held that actuarial valuation reports do fall under the residual clause of § 1024(b)(4) and must be furnished upon request. See Bartling v. Fruehauf Corp., 29 F.3d 1062, 1069–70 (6th Cir.1994). And we have further held that the failure to request a specific document by name does not justify withholding the document when it “so obviously contains the information” described in the request that the administrator either knows or should know that it was obliged to produce it. Id. at 1071. For example, the plaintiffs in Bartling asked for “benefit computation worksheets.” The plan administrator responded that such documents did not exist because computations were performed by a computer. The administrator \*556 did have in its possession, however, a written “Calculation Procedure,” which described in step-by-step detail the procedures followed to derive a participant's benefits under the plan and was equivalent to what plaintiffs had specifically requested. Id. at 1070. We stated that “[i]mposing a burden upon Plaintiffs to ask for the Calculation Procedure by name rather than by description would be contrary to the spirit of § 1024(b)(4).” Id. at 1071.

Here, plaintiffs have pointed to no specific request in their March 11 letter that so obviously refers to the actuarial valuation reports. If they wish to take advantage of the leniency that Bartling prescribes, they must make a minimal effort on appeal to identify which of their specific requests reasonably embodies the actuarial valuation reports. Indeed, given that it has been the law in this circuit since 1994, when Bartling was decided, that such reports must be furnished upon request, the Fund reasonably could have concluded that, had plaintiffs wanted the reports, they would have clearly requested them.

With respect to the “procedures” and “calculations” plaintiffs apparently requested but never received, plaintiffs do not identify specifically what they are talking about or explain why the requests were not covered by the Fund's response. Their request sought “[a]ll documents ... regarding ... benefit calculations...” The Fund's letter in response states: “[A]ttached are the following plan documents that are required to be provided under section 104(b)(4) of ERISA and copies of the most recent benefit calculations previously prepared for your clients.” (Emphasis added.) The response obviously covers the requested calculations. As for “procedures,” nowhere in plaintiffs' request did they ask for “procedures” by itself, and they have not specifically identified what document they want. If they are referring to the procedures for determining pension benefits, the furnished documents were responsive. See R.21–3 at 2 (“Accordingly, the documents provided should enable you to determine your clients' eligibility for benefits, the amount of their benefits, and their rights under the Plan.”). If the response was insufficient, plaintiffs should have availed themselves of the Fund's offer to provide more documents upon a specific request. See id. (“If you believe your clients are entitled to receive additional documents, please send me a written request clearly describing such documents.”). Therefore, count four was properly dismissed.

## VII.

In count two, plaintiffs assert a claim for equitable accounting, restitution, and “other equitable relief.” The district court dismissed this count on the ground that it was entirely derivative of the fiduciary-duty claims the court had dismissed.

According to plaintiffs, count two is premised on 29 U.S.C. § 1132(a)(3), which permits a participant or beneficiary to obtain injunctive or “other appropriate equitable relief” to redress ERISA violations or enforce the plan. By its terms, however, § 1132(a)(3) speaks of *remedies* or appropriate forms of *relief*. Plaintiffs cannot obtain such relief in the abstract; they must first establish that at least one defendant breached the plan documents or violated ERISA in some other way. *See Peacock v. Thomas*, 516 U.S. 349, 353, 116 S.Ct. 862, 133 L.Ed.2d 817 (1996) (“Section [1132(a)(3)] does not ... authorize ‘appropriate equitable relief’ *at large*, but only ‘appropriate equitable relief’ for the purpose of ‘redressing any violations or enforcing any provisions’ of ERISA or an ERISA plan.” (citation, internal quotation marks, alterations, and ellipsis omitted)). \*557 And because plaintiffs have failed to state a violation of ERISA, they are not entitled to any equitable relief.

## VIII.

Finally, counts five through eight in plaintiffs' complaint assert claims under Ohio's common law for fraud, negligence, breach of fiduciary duty, and promissory estoppel. The district court concluded that ERISA preempted all of these claims.

ERISA preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. § 1144(a). Congress intended for ERISA to preempt only traditional state-based laws that implicate relations among the traditional ERISA plan entities, including the principals, the employer, the plan, the plan fiduciaries, and the beneficiaries. *Thurman v. Pfizer, Inc.*, 484 F.3d 855, 861 (6th Cir.2007). “[W]hen a state law claim may fairly be viewed as an alternative means of recovering benefits allegedly due under ERISA, there will be preemption.” *Briscoe v. Fine*, 444 F.3d 478, 498 (6th Cir.2006) (citation and internal quotation marks omitted). Moreover, if resolution of the state-law claim “necessarily requires evaluation of the plan and the parties' performance pursuant to it, the claim is preempted.” *Thurman*, 484 F.3d at 862 (citation and internal quotation marks omitted).

Plaintiffs anticipated ERISA-preemption by prefacing their allegations regarding the common-law claims with the following: “In the event that any of the Plaintiffs' claims do not relate to the Pension Plans or any Defendant is not an ERISA fiduciary, the Plaintiffs assert the following common law cause of action for [fraud/negligence/breach of fiduciary duty/promissory estoppel].” The problem, however, is that each of plaintiffs' common-law claims *does relate* to the pension plan. Plaintiffs seek to have their plan administered and their pension benefits calculated in a way that is different from what the plan documents expressly require, based upon alleged breaches of legal duties created and imposed by state law. ERISA's broad preemptive reach does not countenance this. Furthermore, these common-law claims would require the court to consider the plan documents to determine whether there had been any breaches of these state-law duties, a further indication that ERISA preempts these claims. The district court properly dismissed plaintiffs' common-law claims.

## IX.

For these reasons, we affirm the judgment of the district court.

### All Citations

676 F.3d 542, 52 Employee Benefits Cas. 2815, Pens. Plan Guide (CCH) P 24011V

---

### Footnotes

- \* The Honorable S. Thomas Anderson, United States District Judge for the Western District of Tennessee, sitting by designation.
- 1 The entire statute of limitations reads as follows:
- No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—
- (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or
- (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;
- except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.
- 29 U.S.C. § 1113.
- 2 Although the complaint is not clear on this point, we assume for purposes of this analysis that plaintiffs are not asserting a right to individual benefits under § 1132(a)(1)(B), to which we would apply the most analogous state statute of limitations rather than § 1113. See Meade v. Pension Appeals & Review Comm., 966 F.2d 190, 194–95 (6th Cir.1992) (applying Ohio's fifteen-year limitations period for breach of contract claims to a plaintiff's claim for benefits); see also Kennedy v. Electricians Pension Plan, 954 F.2d 1116, 1120 (5th Cir.1992) (“Congress limited the application of § 1113 ‘to suits claiming breach of an ERISA trustee's fiduciary duty “under this part,” which does not include beneficiary suits under § 1132(a)(1)(B).’ ” (quoting Johnson v. State Mut. Life Assurance Co. of Am., 942 F.2d 1260, 1262 (8th Cir.1991))).
- 3 The promises upon which these claims are based were allegedly made in early 2003, and plaintiffs learned the promises were false later that year. The complaint was filed on June 1, 2009. Although the complaint does not identify the specific dates on which the misrepresentations were made, U.S. Steel and the Fund do not argue that plaintiffs failed to file within six years of discovering the violation.
- 4 Although the complaint contains allegations of “concealment,” they are wholly conclusory, and we do not consider them. See Ashcroft v. Iqbal, 556 U.S. 662, 129 S.Ct. 1937, 1949–50, 173 L.Ed.2d 868 (2009).
- 5 Indeed, no party before us cites Farrell in support of their respective positions.
- 6 It is unclear what other theories of fiduciary liability (if any) are contained in count one.
- 7 The other plaintiffs do not allege any detrimental reliance upon defendants' alleged misrepresentations, an essential element in a claim of fraud. See Caputo, 267 F.3d at 191.
- 8 Although this appeal only involves three defendants, the complaint named sixteen.
- 9 Despite plaintiffs' reference to “Defendants,” which would include U.S. Steel, the Fund, and USW, the statutory duty they seek to enforce here applies only to plan administrators, see 29 U.S.C. § 1024(b)(4), and the Fund is the only such administrator in this action. See Hiney Printing Co. v. Brantner, 243 F.3d 956, 961 (6th Cir.2001) ( “The law in this

Circuit is clear that only a plan administrator can be held liable under section 1132(c).” (citation, internal quotation marks, and alteration omitted).

---

End of Document

© 2025 Thomson Reuters. No claim to original U.S. Government Works.

# EXHIBIT 3

2024 WL 4534677

2024 WL 4534677

Only the Westlaw citation is currently available.  
United States Court of Appeals, Sixth Circuit.

Bradley H. FLEMING, Plaintiff-Appellant,  
v.  
KELLOGG COMPANY et al., Defendant-Appellee.

Case No. 23-1966

|

FILED October 21, 2024

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN

**Attorneys and Law Firms**

Rachana Pathak, Bridget Asay, John Stokes, Peter K. Stris, Stris & Maher, Los Angeles, CA, Troy W. Haney, Haney Law Office, Grand Rapids, MI, Paul M. Secunda, Walcheske & Luzi, Brookfield, WI, Colleen R. Smith, Stris & Maher, Washington, DC, for Plaintiff-Appellant.

Joseph J. Torres, Alexis Bates, Jenner & Block, Chicago, IL, for Defendant-Appellee.

Before: GIBBONS, KETHLEDGE, and DAVIS, Circuit Judges.

OPINION

DAVIS, Circuit Judge.

\*1 Plaintiff-Appellant Bradley H. Fleming, a participant in a defined contribution retirement plan in the form of a 401(k) established by his former employer, Kellogg Company<sup>1</sup>, filed an action against the fiduciaries of the Plan alleging that they breached their fiduciary duties owed to the Plan. Fleming asserted that Kellogg's imprudence damaged the Plan to the tune of more than \$7 million in excessive recordkeeping and administrative fees paid between 2016 and 2020. In his amended complaint, Fleming sought various forms of relief, including appointment of an independent fiduciary to manage the Plan and an order directing Kellogg to restore all losses to the Plan and to disgorge any profits it obtained from the fiduciary breaches. **Kellogg moved to dismiss the complaint and compel arbitration pursuant to the arbitration clause in the plan document.** The district court granted the motion and dismissed Fleming's claims, concluding that enforcing the Plan's arbitration provision would not prevent Fleming from effectively vindicating the statutory remedies sought in his complaint. Fleming appeals that ruling. We reverse.

I.

*Factual Background.* Kellogg is a global food manufacturing company where Fleming worked as an accountant for thirteen years until August 2019. Kellogg offers its employees several benefits, one which is the opportunity to participate in the Kellogg Company Savings and Investment Plan, a defined contribution 401(k) plan (the "Plan"). The Plan allows employees to set aside a portion of their pre-tax earnings, obtain employer matching contributions, and invest the total of the employee and employer contributions. The value of these investments is allocated to individual employees' accounts for bookkeeping purposes, but the Plan's assets (over \$1 billion) are held collectively in a trust.

2024 WL 4534677

Fleming alleges that, over a four-year period, the Plan's fiduciaries caused it to pay recordkeeping and administrative (“RK&A”) fees to its recordkeeper, Transamerica Retirement Solutions, that were four times higher than such fees paid by other “mega” plans. And because of Kellogg's imprudence, “the Plan paid an effective average annual recordkeeping fee of \$137 per participant.” (R. 15, PageID 866, ¶ 100). From 2016 to 2020, says Fleming, the fiduciaries’ ill-considered RK&A payments cost the Plan and its participants a minimum of \$7,462,978 and injured Fleming's account in the process.

The Plan was amended, effective January 1, 2020, to require arbitration of certain claims, including those for breach of fiduciary duty. After the amendment, Section 17.4(b) of the Plan read in relevant part:

Any arbitration will be conducted on an individual basis only, and not on a class, collective or representative basis .... The arbitrator shall have no authority to arbitrate any claim on a class or representative basis and may award relief only on an individual basis. By participating in the Plan and accepting benefits hereunder, Participants and Beneficiaries waive the right to participate in a class, collective or representative action; provided, however, that if such waiver is held by a court of competent jurisdiction to be unenforceable, any claim on a class, collective or representative basis shall be filed and adjudicated in federal district court in the Western District of Michigan, and not in arbitration.

\*2 (R. 12-2, PageID 243).

Fleming, who had stopped working at Kellogg about four months before the arbitration provision went into effect, contends that he neither received notice of the mandatory arbitration clause nor personally assented to arbitration. About seven months after the Plan adopted the mandatory arbitration provision, Fleming rolled out of the Plan. Then, on December 17, 2021, Kellogg retroactively amended Section 17.4(b) to include one additional phrase:

“The arbitrator shall have no authority to arbitrate any claim on a class or representative basis and may award relief only on an individual basis; *provided, however, that the arbitrator may award any relief otherwise available under ERISA.*”

(R. 12-3, PageID 268) (emphasis added). Fleming also received no notice of the amended arbitration clause. Both arbitration clauses (2020 and 2021) are expressly non-severable. *See, e.g., Henry ex rel. BSC Ventures Holdings, Inc. Emp. Stock Ownership Plan v. Wilmington Tr. NA*, 72 F.4th 499, 503 (3d Cir. 2023), *cert. denied*, 144 S. Ct. 328 (2023) (stating that arbitration provision containing class action waiver is expressly non-severable where entire arbitration provision would be nullified if class action waiver were to be found unenforceable by a court of competent jurisdiction).

*Procedural History.* Fleming's amended complaint against Kellogg, Steven A. Cahillane, the ERISA Administrative Committee of Kellogg, and the ERISA Finance Committee of Kellogg (collectively, “Kellogg”) asserts two claims under ERISA § 502(a) (2), 29 U.S.C. § 1132(a)(2), to redress Kellogg's alleged imprudence. Fleming sought plan-wide monetary and equitable relief, including (1) an order directing Kellogg to restore all losses to the Plan and to disgorge any profits obtained as a result of any fiduciary breaches, and (2) the appointment of an independent fiduciary to manage the Plan.

Defendants moved to dismiss the amended complaint and order arbitration based on the 2020 and 2021 arbitration clauses. The district court granted the motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6).<sup>2</sup> In doing so, the district court agreed with Defendants “that the Kellogg arbitration provision constitutes sufficient manifestation of the Kellogg Plan's consent to arbitrate, and the provision properly applies to representative suits brought on behalf of the Kellogg Plan.” (R. 42, PageID 1172–73). Fleming moved to alter or amend the judgment pursuant to Federal Rule of Civil Procedure 59(e), seeking clarification about whether “the arbitrator may award all of the Plan-wide relief that a federal court can award under ERISA Sections 409(a) and 502(a)(2).” (R. 43, PageID 1178). The court denied the Rule 59(e) motion without addressing whether the arbitrator was authorized to award full loss restoration and other plan-wide relief. Fleming timely appealed.<sup>3</sup>

## II.

\*3 We review de novo a district court's decision to dismiss a suit and compel arbitration. See *Boykin v. Fam. Dollar Stores of Mich., LLC*, 3 F.4th 832, 836 (6th Cir. 2021). Because Fleming seeks to prevent arbitration, he bears the burden of proving that his claims are not well suited for arbitration. *Hawkins v. Cintas Corp.*, 32 F.4th 625, 629 (6th Cir. 2022) (citing *Green Tree Fin. Corp.-Ala. v. Randolph*, 531 U.S. 79, 91 (2000)). “[T]hat policy[,] [however,] must be balanced with ‘ERISA’s policy ... to provide ready access to the Federal courts.’ ” *Id.* (internal quotation marks omitted) (quoting *Smith v. Aegon Cos. Pension Plan*, 769 F.3d 922, 931 (6th Cir. 2014)).

### A. Legal Framework

*Federal Arbitration Act*. Fleming's appeal calls on us to consider the interplay between ERISA and the Federal Arbitration Act (“FAA”). The FAA “establishes ‘a liberal federal policy favoring arbitration agreements.’ ” *Epic Sys. Corp. v. Lewis*, 584 U.S. 497, 505 (2018) (quoting *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983)). Under the FAA, arbitration clauses are as “valid, irrevocable, and enforceable” as any other contractual obligation, 9 U.S.C. § 2, and cannot be invalidated by “defenses that apply only to arbitration or that derive their meaning from the fact that an agreement to arbitrate is at issue,” *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 339 (2011).

“A core concern of the FAA is protecting the enforceability of agreements to vindicate substantive rights through an arbitral forum using arbitral procedures.” *Cedeno v. Sasson*, 100 F.4th 386, 395 (2d Cir. 2024) (citing *Scherk v. Alberto-Culver Co.*, 417 U.S. 506, 519 (1974)). “But the FAA does not purport to reach agreements to waive *substantive rights and remedies*, and courts will invalidate provisions that prevent parties from effectively vindicating their statutory rights.” *Id.* (citing *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 637 n.19 (1985); *14 Penn Plaza LLC v. Pyett*, 556 U.S. 247, 273–74 (2009)). In that vein, the Supreme Court recently reiterated that the FAA “does not require courts to enforce contractual waivers of substantive rights and remedies.” *Viking River Cruises, Inc. v. Moriana*, 596 U.S. 639, 653 (2022). “[B]y agreeing to arbitrate a statutory claim, a party does not forgo the substantive rights afforded by the statute; it only submits to their resolution in an arbitral ... forum.” *Id.* (citation omitted).

*ERISA*. Congress enacted ERISA “to protect ... the interests of participants in employee benefit plans and their beneficiaries” by setting guidelines for fiduciaries of employee benefit plans and providing legal remedies. 29 U.S.C. § 1001(b). The heart of ERISA is the employee benefit “plan,” a distinct legal entity with the power to sue or be sued. 29 U.S.C. § 1132(d)(1). ERISA requires, among many other things, that all plan fiduciaries act “solely in the interest of [plan] participants and beneficiaries” and act with care and prudence when dealing with plan assets. 29 U.S.C. § 1104(a).

ERISA Sections 409(a) and 502(a)(2) work in tandem to provide a path for plan participants to bring civil actions against plan fiduciaries who breach their duties to the plan. Section 409(a) describes the liability that attaches for breach of fiduciary duty. And Section 502(a)(2) essentially acts as the enforcement mechanism of Section 409(a): it authorizes the Secretary of Labor, a participant, beneficiary, or fiduciary to bring a civil action on behalf of the plan and to seek “appropriate relief” under 29 U.S.C. § 1109 for fiduciary breaches. 29 U.S.C. § 1132(a)(2); *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 253, 256 (2008).

\*4 *Effective Vindication Exception*. The judicially made “effective vindication” exception “finds its origin in the desire to prevent ‘prospective waiver of a party's right to pursue statutory remedies.’ ” *Am. Express Co. v. Italian Colors Rest.*, 570 U.S. 228, 235–36 (2013) (quoting *Mitsubishi Motors*, 473 U.S. at 637 n.19). Its key question is whether “the prospective litigant effectively may vindicate its statutory cause of action in the arbitral forum.” *Id.* at 235 (internal quotation marks and citation omitted). Thus, for example, “a provision in an arbitration agreement forbidding the assertion of certain statutory rights” could be invalidated by the effective vindication exception. *Id.* at 236.

2024 WL 4534677

Since the Supreme Court recognized the effective vindication exception nearly forty years ago in *Mitsubishi*, it has rarely applied it. See *Cedeno*, 100 F.4th at 395–96. Nonetheless, both this circuit and our sister circuits have invalidated arbitration clauses that prohibited plan-wide remedies under Section 502(a)(2) based on the exception. See, e.g., *Parker v. Tenneco Inc.*, 114 F.4th 786, 798 (6th Cir. 2024); *Harrison v. Envision Mgmt. Holding, Inc. Bd. of Dirs.*, 59 F.4th 1090, 1112 (10th Cir. 2023); *Henry*, 72 F.4th at 507; *Smith v. Bd. of Dirs. Triad Mfg.*, 13 F.4th 613, 621–22 (7th Cir. 2021); *Cedeno*, 100 F.4th at 400.

#### B. Kellogg's Arbitration Clause Bars Representative Actions

At issue in this case is whether and how the effective vindication exception may apply to Fleming's claims under Section 502(a)(2) of ERISA and to the FAA more broadly. The text of the statute and Supreme Court precedent demonstrate that ERISA contemplates both plan-wide remedies for certain breaches of fiduciary duties and the representative actions frequently employed to obtain those plan-wide remedies. See *Cedeno*, 100 F.4th at 402–03 (considering, in ERISA context, *Viking River's* recognition of “a qualitative difference between” class action waivers and “waivers that preclude a party from arbitrating in a representational capacity *on behalf of a single absent principal*”); *Parker*, 114 F.4th at 798. Because Kellogg's 2021 arbitration clause precludes such representative actions, it is invalid and unenforceable.<sup>4</sup>

#### 1. Fleming's Fiduciary Breach Claims Under Section 502(a)(2) Are Representative Actions Brought on the Plan's Behalf

Section 502(a)(2) provides that a plan participant may bring an action “for appropriate relief” under Section 409. 29 U.S.C. § 1132(a)(2). Section 409(a), in turn, provides that a fiduciary who breaches statutory duties:

[S]hall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

29 U.S.C. § 1109(a). The Supreme Court has explained that Section 409(a) “provid[es] relief singularly to the plan” and seeks to “protect the entire plan” rather than “the rights of an individual beneficiary.” *Mass. Mut. Life Ins. v. Russell*, 473 U.S. 134, 142 (1985); see also *Patterson v. United HealthCare Ins.*, 76 F.4th 487, 498 (6th Cir. 2023) (stating that Section “1109 only contemplates suit to remedy harm to the plan itself”); *Pfahler v. Nat'l Latex Prods. Co.*, 517 F.3d 816, 825 (6th Cir. 2007) (“Because a § 502(a)(2) suit is a derivative action, a plaintiff bringing suit under this provision cannot obtain personal monetary relief, but must instead seek relief for the plan.”). All claims under Section 502(a)(2)—including those pertaining to a breach that harms only a single participant's account—are not individual actions but instead remain “actions on behalf of a plan to recover for violations of the obligations defined in § 409(a).” *LaRue*, 552 U.S. at 253.

\*5 Applying both *Russell* and *LaRue* in *Hawkins v. Cintas Corp.*, we found that because Section 502(a)(2) “addresses losses to ERISA plans resulting from fiduciary misconduct, ... suits under it are derivative in nature—that is, while various parties are entitled to bring suit (participants, beneficiaries, fiduciaries, and the Secretary of Labor), they do so on behalf of the plan itself.” 32 F.4th at 632 (quoting *Graden v. Conexant Sys. Inc.*, 496 F.3d 291, 295 (3d Cir. 2007) (footnote omitted)). And while Section 502(a)(2) claims are brought by individual plaintiffs who “will indirectly benefit from a remedy accruing to the Plan as a whole,” the plaintiff's claim does not thereby become “individualized.” *Id.* at 634.

We followed suit in *Parker*. Applying *Hawkins*, we concluded that when a named individual can be swapped out for any Plan participant, and “nothing material in the complaint would need to be changed,” *Hawkins*, 32 F.4th at 635, the harms alleged by the named individual are plan wide, *Parker*, 114 F.4th at 798. The *Russell* Court drove this point home when it explained that “[a] fair contextual reading of the statute makes it abundantly clear that its [drafters] were primarily concerned with the

2024 WL 4534677

possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary.” *Russell*, 473 U.S. at 142. The plaintiff in *Russell* therefore could not use Section 502(a)(2) to recoup her personal losses because such losses would benefit her individually and not the entire plan. *See id.* at 148.

Here, Fleming seeks to redress a shared injury suffered by the Plan. He contends that the Plan paid over \$7 million more than it should have for RK&A services between 2016 and 2020. Fleming, therefore, seeks to have Kellogg restore that amount to the Plan, and he seeks to have Kellogg pay any profits earned as a result of any fiduciary breaches to the Plan. Fleming also pursues equitable plan-wide relief authorized by Section 1109, including removal of the breaching fiduciaries and appointment of an independent fiduciary.

The harms that Fleming alleges are akin to the plan-wide harms we found in *Parker*. Like the plaintiffs there, Fleming alleges excessive RK&A spending, which harmed the Plan as a whole. *Parker*, 114 F.4th at 798. Fleming requests no remedy to his individual account; rather “the monetary remedies that [he] requests flow to the Plan[ ].” *Id.* In short, Fleming seeks “[p]lan-wide relief through a statutory mechanism that is designed for representative actions on behalf of the Plan,” and representative actions only. *Hawkins*, 32 F.4th at 635.

Accordingly, in bringing a fiduciary breach claim under Section 502(a)(2), Fleming is acting—indeed, can only act—in a representative capacity on the Plan's behalf. *See Parker*, 114 F.4th at 801; *Cedeno*, 100 F.4th at 404–05.

## 2. Kellogg's Arbitration Clause Does Not Allow Fleming to Proceed in a Representative Capacity

The language of Kellogg's arbitration clause forecloses arbitration for class, collective, and *representative* actions. Kellogg argues that its arbitration clause does not limit Fleming's ability to proceed in a representative capacity. Specifically, Kellogg maintains that the district court correctly held that the Plan expressly allows any relief ERISA provides and therefore, “the provision properly applies to representative suits brought on behalf of the Kellogg Plan.” (ECF 23, Appellee's Br. 19). For support, Kellogg commends *Dorman v. Charles Schwab Corp.*, 780 F. App'x 510 (9th Cir. 2019) (“*Dorman IP*”), an unpublished decision from the Ninth Circuit in which a panel upheld an arbitration clause that required individual arbitration for claims similar to Fleming's. This argument fails for several reasons. First, as will be explained below, Kellogg's arbitration provision blocks Fleming from proceeding in a representative manner. Second, *Dorman II* suggests that a Section 502(a)(2) claim is “inherently individualized” in the context of a defined contribution plan and that a participant can therefore only seek losses sustained by his own individual account. 780 F. App'x at 514. This conclusion, however, cannot be reconciled with *LaRue*. *See 552 U.S. at 256* (“[Section] 502(a)(2) does not provide a remedy for individual injuries distinct from plan injuries....”). And significantly, we have concluded post-*LaRue* that participants are entitled to recover—on behalf of the plan—all losses to the plan resulting from the fiduciary breach. *See Parker*, 114 F.4th at 800. Therefore, Kellogg's bar on representative actions necessarily infringes on the remedies available to Fleming under ERISA.

### C. Kellogg's Arbitration Clause Infringes on Fleming's Ability to Effectively Vindicate His ERISA Claims

\*6 In barring Fleming's ability to bring a Section 502(a)(3) claim, Kellogg's arbitration provision violates the effective vindication exception. “By agreeing to arbitrate a statutory claim, a party does not forgo the substantive rights afforded by the statute; it only submits to their resolution in an arbitral ... forum.” *Preston v. Ferrer*, 552 U.S. 346, 359 (2008) (quoting *Mitsubishi Motors Corp.*, 473 U.S. at 628). Under the effective vindication exception, an arbitration provision is invalid if it attempts to “forbid[ ] the assertion of certain statutory rights,” *Italian Colors*, 570 U.S. at 236, or if it acts as a “prospective waiver of a party's right to pursue statutory remedies,” *Mitsubishi Motors Corp.*, 473 U.S. at 637 n.19. While the use of the effective vindication exception is “rare,” *see Smith*, 13 F.4th at 621, we find that this case fits within the narrow construction of that exception.

The 2021 arbitration clause prohibits arbitration from being “conducted on a ... representative basis,” denies the arbitrator “authority to arbitrate any claim on a ... representative basis,” and requires participants to “waive the right to participate in a ... representative action.” (R. 12-3, PageID 268). Because Section 502(a)(2) claims can only be brought in a representative capacity on behalf of the plan, an arbitration clause that eliminates a participant's ability to bring a representative claim effectively forecloses his substantive right to bring a fiduciary breach claim under that section. Yet, Kellogg's 2021 arbitration clause does exactly that. Section 17.4(b) states that

[t]he arbitrator shall have no authority to arbitrate any claim on a class or representative basis and may award relief only on an individual basis; *provided, however, that the arbitrator may award any relief otherwise available under ERISA.*

(*Id.*) (emphasis added). It also makes the representative action waiver non-severable by stating that if such waiver is unenforceable, “any claim on a ... representative basis” must be heard in federal district court “and not in arbitration.” (*Id.*).

### 1. Kellogg's “provided, however” Proviso Does Not Cure the Problems Created By Its Arbitration Clause

Kellogg hangs its hat on the inclusion of the “provided, however” proviso (singled out for emphasis above) which it contends “qualifies and conditions the clause's limitations on the arbitrator's authority to arbitrate only individual actions and award relief.” (ECF 23, Appellee's Br. 21). Kellogg argues that the appropriate construction of this proviso is that it prohibits only class, collective, or “group” actions, which is permissible. But reading Kellogg's proviso in this way is illogical. The arbitration clause explicitly forbids “representative” actions. And as we have stated, in the context of Section 502(a)(2) claims, “representative” has a technical meaning—in order to obtain plan-wide remedies such as full-loss restoration, Fleming must proceed as a representative of the Plan. See *Cedeno*, 100 F.4th at 404–05; *Parker*, 114 F.4th at 798.

Kellogg claims that its proviso saves the day by granting plan participants access to any remedy permitted by ERISA. It relies on the Seventh Circuit's decision in *Smith v. Board of Directors of Triad Manufacturing, Inc.*, which invalidated a similar arbitration clause prohibiting certain plan-wide relief. 13 F.4th at 621–22. Kellogg suggests that the Seventh Circuit's only issue with the representative-action waiver was “its prohibition on certain plan-wide remedies, not plan-wide representation.” So, Kellogg claims, it fixed any problem with its waiver by adding the referenced “provided, however” proviso, making available any remedy provided by ERISA. However, we are neither bound by *Triad* nor convinced by its dicta on this specific point.

\*7 Moreover, since *Triad*, we have had occasion to address a similar arbitration provision in *Parker*. There, we did not limit our reasoning to the arbitration clause's express bar on remedies; we also considered the implications of the arbitration clause's bar on plan participants' access to a mechanism to vindicate their claims. *Parker*, 114 F.4th at 798. The problem with these representative-action waivers lies in the waivers themselves; waivers like the one at issue in *Parker* and Kellogg's limit access to ERISA's statutory remedy by foreclosing the only avenue through which a plaintiff may assert a Section 502(a)(2) claim. *Id.* at 800 (citing *Harrison*, 59 F.4th at 1106–07, 1109). It is because Section 502(a)(2) claims are inherently representative that Kellogg's clause is void on its face.

And the “provided, however” proviso does not alter this result because the proviso can only provide effective vindication if it affirmatively authorizes Fleming to proceed on behalf of the Plan, or in other words, in a representative capacity. But the proviso does not do this. Rather, by its plain language, the proviso modifies only what *relief* the arbitrator can award; there is no textual indication that it modifies the kind of claims that can be heard in arbitration—i.e., it does not make class or representative claims arbitrable.

## 2. Because Kellogg's Arbitration Clause and Proviso Are Unambiguous, We Enforce Them As Written

Seeking to salvage the arbitration clause, Kellogg argues that we should read the clause's language in such a way as to avoid the “incongruence” that Fleming's proposed construction would cause. Kellogg says we should not interpret the clause to foreclose an entire category of ERISA claims given that it specifically amended the Plan to allow whatever relief ERISA provides. See *Metro E. Ctr. for Conditioning & Health v. Qwest Commc'ns Int'l, Inc.*, 294 F.3d 924, 925–26 (7th Cir. 2002). “[T]he interpretation of an arbitration agreement is generally a matter of state law.” *Stolt-Nielsen S.A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662, 681 (2010) (citing *Arthur Andersen LLP v. Carlisle*, 556 U.S. 624, 630–31 (2009)). The arbitration agreement at issue in this case is subject to Michigan state law.

Under Michigan law, “[i]f the language of the contract is unambiguous, we construe and enforce the contract as written.” *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724, 727 (Mich. Ct. App. 2010) (quoting *Quality Prod. & Concepts Co.*, 666 N.W.2d 251, 259 (Mich. 2003)). So, the problem with Kellogg's argument is that, as a practical matter, the language in Kellogg's clause is unambiguous and requires no further interpretation to enforce it according to its terms. This is because “[o]nly when contractual language is ambiguous does its meaning become a question of fact.” *Id.* (citing *Port Huron Ed. Ass'n v. Port Huron Area Sch. Dist.*, 550 N.W.2d 228, 237 (Mich. 1996)).<sup>5</sup>

Context reveals the lack of ambiguity. To avoid the alleged “incongruity,” Kellogg asks us to read “representative” in the arbitration provision as alluding to “group” actions, not those brought to vindicate wrongs to the Plan. To be sure the word “representative” carries several meanings. But Kellogg cannot avoid the fact that, under Michigan law, contractual definitions are informed by context. See *Hastings Mut. Ins. v. Safety King, Inc.*, 778 N.W.2d 275, 294 (Mich. Ct. App. 2009) (citing *Henderson v. St. Farm Fire & Cas. Co.*, 596 N.W.2d 190, 194 (Mich. 1999)). The arbitration clause explicitly references “any relief” under ERISA. (R. 12-3, PageID 268). ERISA only affords relief under Section 502(a)(2) claims via “representative” actions—i.e., those brought on behalf of the plan to vindicate an injury to the plan. *Hawkins*, 32 F.4th at 635. Even though Fleming brings the action as an individual plaintiff, he sues—and can only sue—under Section 502(a)(2) as a representative of the Plan. *LaRue*, 552 U.S. at 253, 256. Kellogg cannot avoid the implication of the well-settled legal doctrine its contract language evokes: contracts are defined by their context. This is especially so here, where Kellogg admits it added the “provided, however” proviso to address incongruities found by other courts between Section 502(a)(2) actions and collective-action waivers. “[T]he language used by [Kellogg] is plain and unambiguous even though the [sentences within the provision], when read together, are completely incongruent.” *Gauthier v. Alpena Cnty. Prosecutor*, 703 N.W.2d 818, 822 (Mich. Ct. App. 2005); see also *Zwiker v. Lake Superior St. Univ.*, 986 N.W.2d 427, 442 (Mich. Ct. App. 2022) (“It is not this Court's role to undermine the parties' freedom to contract by rewriting clear contractual language to comply with what the Court perceives as the parties' intent.”). Kellogg's added proviso aside, “[t]he individual arbitration provision ... functions as a prospective waiver of [Fleming's] substantive statutory remedies.” *Parker*, 114 F.4th at 801.

## 3. The Effective Vindication Exception Invalidates Kellogg's Arbitration Provision

\*8 A Plan participant's ability to bring a breach of fiduciary duty claim under Section 502(a)(2) is a substantive right granted by ERISA. *Id.* at 798. And as discussed, all Section 502(a)(2) claims initiated by a plan participant are necessarily brought in a representative capacity on behalf of the plan. Here, Fleming's breach of fiduciary duties claims were brought on behalf of the Plan. Despite Kellogg's arguments to the contrary, its arbitration clause prevents a plaintiff from proceeding in a representative manner. And, while Kellogg contends that the manner of bringing suit is merely a procedural matter, in this context, it has the practical effect of blocking a whole class of claims. In doing so, it effectively eliminates a participant's substantive right to bring a fiduciary breach claim under Section 502(a)(2). See *Harrison*, 59 F.4th at 1106–07 (stating that a “prohibition on a claimant proceeding in a representative capacity is inconsistent with, and prevents a claimant from effectively vindicating the remedies afforded by, § 1132(a)(2)”); see also *Harris v. Paredes*, No. 3:23-CV-50231, 2024 WL 774874, at \*6 (N.D. Ill. Feb. 26, 2024) (explaining that “a claimant's right to effectively vindicate the remedies available under ERISA would be frustrated” by

2024 WL 4534677

an arbitration provision barring representative claims under Section 502(a)(2) but rejecting the effective vindication challenge because of an amendment to the clause removing the language that barred claims brought in a representative capacity).

And as we recently held, arbitration clauses that forbid participants from obtaining plan-wide remedies under ERISA are unenforceable. *Parker*, 114 F.4th at 801; see also *id.*, at 798–801 (collecting sister-circuit cases holding same). Given the impermissible restrictions built into Kellogg's arbitration provision and its non-severability clause, we find that Kellogg's arbitration provision is invalid and unenforceable. And because the clause is void, we decline to reach Fleming's alternative argument for reversal that he did not consent to the arbitration clause.

### III.

For the reasons discussed, we reverse.

#### All Citations

Not Reported in Fed. Rptr., 2024 WL 4534677

---

#### Footnotes

- 1 Now known as Kellanova.
- 2 In *Smith v. Spizzirri*, 601 U.S. 472 (2024), the Supreme Court answered whether Section 3 of the FAA permits a federal district court to dismiss a case, as opposed to staying it, when the action is subject to arbitration and a party requests a stay pending arbitration. The Court explained that the statute does not permit dismissal. *Id.* at 477–78. Instead, when a motion to compel arbitration is granted, the district court must enter a stay at the party's request. *Id.* Here, Fleming did not request that the district court stay the case pending arbitration. Therefore, the district court's dismissal of the case was not improper under *Spizzirri* but was improper for other reasons as explained herein.
- 3 Fleming and Kellogg initiated arbitration proceedings in October 2023, and in February 2024, the parties agreed to stay the arbitration for six months.
- 4 While we assume that the 2021 arbitration clause is the operative agreement, our analysis would lead to the same outcome for the 2020 plan because it also prevented claimants from obtaining plan-wide remedies under ERISA.
- 5 Kellogg suggests that the arbitration provision is ambiguous and retreats to the Plan sponsor's purported intent to avoid the effective vindication problem. But Kellogg took the position below that “[t]he arbitration clause at issue here is not ambiguous.” (R. 27, PageID 963 n.3). It cannot take a contrary position on appeal. See *Est. of Romain v. City of Grosse Pointe Farms*, 935 F.3d 485, 491 (6th Cir. 2019) (quoting *Bowles v. Marx Hide & Tallow Co.*, 153 F.2d 146, 149 (6th Cir. 1946) (“[A party], on appeal, cannot change the theory of his case made by his pleadings and his conduct of the case.”)); *Montanez v. City of Orlando*, 678 F. App'x 905, 912 (11th Cir. 2017) (stating that a party “cannot change positions on appeal to [avoid] reversal”).

# EXHIBIT 4

146 F.4th 496  
United States Court of Appeals, Sixth Circuit.

GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS; Grand Traverse  
Band of Ottawa and Chippewa Indians Employee Welfare Fund, Plaintiffs-Appellants,  
v.  
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant-Appellee.

No. 24-1367

Argued: December 12, 2024

Decided and Filed: July 28, 2025

### Synopsis

**Background:** Indian tribe and its employee welfare plan brought action against third-party plan administrator, alleging breach of fiduciary duties under Employee Retirement Income Security Act (ERISA) and violations of Michigan Health Care False Claims Act (HCFCFA) for failing to apply Medicare-Like Rate (MLR) discounts to claims. The United States District Court for the Eastern District of Michigan, Judith E. Levy, J., 2017 WL 3116262, dismissed tribe's ERISA and common-law fiduciary duty claims as time-barred, granted administrator's motion for summary judgment on HCFCFA claim, and denied tribe's motion for leave to amend complaint a second time, and denied reconsideration, 2017 WL 6594220. Tribe appealed.

**Holdings:** The Court of Appeals, Bush, Circuit Judge, held that:

Tribe had actual knowledge of its breach of fiduciary duty claim, triggering three-year statute of limitations, when administrator informed Tribe that system-wide changes to apply MLR discounts were not feasible;

administrator's failure to take advantage of MLR discounts available to Tribe could not be considered ongoing breach, and therefore three-year limitation period could not be tolled on that basis;

claim alleging that administrator failed to honor promise under claim processing agreement to obtain rates close to MLR sounded in contract, not tort, and therefore recovery in tort was not available;

administrator was prejudiced by Tribe raising new misrepresentation theory on its cross-motion for summary judgment on HCFCFA claim;

relabeling rate representations in subsequent claims processing agreement between Tribe and administrator as tortious misfeasance when administrator's fiduciary duty to Tribe was established in prior administrative service contract did not revive otherwise time-barred breach of fiduciary duty claim;

regulations governing payment of claims for Contract Health Service (CHS) care using tribal plan assets could not be broadly interpreted to include administrator as Tribe's fiduciary; and

administrator's subsequently-acquired knowledge that MLR were significantly lower than contractual discounts it obtained with hospitals did not toll three-year limitation period on Tribe's ERISA breach-of-fiduciary-duty claim.

Affirmed.

**Procedural Posture(s):** On Appeal; Motion to Dismiss for Failure to State a Claim; Motion for Summary Judgment; Motion to Amend the Complaint; Motion for Reconsideration.

Appeal from the United States District Court for the Eastern District of Michigan at Ann Arbor. No. 5:14-cv-11349—Judith E. Levy, District Judge.

**Attorneys and Law Firms**

ARGUED: Perrin Rynders, VARNUM LLP, Grand Rapids, Michigan, for Appellants. Phillip J. DeRosier, DICKINSON WRIGHT PLLC, Detroit, Michigan, for Appellee. ON BRIEF: Perrin Rynders, Herman D. Hofman, VARNUM LLP, Grand Rapids, Michigan, for Appellants. Phillip J. DeRosier, DICKINSON WRIGHT PLLC, Detroit, Michigan, Scott R. Knapp, Brandon C. Hubbard, DICKINSON WRIGHT PLLC, Lansing, Michigan, for Appellee.

Before: BATCHELDER, MOORE, and BUSH, Circuit Judges.

**OPINION**

JOHN K. BUSH, Circuit Judge.

\*502 The Grand Traverse Band of Ottawa and Chippewa Indians (Grand Traverse Band or the Tribe) and its employee welfare plan (the Plan) allege that Blue Cross Blue Shield of Michigan (Blue Cross) breached fiduciary duties owed to the Tribe under the Employee Retirement Income Security Act (ERISA) and related duties under Michigan state law. According to the amended complaint, Blue Cross submitted false claims to the Tribe, causing the Tribe to overpay for hospital services received by its members and employees. On appeal, the Tribe challenges the district court's (1) dismissal of its ERISA and common-law claims, (2) grant of summary judgment to Blue Cross on the Michigan Health Care False Claims Act (HCFCA) claim, and (3) denial of the Tribe's motion for leave to amend its complaint a second time. For the reasons set forth below, we **AFFIRM**.

**I.**

Grand Traverse Band is a federally recognized Indian Tribe. Its Plan is a self-funded employee and member welfare plan that pays claims from health care providers for covered services provided to the Plan's participants. The Plan covers three groups: (1) Group # 01019, consisting of Tribe members who are employees of the \*503 Tribe (Employee Group); (2) Group # 01020, consisting of Tribe members who are not employees of the Tribe (Member Group); and (3) Group # 48571, consisting of Tribe employees who are not Tribe members. The two policies of the Plan relevant to this appeal are for the Employee Group (# 01019) and the Member Group (# 01020).

Grand Traverse Band, the Plan, and Blue Cross began their business relationship in 2000, when they signed an agreement known as the Administrative Services Contract (ASC). The ASC specifically mandates (as alleged in the amended complaint) that, “[f]or each claim for payment presented by a medical provider for services rendered to a Plan participant (or dependent),” Blue Cross is “responsible for determining whether or not the claim should be paid for by” the Tribe and the Plan “and, if so, how much the medical provider would be paid from Plan funds.” R. 90, Am. Compl. ¶ 3, PageID 2539. In short, the ASC tasked Blue Cross with the processing and payment of claims for all Tribe groups under the Plan. The agreement also triggered a fiduciary duty, wherein Blue Cross was to, among other things, preserve Plan assets and administer the Plan with the skill and care of a prudent person.

In 2007, the federal government released new federal regulations implementing § 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, codified at 42 U.S.C. § 1395cc. These new rules pertain to what is known

as the Medicare-Like Rate (MLR). *See generally* 42 C.F.R. §§ 136.30–136.32. Relevant here, these MLR regulations require Medicare-participating hospitals to accept payment not to exceed the corresponding Medicare rate, so long as the services are approved by a federally recognized tribe operating a Contract Health Service (CHS) program on behalf of the Indian Health Service (IHS). *See id.* § 136.30(a)–(b). Furthermore, “if an amount has been negotiated with the hospital or its agent,” the Tribe is to pay “the lesser of” MLR or the negotiated amount. *Id.* § 136.30(f). Because of the MLR regulations, Medicare-participating hospitals must accept MLR or lower contracted rates for services provided to participants in any health plans operated by the Grand Traverse Band through the IHS’s contract health service program. *See id.* § 136.30(a)–(b), (f). And for purposes of the MLR regulations, a qualifying plan includes a “contract health service [ ] program of the Indian Health Service [ ]”; “a Tribe or Tribal organization carrying out a CHS program of the IHS”; or “an urban Indian organization[.]” *Id.* § 136.30(b).

After the new regulations went into effect, the Tribe “asked [Blue Cross] to ensure that Plaintiffs were obtaining Medicare-Like Rate discounts” on eligible claims. R. 90, Am. Compl. ¶ 50, PageID 2551. Blue Cross replied that “it could not adjust its entire system to calculate MLR on those claims eligible for MLR discounts.” *Id.* ¶ 51, PageID 2552. Instead, Blue Cross allegedly promised that it “could provide” the Tribe “a rate which ... would be ‘close to that which would be payable under the New Regulations’ by providing a discount on Plaintiffs’ claims for hospital services at Munson Medical Center” for the Member Group only. *Id.* Grand Traverse Band claims it relied on this representation when it negotiated and entered into the Facility Claims Processing Agreement (FCPA) with Blue Cross and Munson, “whereby [Blue Cross] agreed to process Plaintiffs’ claims for services at Munson at a discount ... on top of the [Blue Cross] standard contractual rate.” *Id.* ¶ 52, PageID 2552.

\*504 The FCPA included the following pertinent recitals: “WHEREAS, effective July 5, 2007, new regulations found at 42 CFR 136.30-136.32 [called the “New Regulations”] went into effect that provide that a Medicare-participating hospital must accept as payment in full no more than the rates of payment” under the New Regulations’ MLR calculation; “WHEREAS, questions have been raised as to the applicability of the New Regulations in the ... context” of the agreement for Blue Cross’s administration of the Tribe’s Member Plan; and “WHEREAS, [Blue Cross] is willing to accommodate the desire of both Munson and [the Tribe] by processing claims by Enrollees for services at Munson Medical Center at a price they believe is close to that which would be payable under the New Regulations.” R. 90-4, FCPA, PageID 2589. The FCPA also stated that “[t]he Parties agree that [Blue Cross] shall process Munson Claims in the normal course of business using the [Blue Cross] Rate [that is, the contracted network rate] and then” apply a percentage discount, initially set at 8%, but to be calculated annually by a formula set forth in the agreement. *See id.* at PageID 2590.

In 2012, Grand Traverse Band sought a third-party audit to “obtain a comparison of the costs of going with a different third-party administrator.” R. 90, Am. Compl. ¶ 56, PageID 2552. The Tribe alleges that this audit revealed that Blue Cross had been overpaying on claims eligible for MLR and that the FCPA discount was nowhere near the amount that would be payable under the federal regulations. The Tribe contends that Blue Cross breached its duty of care by failing to preserve plan assets when it deliberately chose not to capitalize on available discounts on eligible claims. Important to the survival of its claims, Grand Traverse Band alleges it “did not discover the full extent of” Blue Cross’s conduct until 2013. *Id.* ¶ 70, PageID 2555. Soon after this realization, the Tribe filed suit, alleging breach of fiduciary duty under ERISA and a handful of supplemental state-law claims.

The Tribe filed its initial complaint on April 1, 2014. Nearly two years later, in January 2016, Blue Cross moved for judgment on the pleadings, which the district court granted in part, dismissing the ERISA breach of fiduciary duty claim with prejudice. Then, in January 2017, the Tribe filed its First Amended Complaint, alleging (i) breach of fiduciary duty under ERISA, 29 U.S.C. § 1001 *et seq.*; (ii) violations of Michigan’s HCFCA, Mich. Comp. Laws § 752.1001, *et seq.*; (iii) breach of contract and the covenant of good faith and fair dealing; (iv) breach of common-law fiduciary duty; (v) fraud/misrepresentation; and (vi) silent fraud. This revised pleading remains the operative complaint.

Blue Cross moved to dismiss the amended complaint, and the district court granted the motion in part. The court dismissed the Tribe’s ERISA claim as time-barred under the statute of limitations, its fraud and silent fraud claims as duplicative of breach of contract, and part of the Tribe’s breach-of-contract claim for failure to adequately allege a violation of the covenant of good

faith and fair dealing.<sup>1</sup> Also, by agreement of the parties, the court dismissed the Tribe's HCFCAs and common-law breach-of-fiduciary-duty claims as preempted by ERISA.

The district court denied the Tribe's motions for reconsideration and for leave to file a second amended complaint. But after our court decided *Saginaw Chippewa Indian Tribe of Michigan v. Blue Cross Blue Shield of Michigan*, the parties agreed to restore the Tribe's HCFCAs and common-law fiduciary claim *only* as to the Member Group given our holding that similar claims related to tribal member groups were not preempted by ERISA. 748 F. App'x 12, 19 (6th Cir. 2018) (SCIT I).

Blue Cross then moved to dismiss the reinstated claims, and the district court granted the motion in part and denied it in part. The court dismissed as time-barred the common-law fiduciary-duty claim but allowed the HCFCAs claim to move forward. After three more years of litigation, the parties filed cross motions for partial summary judgment on the HCFCAs claim, and the court granted Blue Cross's motion, denying the Tribe's motion. The Tribe moved for reconsideration of the district court's order, but the court denied the motion. Because the HCFCAs claim was the lone remaining claim, the grant of summary judgment to Blue Cross constituted final judgment.

## II.

As noted, the Tribe raises three issues in its timely appeal: that the district court erred in (1) dismissing its ERISA and common-law breach-of-fiduciary-duty claims as time-barred; (2) granting summary judgment to Blue Cross on the HCFCAs claim; and (3) denying the Tribe's motion for leave to amend its complaint a second time.

We review de novo the district court's decision granting Blue Cross's motions to dismiss. *Kovalchuk v. City of Decherd*, 95 F.4th 1035, 1037 (6th Cir. 2024). We construe the facts in the light most favorable to Grand Traverse Band, accept the allegations as true, and draw all reasonable inferences in the Tribe's favor. *Bickerstaff v. Lucarelli*, 830 F.3d 388, 396 (6th Cir. 2016). “Against that backdrop, we ask whether the complaint contains sufficient factual matter to state a claim to relief that is plausible on its face.” *Royal Truck & Trailer Sales & Serv., Inc. v. Kraft*, 974 F.3d 756, 758 (6th Cir. 2020) (cleaned up).

We also review de novo the district court's decision to grant Blue Cross's motion for partial summary judgment and to deny the Tribe's similar motion. *Hyman v. Lewis*, 27 F.4th 1233, 1237 (6th Cir. 2022). Summary judgment is appropriate when, viewing the facts in the light most favorable to the non-movant, no genuine dispute of material fact exists and the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a); *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 585–87, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986). A genuine dispute of material fact exists “if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). The movant bears the initial burden of showing no dispute of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). If successful, the burden shifts to the non-movant to present facts showing a genuine issue exists for trial. *Anderson*, 477 U.S. at 250, 106 S.Ct. 2505.

Lastly, we review de novo the district court's decision, based on futility of amendment, to deny the Tribe's motion for leave to amend the complaint a second time under Federal Rule of Civil Procedure 15(a)(2). *Williams v. City of Cleveland*, 771 F.3d 945, 949 (6th Cir. 2014).

## III.

The amended complaint advances two related but distinct theories. For its fiduciary-duty **\*506** claims, Grand Traverse Band alleges that Blue Cross breached its obligations under ERISA and common law by failing to act prudently, preserve plan assets, and act solely in the interest of beneficiaries—specifically by ignoring a cost-saving opportunity through MLR. At the same

time, and pertinent to its HCFA claim, many of the Tribe's allegations rest on the assumption that Blue Cross was legally required to apply MLR and violated the applicable regulations by not doing so.

We have little precedent to guide our analysis, but two cases are relevant. In *SCIT I*, this court held that an Indian Tribe had stated a viable ERISA breach-of-fiduciary-duty claim through allegations that its third-party administrator, Blue Cross, overpaid medical claims by failing to apply MLR discounts. 748 F. App'x at 20. We rejected the notion that ERISA fiduciary duties are confined solely to the plan's terms and cannot account for external cost-saving opportunities. *Id.* at 20–21. Instead, we found that the plaintiff Tribe's claim in that case arose directly from ERISA's duty to act prudently and preserve plan assets. *Id.* At the pleading stage, those allegations were sufficient to survive dismissal. *Id.* at 21–22; cf. *Tiara Yachts, Inc. v. Blue Cross Blue Shield of Mich.*, 138 F.4th 457 (6th Cir. 2025) (reversing the district court's dismissal of self-funded healthcare benefits plan sponsor's claim for breach of fiduciary duty under ERISA, where the plaintiff alleged, among other things, Blue Cross was overpaying on some categories of claims).

Four years later, we reinforced and expanded that reasoning in *Saginaw Chippewa Indian Tribe of Michigan v. Blue Cross Blue Shield of Michigan*, 32 F.4th 548 (6th Cir. 2022) (*SCIT II*). There, the question was whether MLR is categorically unavailable when services are authorized under an Indian Tribe's CHS program but paid through Blue Cross insurance plans. The *SCIT II* district court said yes—MLR applies only when services are paid with CHS funds. *Id.* at 557. We disagreed, holding that MLR eligibility turned on whether the Tribe in that case authorized the services under its CHS program—not the source of payment. *Id.* at 561. As a result, we reversed and remanded for the district court to consider the facts in light of the holding that MLR was available to the Tribe on eligible claims. *Id.* at 565.

Together, *SCIT I* and *SCIT II* establish two principles applicable here: first, a Tribe may state a viable ERISA fiduciary duty claim by alleging that a plan administrator failed to pursue available MLR discounts; and second, MLR eligibility depends on whether care was authorized under a CHS program—not on whether CHS funds were the direct source of payment. These cases provide useful guidance to an extent but leave unanswered one other legal issue presented in this case: whether MLR obligations apply to Blue Cross.

With that background, we proceed to Grand Traverse Band's claims.

### A. Breach of Fiduciary Duty

Our analysis of the ERISA and common-law fiduciary-duty claims starts and ends with timeliness. As an initial matter, the Tribe argues that *SCIT II* controls our decision here and mandates reversal. It argues that we should reverse because in a nearly identical case involving the same defendant, same underlying conduct, and same claim, this court held that that questions about when the plaintiff Tribe had actual knowledge of the breach and whether Blue Cross concealed its actions created a genuine dispute of material fact over the statute of limitations.

\*507 Grand Traverse Band's reliance on *SCIT II* is misplaced. The Tribe selectively quotes from the court's opinion for its benefit, misstating *SCIT II*'s holding. Contrary to the Tribe's reading, we refrained from answering the statute of limitations question and instead sent the case back to the district court to resolve the issue in the first instance after correcting its legal error related to the applicability of MLR. See *SCIT II*, 32 F.4th at 565. We noted that the district court had incorrectly “concluded that the MLR regulations were inapplicable to services under the Employee and Member Plans,” and that it must first “parse the complicated factual record to determine when the Tribe had actual knowledge of the breach and whether Blue Cross's actions amounted to fraud or concealment.” *Id.*

Significant for our decision here, *SCIT II* can be distinguished because it arose in the context of a summary judgment record where the statute-of-limitations issue was not conclusively resolved. That is not the case for Grand Traverse Band's fiduciary-duty claims. Both of the Tribe's claims were dismissed at the pleading stage because the fatal defect appears on the face of the amended pleading: the Tribe knew by 2009 that it was not receiving MLR. As will be explained, that factual concession is dispositive under both ERISA and Michigan law.

All said, *SCIT I* and *II* established that MLR is legally available for Blue Cross to pursue on behalf of Tribes and that Blue Cross's alleged failure to do so can give rise to a claim for breach of fiduciary duty. That is firmly established and is not in dispute. The problem for Grand Traverse Band's fiduciary-duty claims is not a legal one—it's a factual one.

*i. ERISA*

Depending on the circumstances, ERISA provides either a six- or a three-year limitations period for claims of breach of fiduciary duty. 29 U.S.C. § 1113. A claim is timely if filed within “six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation.” *Id.* § 1113(1). But a plaintiff becomes subject to an accelerated three-year limitations period as of “the earliest date on which the plaintiff had actual knowledge of the breach or violation, except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.” *Id.* § 1113(2).

Grand Traverse Band alleges that Blue Cross breached its fiduciary duty of care under ERISA by failing to act as a prudent person, preserve Plan assets, and act for the exclusive purpose of providing benefits to its beneficiaries when it failed to pursue MLR on eligible claims. The district court recognized as much, holding that “it is plausible that, in deciding whether to pay claims and whether the negotiated rate should apply, [Blue Cross] should have requested the provider accept MLR as payment in full as an ‘ordinary and natural means’ of preserving plan assets and providing benefits to plan beneficiaries.” R. 99, Op. & Order, PageID 2928–29. But the district court nonetheless dismissed the ERISA claim based on the three-year statute of limitations. Because Grand Traverse Band knew that it was not receiving MLR in 2009, the Tribe needed to bring its fiduciary-duty claims by 2012. The suit was not brought until 2014, so the Tribe's ERISA claim is time-barred.

On appeal, Grand Traverse Band contends that the district court erred in its statute-of-limitations ruling because, even if the Tribe knew in 2009 that it was not \*508 receiving MLR, it did not have actual knowledge that the rates were not “close to” MLR (as Blue Cross had allegedly promised) until the 2013 audit. Blue Cross responds that the district court correctly dismissed the claim as untimely because Grand Traverse Band's own admissions demonstrate that it had “actual knowledge” that Blue Cross was not pursuing MLR in 2009. Indeed, Blue Cross emphasizes that the Tribe entered into the FCPA because Blue Cross explicitly told the Tribe “that it could not adjust its entire system to calculate MLR” on claims eligible for those discounts. R. 90, Am. Compl. ¶ 51, PageID 2552. At that point, Blue Cross argues, Grand Traverse Band had the requisite knowledge of the fact underlying its breach-of-fiduciary-duty claim: that Blue Cross “[failed] to take advantage of MLR discounts available to Plaintiffs when processing claims for payment[.]” *Id.* ¶ 10, PageID 2541.

We agree with Blue Cross. In 2020, the Supreme Court clarified the meaning of “actual knowledge” under 29 U.S.C. § 1113(2). See *Intel Corp. Inv. Pol’y Comm. v. Sulyma*, 589 U.S. 178, 140 S.Ct. 768, 206 L.Ed.2d 103 (2020). The Court first stated that “actual” means “existing in fact or reality” and knowledge means “the fact or condition of being aware of something.” *Id.* at 184, 140 S.Ct. 768 (quoting Webster's Seventh New Collegiate Dictionary 10, 469 (1967)). Thus, to satisfy § 1113(2), a plaintiff must “in fact be aware of” the relevant information; it is not enough that the information was disclosed or made available. *Id.* at 184, 186–87, 140 S.Ct. 768. The Court also distinguished “actual knowledge” from “constructive knowledge,” which is based on what a reasonably diligent person would have known or learned. *Id.* at 184–85, 140 S.Ct. 768. And it rejected the argument that receipt of disclosures alone establishes actual knowledge, emphasizing that such an interpretation would improperly transform § 1113(2) into a constructive knowledge standard. *Id.* at 187, 140 S.Ct. 768.

Although the district court here did not have the chance to consider *Sulyma* because that opinion came down three years after the district court's order dismissing the claim, the district court correctly applied the actual knowledge standard to the facts of this case. At the point of its decision, the controlling circuit precedent was (and still is) *Wright v. Heyne*, 349 F.3d 321 (6th Cir. 2003). *Wright* described the “actual knowledge” standard as sitting somewhere between knowing “every last detail” and “something was awry,” and emphasized the important distinction between constructive and actual knowledge. *Id.* at 329 (quoting *Martin*

*v. Consultants & Adm'rs, Inc.*, 966 F.2d 1078, 1086 (7th Cir. 1992)). That description is not inconsistent with *Sulyma*. Under *Wright*, a plaintiff need not “have actual knowledge that the facts establish a cognizable legal claim under ERISA to trigger the running of the statute”; a plaintiff need only have “knowledge of the facts or transaction that constituted the alleged violation” to trigger the statute of limitations. *Id.* at 330.

Here, as early as 2009, Grand Traverse Band had actual knowledge of the relevant facts supporting its ERISA breach-of-fiduciary-duty claim—that is, Blue Cross's “failure to take advantage of MLR discounts available to” the Tribe. R. 90, Am. Compl., ¶¶ 10, 51, PageID 2541–42, 2552. For that reason, the Tribe had to bring the claim by 2012. The amended complaint, as framed, supports no other conclusion. That pleading itself acknowledges that Blue Cross informed the Tribe that system-wide changes to apply MLR discounts were not feasible. In response, according to the amended complaint, the parties negotiated \*509 a new agreement—the FCPA—based on Blue Cross's representation that it could provide rates at Munson Medical “close to that which would be payable under the New Regulations” for the Member Group only. *Id.* ¶ 51, PageID 2552. This admission alone evinces Grand Traverse Band's knowledge that Blue Cross was not applying MLR discounts and would not do so going forward.

The Tribe's knowledge was not “hypothetical” or “theoretical.” *Sulyma*, 589 U.S. at 185, 140 S.Ct. 768 (quoting Black's Law Dictionary 53 (4th ed. 1951)). Because of how the Tribe chose to frame its claim, Blue Cross's failure to pursue MLR discounts forms the basis of its claim and constitutes the only “relevant fact,” *Wright*, 349 F.3d at 328, that triggered the statute of limitations. The face of the amended complaint thus confirms Grand Traverse Band's knowledge in 2009. Because the Tribe cannot change when it learned of Blue Cross's conduct, its claim for breach of fiduciary duty under ERISA is untimely.

Grand Traverse Band advances two arguments to the contrary. Neither persuades us. First, it attempts to recast its claim as an ongoing breach, contending that Blue Cross's continued failure to capitalize on MLR discounts harmed plan assets. But the Tribe identifies no allegation in the amended complaint or elsewhere suggesting that it had reason to believe Blue Cross was ever pursuing MLR discounts. Nor does it allege that Blue Cross offered any assurance that it would begin seeking such discounts in the future. In fact, the opposite is true: Grand Traverse Band negotiated the FCPA with the understanding that it would receive rates “close to” (but not equivalent to) MLR. Absent additional allegations—such as later promises or conduct indicating a change in Blue Cross's position—the Tribe cannot now disavow what it plainly knew. Its own allegations establish that in 2009, it had actual knowledge of Blue Cross's refusal to pursue MLR. That knowledge forecloses any argument that the Tribe was unaware of Blue Cross's failure to pursue MLR before 2013.

Second, Grand Traverse Band argues that the statute of limitations should be tolled based on fraud or concealment because Blue Cross allegedly provided misleading information about payment rates and their relationship to MLR. But as we've explained, the Tribe concedes it knew from the outset that it was not receiving MLR. And the Tribe admits Medicare-Like Rates are known to be “significantly lower” than contractual rates. See R. 90, Am. Compl. ¶ 6, PageID 2540; *SCIT I*, 748 F. App'x at 20. The only allegedly concealed information was that the margin between MLR and Blue Cross's rates was greater than expected. That alleged discrepancy is relevant to the FCPA, but that agreement applies only to the Tribe's Member Plan not covered by ERISA. Thus, even if misrepresentations occurred, they relate to a contract outside the scope of ERISA and cannot revive the Tribe's federal fiduciary-duty claim.

Because Grand Traverse Band had actual knowledge in 2009 of the very conduct that forms the basis of its claim, and because it has alleged no facts that would toll the limitations period, its ERISA fiduciary-duty claim is time-barred.

## ii. Common Law

The Tribe advances the same arguments in support of its common-law fiduciary-duty claim as it does for its ERISA claim, and it does not dispute that the duties owed are identical.

Although, for statute of limitations purposes, Michigan's knowledge standard **\*510** for common-law breach of fiduciary duty differs slightly from ERISA's, it does not help the Tribe. Michigan applies a three-year statute of limitations to fiduciary-duty claims. Mich. Comp. Laws § 600.5805(2). But, if a person who is or may be liable for a claim fraudulently conceals the claim or the identity of a liable party, a two-year statute of limitations begins to run when the prospective plaintiff discovers or should have discovered the existence of the claim or the identity of the liable party. *Id.* § 600.5855. In any case, a claim accrues “when the beneficiary knew *or should have known* of the breach”—an objective standard that asks when the plaintiff reasonably should have learned of the existence of an injury and its potential cause. *The Meyer and Anna Prentis Fam. Found. v. Barbara Ann Karmanos Cancer Inst.*, 266 Mich.App. 39, 698 N.W.2d 900, 908–09 (2005) (citation omitted) (emphasis added). Notably, this standard sits in contrast to ERISA's more exacting “actual knowledge” requirement, as the Supreme Court rejected any attempt to impute knowledge based on what a plaintiff should have known. See *Sulyma*, 589 U.S. at 184–85, 140 S.Ct. 768.

Because the federal claim fails under the stricter ERISA standard, the state law claim must also fail under Michigan's more lenient requirements. The amended complaint makes clear that the Tribe was aware as early as 2009 that it was not receiving MLR for its Employee and Member plans, triggering accrual under Michigan law just as under federal law.

To avoid the statute of limitations, Grand Traverse Band makes a fraudulent-concealment argument, but that argument is unavailing. The Tribe claims that it relied on Blue Cross's false representation that the FCPA rates would be “close to” those payable under the MLR regulations, leading the Tribe to believe that Blue Cross was offering MLR-equivalent rates and preserving plan assets. But the Tribe's common-law claim as alleged is grounded in Blue Cross's failure to apply MLR, not its failure to apply rates “close to” MLR. See R. 90, Am. Compl. ¶ 10, PageID 2541–42 (“BCBSM's failure to take advantage of MLR discounts available to Plaintiffs when processing claims for payment was a breach of BCBSM's fiduciary duties.”). And, as above, the Tribe knew all along that it was not receiving MLR.

Michigan law also requires more than a misstatement to delay the running of the statute of limitations. It demands that the fraud be “manifested by an affirmative act or misrepresentation.” *Prentis*, 698 N.W.2d. at 909. That is, the Tribe “must show that [Blue Cross] engaged in some arrangement or contrivance of an affirmative character designed to prevent subsequent discovery.” *Id.* The amended complaint alleges no such scheme. It lacks sufficient facts demonstrating that Blue Cross took affirmative steps to prevent Grand Traverse Band from discovering it was not paying MLR on eligible claims. The Tribe already knew that it was not receiving MLR—that fact was never concealed.

The Tribe also argues that Blue Cross breached its fiduciary obligations by misrepresenting that the FCPA rates were “close to” MLR. Grand Traverse Band advances that theory in an effort to restart the limitations clock. But its argument is legally untenable under Michigan law for two reasons.

First, to the extent the Tribe alleges that Blue Cross failed to honor a contractual promise regarding pricing terms in the FCPA, the claim sounds in contract, not tort. See *Rinaldo's Const. Corp. v. Mich. Bell Tel. Co.*, 454 Mich. 65, 559 N.W.2d 647, 658 (1997). Under Michigan **\*511** law, a tort claim—such as for negligence or breach of fiduciary duty—based on a party's performance (or nonperformance) of a contract may proceed only if the defendant owed a legal duty “separate and distinct” from its contractual obligations. *Id.*; *Fultz v. Union-Com. Assocs.*, 470 Mich. 460, 683 N.W.2d 587, 593 (2004); *DBI Invs., LLC v. Blavin*, 617 F. App'x 374, 381 (6th Cir. 2015). Here, the Tribe claims that Blue Cross committed the tort of breach of fiduciary duty by breaking its contractual promise to obtain rates close to MLR. But that duty arises from the FCPA itself, and the Tribe does not allege a breach of any duty “separate and distinct” from Blue Cross's contractual obligations. *Rinaldo's Const. Corp.*, 559 N.W.2d at 658. Michigan law does not permit recovery in tort for the nonperformance of a contract. *DBI Invs., LLC*, 617 F. App'x at 381 (quoting *Ferrett v. Gen. Motors Corp.*, 438 Mich. 235, 475 N.W.2d 243, 247 (1991)).

Second, the FCPA did not give rise to any new fiduciary obligations that were not already in effect at the time the parties executed the agreement. Any new fiduciary obligations would arguably restart the limitations clock. But the ASC, which the parties executed in 2000, created Blue Cross's fiduciary duties—not the FCPA. The ASC required Blue Cross to manage the Plan prudently and in the Tribe's best interests. This is the duty that Blue Cross allegedly breached. So the Tribe cannot have its

cake and eat it too. It cannot transform its dispute about Blue Cross's alleged breach of the FCPA into a “new” fiduciary-duty breach merely by relabeling the same conduct—namely, rate representations—as tortious misfeasance to revive an otherwise time-barred claim.

Simply put, the amended complaint alleges no fiduciary-duty breach distinct from the conduct the Tribe had long known about and previously addressed through the FCPA itself. We therefore reject the Tribe's attempt to recharacterize a contract-based dispute as a fiduciary-duty breach to escape the statute of limitations.

\* \* \*

Grand Traverse Band's fiduciary-duty claims fail because of its own allegations about its knowledge in 2009. Because the Tribe knew that it was not receiving MLR and because it has not sufficiently pleaded allegations of fraudulent concealment or distinguished the alleged fiduciary breach from its contractual dispute, its claims are untimely.

## **B. HCFCA**

Grand Traverse Band also argues that the district court erred in granting summary judgment by misconstruing the basis of its HCFCA claim. According to the Tribe, the court improperly treated the claim as alleging only that Blue Cross violated the statute by submitting claims in excess of MLR, when, in the Tribe's view, the real theory was that Blue Cross misrepresented that its FCPA discount approximated MLR. Grand Traverse Band maintains that those alleged misrepresentations induced it to enter the FCPA agreement and that allegations to this effect were incorporated by reference into its HCFCA count, even if not repeated verbatim. We begin with the “theory of the amended complaint” argument and then turn to the merits.

### ***i. The Tribe's Theory of the Amended Complaint***

We agree with the district court that, at summary judgment, Grand Traverse Band altered the theory that formed the basis of its amended complaint. A plaintiff may not shift its theory of liability at the summary judgment stage in a way that materially alters the pleaded **\*512** factual basis of its claim and prejudices the opposing party. *See S.E.C. v. Sierra Brokerage Servs., Inc.*, 712 F.3d 321, 327–28 (6th Cir. 2013). Under modern federal pleading standards, although plaintiffs are not rigidly bound to the legal theories attached to their pleaded claims, *see Johnson v. City of Shelby*, 574 U.S. 10, 11, 135 S.Ct. 346, 190 L.Ed.2d 309 (2014), the opposing party must have “fair notice of the nature and basis or grounds for a claim,” *see Sierra Brokerage*, 712 F.3d at 327–28 (quoting *Colonial Refrigerated Trans., Inc. v. Worsham*, 705 F.2d 821, 825 (6th Cir. 1983)). A party may not pivot to a new factual basis for liability after the close of discovery if that change would prejudice the opposing party. *Id.* Neither may a plaintiff “expand her claims to assert new theories ... in response to summary judgment or on appeal.” *Alexander v. Carter for Byrd*, 733 F. App'x 256, 265 (6th Cir. 2018) (internal citation and brackets omitted).

The amended complaint alleged a narrow theory: that Blue Cross violated the HCFCA by failing to apply MLR rates when required. It did not assert, within the HCFCA count, that Blue Cross made false representations about the nature of its rates. Although the amended complaint did “incorporate by reference” all prior allegations, the HCFCA count pleaded a specific factual basis for the claim. R. 90, Am. Compl. ¶ 74, PageID 2556 (“The amount charged by [Blue Cross] for paying the claims was false because Plaintiffs were not required to pay more than Medicare-Like Rates on a number of claims administered by [Blue Cross].”). Because Blue Cross would not have had sufficient notice that the Tribe intended to proceed on its HCFCA claim under a misrepresentation-based theory, the district court properly declined to consider that theory, limiting the Tribe to the claims it actually pleaded. *Sierra Brokerage*, 712 F.3d at 327 (citation omitted).

The difference between the two theories is not semantic. As the district court explained, the amended complaint states that Blue Cross violated the HCFCA because it submitted claims for payment that exceeded MLR. The revised theory advanced at summary judgment, by contrast, turned on Blue Cross's alleged misstatements about whether its FCPA discount came close

to MLR savings. That shift raised new factual questions about what Blue Cross said, what Grand Traverse Band believed, and what role those statements played in further contract negotiations.

The Tribe responds that its revised theory merely clarified or refined the original claim using facts developed during discovery and that incorporation by reference gave Blue Cross adequate notice. But Blue Cross was reasonable to read the HCFCFA claim as being based on Blue Cross's alleged failure to apply MLR, rather than its alleged misrepresentations about the proximity of the FCPA rates to MLR. The Tribe reserved the misrepresentation allegations for its fraud-based theories and omitted them from the HCFCFA count. That choice had consequences.

Blue Cross was prejudiced by the Tribe's shift in several respects. First, it had no reason to make arguments regarding the misrepresentation theory's relationship to the HCFCFA claim when that theory was absent from the HCFCFA count. In fact, the Tribe presented this theory only in its cross motion for summary judgment, well after the close of discovery and after Blue Cross had already filed its own cross motion for summary judgment. Second and relatedly, Blue Cross framed its own summary judgment motion to address the claim as pleaded—whether it submitted false claims by not applying MLR, not whether its claims were false because it \*513 made misleading statements during contract negotiations. Third, the misrepresentation theory is not purely a legal issue, but instead raises new fact-intensive questions. Grand Traverse Band's shift at summary judgment altered the factual focus of the case and deprived Blue Cross of the opportunity to respond to that theory. The district court did not err in limiting the Tribe to the theory pleaded in its amended complaint.

## *ii. Merits*

We turn now to the merits of the pleaded HCFCFA claim. Michigan's HCFCFA imposes liability upon “[a] person who knowingly presents or causes to be presented a claim which contains a false statement” to a health care corporation or health care insurer.<sup>2</sup> Mich. Comp. Laws § 752.1009. In its amended complaint, Grand Traverse Band alleges that “[t]he amount charged by [Blue Cross] for paying the claims was false because Plaintiffs were not required to pay more than [MLR] on a number of claims administered by [Blue Cross].” R. 90, Am. Compl. ¶ 74, PageID 2556. The district court concluded that this claim rests primarily on the Tribe's assertion that the false statement under § 752.1009 concerns Blue Cross's alleged overcharging on MLR-eligible claims—specifically, that Blue Cross violated the MLR regulations by submitting claims for payment that exceeded the amount the Tribe was entitled to pay under the regulations.

However, because Grand Traverse Band could not establish that the MLR regulations directly imposed any obligation on Blue Cross, the court concluded that the Tribe could not prove Blue Cross violated the HCFCFA by failing to comply with the MLR regulations.

On appeal, Grand Traverse Band does not dispute that, to succeed on its HCFCFA claim, it must show Blue Cross violated the MLR regulations.<sup>3</sup> Rather, it maintains that properly framing the HCFCFA claim as one based on Blue Cross's promises and misrepresentations—not its failure to comply with MLR—renders the applicability of MLR regulations irrelevant. We have already determined that the Tribe may not pursue this unpleaded theory. Alternatively, the Tribe argues that Blue Cross “violated the HCFCFA by impliedly certifying compliance with MLR regulations” and that the district court erred in finding the regulations inapplicable to Blue Cross's misconduct. Appellant Br. at 47, 51. Blue Cross, meanwhile, asserts the HCFCFA claim fails because Blue Cross was not directly governed by the MLR regulations and therefore could not have presented a “false” claim to the Tribe as provided for in the statute. Having rejected Grand Traverse Band's first argument about the true nature of its HCFCFA claim, we proceed on the assumption that it must establish a regulatory violation.

We agree with the district court that the HCFCFA claim fails as a matter of law. The statute defines a “claim” as “any attempt to cause a health care corporation or health care insurer to make the payment of a health care benefit.” \*514 Mich. Comp. Laws § 752.1002(a). Moreover, a statement is “false” if it is “wholly or partially untrue or deceptive.” *Id.* § 752.1002(c). And “deceptive” means “making a claim to a health care corporation or health care insurer which contains a statement of fact or

which fails to reveal a material fact, which statement or failure leads the health care corporation or health care insurer to believe the represented or suggested state of affair to be other than it actually is.” *Id.* § 752.1002(b). The Tribe’s claim relies on a finding that Blue Cross violated MLR, which would make false the charges to the Tribe in excess of MLR. The central issue, then, is a legal one: whether the MLR regulations apply to third-party administrators (TPAs) like Blue Cross, rather than just Medicare-accepting hospitals.

As always, our interpretation begins with the regulatory text. *Green v. Brennan*, 578 U.S. 547, 553, 136 S.Ct. 1769, 195 L.Ed.2d 44 (2016); *SCIT II*, 32 F.4th at 557. That is the case whether a statute, see *Thompson v. Greenwood*, 507 F.3d 416, 419 (6th Cir. 2007), or a regulation, *Kisor v. Wilkie*, 588 U.S. 558, 574–75, 139 S.Ct. 2400, 204 L.Ed.2d 841 (2019), is at issue. And when the text’s meaning is clear, we must give it effect. See *Conn. Nat’l. Bank v. Germain*, 503 U.S. 249, 254, 112 S.Ct. 1146, 117 L.Ed.2d 391 (1992).

The relevant regulations state that “[a]ll Medicare-participating hospitals ... must accept no more than the rates of payment under the methodology described in this section as payment in full for all terms and services authorized by [Indian Health Service], Tribal, and urban Indian organization entities.” 42 C.F.R. § 136.30(a). They include one exception: if the I/T/U<sup>4</sup> has negotiated a rate with the hospital or its agent, then *the I/T/U will pay* the lower of the MLR rate or the negotiated network rate. *Id.* § 136.30(f) (emphasis added).

The district court correctly concluded that the plain language of § 136.30 unambiguously limits the regulations’ scope to Medicare-participating hospitals, which are the only entities required to accept MLR as payment for qualifying care. The introductory subsection, § 136.30(a), explicitly references only these hospitals, omitting any mention of TPAs.

What’s more, subsections (c) through (e) do not help the Tribe. Although these provisions generally detail how payment shall be made, the passive statements about what Tribes will *pay*, without more, cannot create an affirmative regulatory duty on behalf of payors and administrators to *obtain* MLR, particularly in the face of clear language limiting the scope of the duties imposed by the regulations to Medicare-participating hospitals.

The sole exception to the MLR payment structure also reinforces our conclusion. Under § 136.30(f), if an I/T/U negotiates a separate rate with a hospital or its agent, the I/T/U pays the lesser of the MLR rate or the negotiated rate. This exception speaks exclusively to the relationship between I/T/Us and hospitals (or their agents), not TPAs. The regulations consistently target the behavior and obligations of hospitals, not intermediaries or agents acting on behalf of I/T/Us, like Blue Cross.

Our other interpretive methods point to the same result. For instance, the canon *expressio unius est exclusio alterius*—the express mention of one thing excludes others—supports \*515 the view that the regulations’ reference to “Medicare-participating hospitals” and omission of TPAs indicate that only hospitals are subject to the requirements of § 136.30. See *NFP Franchising, LLC v. SY Dawgs, LLC*, 37 F.4th 369, 383 (6th Cir. 2022).

Likewise, the surrounding regulatory context lends further support. For instance, § 136.32 creates a recovery mechanism for tribal organizations to recoup overpayments or obtain compliance when hospitals fail to honor MLR. But there is no equivalent mechanism for recovering when TPAs or claims administrators fail to honor MLR. If TPAs bore obligations under § 136.30, it would be logical for the regulations to provide an enforcement or recovery process related to their conduct. The absence of such a mechanism underscores their exclusion from the regulatory scheme.

Accordingly, we reject Grand Traverse Band’s argument that the regulations should be broadly interpreted to govern the payment of claims for CHS care using tribal plan assets, thereby including Blue Cross as the Tribe’s fiduciary.

\* \* \*

The district court was correct to hold that Grand Traverse Band cannot expand or shift the basis of its HCFCFA claim at summary judgment without prejudicing Blue Cross, and it properly evaluated the claim under the MLR-based theory pleaded in the complaint. The district court did not err in granting summary judgment to Blue Cross on the HCFCFA claim.

### C. Motion for Leave to Amend

Lastly, Grand Traverse Band contends that the district court erred in denying it leave to amend its complaint a second time. We disagree. The procedural history supports this decision.

Recall that the district court granted Blue Cross's motion for judgment on the pleadings, dismissing the ERISA claims (Count I and II in the original complaint) with prejudice. The court then permitted the Tribe to amend the complaint, and the Tribe repleaded its breach-of-fiduciary-duty claim under ERISA, as well as other state law claims not relevant here. But Blue Cross once again prevailed when the district court partially granted its motion to dismiss the First Amended Complaint. Grand Traverse Band then sought leave to amend a second time, arguing that its new allegations were aimed at “present[ing] the additional facts relevant to the *statute of limitations analysis* that the Court did not consider in deciding [Blue Cross's] *motion to dismiss*.” R. 102, Pls.’ Mot. for Leave to Amend, PageID 2971 (emphasis added). The district court denied the motion as futile.

Although leave to amend should be “freely give[n] ... when justice so requires,” Fed. R. Civ. P. 15(a)(2), courts may deny a request if the amendment would be futile. Williams, 771 F.3d at 949. An amendment is futile if, even with the proposed changes, the complaint still fails to state a claim under Rule 12(b)(6). Greer v. Strange Honey Farm, LLC, 114 F.4th 605, 617 (6th Cir. 2024).

On appeal, Grand Traverse Band folds its leave-to-amend challenge into its argument for summary judgment on its HCFCFA claim, effectively shifting its basis for amendment. Contrary to the Tribe's assertions, the proposed Second Amended Complaint was not aimed at “clarify[ing] the factual predicate” of the HCFCFA claim. Appellant Br. at 36. The district court denied the motion for leave to amend for reasons entirely unrelated to the HCFCFA claim. So the district court cannot be faulted for failing to grant relief it was never asked to consider. Accordingly, we \*516 consider only the question before the district court when it ruled on the Tribe's motion for leave to amend—whether the proposed amendments salvage the ERISA claim. See Williams, 771 F.3d at 949.

They do not. An examination of the differences between the First Amended Complaint and the proposed Second Amended Complaint convinces us that the district court was correct to deny leave to amend a second time. For instance, Grand Traverse Band proposed adding an allegation that Blue Cross “has known since before March 1, 2009 that for most health care services, Medicare-Like Rates are significantly lower than the contractual discounts Blue Cross obtains with hospitals.” R. 102-2, Second Am. Compl. ¶ 7, PageID 2989. But it makes no difference whether *Blue Cross* knew that fact; it matters whether and when *Grand Traverse Band* knew that fact. The Tribe's awareness in 2009 that it was not receiving MLR pricing remains fatal to its claim.

Grand Traverse Band also sought to add an allegation that “[Blue Cross] made multiple representations to Plaintiffs that” the company “was working on developing a system to price claims at MLR.” R. 102-2, Second Am. Compl. ¶ 10(a)(iv), PageID 2991. But even accepting that as true, the statement does not negate the Tribe's knowledge that it was being overcharged. At best, it was a forward-looking assurance—a statement that, as the district court observed, was incomplete and non-committal. At worst, the statement reaffirmed that MLR pricing was not yet being applied. Absent allegations that Blue Cross had implemented MLR pricing or otherwise concealed key facts, the Tribe's amendments do not cure the deficiencies apparent in its ERISA claim. They are futile, and the district court did not err in denying leave to amend.

## IV.

For the foregoing reasons, the district court's judgment is **AFFIRMED**.

**All Citations**

146 F.4th 496

---

**Footnotes**

- 1 In 2022, the parties settled the Tribe's remaining breach-of-contract claim arising from the FCPA.
- 2 We proceed under the assumption—without making a formal determination—that Grand Traverse Band qualifies as a “health care corporation” or “insurer” and thus has statutory standing under the HCFCFA. We need not decide that question because the Tribe's claim, as presently framed, does not succeed on the merits.
- 3 This was a position it also took in the district court. *See*, R. 196, Summ. J. Op., PageID 5884 (“Plaintiffs do not appear to disagree with Defendant [Blue Cross's] contention that they need to first establish that Defendant [Blue Cross] violated the MLR regulations for Plaintiffs’ HCFCFA claim to survive summary judgment.”).
- 4 An I/T/U is defined as a “contract health service program of the Indian Health Service,” a “Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act,” or “an urban Indian organization.” *SCIT II*, 32 F.4th at 554 (quoting 42 C.F.R. § 136.30(b)). The parties agree that Grand Traverse Band is an I/T/U and Blue Cross is not.

---

End of Document

© 2025 Thomson Reuters. No claim to original U.S. Government Works.

# EXHIBIT 5

267 Mich.App. 330  
Court of Appeals of Michigan.

Leo HALL and Susan Hall, Plaintiffs–Appellants,

v.

Douglas S. SMALL and Loretta G. Muzzy, Defendants,

and

Richard Sidick, Carol Shelton, d/b/a Real Estate One, Norma Jean Spreeman, Robert A. Burley, and Burley & Debrow Ltd, d/b/a Century 21 Country Squire, Defendants–Appellees.

Docket No. 252814.

|

Submitted May 3, 2005, at Detroit.

|

Decided May 12, 2005.

|

Approved for Publication July 12, 2005, at 9:00 a.m.

|

Released for Publication Oct. 13, 2005.

**Synopsis**

**Background:** Home purchasers brought action against vendors and against vendors' real estate agents and their own real estate agents for failure to disclose mold infestation problem with home. The Oakland Circuit Court, Deborah G. Tyner, J., granted summary disposition against purchasers. Purchasers appealed.

**Holdings:** The Court of Appeals held that:

release signed by purchasers holding real estate agents harmless for problems with residence did not lack mutuality of agreement;

release did not lack consideration; and

trial court was not required to consider the circumstances surrounding the signing of the release in order to find release valid.

Affirmed.

**Procedural Posture(s):** On Appeal; Motion for Summary Judgment.

**Attorneys and Law Firms**

**\*\*742** Hoffert & Associates, P.C. (by David B. Marmon), Southfield, for Leo and Susan Hall.

Wood, Kull, Herschfus, Obee & Kull, P.C. (by John A. Obee and William R. Graham Jr.), Farmington Hills, for Richard Sidick and Carol Shelton.

Garan Lucow Miller, P.C. (by Robert D. Goldstein and Steven A. Matta), Grand Blanc, for Norma Jean Spreeman, Robert A. Burley, and Burley & Debrow, Ltd.

McClelland & Anderson, L.L.P. (by Gregory L. McClelland and Melissa A. Hagen), for Michigan Association of Realtors, amicus curiae.

Before: O'CONNELL, P.J., and MARKEY and TALBOT, JJ.

### Opinion

PER CURIAM.

**\*331** Plaintiffs appeal by right two orders of the trial court granting summary disposition under MCR 2.116(C)(7) in favor of the real estate agents involved in the sale of real property to plaintiffs. We affirm.

At the heart of this dispute is an improved parcel of real property located in Dryden, Michigan. After purchasing the property from defendants Douglas Small and Loretta Muzzy, plaintiffs discovered that the house thereon was infested with mold. Plaintiffs alleged that Small and Muzzy knew of the mold problem and concealed **\*332** it from them. Plaintiffs further alleged that the sellers' real estate salesperson, Norma Spreeman; her broker, Robert Burley; and Burley & DeBrow Ltd., doing business as Century 21 Country Squire, were negligent in failing to discover and to disclose to plaintiffs the condition of the home. Plaintiffs also alleged that Richard Sidick, who acted as their salesperson in the transaction, along with his broker, Carol Shelton, doing business as Real Estate One, were negligent for failing to discover and disclose the condition of the home.<sup>1</sup> The trial court **\*\*743** granted summary disposition in favor of defendants on the basis of a release plaintiffs signed at the closing.

That release, entitled “Statement of Mutual Satisfaction,” stated that plaintiffs and the sellers agreed to

hold harmless Century 21 Country Squire Properties, Inc. and Real Estate One and their representatives for any condition that may occur regarding the following: sewer, septic system & field, city water, well, water delivery systems, plumbing systems, heating systems, electrical service and wiring systems, structure and structures, roof systems, basement/slab or crawl systems, foundation, and/or any other improvements to the property.

Plaintiffs argue on appeal that the trial court erred in granting summary disposition based on the release because the release was not supported by consideration, mutuality of agreement, or mutuality of obligation, and because the trial court failed to consider the circumstances in which plaintiffs signed the release. We disagree.

**\*333** A trial court's order granting summary disposition pursuant to MCR 2.116(C)(7) is reviewed de novo “to determine whether the moving party was entitled to judgment as a matter of law.” Stoudemire v. Stoudemire, 248 Mich.App. 325, 332, 639 N.W.2d 274 (2001). Issues of contract interpretation are also reviewed de novo. Archambo v. Lawyers Title Ins. Corp., 466 Mich. 402, 408, 646 N.W.2d 170 (2002).

Plaintiffs first assert that the release lacks mutuality of agreement because it was not signed by Century 21 or REO. However, plaintiffs have cited no authority stating that a contract must be signed by the party asserting the validity of the contract in order to be valid. Instead, “a valid contract requires a ‘meeting of the minds’ on all the essential terms [of the contract].” Kamalnath v. Mercy Mem. Hosp. Corp., 194 Mich.App. 543, 548, 487 N.W.2d 499 (1992). “‘Meeting of the minds’ is a figure of speech for mutual assent.” *Id.* at 548–549, 487 N.W.2d 499 (citations omitted).

In this case, plaintiffs have not alleged that they misunderstood the contract or that it contains any ambiguity that indicates that there was no meeting of the minds. Both plaintiffs testified that they signed the release after hearing a brief explanation of its contents. Although the parties may not have read the document thoroughly, absent a showing of fraud or mistake, this claim is

705 N.W.2d 741

insufficient to invalidate the release. *Paterek v. 6600 Ltd.*, 186 Mich.App. 445, 450, 465 N.W.2d 342 (1990). Moreover, both plaintiffs testified that, when they signed the release, they intended to be bound by its terms. The release also shows on its face that only plaintiffs and the sellers were intended to sign the release. See 66 Am. Jur. 2d, Release § 10, 378–379 (stating that a release need not be signed by the party being released if it “shows on its face that it was not \*334 intended to be signed by the party obtaining the release”). Accordingly, we conclude that there was mutuality of agreement.

Plaintiffs also assert that the Statement of Mutual Satisfaction was not supported by consideration. We conclude that this argument also lacks merit. “Where there is no specific recitation of separate consideration for the release, but it is part of a larger contract involving multiple promises, the basic rule of contract \*\*744 law is that whatever consideration is paid for all of the promises is consideration for each one...” *Rowady v. K Mart Corp.*, 170 Mich.App. 54, 59, 428 N.W.2d 22 (1988). In this case, the Statement of Mutual Satisfaction was signed during the closing on a purchase agreement executed between plaintiffs and the sellers. Therefore, the Statement of Mutual Satisfaction was signed as part of a larger contract involving multiple promises. It is clear that there was consideration supporting the larger contract for the purchase of the home. Thus, consideration also supports plaintiffs' promise to hold Century 21 and REO harmless.

Plaintiffs further assert that the Statement of Mutual Satisfaction lacks mutuality of obligation because the agreement does not require anything of Century 21 or REO. “By ‘mutuality of obligation’ is apparently meant that there must be consideration, without which there is no obligation on either party because there is no binding contract.’ ” *Reed v. Citizens Ins. Co. of America*, 198 Mich.App. 443, 449, 499 N.W.2d 22 (1993) (citations omitted); see also 1 Restatement Contracts, 2d § 79 (“If the requirement of consideration is met, there is no additional requirement of ... ‘mutuality of obligation.’ ”). Thus, “[t]he enforceability of a contract depends ... on consideration and not mutuality of obligation.” *Toussaint v. Blue Cross & Blue Shield of Michigan*, 408 Mich. 579, 600, 292 N.W.2d 880 (1980) (citations omitted). Because there was consideration supporting the Statement of Mutual Satisfaction, there was also mutuality of obligation supporting the agreement.

Finally, plaintiffs have failed to put forth any evidence that the Statement of Mutual Satisfaction was not entered into fairly and knowingly. *Denton v. Utley*, 350 Mich. 332, 342, 86 N.W.2d 537 (1957); *Brooks v. Holmes*, 163 Mich.App. 143, 145, 413 N.W.2d 688 (1987). Because plaintiffs never alleged fraud or mistake, and the scope of the release is not in issue, the trial court did not err by failing to consider the circumstances surrounding the signing of the release. See *Denton, supra*, at 345, 86 N.W.2d 537. Accordingly, the Statement of Mutual Satisfaction validly released Century 21 and REO from liability in this case.

Plaintiffs next assert that the Statement of Mutual Satisfaction is invalid as applied to REO because of the integration clause contained in the Exclusive Designated Buyer's Agency Agreement (EDBAA) that they signed with Sidick. Plaintiffs contend that the Statement of Mutual Satisfaction constitutes an attempted modification of the EDBAA, which was not signed by all the parties to the EDBAA. This argument was not raised before the trial court. “Issues raised for the first time on appeal are not ordinarily subject to review.” *Booth Newspapers, Inc. v. Univ. of Michigan Bd. of Regents*, 444 Mich. 211, 234, 507 N.W.2d 422 (1993). Moreover, plaintiffs' brief discussion of this issue in a reply brief, unsupported by any citation of authority, is not sufficient to present the issue on appeal. *Check Reporting Services, Inc. v. Michigan Nat'l Bank*, 191 Mich.App. 614, 628, 478 N.W.2d 893 (1991). We note, however, that even if plaintiffs were correct that the \*336 Statement of Mutual Satisfaction is an invalid modification of the EDBAA, this fact would not invalidate the EDBAA itself, which also validly releases REO from liability. Therefore, even if this Court were to agree with plaintiffs' assertion that the Statement of Mutual Satisfaction is invalid with respect to REO, that conclusion would not alter the fact that the trial court properly granted summary disposition in favor of REO on the basis of a valid release. Accordingly, the trial court properly granted \*\*745 summary disposition in favor of defendants.

Affirmed.

#### All Citations

267 Mich.App. 330, 705 N.W.2d 741

---

**Footnotes**

- 1 For ease of reference, defendants Richard Sidick and Carol Shelton, doing business as Real Estate One, will be referred to throughout this opinion as REO. Defendants Norma Spreeman, Robert Burley, and Burley & DeBrow, Ltd., doing business as Century 21 Country Squire, will be referred to as Century 21. Collectively, REO and Century 21 will be referred to as defendants. The term “defendants” does not refer to Small and Muzzy, who were voluntarily dismissed from the case following a settlement with plaintiffs.

---

End of Document

© 2025 Thomson Reuters. No claim to original U.S. Government Works.

# EXHIBIT 6

32 F.4th 625

United States Court of Appeals, Sixth Circuit.

Raymond HAWKINS and Robin Lung, individually and on behalf of all others similarly situated, Plaintiffs-Appellees,

v.

CINTAS CORPORATION; Investment Policy Committee; Scott D. Farmer, Board of Directors of Cintas Corporation, Defendants-Appellants.

No. 21-3156

|

Argued: December 9, 2021

|

Decided and Filed: April 27, 2022

### Synopsis

**Background:** Former employees brought putative class action against their former employer, its investment policy committee, and its Board of Directors, alleging breaches of fiduciary duties owed to employer's Employee Retirement Income Security Act (ERISA) plan. The United States District Court for the Southern District of Ohio, No. 1:19-cv-01062, Timothy S. Black, J., 2021 WL 274341, denied motion to compel arbitration. Defendants appealed.

**Holdings:** The Court of Appeals, Boggs, Senior Circuit Judge, held that:

in a matter of first impression, employees would not be compelled to arbitrate claims under Federal Arbitration Act (FAA), and even assuming plan's consent was required to arbitrate claims, it did not sufficiently manifest consent to arbitrate claims and, thus, employees would not be compelled to arbitrate claims.

Affirmed.

**Procedural Posture(s):** On Appeal; Motion to Compel Arbitration.

\*627 Appeal from the United States District Court for the Southern District of Ohio at Cincinnati. No. 1:19-cv-01062—Timothy S. Black, District Judge.

### Attorneys and Law Firms

ARGUED: Robert N. Hochman, SIDLEY AUSTIN LLP, Chicago, Illinois, for Appellants. Mark K. Gyandoh, CAPOZZI ADLER, P.C., Harrisburg, Pennsylvania, for Appellees. ON BRIEF: Robert N. Hochman, Mark B. Blocker, Chris K. Meyer, Caroline A. Wong, M. Caroline Wood, SIDLEY AUSTIN LLP, Chicago, Illinois, for Appellants. Mark K. Gyandoh, Donald R. Reavey, Gabrielle Kelerchian, CAPOZZI ADLER, P.C., Harrisburg, Pennsylvania, for Appellees.

Before: BOGGS, GIBBONS, and NALBANDIAN, Circuit Judges.

### OPINION

BOGGS, Circuit Judge.

In deciding whether a case belongs in arbitration, a court typically asks whether the party bringing the claim has agreed to arbitrate. But sometimes it is difficult to discern exactly *who* is bringing *what claim*. Here, individual would-be plaintiffs agreed to arbitrate certain claims, but the claim they seek to adjudicate is brought through an unusual procedure on behalf of an abstract entity.

Plaintiffs-Appellees Raymond Hawkins and Robin Lung alleged that their former employer, Appellant Cintas Corporation, breached the fiduciary duties it owed to the company's retirement plan. They brought a putative class action pursuant to § 502(a)(2) of the Employment Retirement Income Security Act of 1974 (“ERISA”). But the Plaintiffs had each signed employment agreements that contained arbitration provisions. Cintas moved to compel arbitration, arguing that the Plaintiffs were bringing individual claims covered by those provisions.

This case presents issues of first impression for this court. The weight of authority and the nature of § 502(a)(2) claims suggest that these claims belong to the plan, not to individual plaintiffs. Therefore, the arbitration provisions in these individual employment agreements—which only establish the Plaintiffs’ consent to arbitration, not the plan's—do not mandate that these claims be arbitrated. Further, the actions of Cintas and the other defendants do not support a conclusion that the plan has consented to arbitration. We therefore affirm the district court's denial of the motion to compel arbitration.

## I. BACKGROUND

Appellant Cintas is a national uniform and business-supply company. As with many companies, Cintas has established a retirement plan—the Cintas Partners’ Plan (the “Plan”)—for its employees. The Plan is a “defined contribution” plan, meaning that the Plan's sponsor selects a “menu” of investment options in which each participant can invest. Cintas is the Plan's sponsor. Each participant in the Plan maintains an individual account, the value of which is based on the amount contributed, market performance, and associated fees.<sup>1</sup>

\*628 Under § 402(a)(1) of ERISA, all plans must have one or more fiduciaries responsible for managing and administering the plan.<sup>2</sup> 29 U.S.C. § 1102(a)(1). ERISA imposes several duties on these fiduciaries. Two are at issue in this appeal: (1) the duty of loyalty—managing the plan for the best interests of its participants and beneficiaries—and (2) the duty of prudence—managing the plan with the care and skill of a prudent person acting under like circumstances.

Plaintiffs Raymond Hawkins and Robin Lung, who were Cintas employees participating in the Plan, contend that Cintas breached both duties. First, they argue that Cintas offered participants the ability to invest only in actively managed funds, rather than more cost-effective passively managed funds. Second, they claim that Cintas charged the Plan imprudently expensive recordkeeping fees.

Hawkins and Lung sued Cintas, as well the Cintas Investment Policy Committee (which is tasked with administering the Plan) and the Cintas Board of Directors (which appoints members to the committee).<sup>3</sup> The suit was brought as a putative class action; Plaintiffs seek to represent all participants in or beneficiaries of the Plan during the class period.

But Plaintiffs entered into multiple employment agreements with Cintas during the course of their employment. While the various agreements differ slightly, all contained materially similar arbitration provisions and a provision preventing class actions.<sup>4</sup> A representative example of Section 8—the relevant section—includes the following language (with added emphasis):

**The rights and claims of Employee covered by this Section 8, including the arbitration provisions below, specifically include but are not limited to all of Employee's rights or claims arising out of or in any way related to Employee's employment with Employer, such as rights or claims arising under the Age Discrimination in Employment Act, as amended, Title VII of the Civil Rights Act of 1964, as amended (including amendments contained in the Civil Rights Act**

of 1991), the Americans With Disabilities Act, 42 U.S.C. § 1981, the Fair Labor Standards Act, **the Employee Retirement Income Security Act**, state anti-discrimination statutes, other state or local laws regarding employment, common law theories such as breach of express or implied contract, wrongful discharge defamation, and negligent or intentional infliction of emotional distress.

...

**Either party desiring to pursue a claim against the other party will submit \*629 to the other party a written request to have such claim, dispute or difference resolved through impartial and confidential arbitration.**

...

Except for workers' compensation claims, unemployment benefits claims, claims for a declaratory judgment or injunctive relief concerning any provision of Section 4 and claims not lawfully subject to arbitration, **the impartial arbitration proceeding, as provided above in this Section 8, will be the exclusive, final and binding method of resolving any and all disputes between Employer and Employee.**

...

Except as otherwise required under applicable law, Employee and Employer expressly intend and agree that class action and representative action procedures shall not be asserted, nor will they apply, in any arbitration pursuant to this Section 8; Employee and Employer agree that each will not assert class action or representative action claims against the other in arbitration or otherwise; and Employee and Employer shall only submit their own, individual claims in arbitration and will not seek to represent the interests of any other person.

Arguing that those agreements required Hawkins and Lung to arbitrate these claims, Cintas moved to compel arbitration and stay the federal proceedings. The district court denied both motions. It concluded that the action was brought on behalf of the Plan, and it was therefore irrelevant that Hawkins and Lung had consented to arbitration through their employment agreements. Because the Plan itself did not consent, the court reasoned, the matter was not subject to arbitration. Cintas now timely appeals.

## II. ANALYSIS

### A

We review a denial of a motion to compel arbitration de novo. *Huffman v. Hilltop Cos., LLC*, 747 F.3d 391, 394 (6th Cir. 2014). The Federal Arbitration Act, 9 U.S.C. §§ 1 et seq., requires district courts to compel arbitration “on issues as to which an arbitration agreement has been signed.” *Atkins v. CGI Techs. & Sols., Inc.*, 724 F. App'x 383, 389 (6th Cir. 2018) (quoting *KPMG LLP v. Cocchi*, 565 U.S. 18, 22, 132 S.Ct. 23, 181 L.Ed.2d 323 (2011) (per curiam)). This requirement reflects “an emphatic federal policy in favor of arbitral dispute resolution.” *Ibid.* (quoting *KPMG*, 565 U.S. at 21, 132 S.Ct. 23). Generally, “[a] written provision in any ... contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction ... shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.” 9 U.S.C. § 2. The burden of proving that the claims are unsuited to arbitration rests with the party seeking to prevent arbitration. *Green Tree Fin. Corp.-Ala. v. Randolph*, 531 U.S. 79, 91, 121 S.Ct. 513, 148 L.Ed.2d 373 (2000). Still, that policy must be balanced with “ERISA's policy ... to provide ‘ready access to the Federal courts.’” *Smith v. Aegon Cos. Pension Plan*, 769 F.3d 922, 931 (6th Cir. 2014) (quoting 29 U.S.C. § 1001(b)).

This court has not yet determined whether statutory ERISA claims are subject to arbitration. But “every other circuit to consider the issue” has held that “ERISA claims are generally arbitrable.” See *Smith v. Bd. of Dirs. of Triad Mfg., Inc.*, 13 F.4th 613, 620

(7th Cir. 2021) (collecting cases from the Second, Third, Fifth, Eighth, Ninth, and Tenth Circuits). We need not reach that issue, however, \*630 because neither party argues that Plaintiffs’ ERISA claims could not, in theory, be subject to arbitration.

“ERISA imposes high standards of fiduciary duty upon administrators of an ERISA plan.” *Krohn v. Huron Mem’l Hosp.*, 173 F.3d 542, 547 (6th Cir. 1999). Section 502(a) of the statute authorizes civil enforcement actions. 29 U.S.C. § 1132(a). Relevant here, a civil action for breach of those fiduciary duties may be brought “by the Secretary [of Labor], or by a participant, beneficiary or fiduciary.” *Id.* § 1132(a)(2); see also *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 251, 128 S.Ct. 1020, 169 L.Ed.2d 847 (2008) (“Section 502(a)(2) provides for suits to enforce the liability-creating provisions of § 409, concerning breaches of fiduciary duties that harm plans.”).

## B

Cintas contends that the Plaintiffs agreed to arbitrate all “rights and claims” relating to their employment, including the ERISA claims at issue here. The breach-of-fiduciary-duty claims and the “right” to assert them “belong,” it argues, to the Plaintiffs alone, and therefore this case belongs in arbitration. Plaintiffs respond, and the district court agreed, that although Plaintiffs are bringing a putative class action, the claims belong to the Plan itself. It is irrelevant, according to Plaintiffs, that they may have agreed to arbitrate certain claims, since the Plan has not likewise consented to arbitration. We agree that the Plaintiffs’ employment agreements do not force this case into arbitration.

## 1

Section 502(a)(2) suits are “brought in a representative capacity on behalf of the plan as a whole.” *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 n.9, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985). *Russell* featured a participant in a defined-benefit plan seeking damages for the plan administrator’s delay in processing a disputed claim. See *id.* at 136-37, 144, 105 S.Ct. 3085. The Supreme Court held that such a delay did not give rise to a private right of action and that the statute only contemplated relief for “the plan itself.” *Id.* at 144, 105 S.Ct. 3085. More recently, in *LaRue*, the Court re-evaluated *Russell* in the context of a defined-contribution (as opposed to a defined-benefit) plan. 552 U.S. at 248, 128 S.Ct. 1020.

There, the plaintiff alleged that he directed his employer to make certain changes to investments in his individual retirement account. *Id.* at 251, 128 S.Ct. 1020. The employer failed to follow through, allegedly causing the plaintiff’s account to be depleted. *Ibid.* Arguing that this failure constituted a breach of fiduciary duty, the employee sued under § 502(a)(3). *Ibid.* On appeal, he contended that he was also entitled to relief under § 502(a)(2). *Ibid.*

The Court first observed that ERISA imposed statutory duties on plan fiduciaries to “ensur[e] that ‘the benefits authorized by the plan’ are ultimately paid to participants and beneficiaries.” *Id.* at 253, 128 S.Ct. 1020 (quoting *Russell*, 473 U.S. at 142, 105 S.Ct. 3085). The plaintiff in *Russell*, the Court explained, “received all of the benefits to which she was contractually entitled.” *Id.* at 254, 128 S.Ct. 1020. She therefore was not entitled to recovery pursuant to § 502(a)(2) because the relevant fiduciary relationship was between the fiduciary and the plan, not the fiduciary and the plaintiff. *Ibid.* (citing *Russell*, 473 U.S. at 140, 105 S.Ct. 3085). *Russell* “repeatedly identifies the ‘plan’ as the victim of any fiduciary breach and the recipient of any relief” in the defined-benefit \*631 plan context because misconduct by plan administrators only affects an individual’s entitlement to a defined benefit if it risks depleting the entire plan. *Id.* at 254-55, 128 S.Ct. 1020.

But with the advent of defined-contribution plans, fiduciary misconduct could “diminish[ ] plan assets payable to all participants and beneficiaries, or only to persons tied to particular individual accounts.” *Id.* at 255-56, 128 S.Ct. 1020. Therefore, *Russell*’s “emphasis on protecting the ‘entire plan’ from fiduciary misconduct” no longer applies in the defined-contribution context. *Id.* at 254, 128 S.Ct. 1020. Now, the “victim” could be an individual account, even if the plan as a whole remains secure. *Id.* at 255-56, 128 S.Ct. 1020. The Court “therefore [held] that although § 502(a)(2) does not provide a remedy for individual injuries

distinct from plan injuries, that provision does authorize recovery for fiduciary breaches that impair the value of plan assets in a participant's individual account.” *Id.* at 256, 128 S.Ct. 1020.

*LaRue* therefore means that while any claims properly brought under § 502(a)(2) must be for injuries to the plan itself, § 502(a)(2) authorizes suits on behalf of a defined-contribution plan even if the harm is inherently individualized. *LaRue* does not, however, specifically hold that a § 502(a)(2) claim “belongs” to either the plaintiff or the plan itself. Consequently, we must look elsewhere to determine whether an arbitration provision that is binding only on a plan participant draws a § 502(a)(2) suit into arbitration.

2

To demonstrate that these claims belong to the Plan, Plaintiffs look to out-of-circuit cases analyzing *LaRue*. Primarily, they rely on *Munro v. University of Southern California*, 896 F.3d 1088 (9th Cir. 2018).<sup>5</sup> That case presented facts nearly identical to this case. Employees signed arbitration agreements as part of their employment contracts requiring both the employer and employee to “arbitrate all claims that either the Employee or [the Employer] has against the other party.” *Id.* at 1090. A group of employees filed a putative class action alleging breaches of fiduciary duty by administrators of two ERISA-governed retirement plans.<sup>6</sup> *Ibid.* The question before the court, as here, was whether the employer could compel the plaintiffs to arbitrate the breach-of-fiduciary-duty claims.

The Ninth Circuit looked to a different case which asked a similar question: “[W]hether a standard employment arbitration agreement covered *qui tam* claims brought by the employee on behalf of the United States under the False Claims Act (‘FCA’).” *Id.* at 1092 (citing *United States ex rel. Welch v. My Left Foot Children's Therapy, LLC*, 871 F.3d 791 (9th Cir. 2017)). There, “[b]ecause ‘the underlying fraud claims asserted in a FCA case belong to the government and not to the relator,’ [the Ninth Circuit] held that the \*632 claims were not claims that the employee had against the employer and therefore not within the scope of the arbitration agreements.” *Ibid.* (quoting *Welch*, 871 F.3d at 800 & n.3). In analyzing whether § 502(a)(2) claims should be treated in the same fashion, the court observed:

There is no shortage of similarities between *qui tam* suits under the FCA and suits for breach of fiduciary duty under ERISA. Most importantly, both *qui tam* relators and ERISA § 502(a)(2) plaintiffs are not seeking relief for themselves. A party filing a *qui tam* suit under the FCA seeks recovery only for injury done to the government, *Vt. Agency of Nat. Res. v. U.S. ex rel. Stevens*, 529 U.S. 765, 771–72, 120 S. Ct. 1858, 146 L.Ed.2d 836 (2000), and a plaintiff bringing a suit for breach of fiduciary duty similarly seeks recovery only for injury done to the plan. *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 256, 128 S. Ct. 1020, 169 L.Ed.2d 847 (2008); *accord id.* at 261, 128 S. Ct. 1020 (Thomas, J., concurring).

*Id.* at 1092–93.

The court in *Munro* interpreted the principle in *Welch* as “compelled by [the] recognition that the government, rather than the relator, stands to benefit most from the litigation.” *Id.* at 1093 (citing *Welch*, 871 F.3d at 800). The *qui tam* claims were outside the scope of the arbitration agreement even though “the relator is entitled to more than a nominal share of the government's recovery” and “the FCA provides that the relator brings suit not only for ‘the United States Government’ but also ‘for the person.’” *Ibid.* (quoting *Welch*, 871 F.3d at 800 and 31 U.S.C. § 3730(b)). Critically, the “language [in the arbitration agreements] [did] not extend to claims that other entities have against the [employer.]” *Id.* at 1092.

Nor did *LaRue* compel a different result: “The relief sought demonstrate[d] that the Employees [were] bringing their claims to benefit their respective Plans across the board, not just to benefit their own accounts as in *LaRue*.” *Id.* at 1094. Ultimately, then, even though § 502(a)(2) claims “belong” in part to the plaintiffs, *Munro* held that they are not subject to arbitration notwithstanding individual employment agreements because the claims are asserted on behalf of the ERISA plan as a whole.

While *Munro* is not binding on this court, its reasoning is persuasive and supported by the history of § 502(a)(2) suits. The Third Circuit’s discussion of statutory standing in *Graden v. Conexant Systems Inc.* sheds light on the representative nature of § 502(a)(2) claims:

As [§ 502(a)(2)] addresses losses to ERISA plans resulting from fiduciary misconduct, the Supreme Court has held that suits under it are derivative in nature—that is, while various parties are entitled to bring suit (participants, beneficiaries, fiduciaries, and the Secretary of Labor), they do so on behalf of the plan itself. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985); see also *In re Schering-Plough Corp. ERISA Litigation*, 420 F.3d 231, 241 (3d Cir.2005). Consequently, the plan takes legal title to any recovery, which then inures to the benefit of its participants and beneficiaries.

496 F.3d 291, 295 (3d Cir. 2007) (footnote omitted).

The derivative nature of these actions comes from common-law trust principles: “[§ 502(a)(2)] merely codifies for ERISA participants and beneficiaries a classic trust-law process for recovering trust losses through a suit on behalf of the trust.” *Id.* at 296. Although § 502(a)(2) claims are \*633 brought by individual plaintiffs, it is the plan that takes legal claim to the recovery, suggesting that the claim really “belongs” to the Plan. And because § 502(a)(2) claims “belong” to the Plan, an arbitration agreement that binds only individual participants cannot bring such claims into arbitration.

3

Cintas stops short of arguing that *Munro* was wrongly decided.<sup>7</sup> Instead, it aims to distinguish the employment agreements in *Munro* from those signed by Hawkins and Lung. While the agreements in *Munro* required the employees to “arbitrate ‘all claims’,” *Munro*, 896 F.3d at 1092, the agreements here, as Cintas recites, “cover ‘**all** of Employee’s **rights or claims** ... arising under ... **the Employee Retirement Income Security Act.**’ By contrast, the agreements in *Munro* covered only ‘claims’ of the employees—not any ‘rights’—and they did not refer to ERISA at all.” Appellant Br. at 21 (emphasis and alterations in original) (citations omitted). The “right” to bring the § 502(a)(2) claim, the argument goes, “indisputably belongs to Plaintiffs,” because the statute “confers on ‘participants,’ but not plans, the right to assert claims for breach of fiduciary duty under ERISA.” *Ibid.*

But the inclusion of the word “rights” does not render the Plaintiffs’ agreements fundamentally different from the agreements in *Munro* and *Welch*. Cintas does not provide any case law interpreting the word “rights.” And Plaintiffs’ “right,” even according to Cintas, is to bring a representative action pursuant to § 502(a)(2). Cintas does not explain how it would be possible to arbitrate such a “right” (or any “right” at all).

Moreover, Cintas’s argument glides over the text of the employment agreements, which do not expressly require employees to “arbitrate” all “rights.” Instead, the arbitration section contains three key provisions. The first is: “The rights and claims of Employee covered by this Section 8, including the arbitration provisions below, specifically include but are not limited to all of Employee’s rights or claims arising out of or in any way related to Employee’s employment with Employer, such as rights or claims arising under [ERISA].” The second relevant provision, with added emphasis, is: “Either party desiring to pursue a

claim against the other party will submit to the other party a written request to have such *claim, dispute or difference* resolved through impartial and confidential arbitration.” The third, finally, is:

“Except for workers’ compensation claims, unemployment benefits claims, claims for a declaratory judgment or injunctive relief concerning any provision of Section 4 and claims not lawfully subject to arbitration, the impartial arbitration proceeding, as provided above in this Section 8, will be the exclusive, final and binding method of resolving any and \*634 all disputes between Employer and Employee.”

In other words, a “claim, dispute or difference” is subject to arbitration, and the employee’s ERISA-related rights and claims are “covered” by the “arbitration provision.” So it is not “rights” that are subject to arbitration, but “claims,” “disputes,” and “differences.” The arbitration provisions in Plaintiffs’ employment agreements, therefore, are not materially different from the corresponding provisions in *Munro* (employees agreed to arbitrate “all claims”) and *Welch* (employees agreed to arbitrate “all disputes”). 896 F.3d at 1092; 871 F.3d at 797-98.

Cintas also argues that, unlike the Plaintiffs in *Munro*, the Plaintiffs here are actually asserting claims on their own behalf, not on behalf of the Plan. First, it distinguishes defined-contribution plans (such as the Plan) from defined-benefit plans and asserts that the former claims belong to the individual participant because “any relief that the participant obtains depends on the value of her individual account and redounds entirely to her.” True, the Ninth Circuit has observed, in dicta, that an ERISA claim “belonged to the individual plaintiff” and not the plan. *Comer v. Micor, Inc.*, 436 F.3d 1098, 1103 (9th Cir. 2006). But the context was different—the court was discussing its holding in a prior case where it declined to treat the plan as the “real plaintiff” because doing so would unfairly bar the plaintiff’s claim due to a statute of limitations. *Ibid.* (quoting *Landwehr v. DuPree*, 72 F.3d 726, 732 (9th Cir. 1995)).

Moreover, interpreting the claim as belonging to the individual, rather than the Plan, appears to conflict with *LaRue*, which held that “§ 502(a)(2) does not provide a remedy for individual injuries distinct from plan injuries.” 552 U.S. at 256, 128 S.Ct. 1020; *accord id.* at 261, 128 S.Ct. 1020 (“The plain text of § 409(a), which uses the term ‘plan’ five times, leaves no doubt that § 502(a)(2) authorizes recovery only for the plan.”) (Thomas, J., concurring in the judgment). The fact that the individual Plaintiffs will indirectly benefit from a remedy accruing to the Plan as a whole does not render the claims individualized.

Nor does Cintas’s selective quotation of the Complaint persuade otherwise. It is true that Plaintiffs state that they are seeking relief “on behalf of themselves.” But the Complaint plainly seeks relief for the Plan as a whole and expressly states that Plaintiffs are suing on behalf of the Plan. It is also true that Plaintiffs are proceeding as a putative class. That appears to be due, however, to the unusual representative nature of a § 502(a)(2) action. There is no indication that Plaintiffs seek relief for actions that affected them individually, as in *LaRue*. Instead, Plaintiffs argue that Cintas breached its fiduciary duties by offering higher-cost investment options and charging excessive recordkeeping fees. Those alleged breaches do not impact the Plaintiffs specifically; the harm (and the recovery) is to the Plan.

Cintas’s other examples supposedly demonstrating that Plaintiffs “understood” they were filing individual claims fare similarly. For example, Cintas notes that Plaintiffs brought a putative class action, contending that if they were truly representing the Plan, and not individuals, this would be unnecessary. It also notes that Plaintiffs seek attorney’s fees for their own attorneys, though these attorneys do not represent the Plan.

Those arguments are unpersuasive. The fact that Plaintiffs are seeking certain relief, some of which they may ultimately not be entitled to, does not bear on the legal status of their claims. And Plaintiffs do not concede that their action requires an ultimate grant of class certification. Instead, \*635 they argue, they proceeded as a class because some courts have held “that the representative nature of the section 502(a)(2) right of action implies that plan participants must employ some procedures to protect effectively the interests they purport to represent.” *Coan v. Kaufman*, 457 F.3d 250, 259 (2d Cir. 2006). Although Cintas cites a Seventh Circuit case, *Spano v. The Boeing Co.*, 633 F.3d 574 (7th Cir. 2011), to suggest that the class-action context implies individual claims, that case in fact cuts against its argument. In *Spano*, the court evaluated whether *LaRue* permitted class actions for participants in defined-contribution plans. *See id.* at 579–85. It distinguished “between an injury to one person’s

retirement account that affects only that person, and an injury to one account that qualifies as a plan injury. The latter kind of injury potentially would be appropriate for class treatment, while the former would not.” *Id.* at 581. The Plaintiffs’ injuries here are, as discussed above, injuries to the Plan as a whole. If, for instance, the named Plaintiffs were to be swapped out with two other employees, nothing material in the complaint would need to be changed. Plaintiffs’ class-action posture does not suggest that they are bringing individual, as opposed to Plan, claims.

A different sort of claim might change the analysis. In *LaRue*, for example, Chief Justice Roberts suggested that some suits masquerading as § 502(a)(2) claims should instead be brought pursuant to § 503(a)(1)(B). *See LaRue*, 552 U.S. at 257-58, 128 S.Ct. 1020 (Roberts, C.J., concurring in part and concurring in the judgment). “That provision allows a plan participant or beneficiary ‘to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.’ ” *Id.* at 257, 128 S.Ct. 1020 (quoting 29 U.S.C. § 1132(a)(1)(B)). When suits should really be brought under § 503(a)(1)(B), relief under § 502(a)(2) may not be available. *Id.* at 258, 128 S.Ct. 1020.

But the claim in *LaRue* had more hallmarks of a § 503(a)(1)(B) claim than does the claim brought by these Plaintiffs. *LaRue*’s claim was “a claim for benefits that turns on the application and interpretation of the plan terms, specifically those governing investment options and how to exercise them.” *Id.* at 257, 128 S.Ct. 1020. Plaintiffs, on the other hand, allege that the defendants violated fiduciary duties rather than the Plan terms themselves. Had Plaintiffs brought a claim under § 503(a)(1)(B), or a claim that should have been brought under that section, then it might be the kind of individual claim subject to arbitration under an individual participant’s employment agreement. **And while we need not decide whether a § 502(a)(2) claim could ever be covered by an individual employment agreement’s arbitration provision, we hold that these Plaintiffs’ claims are not covered by the employment agreements in this case.**

**Ultimately, the Plaintiffs are seeking Plan-wide relief through a statutory mechanism that is designed for representative actions on behalf of the Plan. The weight of authority suggests that these claims should be thought of as Plan claims, not Plaintiffs’ claims. And because the arbitration provisions only establish the Plaintiffs’ consent to arbitration, the employment agreements do not subject these claims to arbitration.**

## C

### 1

Even assuming *arguendo* that the claims here are the Plaintiffs’ claims, or that it is Plaintiffs’ right to bring the claim and that \*636 “right” is covered by the arbitration provision, compelling arbitration would still be improper absent Plan consent. First, the “right” to bring the claim is not necessarily exclusive. Section 502(a)(2) claims belong to the Plan as well. *See In re Schering Plough Corp. ERISA Litig.*, 589 F.3d 585, 594 (3d Cir. 2009) (“Section 502(a)(2) claims are, by their nature, plan claims.”). Plaintiffs compare this situation to a release of claims, where one party cannot unilaterally waive another’s rights. They cite a wide body of case law—albeit none from this court—holding that individuals cannot release a defined-contribution plan’s right to recover for breaches of fiduciary duty. *See, e.g., ibid.* (“[A] number of courts have held that, as a matter of law, an individual cannot release the plan’s claims ....”); *Bowles v. Reade*, 198 F.3d 752, 760 (9th Cir. 1999) (“Because Bowles’s claims are not truly individual, it was proper for the district court to conclude that Bowles could not settle them without The Plans’ consent.”); *Leber v. Citigroup 401(k) Plan Inv. Comm.*, 323 F.R.D. 145, 161 (S.D.N.Y. 2017) (“In cases brought on behalf of a plan, most courts have held that individuals do not have the authority to release a defined contribution plan’s right to recover for breaches of fiduciary duty; the consent of the plan is required for a release of 29 U.S.C. § 1132(a)(2) claims.”) (quotation marks and citation omitted).

Cintas responds that waivers and releases are the wrong analogy. Instead, it urges, we should think of arbitration provisions as specialized forum-selection clauses: Just as Plaintiffs chose to bring this case in Ohio federal court, so too they “chose” to

arbitrate ERISA claims. Cintas cites *Smith*, 769 F.3d 922, for this proposition. There, this court considered whether ERISA precluded the application of a venue-selection clause in the plan documents. *Id.* at 931-33. To support the conclusion that those clauses were enforceable, we observed that “[w]e have previously upheld the validity of mandatory arbitration clauses in ERISA plans.” *Id.* at 932 (citing *Simon v. Pfizer Inc.*, 398 F.3d 765, 773 (6th Cir. 2005)). But in *Simon*, the claims subject to arbitration stemmed from the same agreement that contained the arbitration provision. 398 F.3d at 772-73. And, moreover, we held that the plaintiff’s statutory ERISA claims were not subject to arbitration because the arbitration provision’s scope was limited to disputes concerning termination. *Id.* at 775-76. In both decisions, then, arbitration provisions in the plan documents were dispositive; individual employment agreements did not play a role. *Smith* does not therefore suggest that individuals can consent to arbitration without the consent of the Plan. Nor does Cintas provide any authority suggesting that Plaintiffs can unilaterally bind an ERISA plan to arbitration in the absence of an arbitration provision in the plan documents or some other manifestation of the plan’s consent.

2

Finally, Cintas argues in the alternative that even if the Plan’s consent is required, it nonetheless should prevail because the Plan *has* consented to arbitration here. Noting that the Plan can only act through its agents, it suggests that a plan sponsor, acting alone, can enter into agreements that bind a plan. It also suggests that because the sponsor has consented to arbitration (including by filing this lawsuit) the Plan has also consented. But Cintas stretches case law too far. True, we have held that non-signatories may be bound to an arbitration agreement through agency principles. See *Crossville Med. Oncology, P.C. v. Glenwood Sys., LLC*, 310 F. Appx 858, 860 (6th Cir. 2009) (quoting *Javitch v. First Union Sec., Inc.*, 315 F.3d 619, 629 (6th Cir. 2003)). But \*637 *Crossville* bound a non-signatory to an arbitration agreement only because the signatory entity was its alter ego. *Ibid.* The same is true of the entities in *Pritzker v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 7 F.3d 1110, 1122 (3d Cir. 1993). Cintas does not provide any authority suggesting that the relationship between an ERISA plan and its sponsor is akin to that of alter-ego business entities.

Its estoppel theory is similarly underdeveloped.<sup>8</sup> But neither of the two cited cases involved arbitration. *Deschamps v. Bridgestone Americas, Inc. Salaried Employees Retirement Plan* discussed equitable estoppel in the ERISA context and listed several elements required for a finding of equitable estoppel. See 840 F.3d 267, 273 (6th Cir. 2016). The same is true of *Paul v. Detroit Edison Co. & Michigan Consolidated Gas Co. Pension Plan*, 642 F. Appx 588, 593 (6th Cir. 2016). Cintas does not attempt to explain how those requirements are met here.

The fact that other non-signatories to the employment agreements, such as Cintas’s board, investment policy committee, and CEO, are parties to the lawsuit also does not help Cintas’s position. Cintas suggests that including them as defendants constitutes a tacit admission that those parties consented to arbitration, and that the Plan should be treated like these non-signatories. But Plaintiffs have not suggested that those parties have in fact consented to arbitration. Instead, the lawsuit alleges that those parties, acting on behalf of Cintas, have breached fiduciary duties owed to the Plan.

Ultimately, Cintas’s position dissolves the distinction between the Plan sponsor and the Plan as a legal entity. Moreover, as the district court observed, Cintas is hinting that it should be able to unilaterally decide it wants to arbitrate claims against itself. See *Brown ex rel. Henny Penny Corp. Emp. Stock Ownership Plan v. Wilmington Tr., N.A.*, No. 3:17-cv-250, 2018 WL 3546186, at \*5 (S.D. Ohio July 24, 2018) (“Allowing the fiduciary to unilaterally require plan participants to arbitrate claims for breach of fiduciary duty would, in a sense, be allowing the fox to guard the henhouse.”) (quotation marks and citation omitted). True, Cintas could amend the plan documents to include an arbitration provision, which might accomplish the same goal. But we need not, and do not, decide whether an arbitration provision in the plan documents would subject § 502(a)(2) claims to arbitration.

In the absence of a sufficient manifestation of the Plan’s consent to arbitrate these claims, we hold that the Plan has not consented to arbitration. There is, therefore, no basis for the Plaintiffs’ claims to be arbitrated.

### III. CONCLUSION

For the reasons given above, we **AFFIRM** the district court's conclusion that the § 502(a)(2) claims are not covered by the arbitration provisions in the Plaintiffs' respective employment agreements and that the Plan's consent is required for arbitration. We further **AFFIRM** the district court's ruling that the Plan has not in fact consented to arbitration.

#### All Citations

32 F.4th 625

---

#### Footnotes

- 1 Defined-contribution plans differ from defined-benefit plans. The Supreme Court has summarized the difference between the two kinds of plans:

As its names imply, a “defined contribution plan” or “individual account plan” promises the participant the value of an individual account at retirement, which is largely a function of the amounts contributed to that account and the investment performance of those contributions. A “defined benefit plan,” by contrast, generally promises the participant a fixed level of retirement income, which is typically based on the employee's years of service and compensation.

*LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 250 n.1, 128 S.Ct. 1020, 169 L.Ed.2d 847 (2008) (citations omitted).
- 2 Cintas does not dispute that it, as the Plan's sponsor, is such a fiduciary. The Plaintiffs allege that each defendant is a fiduciary.
- 3 Additional defendants include several John Does, who are members of the committee and other Cintas employees and officers.
- 4 Hawkins signed employment agreements in 2011, 2014, and 2016. Lung signed employment agreements in 2013, 2014, 2015, 2016, and 2017. The parties agree that the agreements are functionally the same, except for Hawkins's 2011 agreement, which did not contain a class-action waiver.
- 5 Plaintiffs also suggest that a recent Second Circuit opinion, *Cooper v. Ruane Cunniff & Goldfarb Inc.*, 990 F.3d 173 (2d Cir. 2021), supports their position. While the court held that a plaintiff's § 502(a)(2) suit did not fall under an arbitration provision in his employment agreement, it reached this conclusion because the breach-of-fiduciary-duty claims did not “relate to” his employment. *Cooper*, 990 F.3d at 185. That reasoning, therefore, does not assist us in determining whether a § 502(a)(2) claim “belongs to” the Plan or the Plaintiffs.
- 6 While the opinion does not expressly state that the plaintiffs brought suit pursuant to § 502(a)(2), it is clear from context that the case concerned that type of suit. *See Munro*, 896 F.3d at 1092.
- 7 In arguing that the Plan has consented to arbitration, however, Cintas suggests that *Munro*'s analogy between FCA claims and § 502(a)(2) claims is misguided. FCA claims, according to Cintas, are entirely unlike § 502(a)(2) claims. But Cintas overstates its point. While it does cite differences between the statutory schemes, the fundamental point remains the same: Both statutes require a plaintiff to bring suit in the plaintiff's own name on behalf of a non-party entity, and the

remedy is paid out to that non-party entity. In fact, as *Munro* explains, FCA claims “belong” more to the plaintiff than a § 502(a)(2) suit, because in FCA claims the relator is statutorily entitled to a portion of the recovery. See *Munro*, 896 F.3d at 1094. (“If anything, because recovery under ERISA § 409(a) is recovery singularly for the plan, the *qui tam* relator has a stronger stake in the outcome of an FCA case than does a § 502(a)(2) plaintiff in an ERISA claim.”) (citations omitted).

8 Cintas says that “this Court has even held that a plan sponsor's actions can bind a plan under an estoppel theory, *without* the formation of an enforceable agreement entered into by either the plan sponsor or the plan.” Appellant Br. at 32. It then cites *Deschamps* and *Paul*. *Ibid*.

---

End of Document

© 2025 Thomson Reuters. No claim to original U.S. Government Works.

# EXHIBIT 7

114 F.4th 786  
United States Court of Appeals, Sixth Circuit.

Tanika PARKER and Andrew Farrier, individually and on behalf of the DRiV 401(k)  
Retirement Savings Plan, and all others similarly situated, Plaintiffs-Appellees,

v.

TENNECO, INC.; DRiV Automotive, Inc.; Tenneco Automotive Operating Company, Inc.;  
Tenneco Benefits Committee; Federal-Mogul Corporation; Federal-Mogul, LLC; Federal-Mogul  
Powertrain, LLC; Tenneco Benefits & Pension Investment Committee, Defendants-Appellants.

No. 23-1857

|  
Argued: May 2, 2024

|  
Decided and Filed: August 20, 2024

### Synopsis

**Background:** Participants in 401(k) retirement plans covered by Employee Retirement Income Security Act (ERISA) filed putative class action on behalf of plans, themselves, and all others similarly situated, claiming that plan fiduciaries breached their fiduciary duties owed under ERISA and seeking all losses accruing to plans, disgorgement of all profits, and other injunctive remedies. The United States District Court for the Eastern District of Michigan, George Caram Steeh, J., 2023 WL 5350565, denied fiduciaries' motion to compel arbitration, under plans' mandatory individual arbitration provisions. Fiduciaries appealed.

The Court of Appeals, Gibbons, Circuit Judge, held that individual arbitration provisions were invalid as prospective waiver of statutorily guaranteed rights and remedies.

Affirmed.

McKeague, Circuit Judge, filed concurring opinion.

**Procedural Posture(s):** On Appeal; Motion to Compel Arbitration.

\*788 Appeal from the United States District Court for the Eastern District of Michigan at Detroit. No. 2:23-cv-10816—George Caram Steeh III, District Judge.

### Attorneys and Law Firms

ARGUED: Todd D. Wozniak, HOLLAND & KNIGHT LLP, Atlanta, Georgia, for Appellants. Scott C. Nehrbass, FOULSTON SIEFKIN LLP, Overland Park, Kansas, for Appellees. Sarah M. Karchunas, UNITED STATES DEPARTMENT OF LABOR, Washington, D.C., for Amicus Curiae. ON BRIEF: Todd D. Wozniak, HOLLAND & KNIGHT LLP, Atlanta, Georgia, Lindsey R. Camp, HOLLAND & KNIGHT LLP, West Palm Beach, Florida, for Appellants. Scott C. Nehrbass, Boyd A. Byers, FOULSTON SIEFKIN LLP, Overland Park, Kansas, E. Powell Miller, Sharon S. Almonrode, Mitchell J. Kendrick, THE MILLER LAW FIRM, P.C., Rochester, Michigan, for Appellees. Sarah M. Karchunas, UNITED STATES DEPARTMENT OF LABOR, Washington, D.C., for Amicus Curiae.

Before: GIBBONS, McKEAGUE, and STRANCH, Circuit Judges.

GIBBONS, J., delivered the opinion of the court in which McKEAGUE and STRANCH, JJ., joined. McKEAGUE, J. (pp. 802-03) delivered a separate concurring opinion.

## OPINION

JULIA SMITH GIBBONS, Circuit Judge.

\*789 Tanika Parker and Andrew Farrier, employees of subsidiaries of Tenneco Inc., each participated in 401(k) plans covered by the Employee Retirement Income Security Act (ERISA). Both plans (together, the “Plans”) had been amended to include mandatory individual arbitration provisions. These provisions required plan participants to bring suit in arbitration only in an individual capacity, not in a representative, class, or collective capacity, and to seek remedies only for losses to the participant's individual plan account, not for monetary benefits that would accrue to any other participant's account. These provisions explicitly applied to actions under ERISA § 502(a)(2) for relief under ERISA § 409(a). Parker and Farrier alleged that the fiduciaries of their Plans (the “Fiduciaries”) breached their fiduciary duties and sued under § 502(a)(2) on behalf of their Plans for all losses accruing to the Plans, disgorgement of all profits, and other injunctive remedies under § 409(a). **The Fiduciaries moved to compel arbitration, arguing that the individual arbitration provisions blocked such a representative suit for plan-wide monetary remedies.** The question for this court is whether the individual arbitration provisions are invalid as a prospective waiver of statutorily guaranteed rights and remedies. We hold that they are and affirm the judgment of the district court.

### I.

This case involves two 401(k) plans—the “DRiV Plan” and the “Tenneco Plan.” Tanika Parker is employed by DRiV Automotive Inc. and has been a participant in the DRiV Plan throughout the relevant period.<sup>1</sup> Following the DRiV Plan's merger with the Tenneco Plan on July 1, 2022, Parker became a participant of the Tenneco Plan. Andrew Farrier was employed by Tenneco Automotive Operating Company Inc., a subsidiary of Tenneco Inc., and was a participant of the Tenneco Plan during part of the relevant period.

Tenneco Inc., the parent company of DRiV and Tenneco Automotive, administered both ERISA-covered 401(k) plans at issue. The Plans are both defined contribution plans.<sup>2</sup> Originally, neither the DRiV Plan nor the Tenneco Plan contained an arbitration provision or representative action waiver. In 2021, the Administrative \*790 Committee of Tenneco Inc., which had the power to act as plan administrator and adopt certain amendments, adopted Amendment 2021-1 to the DRiV and Tenneco Plans.

Amendment 2021-1 created a mandatory and binding arbitration procedure for disputes, including any claim for breach of fiduciary duty. The arbitration procedure bars representative, group, or class arbitrations and mandates solely individual arbitration (the “individual arbitration provision”). In relevant part, the provision reads:

**No Group, Class, or Representative Arbitrations.** All Covered Claims must be brought solely in the Claimant's individual capacity and not in a representative capacity or on a class, collective, or group basis. Each arbitration shall be limited solely to one Claimant's Covered Claims and that Claimant may not seek or receive any remedy which has the purpose or effect of providing additional benefits or monetary relief (whether such monetary relief is described as legal damages or equitable relief) to any Employee, Participant, or Beneficiary other than the Claimant.

DE 9-1, DRiV Amend. 2021-1, Page ID 239–40; *see* DE 9-1, Tenneco Amend., Page ID 331. The provision also provides a specific example, relevant here:

For instance, with respect to any claim brought under ERISA § 502(a)(2) to seek appropriate relief under ERISA § 409, the Claimant's remedy, if any, shall be limited to (i) the alleged losses to the Claimant's *individual* Plan account resulting from the alleged breach of fiduciary duty, (ii) a pro-rated portion of any profits allegedly made by a fiduciary through the use of Plan assets where such pro-rated amount is intended to provide a remedy solely to Claimant's *individual* Plan account, and/or (iii) such other remedial or equitable relief as the arbitrator deems proper so long as such remedial or equitable relief does not include or result in the provision of additional benefits or monetary relief to any Employee, Participant Beneficiary other than the Claimant, and is not binding on the Committee or Trustee or with respect to any Employee, Participant or Beneficiary other than the Claimant.

DE 9-1, DRiV Amend. 2021-1, Page ID 240 (emphases in original); *see* DE 9-1 Tenneco Amend., Page ID 331 (materially identical). There is an important caveat to this:

Notwithstanding the foregoing, nothing in this provision shall be construed to preclude a Claimant from seeking injunctive relief, including, for example, seeking an injunction to remove or replace a Plan fiduciary.

DE 9-1, DRiV Amend. 2021-1, Page ID 240; DE 9-1, Tenneco Amend., Page ID 331. Finally, the individual arbitration provision is non-severable from the rest of the arbitration agreement.<sup>3</sup>

Parker and Farrier (together, “Parker”) sued in federal court “on behalf of [the Plans], themselves, and all others similarly situated” via a putative class action against the Fiduciaries of the Plans<sup>4</sup> for \*791 alleged breaches of fiduciary duties owed pursuant to ERISA §§ 404(a)(1) and 405(a). 29 U.S.C. §§ 1104(a)(1), 1105(a). Parker alleged that the Plans’ Fiduciaries breached their duties by failing to employ a prudent process for selecting, monitoring, and removing investment options from the Plans’ menus. As a result, the Plans offered investment options that were nearly identical, yet higher in cost, to other available investment options. This reduced participants’ possible retirement savings. Additionally, the fees charged for managed account services, recordkeeping, and account administration were higher than comparable fees and services available, also resulting in a reduction in savings. Parker alleged that the Plans’ Fiduciaries were liable for these purported breaches pursuant to ERISA §§ 409 and 502(a)(2). 29 U.S.C. §§ 1109, 1132(a)(2). In terms of relief for these breaches, Parker requested “all losses caused by their breaches of fiduciary duties,” restoration of “any profits resulting from such breaches,” and “equitable relief and other appropriate relief.” DE 2, Amend. Compl., Page ID 106, 109; *see id.* at 110–11. Parker's prayer for relief included, among other items, the following requests: (1) a determination that Parker could proceed on behalf of the Plans in accordance with ERISA, (2) a declaration that the Fiduciaries had breached their fiduciary duties under ERISA, (3) an order compelling the Fiduciaries “to make good to the Plans all losses to the Plans” resulting from their breaches, (4) actual damages “in the amount of any losses the Plans suffered, to be allocated among the participants’ individual accounts in proportion to the accounts’ losses,” (5) an order enjoining the Fiduciaries from any further violations of their ERISA fiduciary duties, responsibilities, and obligations, (6) other equitable relief, including removal of the current Fiduciaries and appointment of an independent fiduciary or fiduciaries to run the Plans, (7) pre-judgment interest, and (8) costs and attorneys’ fees under 29 U.S.C. § 1132(g). *Id.* at 113–14.

In response, the Fiduciaries moved to compel individual arbitration, arguing that the individual arbitration provision required arbitration of Parker and Farrier's claims on an individual basis (i.e., only losses to their individual accounts) and barred them from suing on behalf of the Plans or in a representative capacity. The district court denied the Fiduciaries' motion to compel, finding that the individual arbitration provision limited participants' substantive rights under ERISA, as it eliminated their substantive, statutory right to bring suit on behalf of a plan and pursue plan-wide remedies under ERISA §§ 409 and 502(a)(2).

II.

This court reviews de novo a district court's denial of a motion to compel arbitration. <sup>5</sup> *Becker v. Delek US Energy, Inc.*, 39 F.4th 351, 354 (6th Cir. 2022); *Hawkins v. Cintas Corp.*, 32 F.4th 625, 629 (6th Cir. 2022), *cert. denied*, — U.S. —, 143 S. Ct. 564, 214 L.Ed.2d 335 (2023).

III.

A.

The ERISA rights and remedies at issue are located in §§ 409(a) and 502(a)(2). Section \*792 502(a)(2) provides that “[a] civil action may be brought ... by the Secretary [of Labor], or by a participant, beneficiary or fiduciary for appropriate relief under [ERISA § 409].” 29 U.S.C. § 1132(a)(2). Section 409(a), in turn, imposes liability for breaches of fiduciary duties and outlines the remedies available for such breaches. *See id.* § 1109(a). The statute establishes that

[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

*Id.*

Also relevant here is the Federal Arbitration Act (FAA). Congress enacted the FAA in 1925 in response to a perception that federal courts were unduly hostile toward arbitration. *Epic Sys. Corp. v. Lewis*, 584 U.S. 497, 505, 138 S.Ct. 1612, 200 L.Ed.2d 889 (2018). The FAA “establishes ‘a liberal federal policy favoring arbitration agreements,’ ” *id.* (quoting *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24, 103 S.Ct. 927, 74 L.Ed.2d 765 (1983)), and makes arbitration “agreements as enforceable as other contracts, but not more so.” *Morgan v. Sundance, Inc.*, 596 U.S. 411, 418, 142 S.Ct. 1708, 212 L.Ed.2d 753 (2022) (quoting *Prima Paint Corp. v. Flood & Conklin Mfg. Co.*, 388 U.S. 395, 404 n.12, 87 S.Ct. 1801, 18 L.Ed.2d 1270 (1967)). Under the FAA, an agreement to arbitrate “shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.” 9 U.S.C. § 2. Via this savings clause, courts may invalidate an arbitration agreement “based on generally applicable contract defenses like fraud or unconscionability, but not on legal rules that apply only to arbitration or that derive their meaning from the fact that an agreement to arbitrate is at issue.” *Viking River Cruises, Inc. v. Moriana*, 596 U.S. 639, 650, 142 S.Ct. 1906, 213 L.Ed.2d 179 (2022) (internal quotations omitted) (quoting *Kindred Nursing Ctrs. L.P. v. Clark*, 581 U.S. 246, 251, 137 S.Ct. 1421, 197 L.Ed.2d 806 (2017)).

For example, the savings clause would not allow a court to invalidate an arbitration agreement with a class action waiver based on the claim that class action waivers are unconscionable under state law—that argument, premised as it is on “the individualized nature of arbitration procedures,” “interfere[s] with a fundamental attribute of arbitration.” *Epic Sys.*, 584 U.S. at 508, 138 S.Ct. 1612. By contrast, “traditional, generally applicable contract defense[s]” may apply in “arbitration cases” just as they do elsewhere. *Id.* at 509, 138 S.Ct. 1612. And one generally applicable defense concerns contractual provisions that “violate an express provision of positive law,” contradict “the purpose of positive law,” or “are otherwise inimical to public policy,” all of which may be unenforceable. 5 Williston on Contracts § 12:1 (4th ed. 2024).

One manifestation of these principles concerning the operation of the FAA's savings clause is the “effective vindication” doctrine. In *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, which dealt with claims under the Sherman Act, the Court noted that where arbitration clauses operate “as a prospective waiver of a party's right to pursue statutory remedies for antitrust violations, we \*793 would have little hesitation in condemning the agreement as against public policy.” 473 U.S. 614, 637 n.19, 105 S.Ct. 3346, 87 L.Ed.2d 444 (1985). “By agreeing to arbitrate a statutory claim, a party does not forgo the substantive rights afforded by the statute; it only submits to their resolution in an arbitral, rather than a judicial, forum.” *Id.* at 628, 105 S.Ct. 3346 (emphasis added); see also *Viking River*, 596 U.S. at 653, 142 S.Ct. 1906 (“[T]he FAA does not require courts to enforce contractual waivers of substantive rights and remedies.”); *14 Penn Plaza LLC v. Pyett*, 556 U.S. 247, 273, 129 S.Ct. 1456, 173 L.Ed.2d 398 (2009) (acknowledging that “a substantive waiver of federally protected civil rights will not be upheld”); *Green Tree Fin. Corp.-Ala. v. Randolph*, 531 U.S. 79, 90, 121 S.Ct. 513, 148 L.Ed.2d 373 (2000) (stating that “claims arising under a statute designed to further important social policies may be arbitrated ... so long as the prospective litigant effectively may vindicate his or her statutory cause of action in the arbitral forum”) (cleaned up); *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 28, 111 S.Ct. 1647, 114 L.Ed.2d 26 (1991) (“[S]o long as the prospective litigant effectively may vindicate [his or her] statutory cause of action in the arbitral forum, the statute will continue to serve both its remedial and deterrent function.” (alterations in original) (quoting *Mitsubishi*, 473 U.S. at 637, 105 S.Ct. 3346)). The Court has since noted that if an arbitration agreement “forbid[s] the assertion of certain statutory rights,” the effective vindication doctrine would “certainly” apply. *Am. Exp. Co. v. Italian Colors Rest.*, 570 U.S. 228, 236, 133 S.Ct. 2304, 186 L.Ed.2d 417 (2013). While *Italian Colors* declined to apply the effective vindication doctrine to a class action waiver in an arbitration provision, it did so because the class action waiver “merely limit[ed] arbitration to the two contracting parties” and did not “eliminate[ ] those parties’ right to pursue their statutory remedy” under § 1 of the Sherman Act. *Id.* at 236, 239, 133 S.Ct. 2304. These various proclamations emphasize that the FAA “protect[s] the enforceability of agreements to vindicate substantive rights through an arbitral forum using arbitral procedures,” but that “the FAA does not ... reach agreements to waive substantive rights and remedies.” *Cedeno v. Sasson*, 100 F.4th 386, 395 (2d Cir. 2024) (emphases in original).

Following this reasoning, four circuits have struck down arbitration provisions that barred “effective vindication” of the statutory rights guaranteed by ERISA. See *id.* at 406–07; *Henry ex rel. BSC Ventures Holdings, Inc. Emp. Stock Ownership Plan v. Wilmington Tr. NA*, 72 F.4th 499, 506 (3d Cir.), cert. denied, — U.S. —, 144 S. Ct. 328, 217 L.Ed.2d 171 (2023); *Harrison v. Envision Mgmt. Holding, Inc. Bd. of Dirs.*, 59 F.4th 1090, 1097–1100, 1107 (10th Cir.), cert. denied, — U.S. —, 144 S. Ct. 280, 217 L.Ed.2d 128 (2023); *Smith v. Bd. of Dirs. of Triad Mfg., Inc.*, 13 F.4th 613, 620–23 (7th Cir. 2021). The question for this court is whether the individual arbitration provision's requirement that claims be brought in an “individual capacity and not in a representative capacity,” and its limitation of relief to a claimant's “individual Plan account” and other equitable or remedial relief so long as it “does not include or result in the provision of additional benefits or monetary relief” to any other participant, bar Parker from effectively vindicating her statutory rights under ERISA in the arbitral forum Tenneco constructed. For the following reasons, we conclude that it does so bar Parker, and the individual arbitration provision is unenforceable.

## B.

Congress enacted ERISA, including the two provisions at issue, in 1974. See \*794 *Pension Benefit Guar. Corp. v. R.A. Gray & Co.*, 467 U.S. 717, 720, 104 S.Ct. 2709, 81 L.Ed.2d 601 (1984). Approximately ten years later, the Supreme Court considered these provisions in the context of a defined benefit plan. In *Massachusetts Mutual Life Insurance Co. v. Russell*, the Court

considered the question of whether a participant in a defined benefit plan could utilize §§ 409(a) and 502(a)(2) to recover consequential damages from a delay in the processing of her claim. 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985). Russell, a beneficiary under an ERISA-governed plan, argued that she was injured by the plan's refusal to pay her benefits during a five-month period based on its improper determination about her disability. *Id.* at 136, 105 S.Ct. 3085. While Russell had been paid all benefits under her plan, she asserted consequential damages based on the period of nonpayment to her. *Id.*

The Court denied her individual claim, holding that, based on the text of § 409, recovery for a violation of § 409 “inures to the benefit of the plan as a whole.” *Id.* at 140–42, 105 S.Ct. 3085. The Court explained that “the relevant fiduciary relationship [is] characterized at the outset as one ‘with respect to a plan.’ ” *Id.* at 140, 105 S.Ct. 3085 (quoting 29 U.S.C. § 1109). Similarly, “the potential personal liability of the fiduciary is ‘to make good to such plan any losses to the plan ... and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan....’ ” *Id.* (emphases and alterations in original) (quoting 29 U.S.C. § 1109(a)). The statutory text of § 409(a) thus refers to “benefitting, in the first instance, solely the plan.” *Id.* at 141–42, 105 S.Ct. 3085. This contextual reading of the statute, the Court asserted, demonstrates “that its draftsmen were primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary.” *Id.* at 142, 105 S.Ct. 3085. The Court added that the legislative history of the provision likewise “emphasize[s] the fiduciary's personal liability for losses to the plan.” *Id.* at 140 n.8, 105 S.Ct. 3085 (emphasis in original). Similarly, § 502(a)(2)'s authorization of the Secretary to bring suit under § 409(a) evinced “Congress’[s] intent that actions for breach of fiduciary duty be brought in a representative capacity on behalf of the plan as a whole.” *Id.* at 142 n.9, 105 S.Ct. 3085. In sum, “the entire text of § 409” persuaded the Court “that Congress did not intend that section to authorize any relief except for the plan itself.” *Id.* at 144, 105 S.Ct. 3085. The nature of Russell's claim, consequential damages for nonpayment to her specifically, precluded her use of §§ 409(a) and 502(a)(2). In short, § 502(a)(2) did not provide a cause of action for this individual—as opposed to plan-wide—harm.

The Court's disposal of Russell's individual consequential damages claim crystallized two principles. First, § 502(a)(2) contemplates the ability of participants to sue in a representative capacity on behalf of a plan. *See id.* at 142 n.9, 105 S.Ct. 3085 (explaining that Congress intended § 502(a)(2) “actions for breach of fiduciary duty be brought in a representative capacity on behalf of the plan as a whole”). Second, based on the plain language of the statutory text, relief under § 409(a) flows to the plan. *See* 29 U.S.C. § 1109(a) (a fiduciary who breaches his duties “shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary” (emphases added)).

Contrary to the Fiduciaries' assertion, *LaRue v. DeWolff, Boberg & Associates, Inc.* reinforces, rather than undermines, \*795 these conclusions. 552 U.S. 248, 128 S.Ct. 1020, 169 L.Ed.2d 847 (2008). In *LaRue*, the Court clarified *Russell* in the context of defined contribution plans. *LaRue*, a defined contribution plan participant, alleged that he had directed his employer, DeWolff, to make certain changes to his investments in his individual account, and that DeWolff had failed to do so, resulting in an alleged depletion to *LaRue*'s individual account. *Id.* at 251, 128 S.Ct. 1020. The court of appeals, citing the Court's decision in *Russell*, rejected *LaRue*'s action under § 502(a)(2). *Id.* at 251–52, 128 S.Ct. 1020. The Court reversed, holding that *LaRue* could bring an action based on these losses.

*LaRue* distinguished the result in *Russell* on the basis that *Russell* dealt with a defined benefit plan, while *LaRue* dealt with a defined contribution plan. *Id.* at 255, 128 S.Ct. 1020. When ERISA was enacted and *Russell* decided, defined benefit plans were the norm. *Id.* *LaRue* explained that a sea change in retirement offerings had occurred, and now defined contribution plans were the norm. *Id.* This was critical because defined benefit plans paid a fixed amount based on the employee's salary, and so “[m]isconduct by the administrators of a defined benefit plan will not affect an individual's entitlement” except to the extent that it affects the entire plan. *Id.* On the other hand, for defined contribution plans, “fiduciary misconduct need not threaten the solvency of the entire plan to reduce benefits below the amount that participants would otherwise receive.” *Id.* at 255–56, 128 S.Ct. 1020. “Whether a fiduciary breach diminishes plan assets payable to all participants and beneficiaries, or only to persons tied to particular individual accounts, it creates the kind of harms that concerned the draftsmen of § 409.” *Id.* at 256, 128 S.Ct. 1020. “*Russell*'s emphasis on protecting the ‘entire plan’ ” reflected the fixed benefit nature of the plan at issue. *Id.* at 254, 128 S.Ct. 1020 (quoting *Russell*, 473 U.S. at 142, 105 S.Ct. 3085). “Now,” with defined contribution plans, “the ‘victim’

could be an individual account, even if the plan as a whole remain[ed] secure.” *Hawkins*, 32 F.4th at 631. With this distinction clarified, *LaRue* held that “although § 502(a)(2) does not provide a remedy for individual injuries distinct from plan injuries, that provision does authorize recovery for fiduciary breaches that impair the value of plan assets in a participant’s individual account.” *LaRue*, 552 U.S. at 256, 128 S.Ct. 1020; see also *id.* at 261, 128 S.Ct. 1020 (Thomas, J., concurring) (“The plain text of § 409(a), which uses the term ‘plan’ five times, leaves no doubt that § 502(a)(2) authorizes recovery only for the plan.”).

While *LaRue* acknowledged the possibility of a participant bringing a claim under § 502(a)(2) regarding her individual plan account, *LaRue* still affirmed the principle in *Russell* that § 502(a)(2) provides a remedy for “plan injuries,” not individual ones. See *id.* at 256, 128 S.Ct. 1020. While *LaRue* recognized that fiduciary misconduct “need not threaten the solvency of the entire plan” to create a claim, liability can (and will) still accrue from fiduciary misconduct that threatens the entire plan. See *id.* at 255–56, 128 S.Ct. 1020. In other words, *LaRue* “broadens, rather than limits, the relief available under § 502(a)(2) in holding that a derivative fiduciary claim may be brought on behalf of a ‘plan,’ even if the ultimate relief may be individualized.” *In re Schering Plough Corp. ERISA Litig.*, 589 F.3d 585, 595 n.9 (3d Cir. 2009). Following *LaRue*, our sister circuits have continued to allow participants in defined contribution plans to sue on the plan’s behalf for all losses resulting from a fiduciary breach and have not interpreted *LaRue* as a bar to plan-wide recovery. See \*796 *Munro v. Univ. of S. Cal.*, 896 F.3d 1088, 1093–94 (9th Cir. 2018); *L.I. Head Start Child Dev. Servs., Inc. v. Econ. Opportunity Comm’n of Nassau Cnty., Inc.*, 710 F.3d 57, 65–66 (2d Cir. 2013); see also *Spano v. The Boeing Co.*, 633 F.3d 574, 579–81, 586 (7th Cir. 2011).

Moreover, our circuit has already considered the question of whether § 502(a)(2) claims belong to individuals or to the plan as a whole in light of the above Supreme Court case law. *Hawkins*, 32 F.4th at 629, 631. In *Hawkins*, the plaintiffs brought a putative class action under § 502(a)(2) based on allegations that their former employer, Cintas, breached fiduciary duties owed to their retirement plan. *Id.* at 627. Specifically, the plaintiffs argued Cintas had offered participants the ability to invest only in more expensive actively managed funds, as opposed to less expensive passively managed funds, and that Cintas charged the plan excessive recordkeeping fees—like the claims at issue here. *Id.* at 628. But unlike this case, the individual would-be plaintiffs had signed employment agreements that contained arbitration provisions (as opposed to here, where the Plan documents contained the arbitration procedure). *Id.* Cintas moved to enforce the arbitration provisions, which included a class action and representative action waiver. *Id.* at 627, 629. The district court concluded that because the plaintiffs had signed arbitration agreements in their employment contracts, there was no evidence that the plan had consented to arbitration, and so the matter was not subject to arbitration. *Id.* at 629.

The key question for *Hawkins* was whether § 502(a)(2) claims belonged to the plan or to individual plaintiffs. *Id.* at 627. That governed whether the arbitration provisions in the employment agreements could operate: if § 502(a)(2) claims belonged to the individuals, the arbitration provisions in the employment agreements would apply, whereas if § 502(a)(2) claims belonged to the plan, the arbitration provisions in the employment agreements would not apply absent plan consent. See *id.* After considering *Russell*, *LaRue*, and other out-of-circuit precedent, *Hawkins* concluded that “[a]lthough § 502(a)(2) claims are brought by individual plaintiffs, it is the plan that takes legal claim to the recovery, suggesting that the claim really ‘belongs’ to the Plan.” *Id.* at 631–33.

*Hawkins* understood that, although *LaRue* reevaluated *Russell* in the context of defined contribution plans, *LaRue* did not overrule *Russell* or abrogate its fundamental precept that “[s]ection 502(a)(2) suits are ‘brought in a representative capacity on behalf of the plan as a whole.’ ” *Id.* at 630 (quoting *Russell*, 473 U.S. at 142 n.9, 105 S.Ct. 3085). *Hawkins* interpreted *LaRue* to mean that, “while any claims properly brought under § 502(a)(2) must be for injuries to the plan itself, § 502(a)(2) authorizes suits on behalf of a defined-contribution plan even if the harm is inherently individualized.” *Id.* at 631. In other words, *LaRue* allows an individual plaintiff to bring a § 502(a)(2) representative suit for losses to her individual plan account, even though the injury is to the plan.

*Hawkins* acknowledged that *LaRue* did not explicitly hold that a § 502(a)(2) claim belongs to either the plaintiff or the plan itself. *Id.* But *Hawkins* concluded, based on persuasive Ninth and Third Circuit precedent as well as the history of § 502(a)(2) suits, that § 502(a)(2) claims belong to the plan. *Id.* at 632–33. Specifically, § 502(a)(2) suits are derivative actions finding

their origin in common law trust principles. *LaRue*, 552 U.S. at 253 n.4, 128 S.Ct. 1020; *Russell*, 473 U.S. at 152–53, 105 S.Ct. 3085 (Brennan, J., concurring). Section 502(a)(2) “merely codifies for ERISA participants and beneficiaries a classic trust-law process for recovering \*797 trust losses through a suit on behalf of the trust.” *Hawkins*, 32 F.4th at 632 (quoting *Graden v. Conexant Sys. Inc.*, 496 F.3d 291, 296 (3d Cir. 2007)). As a breach by a common law trustee allows any beneficiary whose beneficial interests were affected to sue the trustee to make good on the loss, so too may a participant sue a fiduciary under § 502(a)(2) to “make good to [the] plan any losses to the plan resulting from” his breach and “to restore to [the] plan any profits.” 29 U.S.C. § 1109(a) (emphasis added); *Graden*, 496 F.3d at 295–96.

*Hawkins* also noted that interpreting the plaintiffs’ claim as belonging to them as individuals, as opposed to belonging to the plan, would conflict with *LaRue*. *Hawkins*, 32 F.4th at 634. As discussed above, *LaRue* explicitly held that “§ 502(a)(2) does not provide a remedy for individual injuries distinct from plan injuries.” *Id.* (quoting *LaRue*, 552 U.S. at 256, 128 S.Ct. 1020). And just because plaintiffs would benefit from a remedy accruing to the plan as a whole did not render their claims individualized. *Id.* *Hawkins* interpreted the plaintiffs’ complaint as seeking relief for the plan as a whole, as opposed to actions that affected their accounts individually. *Id.* The allegation that Cintas offered higher-cost investment options and charged excessive recordkeeping fees were not “actions that affected them individually, as in *LaRue*,” but rather reflected harm (and recovery) to the plan. *Id.* “If, for instance, the named Plaintiffs were to be swapped out with two other employees, nothing material in the complaint would need to be changed.” *Id.* at 635. Given this, *Hawkins* held that the plaintiffs were “seeking Plan-wide relief through a statutory mechanism that is designed for representative actions on behalf of the Plan.” *Id.*

The operative difference between *Hawkins* and our case is the fact that the Plans here “consented” to arbitration by adopting arbitration provisions via Amendment 2021-1, whereas in *Hawkins* the arbitration provisions were in the employment agreements and thus not consented to by the plan itself. See *id.* at 637. Even so, *Hawkins*’s discussion of *Russell* and *LaRue*, as well as its ultimate conclusion that § 502(a)(2) claims belong to the plan, inform this court’s understanding of the rights conferred by ERISA.

Here, Parker brought a putative class action, alleging that the Fiduciaries breached their fiduciary duties in two main ways: First, by failing to employ a prudent process for selecting, monitoring, and removing investment options from the Plans’ menus, which resulted in participants choosing higher-cost investment options when nearly identical lower-cost options existed on the market, thus reducing their retirement savings; and second, by charging excessive account services, recordkeeping, and administration fees that also exceeded near-identical options in the market and thus resulted in a reduction in savings. While the complaint alleges that these breaches harmed Parker and Farrier’s individual accounts, the complaint also alleges harm to the Plans as a whole. Further, Parker’s complaint explicitly requests plan-wide, as opposed to individualized, remedies under §§ 409(a) and 502(a)(2). Parker requests damages “in the amount of any losses the Plans suffered” due to the breaches of fiduciary duties, restoration “to the Plans all profits” resulting from such breaches, and a judicial determination that Parker and Farrier may proceed on behalf of the Plans in accordance with ERISA, among other requests. DE 2, Amend. Compl., Page ID 106, 109, 113–14.

The harms that Parker’s complaint alleges are akin to the plan-wide harms in *Hawkins*, not the individualized harms in *LaRue*. Here, as in *Hawkins*, Parker alleges \*798 that the Fiduciaries offered participants the ability to invest only in more expensive funds, as opposed to other available less expensive funds, thus resulting in a reduction in retirement savings. See *Hawkins*, 32 F.4th at 628, 634. Like *Hawkins*, the names of Parker and Farrier are immaterial—if these two named individuals were swapped with two other Plan participants, “nothing material in the complaint would need to be changed,” thus evidencing plan-wide, as opposed to individual, harms. *Id.* at 635. And even putting aside the Plans’ menu options, excessive recordkeeping and administrative fees harmed the Plans as a whole. See *id.* at 634 (considering excessive recordkeeping fees as a plan-wide harm). Moreover, the harms Parker alleges bear no resemblance to the individual claim alleged in *LaRue*, where LaRue directed his employer to make certain changes to his individual account, and the employer failed to do so, resulting in losses specific to his individual account. *LaRue*, 552 U.S. at 251, 128 S.Ct. 1020. Parker’s complaint invokes not just individual injuries to a particular account, but “plan injuries”—an overall reduction in the Plans’ savings via the provision of higher-cost investment options and excessive fees. See *id.* at 256, 128 S.Ct. 1020.

Additionally, the monetary remedies that Parker requests flow to the Plans, not individual participants. Parker requests restitution of all losses to the Plans resulting from the fiduciary breaches, a remedy expressly authorized by the plain language of § 409(a) and inuring to the plan. *See* 29 U.S.C. § 1109(a) (mandating that a fiduciary must “make good to such plan *any losses to the plan* resulting from each such breach” (emphasis added)). Parker further requests disgorgement of all profits, also a remedy created by § 409(a)’s text and flowing to the plan. *See id.* (mandating that fiduciaries shall “restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary”). Finally, Parker and Farrier seek a determination that they may proceed on behalf of the Plans in accordance with ERISA. As discussed above, § 502(a)(2) contemplates suits in a representative capacity on behalf of a plan as a whole. *Russell*, 473 U.S. at 142 n.9, 105 S.Ct. 3085; *see LaRue*, 552 U.S. at 256, 128 S.Ct. 1020.

In sum, Parker seeks “Plan-wide relief through a statutory mechanism that is designed for representative actions on behalf of the Plan[s].” *Hawkins*, 32 F.4th at 635. The individual arbitration provision, however, restricts Parker to actions brought in an “individual capacity and not in a representative capacity,” and restricts the monetary relief Parker can obtain to losses to her individual Plan account and prorated profits. The individual arbitration provision thus eliminates the ability to proceed in a representative capacity on behalf of the Plans and obtain relief for losses to the Plans, which, as demonstrated by *Russell*, *LaRue*, and *Hawkins*, are substantive statutory remedies provided by ERISA. The provision is therefore unenforceable as a prospective waiver of these statutory rights.

### C.

While not binding on our court, the decisions of four other circuits on the same issue reinforce this conclusion. The first in this line of cases was *Smith v. Board of Directors of Triad Manufacturing, Inc.* There, the Seventh Circuit considered an arbitration provision in a defined contribution plan document that required individual arbitration of ERISA claims and barred claimants from “seek[ing] or receiv[ing] any remedy which has the purpose or effect of providing additional benefits or monetary or other relief to any Eligible \*799 Employee, Participant or Beneficiary other than the Claimant.” *Smith*, 13 F.4th at 616. The plaintiffs brought a class action complaint, alleging breaches of fiduciary duty based on an improper inside transaction that depleted the plan’s holdings. *Id.* at 616–17. The requested relief included removal of the current plan trustee, appointment of a new independent fiduciary, and “ ‘other and further relief’ under § 1132(a)(2).” *Id.* at 617. *Smith* held the arbitration provision unenforceable under the effective vindication doctrine. *Id.* at 621. Although “rare,” application of the effective vindication doctrine was proper because § 409(a) provided relief for fiduciary breaches including “such other equitable or remedial relief as the court may deem appropriate,” including removal of a fiduciary. *Id.* (quoting 29 U.S.C. § 1109(a)). The plan’s class action waiver precluded participants from pursuing “any remedy” which would provide “additional benefits or monetary or other relief” to other participants. *Id.* at 616, 621. Because removal of a fiduciary—a statutory remedy guaranteed by § 409—would provide relief to other participants in addition to the individual claimant, the plain text of § 409 and the arbitration provision conflicted. *Id.* at 621–22. As the arbitration provision acted as a “prospective waiver of a party’s right to pursue statutory remedies,” the effective vindication doctrine invalidated the class action waiver. *Id.* at 621 (quoting *Mitsubishi*, 473 U.S. at 637 n.19, 105 S.Ct. 3346).

The Third Circuit similarly applied the effective vindication doctrine in *Henry ex rel. BSC Ventures Holdings, Inc. Employee Stock Ownership Plan v. Wilmington Trust NA*. *Henry* dealt with a near-identical class action waiver to that in *Smith*, and similarly concluded that its prohibition on equitable relief to plan participants other than the claimant conflicted with § 409(a)’s provision specifying removal of the fiduciary as a form of relief. *Henry*, 72 F.4th at 507 (citing *Smith*, 13 F.4th at 621–22). But *Henry* went a step farther, finding another conflict between the statutory relief that plaintiffs requested and the class action waiver. *Henry* sought, as part of his requested relief, disgorgement. *Id.* at 503. Section 409(a) authorizes a participant to seek restitution of plan losses from a fiduciary, thus permitting “recovery of all plan losses caused by a fiduciary breach.” *Id.* at 507 (emphasis in original) (quoting *LaRue*, 552 U.S. at 261, 128 S.Ct. 1020 (Thomas, J., concurring)). This created a conflict with the class action waiver, as “[r]estitution of ‘all plan losses’ would necessarily result in monetary relief to non-party plan

participants.” *Id.* (explaining that restitution to the plan is both “expressly authorized by statute and necessarily plan-wide”). Because the class action waiver thus operated as a “prohibited prospective waiver” of the statutorily created remedy, the Third Circuit refused to enforce it. *Id.*

Of the four cases from our sister circuits, the class action waiver in *Harrison v. Envision Management Holding, Inc. Board of Directors* is the most like the individual arbitration provision here. Harrison, a participant in an ERISA-protected defined contribution plan, brought a purported class action suit against the plan fiduciaries, alleging a breach of fiduciary duty based on an insider transaction that significantly depleted the value of the plan and thus participants’ retirement savings. See *Harrison*, 59 F.4th at 1095. The plan fiduciaries moved to compel arbitration, arguing that the plan’s class action waiver compelled Harrison to arbitrate his claims on an individual \*800 basis. *Id.* at 1095–96. The class action waiver mandated that claims “be brought solely in the Claimant’s individual capacity and not in a representative capacity or on a class, collective, or group basis.” *Id.* at 1105. Further, claimants could “not seek or receive any remedy which has the purpose or effect of providing additional benefits or monetary or other relief” to anyone other than the claimant. *Id.* Like the individual arbitration provision here, the class action waiver in *Harrison* specified that, with respect to ERISA §§ 409 and 502(a)(2), the claimant’s remedy was “limited to (i) the alleged losses to the Claimant’s individual Account ... (ii) a pro-rated portion of any profits allegedly made by a fiduciary through the use of Plan assets ... and/or (iii) such other remedial or equitable relief” so long as such relief did not “result in the provision of additional benefits or monetary relief” to any other participant or third party. *Id.*

*Harrison* suggested that the effective vindication doctrine might apply to “the prohibition on a claimant proceeding in a representative capacity,” where the claimant alleges “plan-wide harm and not just harm to the claimant’s own account[,] and the claimant seeks relief under [§ 502(a)(2)].” *Id.* at 1106. Moreover, Harrison sought to impose liability on the fiduciaries for losses suffered by the plan generally, an order removing the trustee, an order appointing a new independent fiduciary and directing defendants to pay the cost of that fiduciary, and an order directing restoration of all losses resulting from the fiduciary breaches and disgorgement of all profits. *Id.* at 1106–07. Each of these forms of relief would have the purpose or effect of providing additional benefits or monetary relief to other plan participants, and so their effective vindication conflicted with the class action waiver. *Id.* at 1107. Further, Harrison’s complaint alleged harms to the plan as a whole (an insider transaction that reduced the value of plan assets) rather than harms specific to his individual account. *Id.* at 1109. Sections 409 and 502(a)(2), the court in *Harrison* declared, “allow claimants to obtain certain forms of plan-wide relief.” *Id.* at 1111. In sum, the arbitration provision was “not problematic because it require[d] Harrison to arbitrate his claims, but rather because it purport[ed] to foreclose a number of remedies that were specifically authorized by Congress.” *Id.* at 1107. *Harrison*, above all, made clear that the key is not the arbitration forum itself, but rather the relief allowed in the arbitration forum.

Finally, and most recently, in *Cedeno v. Sasson*, the Second Circuit became the fourth circuit to apply the effective vindication doctrine when faced with potential arbitration of ERISA claims. *Cedeno* held that an individualized arbitration provision in the plan’s governing document, which barred representative suits and limited relief to the claimant’s account, was unenforceable because it prevented claimants from pursuing substantive statutory remedies provided by ERISA. Like our decision here, *Cedeno* understood *LaRue* as broadening *Russell*, rather than limiting it. See *Cedeno*, 100 F.4th at 399 (“At most, *LaRue* recognized that Section 502(a)(2) provides a remedy for injuries to the plan that are felt only at an individual account level; the Court did not suggest that Section 502(a)(2) allows individualized relief for injuries that *are* felt at the plan level.” (emphases in original)). And *Cedeno* also viewed *LaRue* as reinforcing, rather than undermining, the conclusion in *Russell* that § 502(a)(2) “provides no remedy for ‘individual injuries distinct from plan injuries.’ ” *Id.* (quoting *LaRue*, 552 U.S. at 256, 128 S.Ct. 1020).

As in *Smith* (improper inside transaction that depleted plan holdings), *Henry* (plan incurred debt to purchase inflated stock that depleted plan assets), *Harrison* (improper inside transaction that depleted plan holdings), and *Cedeno* (plan overpaid for private company shares), Parker’s complaint \*801 alleges plan-wide harms. See *Smith*, 13 F.4th at 616–17; *Henry*, 72 F.4th at 503; *Harrison*, 59 F.4th at 1095; *Cedeno*, 100 F.4th at 391, 405. And like the plaintiffs in *Henry* and *Harrison*, Parker requests restitution of all losses to the Plans resulting from the fiduciary breaches, a plan-wide remedy created by § 409(a). *Henry*, 72 F.4th at 507; *Harrison*, 59 F.4th at 1106–07. Further, Parker requests disgorgement of all profits to be allocated to each account in proportion to that account’s losses, a remedy that *Harrison* determined constituted relief provided by § 409(a). *Harrison*, 59

F.4th at 1106–07. Finally, Parker and Farrier seek to proceed in a representative capacity, the prohibition of which *Harrison* found “problematic, at least where, as here, the claimant alleges that the named defendants violated fiduciary duties that resulted in plan-wide harm and not just harm to the claimant’s own account and the claimant seeks relief under [§ 502(a)(2)].” *Id.* at 1106.

The Fiduciaries argue that we should disregard *Henry* and *Harrison*, because the class action waivers in those cases are distinguishable from the waiver here. Specifically, the individual arbitration provision here allows claimants to seek “injunctive relief, including, for example, seeking an injunction to remove or replace a Plan fiduciary,” whereas the waivers in *Henry* and *Harrison* precluded all injunctive relief. DE 9-1, DRiV Amend. 2021-1, Page ID 240; DE 9-1, Tenneco Amend., Page ID 331. But both *Henry* and *Harrison* contain broader holdings than just the injunctive relief point—both held, independently of the injunctive relief point, that prohibitions on plan-wide monetary relief were themselves unenforceable under the effective vindication doctrine. *Henry*, 72 F.4th at 507; *Harrison*, 59 F.4th at 1106–07. That the individual arbitration provision here still allows plan-wide injunctive relief has no bearing on the fact that it eliminates statutorily created plan-wide monetary relief. And, based on the assumption that § 502(a)(2) are plan claims, not individual plaintiff claims, *Harrison* suggested that a prohibition on proceeding in a representative capacity might be “problematic.” *Harrison*, 59 F.4th at 1106.

#### IV.

To summarize, sections 409(a) and 502(a)(2), as reflected by their plain language and interpreted by *Russell* and *LaRue*, allow participants to sue on behalf of a plan for remedies that accrue to the plan. *See Russell*, 473 U.S. at 140–42, 105 S.Ct. 3085; *LaRue*, 552 U.S. at 256, 128 S.Ct. 1020. *Hawkins* similarly held that § 502(a)(2) claims belong to the plan, and the plan takes the legal claim to recovery under § 409. 32 F.4th at 632–33. Here, Parker alleges plan-wide injuries. Parker and Farrier seek to proceed in a representative capacity on behalf of the Plans, which the individual arbitration provision prohibits. And Parker requests at least two remedies under § 409(a) that the individual arbitration provision prohibits: “all losses” to the Plans caused by the breaches of fiduciary duties, and restoration to the Plans of “any profits resulting from such breaches.” DE 2, Amend. Compl., Page ID 106, 109, 110–11; *see also* 29 U.S.C. § 1109. The individual arbitration provision therefore functions as a prospective waiver of Parker’s substantive statutory remedies and is unenforceable. Because the individual arbitration provision is non-severable from the arbitration procedure, the arbitration procedure is unenforceable.

It is just as important to note what we do not hold. Nothing in this opinion should be construed as implying that §§ 409(a) and 502(a)(2) are incompatible with the arbitral forum. The problem here lies with this individual arbitration provision, which \*802 is non-severable, limiting statutory remedies that bar effective vindication of statutory rights. *See Harrison*, 59 F.4th at 1106–07, 1109.

For the foregoing reasons, the district court’s judgment is affirmed.

#### CONCURRENCE

McKEAGUE, Circuit Judge, concurring.

Writing on a blank slate, this case would be difficult. It raises hard questions of statutory interpretation, requires us to consider the interplay between ERISA and the FAA, and tasks us with applying a judge-made doctrine.

Fortunately for us, much ink has been spilled on these topics. This Circuit has accepted and applied the effective vindication doctrine, although in a different context. *See Morrison v. Cir. City Stores, Inc.*, 317 F.3d 646, 658 (6th Cir. 2003) (en banc) (Title VII); *McMullen v. Meijer, Inc.*, 355 F.3d 485, 491–92 (6th Cir. 2004) (per curiam) (same). Binding precedent has also made clear, as the majority opinion explains, that ERISA claims under § 502(a)(2) are “representative actions” that “belong

to the plan,” which takes “legal claim to the recovery.” *Hawkins v. Cintas Corp.*, 32 F.4th 625, 627, 633, 635 (6th Cir. 2022), cert. denied, — U.S. —, 143 S. Ct. 564, 214 L.Ed.2d 335 (2023). Given the arbitration provision here—which generally bars claims brought in a representative capacity and plan-wide remedies—those rulings are enough for us to affirm. Even so, I write separately to note two things.

First, judge-made doctrines are being scaled back. See, e.g., *Egbert v. Boule*, 596 U.S. 482, 490–92, 142 S.Ct. 1793, 213 L.Ed.2d 54 (2022) (discussing the court's approach to “judicially created causes of action” under *Bivens*); *Loper Bright Enters. v. Raimondo*, — U.S. —, 144 S. Ct. 2244, 2273, 219 L.Ed.2d 832 (2024) (overruling *Chevron*, a “judicially implied ... delegation of interpretive authority” (quoting *id.* at 2287 (Gorsuch, J., concurring))). And the effective vindication doctrine may be next. Though the doctrine has been mentioned in dicta—which we generally must follow—it has never been used by the Supreme Court to bar an arbitration provision under ERISA. See *Am. Exp. Co. v. Italian Colors Rest.*, 570 U.S. 228, 235, 133 S.Ct. 2304, 186 L.Ed.2d 417 (2013) (explaining that the Court has “declined to apply [the doctrine] to invalidate the arbitration agreement[s] at issue”). The doctrine also conflicts with two principles. One: we have a national policy favoring arbitration. *Buckeye Check Cashing, Inc. v. Cardegna*, 546 U.S. 440, 443, 126 S.Ct. 1204, 163 L.Ed.2d 1038 (2006). Two: arbitration agreements should be enforced unless the contract was not properly made. 9 U.S.C. § 2; see also *Italian Colors*, 570 U.S. at 239, 133 S.Ct. 2304 (Thomas, J., concurring). If, based on any of these (or other) concerns, the effective vindication doctrine ceases to exist at some point in the future, so too does the force of the majority opinion.

But our job as a lower court is not to decide cases based on the direction that we think the law may be heading; we apply the law as it exists now. And binding precedent requires us to apply the effective vindication doctrine.

Second, I worry that we address an issue that could have been saved for another day. Independent of their argument under the effective vindication doctrine, Parker and Farrier contend that the arbitration provision is unenforceable because it was added through an improper amendment. And they might be right. The administrative committee—which was responsible for amending the plans to include \*803 arbitration provisions—only had the authority to:

make amendments to the Plans that are technical in nature or necessary in the ordinary course of the administration of the Plans and which are reasonably expected to result in an increase in cost or expense to the Company and/or its affiliates of less than \$200,000 per year per amendment.

Admin. Comm. Charter, R.16-1 at PageID 404. The addition of an arbitration provision appears (at least based on the current record) neither “technical in nature” nor “necessary in the ordinary course” of plan administration. So perhaps the most prudent course would have been to remand for the district court to determine the validity of the amendment adding the arbitration provision. That question, in my view, is less susceptible to facing a change in the governing law.

Nevertheless, because Sixth Circuit precedent supports the district court's ruling, I concur.

## All Citations

114 F.4th 786

---

## Footnotes

- 1 Per the complaint, the relevant period is May 27, 2016, through the present.
- 2 A defined contribution plan promises the participant the value of her individual account at retirement, which is largely a function of monetary inputs into the account and the investment performance of those contributions. *See LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 250 n.1, 128 S.Ct. 1020, 169 L.Ed.2d 847 (2008). A defined benefit plan, on the other hand, generally promises the participant a fixed amount of retirement income, often depending on the employee's years of service and compensation. *Id.*
- 3 On July 1, 2022, the Administrative Committee merged the DRiV Plan into the Tenneco Plan. The amended and restated Tenneco Plan incorporated its prior Amendment 2021-1. The language of the amended and restated Tenneco Plan is substantively identical to the two amendments discussed above.
- 4 The Plans' Fiduciaries include Tenneco Inc., DRiV Automotive Inc., Tenneco Automotive Operating Company Inc., Federal-Mogul Powertrain LLC, Federal-Mogul LLC, Federal-Mogul Corporation, the Tenneco Benefits Committee, the Tenneco Benefits & Pension Investment Committee, and John and Jane Does 1 through 30.
- 5 District courts in this circuit are split over the standard of review for a motion to compel arbitration: Some apply the Rule 12(b)(1) or Rule 12(b)(6) motion to dismiss standards, while others apply the Rule 56 summary judgment standard. *See Tillman Transp., LLC v. MI Bus. Inc.*, No. 23-10197, 2023 WL 4875872, at \*3 n.3 (E.D. Mich. July 31, 2023) (summarizing cases). This issue was not addressed by the parties and need not be decided in this case, since the issue for review is solely one of statutory interpretation.

# EXHIBIT 8

871 F.2d 1088

Unpublished Disposition

NOTICE: THIS IS AN UNPUBLISHED OPINION.

(The Court's decision is referenced in a "Table of Decisions Without Reported Opinions" appearing in the Federal Reporter. Use FI CTA6 Rule 28 and FI CTA6 IOP 206 for rules regarding the citation of unpublished opinions.)

United States Court of Appeals, Sixth Circuit.

Irving J. ROSENBAUM, Plaintiff–Appellee,

v.

DAVIS IRON WORKS, Defendant–Appellant.

No. 88–1245.

I

April 19, 1989.

### Synopsis

E.D.Mich., 669 F.Supp. 813.

AFFIRMED IN PART AND REVERSED AND VACATED IN PART.

**Procedural Posture(s):** On Appeal.

On Appeal from the United States District Court for the Eastern District of Michigan.

Before MILBURN and BOGGS, Circuit Judges, and CONTIE, Senior Circuit Judge.

### Opinion

PER CURIAM.

\*1 Appellant Davis Iron Works (Davis) appeals the decision of the district court granting summary judgment to plaintiff-appellee Irving J. Rosenbaum. Rosenbaum sued to recover, under the Employees Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, a pro rata share of the overfunding of Davis's defined benefit pension plan. The court below awarded Rosenbaum a pro rata share of \$63,868, amounting to \$43,832.07. Rosenbaum was also awarded attorney's fees, amounting to approximately \$10,000. Except for the award of attorney's fees, we affirm the judgment entered by the district court.

I

This dispute concerns two pension plans implemented by Davis. From the early 1960s until his resignation on June 8, 1984, Rosenbaum was the majority stockholder and president of Davis. In 1967, under the direction of Rosenbaum, Davis established a pension plan (Original Plan) to cover its eligible non-union employees. Under this plan, Davis agreed to purchase annuity contracts for the covered employees. These contracts would produce a defined monthly pension upon the employee's retirement. The plan stated that "All amounts contributed by the Employer to the Trustee shall represent irrevocable contributions of the Employer to this trust."

While the plan stated that Davis could amend the plan at any time, the plan also stated that "No amendment shall provide for the use of trust funds for any purpose other than for the benefit of the participants and their beneficiaries." It also stated that "No funds contributed to this trust nor assets of the trust shall ever revert to or be made available to the Employer." Finally, the plan provided that "Upon termination of the trust any assets of the trust, other than contracts issued on the lives of participants,

1989 WL 36897

shall be distributed among the then participants in proportion to the attained cash values upon contracts then outstanding on the lives of such participants.”

In 1979, after the passage of ERISA, the Original Plan was reframed in its entirety in order to comply with that legislation. This Amended Plan was again established under the direction of Rosenbaum, and he became the plan's trustee. Subsection 22.2(E) of the plan provided that “In the event there are assets of the Trust Fund remaining after the allocation under Subsection 22.2(D), the remaining assets shall be returned to the Corporation.”

On June 8, 1984, Rosenbaum retired from his position as president of the company and trustee of the plan. Davis and Rosenbaum signed a stock redemption agreement in which Davis purchased Rosenbaum's 75% share of the company's stock. On the date of the signing of this agreement, both sides executed a mutual release of claims concerning the agreement. Rosenbaum elected, as permitted under the plan, to have the cash equivalent of his accrued benefits in the Plan transferred to a separate account to be held by the Plan until he decided to withdraw them. The money in this account was to be invested as directed by Rosenbaum, and the proceeds of the investments were to go into the account.

\*2 On October 5, 1984, Davis terminated the plan. On March 24, 1985, before the Plan participants were paid, Davis notified Rosenbaum that the Plan had miscalculated his benefits and overpaid his account by \$65,324. Davis insisted that Rosenbaum return the excess to the Plan. Rosenbaum disputed the amount of the overpayment. On November 1, 1985, Rosenbaum, Davis, and the Plan settled the dispute and signed an agreement defining the plaintiff's benefits (the “release”). In consideration for Davis's agreement to pay a compromise amount, Rosenbaum agreed to release his claims against Davis, specifically exempting a claim against Davis for an increased redemption price for his stock due to an overfunding of the plan. At this point, both parties knew there was some overfunding of the plan, but neither knew the extent of the overfunding.

On November 21, 1985, Davis received the first portion of the excess assets of the plan. On December 24, 1985, Davis received the balance of the assets pursuant to Subsection 22.2(E) of the Amended Plan. In July 1986, Rosenbaum filed a claim in state court alleging that his redeemed shares were undervalued to the extent of 75% of the reversion. This claim was the one specifically reserved in the release. In January 1987, however, Rosenbaum filed this action asking for a pro rata share of the reversion. (The state court agreed to dismiss the stock redemption claim without prejudice.) Both sides in this action filed motions for summary judgment. In September 1987, the court below granted summary judgment to the plaintiff on his claim and also dismissed counterclaims filed by the defendant.<sup>1</sup> *Rosenbaum v. Davis Iron Works*, 669 F.Supp. 813 (E.D.Mich.1987). This appeal followed.

## II

Davis first contends that Rosenbaum lacks standing to maintain this action because he had already received all his benefits from the Plan before the residual assets were discovered. Davis argues that the segregation of Rosenbaum's assets from the Plan into a separate account constituted a constructive receipt of the benefits, disqualifying Rosenbaum from maintaining this suit. In support of this doctrine of constructive receipt, Davis looks to Federal tax law on when benefits received pursuant to ERISA pension plans are taxable.

In order to maintain an action under ERISA, one must be considered a participant under the plan. 29 U.S.C. § 1002(7) defines a participant as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan....” A former employee whose accrued benefits under a plan have already been distributed in a lump sum is not “eligible to receive a benefit” and thus is not a participant under ERISA. *Kuntz v. Reese*, 785 F.2d 1410, 1411 (9th Cir.1986).

Davis argues that, at the time of the reversion, Rosenbaum had already retired and received his benefits. The fact that he chose to keep his benefits in a segregated account maintained by the trust does not affect the fact that he already received his benefits.

The account, while maintained by the trust, was invested at the direction of Rosenbaum. In order to receive his money, he had only to ask that the distribution be made. This control shows, according to Davis, that he constructively received his benefits.

\*3 Davis claims that the treatment of these benefits under Federal tax law supports its constructive receipt theory. Prior to 1981, § 402 of the Internal Revenue Code treated these benefits as being received for tax purposes. However, as Rosenbaum points out, this section was amended in 1981 to read that only benefits that are actually distributed are taxed. Davis claims that while the change in the law did allow the delay of taxation of benefits by pension recipients, this change did not mean that the recipient could delay the distribution of his benefits as long as he wants. The intention of the law was to allow recipients to tell the administrators of the pension plan when they wished their benefits distributed, and the benefits would be distributed at that later date. In the present case, Rosenbaum did not set any date that his assets were to be released; under the provisions of the plan, he could delay distribution as long as he wanted. Under this kind of scheme, Davis argues, Rosenbaum should be considered to have received his benefits.

Davis argues that if the law is not interpreted in this manner, a massive tax loophole will have been created that Congress did not intend to create. In any event, the issue here, Davis argues, is whether Rosenbaum should be accorded standing under ERISA to sue for a reversion of assets after he received all the benefits due him under the plan. Davis argues that it makes no sense to allow Rosenbaum standing in this case and not allow it to those people who received their benefits in a lump sum.

We are not persuaded. Even if Davis were correct as to the tax treatment of Rosenbaum's benefits, it would not be dispositive of the issue in this case. In any event, it is not at all clear that Davis is correct. The language of the statute seems to support Rosenbaum. Section 402(a)(1) of the IRS Code states, in pertinent part, that "the amount actually distributed to any distributee by an employees' trust ... shall be taxable to him, in the year in which so distributed." It is undisputed that Rosenbaum's benefits were not distributed to him until November 1985, well after the termination of the plan. Thus, one can argue that, using Davis's own analogy, Rosenbaum had not yet received his benefits and was a participant in the fund.

In addition, it is our view that the *Kuntz* rule disallowing suits by non-participants is inapplicable in this case. In *Kuntz*, the plaintiff, who had clearly received his benefits, sought damages for a breach of fiduciary duty under ERISA. He, therefore, was not seeking a benefit from a plan, as a participant would, but rather was seeking monetary damages. In the present case, however, Rosenbaum is seeking a benefit under the plan, not damages for a violation of a fiduciary duty. Even someone who has ostensibly received all his benefits should be able to sue in a case such as this because the suit is for benefits the claimant was allegedly entitled to under the plan. Any other ruling would allow plan administrators to take benefits from plan recipients and then become immune to suit by paying beneficiaries some of the benefits to which they were entitled, while falsely representing that the amount paid was the full amount of the benefits due.

\*4 This kind of analysis was approved in a recent decision by the Ninth Circuit, the court that decided *Kuntz*. In *Amalgamated Clothing & Textile Workers Union et al. v. Murdock et al.*, 861 F.2d 1406 (9th Cir.1988), the court held that a plaintiff who had already received his benefits could maintain an equitable action for a breach of fiduciary duty. The court concluded: "A fiduciary should not be allowed to keep ill-gotten profits simply because plan participants and beneficiaries have been paid their actuarially vested plan benefits." *Id.* at 1418. This conclusion is also supported by the recent Supreme Court decision in *Firestone Tire and Rubber Co. v. Bruch*, 109 S.Ct. 948 (1989). In that case, the Court held that a plaintiff can be considered a participant under the act for purposes of maintaining an action against the plan administrator if he has a 'colorable claim' to benefits. *Id.* at 958. Thus, a plaintiff in this type of case should be treated as a participant if he has a colorable claim to benefits under the plan.<sup>2</sup> Rosenbaum clearly has such a claim. We therefore conclude that Rosenbaum should be treated as a participant and, hence, has standing to sue.

Davis next argues that Rosenbaum is not eligible to receive benefits because he was not a participant as defined by the Original Plan at the time of the discovery of the residual assets. That plan required a participant to be a current employee. The Amended Plan, like ERISA, however, does not exclude a retired employee from being a participant.

Davis argues that if, as the district court held, the Amended Plan's provision that all residual assets go to Davis is inoperative, its definition of participant, at least as it pertains to the distribution of these assets, should be as well. Rosenbaum should not be able to enforce only those parts of each plan that suit his interest.

We reject this contention. The Original Plan allowed all amendments, except for changes to provisions concerning the distribution of surplus assets. The Amended Plan is thus perfectly valid; only the one amendment challenged is void. The rest of the plan, including the definition of participant, remains valid. Rosenbaum can maintain his suit.

#### IV

Davis next argues that the November 1, 1985 release of claims signed by Rosenbaum barred his claim. Davis contends that this release was a general waiver of all of Rosenbaum's claims concerning the residual assets of the Plan, with the exception of an action seeking an increased return for his redeemed stock based on the increased value of the shares due to the residual assets. The language of the release on which Davis relies reads: "In consideration of the agreements and undertakings of Davis and the Trust herein contained, Rosenbaum ... hereby irrevocably and unconditionally releases, acquits, and discharges Davis, the Trust ... of and from any and all claims, actions, and causes of action, however and whenever arising, whether fixed, contingent, liquidated and/or unliquidated, which Rosenbaum ... now ha[s], ever had or may hereafter have against the Releases by virtue of Rosenbaum's relationship with the Trust in any and all capacities whatsoever at any time."

\*5 It would certainly appear, considering the language of the release, that Rosenbaum waived all claims, present and future, as to the trust. The court below, however, held that such a general waiver could not be upheld. It first cited 29 U.S.C. § 1110, which states in pertinent part: "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy." The court held that this provision prevented it from enforcing any waiver as to future claims against the Plan.

Davis argues, however, that this section does not apply to voluntary releases. It cites two cases for support. The first case, *Arnulfo P. Sulit, Inc., et al. v. Dean Witter Reynolds, Inc.*, 847 F.2d 475 (8th Cir.1988), concerned an agreement to take ERISA plan claims to arbitration. The court ruled that § 1110 did not prevent this kind of agreement. *Id.* at 478. Davis also cites an unpublished opinion of this court, *Miller et al. v. General Motors Corp.*, No. 87-1493, (6th Cir., April 27, 1988), in which the panel held that an agreement to waive all employee rights under an employment contract, including benefits, in exchange for the opportunity to purchase stock did not violate § 1110.

These cases are inapposite. *Sulit* only concerned an agreement as to the forum in which claims should be adjudicated, not a release of the claims themselves. *Miller* concerned the waiver of rights under an employment contract, not the waiver of claims that the administrators of a plan violated their fiduciary duty to the plan. The present case, on the other hand, involves exactly the type of case § 1110 was meant to apply to, a waiver of claims of breach of fiduciary duty. The prohibition should apply.

The district court also held that because the waiver applied to future claims, there was a failure of consideration. Davis argues that there was clear consideration for the waiver in that Davis agreed to settle the dispute over the alleged overpayment to Rosenbaum by splitting the difference between each side's demands. The general waiver was the price Davis received in exchange for compromising its demands. In addition, Davis contends that the cause of action in the present case already existed at the time at the release in so much as Rosenbaum knew that there was an overfunding of the plan of some amount. He also knew that Davis, under the provisions of the Plan, intended to keep the reversion. His knowledge of these facts led him to reserve the redeemed

1989 WL 36897

stock action in the release, an action that would mean nothing if there was no overfunding. It is clear, then, Davis argues, that Rosenbaum intended to give up any claim in the residual assets.

We conclude, however, that it is clear that the release only applied to the claim concerning the overpayment of funds to him, not any future claims as to residual assets. Michigan law holds that a release covers only claims intended by the parties to be released and has no greater effect. *Auto-Owners Insurance Co. v. Higby*, 226 N.W.2d 580, 582 (Mich.App.1975). Rosenbaum could not possibly have waived such a claim because at the time this court had not yet decided *Bryant v. Int'l Fruit Products Comp., Inc.*, 793 F.2d 118 (6th Cir.1986), in which this court held for the first time that amendments like the one giving the residual assets to Davis were void. Up until this point, Rosenbaum had no cause to believe that the residual assets would not go to Davis under the Plan.

\*6 In addition, at the time of the release, Davis had not yet even calculated the amount of the residuals, much less taken possession of them. Thus, Rosenbaum could not have any cause of action at the time because up until the point at which Davis took the assets, Davis could have fulfilled its duty and returned the assets to the participants. It was not until December 24, 1985, when Davis paid itself the balance of the assets, that the cause of action accrued. Rosenbaum cannot be deemed to have waived this action on November 1. Finally, it should be pointed out that Rosenbaum would have been very foolish to waive a claim to over \$50,000 for a settlement that netted him about \$2,000. We hold that the release does not bar this claim.

V

Davis next contends that the provision of the Amended Plan allowing a reversion of surplus assets to the company was valid. The district court held that, under the interpretive principles established in *Bryant*, the Original Plan prohibited such an amendment. It found such a prohibition in the provisions of the plan that stated: "No amendment shall provide for the use of trust funds for any purpose other than for the benefit of the participants and their beneficiaries" and that "No funds contributed to this trust nor assets of the trust shall ever revert to or be made available to the Employer." Davis argues that the plan reviewed in *Bryant* is distinguishable from the one at issue here and that the Original Plan allows the amendment authorizing a reversion.

Davis bases its argument concerning the correct interpretation of the Original Plan on the structure of that plan. Davis points to the provisions of the Original Plan that define a contribution under the Plan. Davis argues that participants in the plan are entitled only to the specific amount of benefits discussed in the plan. The company is bound under the provisions of the plan to contribute enough money to provide those benefits. These contributions constitute the trust fund and are the funds which cannot revert back to the employer. Contributions in excess of those needed to generate the required benefits, however, are not part of the plan, are not made for the benefit of the participants, and should be returned to the employer. Thus, the prohibition against the reversion of contributions did not apply to the surplus assets claimed by Davis.

Davis finds support for this view in *In Re C.D. Moyer Company Trust Fund*, 441 F.Supp. 1128 (E.D.Pa.1977), where the court held that where the original plan stated it was "impossible, if any alteration, amendment or revocation be made ... for any of the trust corpus or income to be diverted to or revert to either of the employers or to be used for any purpose other than the exclusive benefits of the participants," an amendment allowing surplus assets to revert to the employer was acceptable because such assets were not part of the trust funds to be paid to beneficiaries. *Id.* at 1131, 1132. Davis also cites *Wilson v. Bluefield Supply Co.*, 819 F.2d 457 (4th Cir.1987). There the court held that a provision stating: "No part of the Fund ... shall be withdrawn, assigned, or otherwise transferred in whole or in part" did not prohibit an amendment allowing residual assets to be diverted to the company. *Id.* at 462, 465. The court reasoned that the "Fund" only included those monies that were to be paid as benefits, not surplus assets. *Id.* at 464. Davis contends that the plan here, as in *Moyer* and *Wilson*, prohibited only the transfer of funds that were to be paid out as benefits.

\*7 We conclude, however, as did the court below, that this case is controlled by *Bryant*. In that case, this court considered exactly the issue disputed here. The original plan in *Bryant* contained a provision reading: "In no event and under no

circumstances shall any contributions to this Trust by the Employer, nor any of the Trust Estate or the income therefrom, revert to or be repaid to the Employer; and all amounts paid by the Employer to the Trustees shall be used and applied for the sole and exclusive benefit of the participants under this Trust.” *Bryant*, 793 F.2d at 120. In a second amended plan, the plan was amended to allow the distribution of the surplus assets to the company.

The court found the amendment void, holding that “this pension plan assured the participating employees that, once contributed, no money paid into the fund could ever be reclaimed by the company.... Even if a surplus from actuarial error might properly be considered not to be a part of the trust estate, nevertheless, the surplus assets did originate as ‘contributions’ to the trust.” *Id.* at 123. The court was also impressed by the fact that the provision stated that under no circumstances, presumably including a surplus, could money revert to the employer. The court distinguished *Moyer* by saying the provision there referred only to the trust funds used for payment, not to the total contributions. *Wilson* can be distinguished on the same basis, as indeed the *Wilson* court did, when it discussed *Bryant*.

The provisions at issue in this case are similar to those in *Bryant*. The Original Plan referred to contributions, not the trust fund, and it also stated that no such funds shall ever revert to the employer. Davis attempts to distinguish *Bryant* by stating that it is not clear that the plan there was designed as was the plan here to eliminate surplus funds. Davis also argues that the *Bryant* plan refers not only to contributions, but also to the trust income and estate, making it clearer than is the case here that no income can be diverted. These attempts to distinguish *Bryant* are unpersuasive. We conclude that, following *Bryant*, the amendment is void.

## VI

Davis also contends that Rosenbaum should be estopped from maintaining this claim because he should not be able to profit from his bad acts. Davis contends that if the Amended Plan's provisions are contrary to the law, Rosenbaum should not be able to profit from these errors because, as president and majority stockholder of Davis, he was responsible for that plan. Rosenbaum, Davis points out, stated in the stock redemption agreement signed when he resigned, that “the Company is not in default in any material respect under any contract to which it is a party.” Rosenbaum, Davis contends, did not keep this promise.

Michigan law holds that estoppel arises where one by his acts, representations, or silence when he ought to speak, intentionally or through culpable negligence induces another to believe in the existence of certain facts and that person justifiably relies on the existence of the assumed facts to his detriment. *Hastings Mutual Insurance Company v. Hartford Accident & Indemnity Company*, 352 N.W.2d 292, 295 (Mich.App.1984). One must have actual or constructive knowledge of the real facts in order for estoppel to exist. *Langschwager v. Pinney*, 88 N.W.2d 276 (Mich.1958).

\*8 Davis contends that Rosenbaum negligently led Davis into amending the plan to its detriment. Davis relied on Rosenbaum's representations that the plan was valid in making contributions to the plan. Had Davis known that any surplus assets were to go to the employees and not the company, it might have been able to avoid making excess contributions. Rosenbaum, as an experienced businessman, must be deemed to have constructive knowledge of the law as it relates to his business. Davis concludes that Rosenbaum should not be able to profit from his questionable acts.

It is our view, however, that Rosenbaum was in no way negligent in making the plan. The amendment was made in 1979, several years before *Bryant* held that such amendments were void. Rosenbaum never meant to injure Davis and, in fact, Davis is not injured. It merely has to give up a windfall to its rightful owners. As to its argument that reliance on the plan's validity led to excess contributions, Davis has argued in this appeal that the plan was designed to limit excess contributions. It should not now be able to argue that in fact it was lulled into overfunding. Lastly, we note that the wrongful act here was not the amendment, but the reversion of the funds. If Davis had not chosen to take the funds, there would have been no violation of the law. Rosenbaum had every right to sue.

VII

Finally, Davis contends that the lower court erred in awarding Rosenbaum fees and denying its motion for fees. The decision of the district court concerning the grant of fees in ERISA cases should not be disturbed unless there is an abuse of discretion. *Operating Engineers Pension Trust v. Beck Engineering & Surveying Co.*, 746 F.2d 557, 569 (9th Cir.1984). The criteria that a court should apply in deciding whether to award fees are laid out in *Central States Pension Fund v. 888 Corp.*, 813 F.2d 760, 767 (6th Cir.1987). They are: (1) the degree of the opposing party's culpability or bad faith; (2) the ability of the opposing party to satisfy an award of attorney's fees; (3) whether an award of fees against the opposing party would deter others from acting in similar circumstances; (4) whether the party requesting fees sought to benefit all participants and beneficiaries of a multiemployer plan or to resolve a significant legal question; and (5) the relative merits of the parties' positions.

The court below held that the grant of fees was warranted because, first, Davis acted in disregard of the law as set out in *Bryant*, even after Rosenbaum cited the case when requesting payment. The release, the court held, does not justify Davis's actions. Second, Davis clearly had the money to pay fees. Third, this award would deter future similar conduct. Fourth, this litigation has resolved key legal questions regarding the distribution of assets, and all the participants will be benefitted by the result. Finally, the court held that Rosenbaum's legal position is far more meritorious than Davis's.

\*9 Davis contends that the court abused its discretion by not considering, when deciding that Davis acted in bad faith, the confusing and unsettled state of the law concerning reversion issues. Davis can also not be accused of bad faith in relying on a general release of claims or in interpreting the agreement as excluding Rosenbaum as a participant. Also, Davis argues that Rosenbaum did not seek to resolve important questions; he merely wanted to receive a windfall. In short, the issues in this case are too complex and the questions too close for fees to be awarded.

Even taking into account the abuse of discretion standard, we agree with Davis that fees should not have been awarded in this case. The issues in this case are unsettled enough that neither party can be said either to be acting with bad faith or to have an obviously more meritorious position than the other. We thus REVERSE and VACATE the award of attorney's fees. On all other issues, the judgment of the court below is AFFIRMED.

**All Citations**

871 F.2d 1088 (Table), 1989 WL 36897

---

**Footnotes**

- 1 The dismissal of the counterclaims has not been appealed.
- 2 We note, as pointed out by the court below, that Davis itself considered Rosenbaum a participant in three corporate documents issued after the segregation of Rosenbaum's assets. Rosenbaum concedes that these documents do not estop Davis from maintaining he is not a participant, but they do at least rhetorically support his position.

# EXHIBIT 9

149 Fed.Appx. 422

This case was not selected for publication in West's Federal Reporter.  
See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also U.S.Ct. of App. 6th Cir. Rule 32.1.

United States Court of Appeals,  
Sixth Circuit.

Marvin TAYLOR, et al., Plaintiffs–Appellants,  
v.  
VISTEON CORPORATION, Defendant–Appellee.

No. 04–1879.

|  
Sept. 1, 2005.

### Synopsis

**Background:** Former employees terminated as part of a reduction in force sued their former employer for breach of fiduciary duty in violation of the Employee Retirement Income Security Act (ERISA). The United States District Court for the Eastern District of Michigan dismissed, and the employees appealed.

The Court of Appeals, Sutton, Circuit Judge, held that the breach-of-fiduciary-duty claims, which allegedly arose during their signing of a release, did not fall outside the scope of the release.

Affirmed.

**Procedural Posture(s):** On Appeal; Motion to Dismiss.

\*423 On Appeal from the United States District Court for the Eastern District of Michigan.

### Attorneys and Law Firms

Donald J. Gasiorek, Sommers, Schwartz, Silver & Schwartz, Southfield, MI, for Plaintiffs–Appellants.

Bernard J. Bobber, David J.B. Froiland, Foley & Lardner, Milwaukee, WI, Phil B. Phillips, Foley & Lardner, Detroit, MI, for Defendant–Appellee.

Before ROGERS and SUTTON, Circuit Judges; FORESTER, District Judge.\*

### Opinion

SUTTON, Circuit Judge.

\*\*1 Ninety former employees of Visteon Corporation appeal the dismissal of their ERISA breach-of-fiduciary-duty claim. Because the lawsuit falls within the scope of a release of claims that the plaintiffs signed, we affirm.

I.

When Visteon, a former subsidiary of Ford Motor Company, terminated numerous employees as part of a reduction in force, it offered the terminated employees two options under the Visteon Separation Program (VSP). Under the first option, employees received separation pay of “[u]p to 3 months of base salary” and medical coverage that continued “for a maximum of three months.” JA 84. Under the second option, Visteon offered more generous benefits to employees who were willing to sign a waiver of claims against the company. If employees signed the Waiver and Release Agreement, they would receive a separation-pay “Waiver Benefit” of (1) “[a]t least 3 and up to 12 months of base salary” and (2) continuing medical coverage “based on years of service up to 12 months.” JA 84.

The Waiver and Release Agreement says, in relevant part:

2. *Release of Employment Claims.* In consideration of the Waiver Benefit, I waive and release any and all rights or claims of any kind I may have ... against Visteon Corporation.... Except as provided in the following paragraph, in the section entitled Rights or Claims that Survive, I agree not to start any proceedings of any kind against the Company relating in any way to my \*424 employment or the separation of my employment. I agree to terminate any proceedings I may have begun or withdraw from any I may be participating in relating to my employment....

3. *Rights or Claims That Survive.* I do not waive or release any rights or claims I may have that may arise after this Agreement is signed or if it is not permitted by law, such as workers' compensation claims in some states.... However, by accepting the Waiver Benefit, I acknowledge that I give up any right I may have to any future recovery from the Company related to my legal claims that arose prior to the date I signed this Agreement.

JA 94.

In December 2003, ninety former employees who had signed the Waiver and Release Agreement sued Visteon, alleging a breach of fiduciary duties under ERISA as well as a number of state-law claims (fraud, misrepresentation and breach of the duties of good faith and fair dealing). The plaintiffs based each of these claims on the fact that Visteon, “in writing, informed each and every Plaintiff that the terms of the VSP, the Waiver Benefit, and the Waiver and Release Agreement were non-negotiable.” JA 73. Despite this representation and despite similar oral representations, the complaint continued, Visteon “did negotiate and gave other employees different and/or additional benefits than those identified in the VSP benefits.” JA 74. Invoking the waiver, Visteon moved to dismiss the suit under Rule 12(b)(6) of the Federal Rules of Civil Procedure for failing to state a claim upon which relief may be granted.

\*\*2 The district court granted the motion. In rejecting plaintiffs' principal argument that their claims arose the moment that they signed the release and that they did not waive claims that arose on the date they signed the release, the district court reasoned: “Reading the release as a whole, it is clear that Plaintiffs released Visteon from any claims existing as they signed the agreement and that they only retained the right to pursue claims arising *after* they signed the release.” JA 101. The district court also provided an independent explanation for rejecting plaintiffs' claims as a matter of law. Relying on its own precedent, see *Bittinger v. Tecumseh Products Co.*, 83 F.Supp.2d 851 (E.D.Mich.1998), and on two unpublished opinions from this court, see *Samms v. Quanex Corp.*, No. 95–2173, 99 F.3d 1139, 1996 WL 599821, at \*3 (6th Cir. Oct. 17, 1996), and *Halvorson v. Boy Scouts of America*, No. 99–5021, 215 F.3d 1326, 2000 WL 571933, at \*3 (6th Cir. May 3, 2000), the court concluded that plaintiffs could not avoid the Waiver and Release Agreement without tendering back the consideration they received for signing it. The district court also determined that the VSP is an ERISA plan and that ERISA preempts the plaintiffs' state law claims, two determinations that plaintiffs do not challenge on appeal.

## II.

Plaintiffs first argue that their breach-of-fiduciary-duty claims fall outside the scope of the release because the claims did not accrue *prior to* the execution of the agreement but only *during* the signing of the agreement. We disagree.

Michigan law, the parties agree, governs the scope of the release. Under Michigan law, “[t]he scope of a release is controlled by the language of the release, and where ... the language is unambiguous, [courts] construe it as written.” *Adair v. State*, 470 Mich. 105, 680 N.W.2d 386, 399 (2004); *Gortney v. Norfolk & Western Ry. Co.*, 216 Mich.App. 535, 549 N.W.2d 612, 614 (1996). “The fact that the parties dispute the \*425 meaning of a release does not, in itself, establish an ambiguity.” *Gortney*, 549 N.W.2d at 615. Rather, “[a] contract is ambiguous only if its language is reasonably susceptible to more than one interpretation.” *Id.*

Plaintiffs' challenge to the district court's decision proceeds along these lines: (1) They did not rely on Visteon's statement that the VSP was non-negotiable until the moment they signed the Waiver and Release Agreement; (2) their breach-of-fiduciary-duty claims did not spring into existence until they signed the Agreement; and (3) accordingly the waiver and release does not bar these at-the-moment-of-signing claims. Even accepting these temporal allegations as true, as we must in assessing the sufficiency of a complaint, *Midkiff v. Adams County Regional Water District*, 409 F.3d 758, 762 (6th Cir.2005), the agreement cannot be read to preserve these claims.

The release agreement contains two pertinent sections—one addressing the “Release of Employment Claims,” the other addressing “Rights or Claims That Survive.” The first section broadly states that the employee “waive[s] ... any and all rights or claims of any kind I may have” against Visteon. JA 94. By itself, this sweeping language waives all claims against the company—those arising prior to signing the agreement, those arising at the moment of signing the agreement and those arising after signing the agreement. To emphasize the breadth of the release, the first section also says that the waiver includes claims “relating in any way to ... the separation of my employment.” *Id.*

**\*\*3** The second section of the agreement removes some claims from the sweep of the release. It says that “any rights or claims I may have that arise *after this Agreement is signed*” survive. *Id.* (emphasis added). Up to this point in the agreement, then, claims that arose before signing or at the moment of signing are waived—for “after” signing does not, in normal usage, include “during” signing.

The rub, plaintiffs argue, comes from still another sentence in the second section of the agreement. It says: “However, by accepting the Waiver Benefit, I acknowledge that I give up any right I may have to any future recovery from the Company related to my legal claims that arose *prior to* the date I signed this Agreement.” JA 94 (emphasis added). Focusing on the “prior to” language, plaintiffs argue that the release does not cover at-the-moment-of-signing claims but only claims in existence before (*e.g.*, “prior to” when) they signed the agreement.

That is not so for several reasons. First of all, this language does not purport to preserve claims but to relinquish them. By its terms, the sentence “give[s] up” claims rather than ensures their survival. And because the sentence does not appear in the “Release of Employment Claims” section, it makes little sense to construe the sentence to cut back on the broad waiver of claims provided there. Rather, the sentence appears in the “Surviv[al]” of “Claims” section as a rough description of the release provided one paragraph above.

Put another way, the release potentially relinquishes three types of claims—before-signing, at-the-moment-of-signing and after-signing claims. One paragraph later, the survival section addresses two types of claims: It says that claims arising “after” signing survive, while reiterating that those claims arising “prior to” signing do not. Silence in the survival section about at-the-moment-of-signing claims does not mean that they are preserved; it means that whatever the release says about them controls. And the language of the release admits of just one interpretation: It covers at-the-moment-of-signing claims.

**\*426** In reaching this conclusion, it is worth emphasizing what plaintiffs have not argued. They have not contended that the alleged misrepresentation amounted to fraud in the inducement, which potentially would permit them to vitiate the entire agreement. That kind of contention does not call for a court to construe the scope of a release of claims but asks whether the agreement may be enforced at all. See *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 943–44 (6th Cir.1997) (setting out test for avoiding an ERISA-governed insurance policy where an insured fraudulently induces the issuance of a policy); *Nash v. Trs. of Boston Univ.*, 946 F.2d 960, 963–67 (1st Cir.1991) (recognizing that federal-common-law contract principles governing

ERISA agreements include the concept of fraud in the inducement); *see also Shipley v. Arkansas Blue Cross & Blue Shield*, 333 F.3d 898, 902 (8th Cir.2003) (“[W]e, like a number of our sister circuits, conclude that federal common law allows for the equitable rescission of an ERISA-governed insurance policy that is procured through the material misstatements or omissions of the insured.”). Whether because some parts of the contract were agreeable to them or for some other reason, plaintiffs simply have not sought to vitiate the agreement in its entirety. *See Taylor Br.* at 12 (“Plaintiffs are not seeking to avoid the release.”).

**\*\*4** Plaintiffs next argue that ERISA prohibits the enforcement of releases of this sort. In doing so, they invoke 29 U.S.C. § 1110(a), which says that “any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy.” The district court never addressed this argument—and with good reason. Plaintiffs, it turns out, never raised the argument below. One of their lower-court briefs, we recognize, cited § 1110(a). But the citation responds to Visteon’s contention that the lawsuit could not proceed until plaintiffs tendered back the Waiver Benefit they received in return for signing the agreement, explaining that a tender-back rule would violate ERISA-based public policy considerations. Because plaintiffs did not argue before the district court that § 1110(a) prohibits the enforcement of this kind of release, much less identify a case applying § 1110(a) in this setting, they cannot do so now. *See PACCAR Inc. v. TeleScan Technologies, L.L.C.*, 319 F.3d 243, 258 (6th Cir.2003).

Nor at any rate does this argument appear to have merit, even if it had been preserved. Not only have plaintiffs failed to identify a single case that supports their interpretation of this section and not only have we been unable to identify one on our own, but several cases contradict their argument. Like most legal claims, ERISA claims (including breach-of-fiduciary-duty claims) may be settled. *See, e.g., Leavitt v. Northwestern Bell Tel. Co.*, 921 F.2d 160, 162 (8th Cir.1990) (“We conclude section 1110(a) does not bar releases of breach of fiduciary duty claims under ERISA.”); *Seman v. FMC Corp. Ret. Plan for Hourly Employees*, 334 F.3d 728, 731–32 (8th Cir.2003) (explaining that settlement agreements releasing claims—including claims against a fiduciary—in exchange for severance benefits may be enforced under ERISA); *Harlan v. Sohio Petroleum Co.*, 677 F.Supp. 1021, 1027 (N.D.Cal.1988) (holding that § 1110(a) did not invalidate a release of “past or present” claims as to ERISA breach-of-fiduciary-duty claims); *cf. Srein v. Soft Drink Workers Union, Local 812*, 93 F.3d 1088, 1095–96 (2d Cir.1996) (declining to decide the meaning of § 1110(a) in this context but noting that relying on it to void indemnification provisions in a settlement **\*427** agreement would be “problematic”); *Packer Eng’g, Inc. v. Kratville*, 965 F.2d 174, 175 (7th Cir.1992) (holding that § 1110(a) did not nullify a provision indemnifying a fiduciary who had been exonerated by a jury because “[m]aking a faithful fiduciary whole hardly ‘relieves’ the fiduciary of responsibility or liability”).

In contrast to a contract purporting to relieve a fiduciary of future duties, a release of past breach-of-fiduciary-duty claims does not appear to implicate § 1110(a) because it “does not relieve a fiduciary of any responsibility, obligation, or duty imposed by ERISA; instead, it merely settles a dispute that the fiduciary did not fulfill its responsibility or duty on a given occasion.” *Leavitt*, 921 F.2d at 161–62; *cf. Rosenbaum v. Davis Iron Works*, 871 F.2d 1088, 1989 WL 36897, at \*5 (6th Cir. Apr.19, 1989) (applying § 1110(a) to bar a release that applied to “present and future” claims). Indeed, to forbid the settlement or release of ERISA breach-of-fiduciary-duty claims would promote “terminal litigation, rather than favoring settlements,” including settlements that benefit litigants similarly situated to plaintiffs. *Leavitt*, 921 F.2d at 162. *See also Aro Corp. v. Allied Witan Co.*, 531 F.2d 1368, 1372 (6th Cir.1976) (“Public policy strongly favors settlement of disputes without litigation.”); *Schering-Plough Corp. v. FTC*, 402 F.3d 1056, 1072–73 (11th Cir.2005) (quoting *Aro Corp.*); *Taylor v. Progress Energy, Inc.*, 415 F.3d 364, 373 (4th Cir.2005) (“[T]here is a general public policy favoring the post-dispute settlement of claims.”); *Valley Drug Co. v. Geneva Pharms., Inc.*, 344 F.3d 1294, 1308 (11th Cir.2003) (quoting *Aro Corp.*).

**\*\*5** Consistent with this case law, plaintiffs released only those claims that related to alleged breaches of fiduciary duty that existed at the time they signed the agreement. JA 94 (“I do not waive or release any rights or claims I may have that may arise after this Agreement is signed.”). Enforcing a waiver of this sort, for which plaintiffs received valuable consideration, does not *relieve* Visteon of any fiduciary duties; it merely *resolves* claims arising from those duties. *Leavitt*, 921 F.2d at 161–62.

Given these conclusions, we need not reach the district court’s alternative ground for dismissing the complaint—that the tender-back rule barred these claims. *See Samms*, 1996 WL 599821, at \*3; *Halvorson*, 2000 WL 571933, at \*3.

III.

For these reasons, we affirm.

**All Citations**

149 Fed.Appx. 422, 2005 WL 2108333, 36 Employee Benefits Cas. 1519, 2005 Fed.App. 0766N

---

**Footnotes**

\* The Honorable Karl S. Forester, Senior United States District Judge for the Eastern District of Kentucky, sitting by designation.

---

End of Document

© 2025 Thomson Reuters. No claim to original U.S. Government Works.

# EXHIBIT 10

138 F.4th 457  
United States Court of Appeals, Sixth Circuit.

TIARA YACHTS, INC., Plaintiff-Appellant,  
v.  
BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant-Appellee.

No. 24-1223  
|  
Argued: February 6, 2025  
|  
Decided and Filed: May 21, 2025

### Synopsis

**Background:** Self-funded healthcare benefits plan sponsor brought action against administrator, alleging breach of fiduciary duties under Employee Retirement Income Security Act (ERISA) by, among other things, overpaying some categories of claims and profiting from its mismanagement by keeping portion of recovered overpayments. The United States District Court for the Western District of Michigan, [Robert J. Jonker, J.](#), granted administrator's motion to dismiss. Sponsor appealed.

**Holdings:** The Court of Appeals, [Bloomekatz](#), Circuit Judge, held that:

administrator acted as an ERISA “fiduciary” when it allegedly overpaid claims;

administrator acted as an ERISA “fiduciary” by exercising discretion over its compensation under overpayment claw back program;

sponsor could seek relief under ERISA provision limiting recovery to plans;

relief was not available under ERISA equitable remedy provision for funds that administrator overpaid and never recovered; and

administrator could seek disgorgement under ERISA equitable relief provision.

Reversed and remanded.

**Procedural Posture(s):** On Appeal; Motion to Dismiss for Failure to State a Claim.

\***460** Appeal from the United States District Court for the Western District of Michigan at Grand Rapids. No. 1:22-cv-00603 —[Robert J. Jonker](#), District Judge.

### Attorneys and Law Firms

ARGUED: [Aaron M. Phelps](#), VARNUM LLP, Grand Rapids, Michigan, for Appellant. [Tacy F. Flint](#), SIDLEY AUSTIN LLP, Chicago, Illinois, for Appellee. ON BRIEF: [Aaron M. Phelps](#), [Perrin Rynders](#), [Herman D. Hofman](#), [Neil E. Youngdahl](#), VARNUM LLP, Grand Rapids, Michigan, for Appellant. [Tacy F. Flint](#), H. Javier Kordí, SIDLEY AUSTIN LLP, Chicago, Illinois, for Appellee.

Before: [Murphy](#), [Davis](#), and [Bloomekatz](#), Circuit Judges.

## OPINION

BLOOMEKATZ, Circuit Judge.

Tiara Yachts, Inc., hired Blue Cross Blue Shield of Michigan (“BCBSM”) to administer its self-funded healthcare benefits plan. It alleges that BCBSM knowingly squandered plan assets by systematically overpaying some categories of claims. BCBSM then allegedly profited from its mismanagement by implementing a program through which it caught overpayments, \*461 clawed them back, and kept a portion of those “savings” for itself.

Tiara Yachts sued BCBSM under the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1001, *et seq.*, and BCBSM moved to dismiss. The district court granted that motion, holding that Tiara Yachts hadn't plausibly alleged that BCBSM acted as an ERISA fiduciary. It also held that ERISA's remedial provisions couldn't provide the relief Tiara Yachts sought. Because the district court erred on both fronts, we reverse.

## BACKGROUND<sup>1</sup>

### I. The Administrative Services Contract

Tiara Yachts is a Michigan corporation that designs and manufactures boats. It offers its employees health insurance through a self-funded benefits plan (“the Plan”). So rather than buying health insurance from another company, Tiara Yachts pays a portion of its employees’ actual medical costs according to the Plan's terms.

In January 2006, Tiara Yachts hired BCBSM to administer the Plan. An Administrative Services Contract (“ASC”) governed their relationship. Under that contract, BCBSM was responsible for interpreting the Plan's terms, calculating benefits, deciding whether to grant or deny claims on Tiara Yachts’ behalf, and ultimately paying providers. In exchange, Tiara Yachts paid BCBSM a monthly fee and periodically deposited money into a BCBSM-owned account, from which BCBSM paid claims. That meant BCBSM decided what claims to pay and for how much, then wrote checks to medical providers out of the Plan's assets.

The ASC granted Tiara Yachts some ways to oversee BCBSM's management of the Plan. For example, the contract allowed Tiara Yachts to dispute any claim BCBSM paid within sixty days. It also allowed Tiara Yachts to request an audit of claims from the preceding twenty-four months.

Tiara Yachts renewed the ASC annually until December 2018, when it terminated its relationship with BCBSM.

### II. “Flip Logic” and Overpaying Claims

Tiara Yachts alleges that BCBSM systematically overpaid claims submitted by medical providers during the years that BCBSM administered the Plan. Understanding Tiara Yachts’ allegations requires some background. BCBSM is just one of thirty-eight Blue Cross Blue Shield Association regional affiliates—colloquially known as the “Blues.” Each of the Blues negotiates with providers in its area to set rates for medical services. Although the Blues operate independently, they process claims and reimbursements through a central electronic system. And the Blues have a policy that allows individuals enrolled in one Blue's plan to receive the benefit of another “Host Blue's” pricing if they need out-of-state medical care. In that scenario, the insuring Blue reimburses the out-of-state medical provider at the rate the Host Blue would pay. When contracting with BCBSM, Tiara Yachts secured this benefit for its Plan's participants. Thus, for example, when a covered Tiara Yachts employee received care in another state—say, Tennessee—BCBSM promised Tiara Yachts that it would reimburse the provider \*462 at whatever rate Tennessee's Blue would pay.

But that is not what happened. Instead, BCBSM processed claims using an “intentional design” called “flip logic.” Compl., R. 1, PageID 7. How did it work? When an out-of-state provider who wasn't part of the Host Blue's network submitted a claim, BCBSM would “flip” its status and reimburse the provider however much it charged rather than at the Host Blue's lower rate.<sup>2</sup> As a result, BCBSM reimbursed “many times over and above the customary amount for such services.” *Id.* at PageID 8. BCBSM implemented flip logic in 1997, long before Tiara Yachts hired it to administer the Plan.

According to internal emails between BCBSM employees, flip logic affected “all” customers on one of BCBSM's claims-processing platforms except those purchasing auto insurance. *See* Sept. 14 Email Chain, R. 1-2, PageID 27. Though the emails do not name any customers, Tiara Yachts was a customer on that platform and did not purchase auto insurance. By 2017, BCBSM knew that flip logic allowed “abusive provider practices” that resulted in reimbursements “far exceed[ing]” the “allowed amount.” *See id.* Despite that knowledge, BCBSM didn't implement “controls in the system logic that would flag suspicious claim activity.” Compl., R. 1, PageID 8.

The issues with BCBSM's claims processing extended beyond flip logic. The platform BCBSM used to manage claims for all similarly situated customers, including Tiara Yachts, allegedly suffered from “processing errors” that allowed providers to improperly code for their services and overbill the Plan, which “consistently result[ed] in improper payments of claims.” *Id.* at PageID 15–16. Tiara Yachts does not cite specific claims that BCBSM overpaid from Plan assets. But that's because, Tiara Yachts says, BCBSM concealed flip logic from its customers and limited access to claims data and explanatory documents.

### III. Shared Savings Plan

Tiara Yachts further alleges that BCBSM implemented a program to profit from its practice of overpaying claims. Starting in January 2018, BCBSM enrolled all self-funded customers, including Tiara Yachts, in a new “Shared Savings Program” (“SSP”). Under that program, among other things, BCBSM hired third parties to claw back past overpayments from providers and to detect and prevent future overpayments before they occurred. In exchange for those services, BCBSM kept 30% of the payments third parties either recovered or prevented.

### IV. Procedural History

Tiara Yachts sued BCBSM, claiming that it had breached its fiduciary duties under ERISA by, among other things, overpaying claims based on flip logic and implementing the SSP. Tiara Yachts also alleged that BCBSM had violated ERISA's strictures on self-dealing by using the SSP to profit off its own mismanagement of Plan assets. Tiara Yachts sought damages, restitution, disgorgement, and a declaratory judgment that BCBSM had breached its fiduciary duties under ERISA.

BCBSM moved to dismiss for failure to state a claim, and the district court granted that motion. It held that Tiara Yachts had not plausibly alleged that BCBSM acted as an ERISA fiduciary, either when paying providers based on flip logic or when paying itself through the SSP. The \*463 district court also determined that ERISA could not provide the relief Tiara Yachts requested.

Tiara Yachts timely appealed.

## ANALYSIS

We review a grant of a motion to dismiss de novo. *Linden v. City of Southfield*, 75 F.4th 597, 601 (6th Cir. 2023). Accepting the complaint's “factual allegations as true and drawing all reasonable inferences in the plaintiff's favor,” *id.*, we ask whether it “contains sufficient factual matter to state a claim to relief that is plausible on its face,” *Royal Truck & Trailer Sales & Serv., Inc. v. Kraft*, 974 F.3d 756, 758 (6th Cir. 2020) (cleaned up).

### I. ERISA Fiduciary Status

Tiara Yachts brings two ERISA claims against BCBSM: one for breaching its fiduciary duties, and one for engaging in transactions prohibited by the statute. For both claims, Tiara Yachts must first plausibly allege that BCBSM was a “fiduciary with respect to” the Plan when it engaged in the complained-of conduct. *See* 29 U.S.C. §§ 1106(b), 1109(a); *DeLuca v. Blue Cross Blue Shield of Mich.*, 628 F.3d 743, 746, 748 (6th Cir. 2010). The district court held that Tiara Yachts failed to meet this threshold element of its ERISA claims, so the court did not address the other elements. BCBSM defends the court's dismissal of Tiara Yachts' claims on this threshold element only.<sup>3</sup> Accordingly, we focus our analysis on whether BCBSM acted as an ERISA fiduciary for Tiara Yachts' Plan when it allegedly overpaid claims and compensated itself through the SSP.

The statutory text tells us that a person or entity can become an ERISA fiduciary by “performing at least one of several enumerated functions with respect to a plan.” *Beddall v. State St. Bank & Tr. Co.*, 137 F.3d 12, 18 (1st Cir. 1998). Relevant here, a party is an ERISA fiduciary when it exercises either (1) any authority or control over plan assets; or (2) discretionary authority over plan management or administration. *See* *Briscoe v. Fine*, 444 F.3d 478, 488 (6th Cir. 2006); 29 U.S.C. § 1002(21)(A) (stating that an entity is a plan's fiduciary to the extent that it “exercises any discretionary authority or discretionary control respecting management of such plan,” “any authority or control respecting management or disposition of its assets,” or “any discretionary authority or discretionary responsibility in the administration of such plan”).

ERISA fiduciary status “is not an all or nothing concept.” *Briscoe*, 444 F.3d at 486 (citation omitted). Instead, we take a functional approach to ERISA fiduciary analysis, *see* *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993), and ask whether BCBSM “was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint,” *Pegram v. Herdrich*, 530 U.S. 211, 226, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000). Tiara Yachts alleges BCBSM violated ERISA by both overpaying claims (including through flip logic) and compensating itself for recovering those overpayments through the SSP. So we ask if each of those actions involved either control over plan assets or discretionary authority over plan management \*464 or administration, which would confer fiduciary status on BCBSM for Tiara Yachts' allegations in this case.

#### A. Overpaying Claims (Flip Logic and Claims-Processing Errors)

We first consider whether Tiara Yachts plausibly alleged that BCBSM acted as an ERISA fiduciary when overpaying providers based on flip logic and other claims-processing errors. “[A]n entity that exercises *any* authority or control over disposition of a plan's assets becomes a fiduciary” as to those actions. *See* *Pipefitters Loc. 636 Ins. Fund v. Blue Cross & Blue Shield of Mich.*, 722 F.3d 861, 867 (6th Cir. 2013) (*Pipefitters IV*) (citation omitted). Every circuit to address the issue has held that “‘discretionary’ control or authority” over plan assets is not required to give rise to ERISA fiduciary status. *See* *Mass. Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass.*, 66 F.4th 307, 324 (1st Cir. 2023) (emphasis added) (collecting cases). “[A]ny” authority or control will do. *Briscoe*, 444 F.3d at 488. Accordingly, “failing to preserve assets” gives rise to fiduciary duties. *See* *Saginaw Chippewa Indian Tribe of Mich. v. Blue Cross Blue Shield of Mich.*, 32 F.4th 548, 563 (6th Cir. 2022) (*SCIT*) (cleaned up).

That's just what Tiara Yachts alleges BCBSM did here. BCBSM “had the authority to write checks on the Plan account” and exercised “control over where Plan funds were deposited and how and when they were disbursed.” *Guyan Int'l, Inc. v. Pro. Benefits Adm'rs, Inc.*, 689 F.3d 793, 798 (6th Cir. 2012). It wrote those checks to medical providers based on its own claims-processing procedures, including flip logic. Tiara Yachts alleges that through flip logic, BCBSM knowingly squandered Plan assets by reimbursing certain out-of-state providers at charge rather than at the Host Blues' lower rates. Although Tiara Yachts does not refer to specific claims BCBSM overpaid through flip logic, it cites internal BCBSM emails that say flip logic affected an entire group of its customers to which Tiara Yachts belonged. That's enough to plausibly allege that BCBSM acted as a fiduciary when it controlled—and then “fail[ed] to preserve”—Plan assets. *See* *SCIT*, 32 F.4th at 564.

The district court held that Tiara Yachts' allegations about flip logic and claims-processing issues “are fully matters of contract,” so they are not actionable under ERISA. Order, R. 23, PageID 474–75. But contractual duties and ERISA fiduciary status are not mutually exclusive. *See, e.g.*, *Guyan*, 689 F.3d at 796, 798; *Pipefitters IV*, 722 F.3d at 867; *Hi-Lex Controls, Inc. v. Blue*

*Cross Blue Shield of Mich.*, 751 F.3d 740, 744–45 (6th Cir. 2014). Administrators of ERISA plans often operate under contract. And a plaintiff's allegation that its administrator breached a contractual term does not remove its claim from ERISA's ambit. Rather, an administrator's performance (or nonperformance) of its contractual obligations can illuminate whether it was acting as an ERISA fiduciary. In *Guyan*, for example, the plaintiffs alleged that their third-party administrator broke its contractual promises by comingling plan funds and using them for its own purposes. 689 F.3d at 796. We held that the administrator's use of “Plan funds in ways contrary to how it had agreed to use them” showed it had authority and control over plan assets, which meant it had acted as an ERISA fiduciary while breaching the contract. *Id.* at 798. The same goes here. Tiara Yachts alleges BCBSM violated the ASC by overpaying providers, which supports Tiara Yachts' contention that BCBSM exerted authority and control \*465 over plan assets. Indeed, to hold that an administrator like BCBSM insulates itself from ERISA liability because a contract governs its relationship with its customer would “gut ERISA's fiduciary provisions.” Sec'y of Lab. Amicus Br. at 25. <sup>4</sup>

The district court also held that BCBSM's alleged practice of systematically overpaying providers did not give rise to ERISA fiduciary status because it constituted a “system-wide business decision[ ]” rather than any action specific to the Plan. Order, R. 23, PageID 476. It cited our decision in *DeLuca v. Blue Cross Blue Shield of Michigan* for the idea that “business dealings” that are “generally applicable to a broad range of health-care consumers” and not “directly associated with the benefits plan at issue” do not give rise to ERISA fiduciary duties. *Id.* at PageID 475 (quoting *DeLuca*, 628 F.3d at 747). Because Tiara Yachts alleged that flip logic and other claims-processing issues affected many customers rather than just itself, the district court held that Tiara Yachts challenged a “business decision” outside ERISA's scope. *Id.* at PageID 476.

As an initial matter, we highlight that such reasoning would yield untenable results. If the inquiry were to focus solely on whether the action is “system-wide,” an administrator that squandered the assets from every plan it managed would be immune from ERISA claims because its error was a business decision for a group of plans, while one that overpaid from only a single plan would face liability. We do not read ERISA to categorically immunize conduct that affects many plans rather than just a few.

*DeLuca* does not hold otherwise. There, we acknowledged that BCBSM was acting in two capacities: one, as a distributor of healthcare services, and two, as a third-party administrator of ERISA plans. *DeLuca*, 628 F.3d at 746–47. The dispute was about actions BCBSM took solely in the former capacity. The plaintiff alleged that while negotiating with providers, BCBSM agreed to increase rates for two buckets of plans (which included his employer's) in exchange for decreasing rates for a third. *Id.* at 746. We held that negotiating rates “generally applicable to a broad range of health-care consumers” did not constitute “management” or “administration” of the plan, so it did not give rise to fiduciary status. *Id.* at 747 (citation omitted). We also observed that the complaint did not allege BCBSM had “squandered plan assets under its authority or control” or had otherwise breached ERISA fiduciary duties in its role as a third-party administrator. *Id.* at 747–48. In fact, the parties did not dispute that BCBSM “acted as a fiduciary” while processing claims, which involved “making discretionary eligibility determinations.” *Id.* at 746. But BCBSM's actions in that capacity weren't at issue in *DeLuca*. Here, they are. Tiara Yachts' complaint focuses on BCBSM's wasting Plan assets in its role “making discretionary eligibility determinations” and paying out claims, not on any actions it took as a “distributor of health-care services.” *Id.* at 747. *DeLuca* simply did not address the issue this case presents. <sup>5</sup>

\*466 BCBSM further argues that the First Circuit rejected “virtually identical” claims to Tiara Yachts' in *Massachusetts Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Massachusetts*, 66 F.4th 307 (1st Cir. 2023), but its reliance on that case is misplaced. Appellee's Br. at 28–29. True, as in this case, the plaintiff there sued its plan's third-party administrator under ERISA for “pa[y]ing providers in amounts exceeding the negotiated rates.” *Mass. Laborers*, 66 F.4th at 310. But the arrangement between the plan and its third-party administrator did not resemble the one between Tiara Yachts and BCBSM under the ASC. Most critically, the administrator there lacked the “final authority” to approve claims. *Id.* at 319–20. In *Massachusetts Laborers'*, the administrator would reprice claims according to the contract, but then the plan would determine claimant eligibility, adjudicate the claims, and provide final approval. *Id.* at 320. Although the administrator wrote the final check, that was a “mechanical administrative task[ ]” that the First Circuit reasoned was “insufficient to confer fiduciary status,” *id.* at 325 (citation omitted), because the administrator “lacked meaningful control over remitting claim payments,” *id.* at 327 (quotations omitted). In other words, the administrator “lacked authority respecting the disposition” of plan assets. *Id.* Not so here. Tiara Yachts alleges that the ASC gave BCBSM the authority to grant or deny claims, and then to pay claims from Plan assets. That

suffices to show that BCBSM exercised “meaningful control” over disposing of Plan assets when it overpaid providers through flip logic and other claims-processing errors, and thus acted as an ERISA fiduciary. *Id.*

Because Tiara Yachts has plausibly alleged that BCBSM controlled the disposition of Plan assets when it was overpaying claims to medical providers, it has plausibly demonstrated that BCBSM was acting as an ERISA fiduciary.<sup>6</sup>

## B. The SSP

Next, we consider whether Tiara Yachts plausibly alleged that BCBSM acted as an ERISA fiduciary by compensating itself through the SSP. But before examining the merits, we turn to the parties’ dispute about the proper pleading standard.

### 1. Heightened Pleading

BCBSM argues that Tiara Yachts’ allegations about the SSP trigger [Federal Rule of Civil Procedure 9\(b\)](#)’s heightened pleading requirements. Ordinarily, a plaintiff’s complaint needs to contain only a “short and plain statement of the claim showing that the pleader is entitled to relief.” *Hensley Mfg. v. ProPride, Inc.*, 579 F.3d 603, 609 (6th Cir. 2009) (quoting \*467 Fed. R. Civ. P. 8(a)(2)). But [Rule 9\(b\)](#) provides that if a plaintiff’s claim sounds in fraud, they must “state with particularity the circumstances constituting fraud or mistake.” Fed. R. Civ. P. 9(b). When determining whether a claim sounds in fraud, we have looked to whether the complaint’s allegations track the elements of common-law fraud. See *Cataldo v. U.S. Steel Corp.*, 676 F.3d 542, 551 (6th Cir. 2012) (citing *Caputo v. Pfizer, Inc.*, 267 F.3d 181, 191 (2d Cir. 2001)). Those elements are material misrepresentation or omission, knowledge of falsity, intent to defraud, reliance, and damages. See *Caputo*, 267 F.3d at 191. We have also held that a plaintiff’s claim need not contain fraud as an element to “sound in fraud,” but our cases otherwise leave open how close a connection there must be to common-law fraud. See *Kolominsky v. Root, Inc.*, 100 F.4th 675, 683 (6th Cir. 2024).

We need not resolve that issue here because Tiara Yachts’ allegations about the SSP do not sound in fraud under any standard. Tiara Yachts claims BCBSM overpaid providers, failed to correct the claims-processing issues that led to that overpayment, and implemented a system to profit off its own mistakes. But the complaint does not, for instance, allege that BCBSM lied about how much it would pay itself under the SSP or concealed the claims it was overpaying in the first place. Rather, Tiara Yachts concedes that BCBSM was up front about collecting 30% of the savings from the SSP and allowed Tiara Yachts to challenge or audit claims. Nor does Tiara Yachts allege that it relied on any misrepresentations related to the SSP in continuing to do business with BCBSM.

Moreover, Tiara Yachts does not need to plead that BCBSM acted fraudulently here, as the elements of common law fraud do not overlap with elements of an ERISA self-dealing claim. See *Cunningham v. Cornell Univ.*, — U.S. —, 145 S. Ct. 1020, 1027, 221 L.Ed.2d 591 (2025) (citing 29 U.S.C. § 1106(a)(1)(C)). ERISA treats self-dealing transactions as “presumptively unlawful,” *id.*, no matter whether the plaintiff alleges the defendant acted “out of fraud or imprudence,” *Appvion, Inc. Ret. Sav. & Emp. Stock Ownership Plan ex rel. Lyon v. Buth*, 99 F.4th 928, 948 (7th Cir. 2024). Tellingly, BCBSM cites no decision from this court applying [Rule 9\(b\)](#) to an ERISA self-dealing claim. Our sister circuits likewise generally have not applied a heightened pleading standard to ERISA claims. See *Concha v. London*, 62 F.3d 1493, 1502–03 (9th Cir. 1995) (explaining why [Rule 9\(b\)](#) should apply “in fraud claims, but not in breach of fiduciary claims generally,” and collecting circuit caselaw).

BCBSM’s arguments to the contrary fall flat. *First*, it cites our decision in *Cataldo v. United States Steel Corp.* for the proposition that [Rule 9\(b\)](#) applies to Tiara Yachts’ claim. See 676 F.3d at 551–52. But that case concerned whether the plaintiffs qualified for the “fraud or concealment” exception to ERISA’s statute of limitations. *Id.* at 548–51. To qualify for that exception—unlike a self-dealing claim—the plaintiffs needed to adequately plead fraud. *Id.* Contrary to BCBSM’s suggestion, *Cataldo* didn’t impose any specific pleading standard on breach of fiduciary duty claims under ERISA. *Second*, BCBSM asserts that the complaint sounds in fraud because it accuses BCBSM of “[m]isleading and deceiving Tiara Yachts by implementing a Shared Savings Plan when it knew Tiara Yachts’ Plan assets were being used to overpay for benefits.” Compl., R. 1, PageID 9. But a single

reference to “misleading and deceiving” in the complaint’s statutory counts does not transform Tiara Yachts’ claim. The rest of \*468 its allegations about the SSP focus on BCBSM’s self-dealing, not lying while doing so. Thus, Rule 9(b) does not apply to Tiara Yachts’ claims about the SSP.

## 2. Discretionary Authority over Plan Management or Administration

We turn now to whether Tiara Yachts has plausibly alleged that BCBSM acted as an ERISA fiduciary by exercising discretion over its compensation under the SSP. As explained above, a plaintiff can show that a defendant acted as an ERISA fiduciary by exercising discretionary authority over plan management or administration. *Briscoe*, 444 F.3d at 488 (citing 29 U.S.C. § 1002(21)(A)). To that end, if a contract grants a plan administrator discretion as to its compensation, using that discretion is a fiduciary act. See *Pipefitters IV*, 722 F.3d at 867; *Hi-Lex*, 751 F.3d at 744–45. But on the other hand, if a contract gives the administrator the unilateral right to a specific amount of compensation, exercising that right does not create fiduciary duties. See *Seaway Food Town, Inc. v. Med. Mut. of Ohio*, 347 F.3d 610, 619 (6th Cir. 2003).<sup>7</sup>

Under the ASC’s terms, BCBSM received a set percentage of the SSP’s savings—30%. At first blush, this fixed term makes it seem like BCBSM had no discretion in how much it got paid for administering the SSP. But when we scratch below the surface, it’s clear that BCBSM exercised discretion in setting its compensation for the SSP. That’s because, when dealing with percentages, a critical question is, “percentage of what”? BCBSM received both 30% of future overpayments the SSP prevented the Plan from paying, and 30% of past overpayments the SSP clawed back from providers. And, critically, BCBSM controlled the number and amount of overpayments the Plan made because under the ASC, BCBSM decided which claims to pay, determined how much to pay for them, and then wrote the checks. In short, BCBSM’s control over the claims-processing apparatus meant it also exercised discretion in setting its compensation under the SSP. Here, Tiara Yachts alleges that the self-dealing was nefarious: BCBSM intentionally inflated the pool of overpayments from which it could profit. The more overpayments BCBSM made on the front-end while processing claims, the more money it could receive on the back-end through the SSP. Based on that, Tiara Yachts has plausibly alleged BCBSM exercised discretion as to its own compensation through the SSP, giving rise to fiduciary duties. See *Pipefitters IV*, 722 F.3d at 867; *Hi-Lex*, 751 F.3d at 744–75.

In response, BCBSM asserts that the ASC allowed it to “retain a fixed percentage of specified amounts as compensation” for the SSP, so it exercised no discretion in how much it collected. Appellee’s Br. at 44. As explained above, that’s only partly true. Although the ASC fixed the *percentage* fee BCBSM would charge for the SSP, the complaint alleges that BCBSM controlled its *total* compensation by exercising authority and discretion over claims processing, including the number and amounts of overpaid claims to which the fixed percentage \*469 fee would apply. BCBSM cites *Seaway* for the proposition that its fixed percentage fee insulates it from ERISA fiduciary duties, but BCBSM’s control over initial overpayments distinguishes this case from *Seaway*. There, the parties’ contract stated that certain discounts and payments from providers were “for the sole benefit” of the administrator, who would “retain any payments resulting therefrom.” *Seaway*, 347 F.3d at 616. We held that the administrator didn’t exercise discretion by retaining those payments because it lacked control over how much it would get paid, including “over factors that determine[d] the actual amount of its compensation”—the discounts and benefits providers chose to offer. *Id.* at 619 (quoting *F.H. Krear & Co. v. Nineteen Named Trs.*, 810 F.2d 1250, 1259 (2d Cir. 1987)). In contrast, Tiara Yachts alleges BCBSM exercised control over a key factor in its compensation: the total pool of overpayments from which the SSP could draw. Rather than helping BCBSM, *Seaway* supports finding that BCBSM acted as an ERISA fiduciary here.

BCBSM next argues that we have only held an administrator exercised discretion over its compensation in a narrow set of circumstances, citing our decisions in *Pipefitters IV* and *Hi-Lex*. In those cases, we held that administrators had exercised discretion over compensation, as the contracts did not specify how much compensation the administrators could keep, and the administrators had not collected the same fees from all similarly situated customers. *Pipefitters IV*, 722 F.3d at 867; *Hi-Lex*, 751 F.3d at 744. According to BCBSM, because the ASC specified that it would collect 30% of savings, and because Tiara Yachts has not alleged BCBSM enforced that fee differently for other customers, it did not exercise “discretion” as defined by *Pipefitters IV* and *Hi-Lex*. But the facts of *Pipefitters IV* and *Hi-Lex* are so far from the allegations here that they are hard to compare.

Moreover, neither case prevents us from considering other indicia of discretion here. As *Seaway* acknowledged, one way an administrator may exercise discretion over its compensation is by controlling “factors that determin[e] the actual amount of its compensation.” 347 F.3d at 619 (quoting *F.H. Krear & Co.*, 810 F.2d at 1259). Tiara Yachts alleges BCBSM had the ability to approve inflated claims on the front-end to increase the SSP’s recovery pool. In other words, the complaint alleges that BCBSM could control a key factor in its compensation, which is enough to trigger ERISA fiduciary duties at this pleading stage.

BCBSM also contends that there were “too many steps between the initial payment and the recovery” for its control over claims processing to amount to discretion over its compensation. Oral Arg. Rec. at 16:50. It argues that third parties—not BCBSM—identified and recovered overpayments through the SSP. It also asserts clawing back past overpayments turned on “providers’ willingness ... to return excessive claims payments,” which was “outside BCBSM’s control.” Appellee’s Br. at 47. In support of its theory that its compensation was too attenuated from its control over claims processing to create fiduciary duties, BCBSM cites *Central Valley Ag Cooperative v. Leonard*, 986 F.3d 1082 (8th Cir. 2021), and *Massachusetts Laborers’*, 66 F.4th 307. In those cases, our sister circuits held that savings arrangements resembling the SSP didn’t give rise to ERISA fiduciary duties. But neither precedent focused on the “number of steps” between claims processing and recovery, or on the role of third parties in identifying and recovering savings. Rather, both found critical that, at bottom, the defendant did *not* exercise discretionary control over the overpayments from which it could later collect. That makes them inapposite \*470 here—at least at the pleading stage when we must accept Tiara Yachts’ factual allegations as true.

Consider the reasoning from each case. In *Central Valley*, a self-funded healthcare plan hired a bill reviewer to analyze some of the plan’s medical bills for “errors or excessive charges” and to recommend how much to pay providers. 986 F.3d at 1085. Then, the plan “decided whether to pay the recommended amount or a greater or lesser amount.” *Id.* Per the parties’ contract, if the plan ended up paying less than the charged amount, the reviewer collected 30% of the “savings.” *Id.* The Eighth Circuit held that this arrangement didn’t give rise to fiduciary duties because the plan retained the power to “approve” or “freely reject” the reviewer’s recommendations, meaning the reviewer lacked discretion as to its compensation. *Id.* at 1087. According to the complaint, Tiara Yachts retained no similar control over BCBSM’s benefits determinations and payments. *Massachusetts Laborers’* is also inapt. See 66 F.4th 307. There, the parties’ contract allowed the plan’s administrator to collect a percentage fee for correcting overpayments “attributable to a third party” but not those attributable to itself. *Id.* at 313, 322. The First Circuit held that the recovery provision didn’t allow discretion over compensation because it “clearly provided” that the administrator could recover only for overpayments other parties caused. *Id.* at 322. By contrast, the ASC here allegedly allowed BCBSM to retain savings from payments it erroneously approved. Again, rather than helping BCBSM, both *Central Valley* and *Massachusetts Laborers’* reflect the principle that where an administrator can recover for overpayments it unilaterally caused or controlled, that constitutes discretion over compensation.

Therefore, Tiara Yachts has plausibly alleged that BCBSM acted as an ERISA fiduciary by exercising discretion over its own compensation for the SSP.<sup>8</sup>

## II. Relief

Tiara Yachts also appeals the district court’s alternative holding for dismissing its complaint—that ERISA does not provide the relief it seeks. ERISA lays out “six carefully integrated civil enforcement provisions.” *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985). Those provisions provide “distinct categories of relief for differing types of harm.” *Patterson v. United HealthCare Ins. Co.*, 76 F.4th 487, 495 (6th Cir. 2023). Two provisions are relevant here: 29 U.S.C. § 1132(a)(2), which allows certain parties to collect damages or “other equitable or remedial relief” on behalf of the plan, and 29 U.S.C. § 1132(a)(3), which provides only for “appropriate equitable relief.” *Varity Corp. v. Howe*, 516 U.S. 489, 512, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996); see also 29 U.S.C. § 1109. The district court concluded that Tiara Yachts could not recover under either provision. We disagree.<sup>9</sup>

### \*471 A. Relief on Behalf of the Plan Under 29 U.S.C. § 1132(a)(2)

Section 1132(a)(2) provides that a plan's fiduciary can sue “for appropriate relief under section 1109.” 29 U.S.C. § 1132(a)(2). Section 1109, in turn, states that a person who violates ERISA fiduciary duties is “personally liable to make good to such plan any losses to the plan” from the breach, and “to restore to such plan any profits” resulting from the breach. See *id.* § 1109(a) (emphasis added). We have interpreted § 1109(a) as authorizing recovery only “to the plan.” See *Kuper v. Iovenko*, 66 F.3d 1447, 1452–53 (6th Cir. 1995), *abrogated on other grounds*, *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 134 S.Ct. 2459, 189 L.Ed.2d 457 (2014). To that end, the district court held that Tiara Yachts couldn't recover under § 1132(a)(2) because its complaint sought recovery on behalf of itself, not the Plan.

We do not read the complaint as narrowly as the district court did, however. True, the complaint does not specify that recovery is “for the Plan.” But in analyzing whether ERISA plaintiffs seek recovery on behalf of a plan, we have explained that courts should not elevate form over substance. See *Tullis v. UMB Bank, N.A.*, 515 F.3d 673, 680–81 (6th Cir. 2008). In *Tullis*, for example, we held that the plaintiffs satisfied § 1109(a), and accordingly could collect damages on the plan's behalf, even though the complaint referred only to their individual damages and “did not specifically allege” that “their plan suffered losses.” *Id.* at 680. A few facts colored that inquiry. *First*, the complaint “clearly indicate[d] that the plaintiffs” sought “recovery for losses to their plan accounts caused by fiduciary breaches” in the plaintiffs’ capacity as participants. *Id.* at 681. *Second*, the complaint placed the defendant “on notice that the plaintiffs [sought] recovery for losses that occurred to their plans.” *Id.* And *third*, the plaintiffs alleged that under their plan's terms, any recovery would “inure to the plan before being allocated” to their specific accounts. *Id.* at 682. Likewise, in *Guyan*, we held that plaintiffs plausibly alleged they sought recovery on behalf of their plans because they alleged “harm to the [p]lans themselves and the [p]lan participants.” 689 F.3d at 800–01. That sufficed to put the defendant “on notice” that plaintiffs sought “recover[y] for losses that occurred to the Plans” when the defendant breached its fiduciary duties. *Id.* at 801.

Following these precedents, Tiara Yachts has plausibly alleged that it seeks to collect on the Plan's behalf. Tiara Yachts did not sue in a representative capacity, but it did specify that it sought recovery in its capacity as the Plan's sponsor “for losses to [the] plan account[ ] caused by fiduciary breaches.” See *Tullis*, 515 F.3d at 681. Though the complaint does not specifically call for “recovery on behalf of the[ ] plan[ ],” *id.* at 680–81, it plausibly placed BCBSM on notice that Tiara Yachts sought recovery for losses to the Plan. The crux of the complaint is that BCBSM breached its fiduciary duties to the Plan by squandering assets, then wrongfully kept a portion of overpaid Plan assets as administrative fees. Finally, the complaint alleges harm both to \*472 Tiara Yachts and to the Plan. See *Guyan*, 689 F.3d at 800–01. For example, it seeks a full accounting of “all payments and uses of Tiara Yachts’ Plan assets,” as well as “all monies taken or charged by BCBSM to Tiara Yachts.” Compl., R. 1, PageID 21. Under *Tullis* and *Guyan*, Tiara Yachts has adequately pleaded that it seeks recovery for the Plan, not for itself. <sup>10</sup>

### B. Equitable Relief Under 29 U.S.C. § 1132(a)(3)

Tiara Yachts also seeks recovery under 29 U.S.C. § 1132(a)(3). That section allows a participant, beneficiary, or fiduciary to sue “to obtain ... appropriate equitable relief” to “redress ... violations” or “enforce any provisions” of ERISA or the plan's terms. To decide whether Tiara Yachts asks for “equitable relief,” we look to whether Tiara Yachts could have brought the same kinds of claims and received the same remedy in traditional courts of equity. *Patterson*, 76 F.4th at 495–96. We have held that ERISA claims for breach of fiduciary duty and self-dealing are “equitable in nature.” *Id.* at 496. Two forms of relief that Tiara Yachts seeks—restitution and disgorgement—both were typically available in courts of equity. *Id.* at 497. Thus, Tiara Yachts seeks “equitable relief” under § 1132(a)(3).

We note, however, that Tiara Yachts cannot recover under § 1132(a)(3) for BCBSM's overpayments to providers that BCBSM never clawed back—that is, for funds that providers still possess. As BCBSM correctly points out, to receive equitable relief “in the universe of transferred assets,” a plaintiff generally must be able to trace the award “back to ‘particular funds or property in the defendant's possession.’ ” *Id.* (quoting *Zirbel v. Ford Motor Co.*, 980 F.3d 520, 524 (6th Cir. 2020)). We have applied the tracing requirement to claims for equitable restitution. *Id.* Here, to the extent that Tiara Yachts seeks restitution of funds BCBSM overpaid and never subsequently recovered, those funds are not in BCBSM's possession and thus are not recoverable under § 1132(a)(3). *Id.*

By contrast, Tiara Yachts’ complaint has plausibly alleged facts suggesting that it can seek to recover for restitution or disgorgement of BCBSM’s SSP profits under § 1132(a)(3). We haven’t expressly held that claims for disgorgement must satisfy the traceability requirement. *Id.* Even if they do, Tiara Yachts has alleged that BCBSM retained specific funds it collected for the SSP. *See id.* at 497–98.

None of BCBSM’s arguments convince us that this relief is unavailable. BCBSM’s assertion that Tiara Yachts essentially seeks “basic contract damages,” a legal remedy, mischaracterizes the complaint. Appellee’s Br. at 56. As noted above, the fact that Tiara Yachts alleges BCBSM broke its promises in the ASC does not transform Tiara Yachts’ claim into one under contract rather than ERISA. *See Guyan*, 689 F.3d at 798. In requesting restitution and disgorgement, Tiara Yachts does not, as BCBSM argues, aim to “put [itself] in as good a position as [it] would have been in had the contract been performed.” Appellee’s Br. at 56 (citation omitted). In other words, Tiara Yachts’ desired equitable relief does not amount to expectation damages. Rather, Tiara Yachts asks for BCBSM to return the funds it overpaid from Plan assets and \*473 the profits it generated from SSP fees. As far as Tiara Yachts explicitly seeks damages, it can recover those on behalf of the Plan via § 1132(a)(2), as described above, but not § 1132(a)(3).

## CONCLUSION

We reverse the district court’s dismissal of Tiara Yachts’ complaint and remand for proceedings consistent with this opinion.

### All Citations

138 F.4th 457

---

## Footnotes

- 1 We accept Tiara Yachts’ factual allegations as true and draw all reasonable inferences in its favor, as we must at this stage. *Linden v. City of Southfield*, 75 F.4th 597, 601 (6th Cir. 2023).
- 2 The exact mechanics of “flip logic” are not necessary to analyzing Tiara Yachts’ claims. At bottom, Tiara Yachts alleges that flip logic caused BCBSM to overpay on claims from certain out-of-state providers.
- 3 Although BCBSM briefed the other elements of Tiara Yachts’ claims before the district court, its appellate brief focuses solely on whether it acted as an ERISA fiduciary when taking the actions alleged. As a result, BCBSM has abandoned any challenge to the other elements of Tiara Yachts’ ERISA claims, and we do not address them here. *Robinson v. Jones*, 142 F.3d 905, 906 (6th Cir. 1998) (order).
- 4 The ASC itself states that ERISA will govern the Plan. That language may not be dispositive. But it certainly indicates that, contrary to the district court’s holding, BCBSM could breach its ERISA fiduciary duties by violating the ASC’s terms. *See Hi-Lex*, 751 F.3d at 746 (rejecting a plan administrator’s “attempts to characterize its arrangement” with the plaintiff as simply “a service agreement between two companies” because parties’ contract referred to their rights and obligations under ERISA).
- 5 BCBSM cites four more cases purportedly holding “that an entity’s broader decisions do not give rise to ERISA fiduciary status.” Appellee’s Br. at 40 n.7. None are analogous. *Holdeman v. Devine*, 474 F.3d 770, 778–80 (10th Cir. 2007), analyzed whether the defendant, who served both as his company’s CEO and as a fiduciary of his employees’ benefits

plan, acted in his fiduciary capacity when he stopped funding the plan. This case does not involve any similar allegations. BCBSM also cites *Hunter v. Caliber System, Inc.*, 220 F.3d 702 (6th Cir. 2000), *Sengpiel v. B.F. Goodrich Co.*, 156 F.3d 660 (6th Cir. 1998), and *Acosta v. Brain*, 910 F.3d 502 (9th Cir. 2018), which concerned whether an employer’s business decisions constituted fiduciary acts. None of these cases provide insight on whether a third-party administrator’s business-wide decision to waste plan assets qualifies as a fiduciary act.

- 6 Because exercising “any authority or control” over plan assets is sufficient to make BCBSM a fiduciary with regard to Tiara Yachts’ charge that it overpaid provider claims, *Guyan*, 689 F.3d at 798 (citing *Briscoe*, 444 F.3d at 490–91), we need not consider whether BCBSM also acted as a fiduciary by exercising “discretionary authority” over administering or managing the Plan when it overpaid providers’ claims, *id.* at 797.
- 7 We read *Seaway*, *Pipefitters IV*, and *Hi-Lex* as concerning whether an administrator acted as an ERISA fiduciary by exercising discretion over its own compensation. Admittedly, these decisions left some ambiguity as to whether they based their holdings on control over plan assets on the one hand, or discretionary authority over plan management or administration on the other. But as the First Circuit explained in *Massachusetts Laborers’*, all three decisions are best understood as concerning the latter path to ERISA fiduciary status—discretionary authority over plan management or administration. 66 F.4th at 318–19.
- 8 To establish BCBSM’s fiduciary status regarding the SSP, Tiara Yachts alternatively argues that BCBSM exercised control over the disposition of plan assets via its compensation. Because we hold that BCBSM did exercise discretionary authority over plan management or administration, we do not have to rely on Tiara Yachts’ alternative theory. But one could argue that by paying itself 30% of prevented overpayments and collecting that fee directly from Plan assets (rather than clawing funds back from providers), BCBSM exercised “authority or control respecting management or disposition of [Plan] assets.” 29 U.S.C. § 1002(21)(A). We need not address that argument here.
- 9 Tiara Yachts’ complaint did not specify the provision or provisions under which it sued. That said, it sought damages, restitution, disgorgement, and a declaratory judgment. BCBSM argued in its motion to dismiss that neither § 1132(a)(2) nor (a)(3) could provide Tiara Yachts its desired relief. Then, in its opposition, Tiara Yachts argued both sections could provide it relief, but not that other civil enforcement provisions should apply. Accordingly, on appeal, the parties dispute only whether §§ 1132(a)(2) and (a)(3) can provide Tiara Yachts relief, not whether any other provisions could do so. So that is the focus of our analysis here.
- 10 Tiara Yachts sought leave to amend, and its proposed amended complaint stated explicitly that it sought relief on behalf of the Plan. The district court denied leave because, in its view, the proposed amended complaint could not cure the issues with ERISA fiduciary status. But, as described above, the district court erred in its analysis of ERISA fiduciary status, so granting Tiara Yachts leave to amend would not have been futile. *See Riverview*

# EXHIBIT 11

349 F.3d 321  
United States Court of Appeals,  
Sixth Circuit.

Frank C. WRIGHT, M.D., John P. Goff, M.D., and Carl A. Krantz, M.D., as Trustees of  
the Wright, Goff, Krantz, Harmon, Jones, M.D.'s Profit Sharing Plan, Plaintiffs–Appellants,

v.

Michael A. HEYNE, and Vestax Securities Corporation, Defendants–Appellees.

No. 01–4359.

|

Argued: May 2, 2003.

|

Decided and Filed: Nov. 14, 2003.

### Synopsis

Retirement plan trustees brought action under Employee Retirement Income Security Act (ERISA) against securities corporation and its owner, advisers to plan, alleging they breached certain fiduciary duties in making investment decisions and engaged in conduct prohibited under ERISA with regard to receipt of commissions. The United States District Court for the Southern District of Ohio, Norah McCann King, United States Magistrate Judge, 2001 WL 1678788, granted defendants' motion for summary judgment on grounds that claims were time-barred. Trustees appealed. The Court of Appeals, Rosen, District Judge, sitting by designation, held that: (1) trustees did not need to know they had cognizable legal claim under ERISA in order to trigger running of statute of limitations, and (2) trustees had “actual knowledge” of material facts upon which their claims for breach of ERISA fiduciary duties were based more than three years before they filed action, which was thus untimely.

Affirmed.

**Procedural Posture(s):** On Appeal; Motion for Summary Judgment.

### Attorneys and Law Firms

\***322** Roger Makley (briefed), Coolidge, Wall, Womsley & Lombard, Dayton, OH, Alphonse P. Cincione (argued and briefed), N. Gerald DiCuccio (briefed), Butler, Cincione, DiCuccio & Barnhart, Columbus, OH, for Plaintiffs–Appellants.

Danny L. Cvetanovich (briefed), Nancy J. Manougian (argued and briefed), Arter & Hadden, Columbus, OH, for Defendants–Appellees.

Before NELSON and COLE, Circuit Judges; ROSEN, District Judge.\*

## OPINION

ROSEN, District Judge.

### I. INTRODUCTION

Plaintiff–Appellants Frank C. Wright, John P. Goff and Carl Krantz brought this action as Trustees of the Wright, Goff, Krantz, Harmon and Jones Profit Sharing Plan (the “Retirement Plan”) under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a) (“ERISA”), against Vestax Securities Corporation (“Vestax”) and its owner, Michael A. Heyne, investment

advisors to Plaintiffs' Retirement Plan, alleging that Vestax and Heyne breached certain fiduciary duties in making investment decisions and engaged in conduct prohibited under ERISA with regard to the receipt of commissions. The District Court for the Southern District of Ohio granted Defendants' Motion for Summary Judgment on the ground that ERISA's three-year statute of limitations barred Plaintiffs' claims. Plaintiffs timely appealed the District Court's decision.

For the reasons set forth below, we affirm the District Court's grant of Defendants' Motion for Summary Judgment.

## II. *FACTUAL BACKGROUND*

Plaintiffs Frank C. Wright, John L. Goff and Carl A. Krantz are trustees of the Wright, Goff, Krantz, Harmon Jones, M.D.'s Profit Sharing Plan (“the Retirement Plan”). They are physicians who practiced together as a professional corporation known as “Wright, Goff, Krantz, \*323 M.D.'s, Inc.” from the late 1970s until 1995 when Goff retired.<sup>1</sup>

Shortly after the corporation was formed, it created a Retirement Plan. Wright and Krantz have been trustees of the Plan since its inception, and Goff was a trustee of the Plan from the time the Plan was created until his retirement from the practice of medicine in 1995.

The Plan included a commonly-managed general account, as well as individual self-directed accounts for those participants who wanted them. Plaintiffs were all participants in the Plan, and each had a self-directed account under the Plan. While Wright, Goff, and Krantz, as trustees, were responsible for directing transactions in the Plan's general account, Goff played the most active role in directing those transactions. With respect to the self-directed accounts, each individual was responsible for the direction of his own self-directed account.

Prior to late 1987, Plaintiffs utilized the services of Professional Investment Management to help them invest the assets of the Plan's general account. Wright, Goff and Krantz also each used the services of Professional Investment Management to help them with investments in their respective self-directed accounts.

Plaintiffs terminated the services of Professional Investment Management in late 1987, and shortly thereafter, hired Defendant Michael Heyne to provide investment advice and services to the Plan with respect to the general account. Each individual also retained Heyne to provide investment advice and services for his self-directed account.

Plaintiffs were also aware that Heyne was affiliated with, and had an ownership interest in, Vestax. In December 1987, the Plan and each of the individual Plaintiffs also entered into a “VesTrak Investment Analysis Service Agreement” with Vestax, under which Vestax was to provide quarterly Investment Analysis Reports to the Plan with respect to the general account, as well as to Plaintiffs with respect to each of their respective self-directed accounts. These reports included a list of each investment made, the date and cost of each investment, the proceeds received from the sale of each investment, the current market value of each investment and the earnings of each investment. The VesTrak Agreements disclosed that Vestax would earn fees for the services it would provide and the amount of the fees that would be earned. The Agreements further disclosed that Vestax could earn commissions on the purchase or sale of certain securities:

Client understands that if he as a purchaser of the VesTrak Investment Analysis Service uses the services of Vestax in connection with the sale or purchase of a security that is the object of the VesTrak Investment Analysis Service, then Vestax may act as principal for its own account or as agent for another person in undertaking such sale or purchase and may be paid a commission on such sale or purchase. Client hereby consents to the payment of such commission to Vestax.

(See JA 1502, 1551)

Also in December 1987, the Plan and Wright, Goff, and Krantz, individually with respect to their self-directed accounts, entered into a Soliciting Agent Agreement with Heyne. The Soliciting Agent Agreements disclosed that Heyne solicited \*324 clients to enter into VesTrak Agreements with Vestax, that Heyne was an officer and stockholder of Vestax, that Heyne could receive a portion of the fees that a client would pay to Vestax, that Vestax would receive “commissions or other compensation” if “financial service products or investments are purchased through Vestax” and that Heyne would receive “a portion of such commissions if such sales are arranged through [Heyne] and [he] is a registered representative of Vestax.” (See JA 1522).

Pursuant to the VesTrak Agreements, quarterly Investment Analysis Reports were provided to the Plan and to Wright, Goff and Krantz, individually, for their respective self-directed accounts. Heyne also usually met with Plaintiffs on a quarterly basis to discuss the reports as well as to answer any questions Plaintiffs had about the investments and other information reflected in the reports.

In 1991 or 1992, approximately three or four years after the Plan's relationship with Heyne and Vestax began, Goff began to feel some “dissatisfaction” with Heyne. The dissatisfaction stemmed from Goff's learning that Heyne was an officer of AFA Financial, Inc., an entity with which the Plan and Wright, Goff and Krantz on behalf of their own respective self-directed accounts had placed money for management. Goff considered Heyne's affiliation with AFA Financial to be a conflict of interest and he instructed Heyne to take his money out of AFA, which Heyne did. Goff was also concerned that the general account and his own self-directed account were not meeting his financial objectives and that the fees and commissions that Heyne was earning was “driving the choice of investment as opposed to the appropriateness of the investment.” (JA 86, 97–104).

During 1992 and 1993, Krantz likewise began to become dissatisfied with Heyne's services. Like Goff, Krantz was concerned with Heyne's affiliation with AFA Financial, Heyne's failure to follow investment objectives, and the fees and commissions paid to Heyne.

Sometime in 1993, Goff asked Philip Shaffer of the Consulting Group at Smith Barney Shearson to review the performance of the general account and his own self-directed account. Shaffer informed Goff that the investments in his portfolio were “driven by fees and commissions” and were “not proper.” (JA 105). Shaffer also informed Goff that Heyne had deviated from the investment plans for the Plaintiffs' self-directed accounts. (JA 125).

Later in 1993 or early 1994, Goff also asked Denny Dicky of Berwanger Overmeyer to review the Plan's investments and performance. Dicky informed Goff that after reviewing the Plan's investments, he “couldn't sleep at night.” (JA 108) Dicky also made statements of “the same tenor as Mr. Shaffer's comments.” *Id.*

In 1994, Wright asked his brother, Tom Wright (who had experience managing his own investments and later registered as an investment advisor), to review his self-directed account. In June 1994, Tom Wright advised his brother to “get away from” Heyne, Vestax, and AFA Financial. (JA 889) Tom Wright further advised his brother that he had received “bad [investment] advice” from Heyne, should “not purchase any more limited partnerships,” and should not “annuitize any more of the annuities.” (JA 1773–74). Tom Wright also concluded that Heyne had been paid “excessive compensation” for his services. (JA 1804–05).

Then, in early 1995, Goff asked William Cseplo of McDonald & Company to review his self-directed account. In a letter dated \*325 March 18, 1995, Cseplo specifically stated that he was “terribly disturbed at the failure of this investment advisor to implement your written desires and the thought that he would place his interests (commissions) before your interests. I have never seen such gross neglect of ethics with regards to this portfolio....” (JA 558–59, 622–23). The letter went on to state:

If you feel as if you have been wronged by what has occurred in this portfolio, I would suggest you could probably seek legal action. I believe you have some basis. Michael Heyne invested your money in high yield bonds that you specifically told him not to buy. He annuitized an annuity and, in my opinion, had no reason to do so.... I would seek full restitution for the transactions that were not in your specific written directions and the annuity transactions that make no sense at all....

*Id.*

On March 26, 1995, just a few weeks after receiving Cseplo's conclusions with respect to his review of Goff's self-directed account, Goff terminated his relationship with Heyne and Vestax and transferred his self-directed account to Cseplo.

In April 1995, Plaintiff Krantz asked Cseplo to review his self-directed account. On April 19, 1995, Cseplo informed Krantz in writing that, although Krantz had instructed Heyne "not to purchase high yield (junk) bond portfolios [ Heyne] began the account in 1988 with a purchase of the very thing you did not want to own...." (JA 598–99, 624). On May 2, 1995, based on Cseplo's conclusions, Krantz terminated his relationship with Heyne and Vestax with respect to his self-directed account and engaged Cseplo to manage the account.

On July 20, 1995, the Plan informed Heyne that it, too, was terminating its relationship with Heyne and Vestax with respect to the general account and on August 10, 1995, the Plan's general account was transferred to Cseplo.

On September 11, 1995, Wright terminated his relationship with Heyne and Vestax with respect to his self-directed account.

On February 27, 1997, Plaintiffs retained the services of an attorney, Tony Merry. In late 1997, after further analysis by Cseplo, in which Cseplo advised at least Goff and Krantz that the Plan had suffered monetary losses at the hands of Heyne and Vestax, Merry advised Plaintiffs that they had valid ERISA claims arising out of Heyne's alleged breach of fiduciary duties. Merry specifically advised Plaintiffs that some of Heyne's investments had created a conflict with organizations in which Heyne and Vestax had personal interests, and that Heyne had been paid excessive compensation.

On October 30, 1998, Plaintiffs filed the instant action. In their Complaint, Plaintiffs alleged that Heyne and Vestax acted in breach of their fiduciary duties in violation of ERISA, 29 U.S.C. §§ 1109, 1132(a)(2), (3), and engaged in conduct prohibited by 29 U.S.C. § 1106(a), (b).

Pursuant to 28 U.S.C. § 636(c)(3) and Fed.R.Civ.P. 73(c), the parties consented to the jurisdiction of a United States Magistrate Judge and further consented that an appeal from the Magistrate Judge's judgment would be directly to the Court of Appeals for the Sixth Circuit. (JA 22).

### III. THE DISTRICT COURT'S DECISION

On July 31, 2001, Defendants filed a Motion for Summary Judgment arguing that because the action had been commenced more than three years after the Plaintiffs acquired actual knowledge of the Defendants' alleged breach of duty, the \*326 claims of the Plaintiffs were barred by the three-year statute of limitations provided in 29 U.S.C. § 1113. (The text of § 1113 is set forth in footnote 2, *infra*.) On November 29, 2001, the District Court issued an Opinion and Order and Judgment agreeing with Defendants that Plaintiffs' Complaint was time-barred.

In reaching its conclusion, the District Court relied on several previous decisions of this Court. While noting that this Circuit has yet to articulate in any published decision a broad definition of “actual knowledge” for purposes of ERISA’s limitations of actions provision, 29 U.S.C. § 1113, the District Court also noted that the Sixth Circuit has examined numerous cases involving the question of whether a plaintiff had “actual knowledge” under § 1113(2). Specifically, the District Court stated:

[T]o charge an ERISA plaintiff “with actual knowledge of an ERISA violation, it is not enough that he had notice that something was awry; he must have had specific knowledge of the actual breach of duty upon which he sues ... [S]ection 1113(a)(2)(A) [sic] means only that *once [the plaintiff] learns of the facts that support his allegation of illegality, he has no more than three years in which to bring his ... suit.*”

(JA 2011) (quoting *Rogers v. Millan*, 920 F.2d 34, 1990 WL 61120 at \*4 (6th Cir.1990) (unpublished decision; text available on WESTLAW) (emphasis added by district court)).

Relying on the information provided to Plaintiffs by various investment advisors in 1994 and 1995, the District Court reached the conclusion that Plaintiffs had “actual knowledge” under § 1113(2) more than three years prior to filing their claim in October 1998. Specifically, the District Court concluded that:

The record in this action does not portray investors (or trustees) who, prior to the Fall of 1997, merely “had general concerns for [their] investments, which every investor should have.” Rather, each of the three trustees had been advised by any number of financial experts, by mid-1995, that defendants had engaged in inappropriate and unauthorized investments, under circumstances that conflicted with the interests of the Plan and its participants.

(JA 2013 (citation omitted)).

The District Court also rejected Plaintiffs’ argument that it was not until the fall of 1997, when William Cseplo informed them that Appellee’s conduct had worked to the financial detriment of the Plan, that Plaintiffs had the requisite “actual knowledge.” The District Court determined that “ERISA’s three-year statute of limitations will apply when the plaintiff has actual knowledge of the facts that give rise to the claims upon which it sues; it ‘cannot wait until the consequences of the act become painful.’” (JA 2013) (citing *Ternes v. Tern-Farm, Inc.*, 904 F.2d 708, 1990 WL 80915 at \*3 (6th Cir.1990) (unpublished decision; text available on WESTLAW)). Therefore, the District Court concluded that Plaintiffs had actual knowledge by at least September 1995 and their claim was, therefore, barred by § 1113(2) of ERISA.

#### IV. DISCUSSION

##### A. STANDARD OF REVIEW

This Court reviews a district court’s grant of summary judgment *de novo*. *Pinney Dock & Transport Co. v. Penn Cent. Corp.*, 838 F.2d 1445, 1472 (6th Cir.1988), *cert. denied*, 488 U.S. 880, 109 S.Ct. 196, 102 L.Ed.2d 166 (1988). In conducting this review, the Court determines, in the light most favorable to the non-moving party, whether any issue of \*327 material fact existed in the record below. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323–24, 106 S.Ct. 2548, 91 L.Ed.2d 265(1986).

##### B. ERISA’S THREE-YEAR STATUTE OF LIMITATIONS

Under ERISA, when a fiduciary breaches an obligation or duty, the victim of the breach normally has six years in which to file suit. 29 U.S.C. § 1113(1). However, this period may be shortened to three years where the victim had “actual knowledge of the breach or violation.” 29 U.S.C. § 1113(2).<sup>2</sup>

The District Court found that Plaintiffs had “actual knowledge of the breach or violation” by at least September 1995. It is clear from the record below that if Plaintiffs did not have “actual knowledge,” their claim was filed within the requisite six-year

period provided in § 1113(1). Therefore, the ultimate question presented here is whether Plaintiffs had “actual knowledge of the breach or violation” more than three years prior to the initiation of this action on October 30, 1998.

### 1. THE “ACTUAL KNOWLEDGE” REQUIREMENT

The basic ERISA limitation period of six years begins on the date of the breach or violation. However, a “plaintiff with actual knowledge of a non-fraudulent breach of ERISA fiduciary duties must file suit within three years.” *Tassinare v. American Nat'l Ins. Co.*, 32 F.3d 220, 223 (6th Cir.1994).

As the District Court observed, the Sixth Circuit has yet to articulate a broad definition of “actual knowledge” under 29 U.S.C. § 1113(2). However, other circuits have examined the issue of what constitutes “actual knowledge” under § 1113(2), and differing views of the definition have emerged.

Plaintiffs urge the Court to apply the standard articulated by the Third Circuit in *Gluck v. Unisys Corp.*, 960 F.2d 1168 (3rd Cir.1992), which was subsequently adopted and applied by the Fifth Circuit in *Reich v. Lancaster*, 55 F.3d 1034, 1057 (5th Cir.1995) and *Maher v. Strachan Shipping Co.*, 68 F.3d 951, 954–55 (5th Cir.1995).

In *Gluck*, the Third Circuit held that “[a]ctual knowledge of a breach or violation” requires that a plaintiff have actual knowledge of all material facts necessary to understand that some claim exists, which facts could include necessary opinions of experts, knowledge of a transaction's harmful consequences, or even actual harm.” *Id.* at 1177. The Third Circuit elaborated upon its formula in *International Union v. Murata Erie North America, Inc.*, 980 F.2d 889 (3rd Cir.1992), stating that “ ‘actual knowledge’ requires a showing that plaintiffs actually knew not only of the events that occurred which constitute the breach or violation but also that those events supported a claim for \*328 breach of fiduciary duty or violation under ERISA.” *Id.* at 900.

However, as indicated above, courts are divided on the issue of what constitutes “actual knowledge” under § 1113(2). The Third Circuit's position represents one view. Other circuits which have examined Section 1113(2)'s “actual knowledge” requirement—specifically, the Seventh, Ninth and Eleventh Circuits—have held that “actual knowledge” requires only knowledge of all the relevant facts, not that the facts establish a cognizable legal claim under ERISA. See *Martin v. Consultants & Administrators, Inc.*, 966 F.2d 1078, 1086 (7th Cir.1992) (“[T]he relevant knowledge for triggering the statute of limitations is knowledge of the *facts* or *transaction* that constituted the alleged violation. Consequently, it is not necessary for a potential plaintiff to have knowledge of every last detail of a transaction, or knowledge of its illegality.” (Emphasis in original)); *Rush v. Martin Petersen Co.*, 83 F.3d 894, 896 (7th Cir.1996) (“We have defined ‘actual knowledge’... as knowledge of the ‘essential facts of the transaction or conduct constituting the violation,’ and have explained that this means it is ‘not necessary for a potential plaintiff to have knowledge of every last detail of a transaction, or knowledge of its illegality.’ ” (internal citations omitted)); *Blanton v. Anzalone*, 760 F.2d 989, 992 (9th Cir.1985) (holding that a claim for breach of ERISA fiduciary duties is not tolled until an attorney advises the plaintiff that the transaction was prohibited and stating: “The statute of limitations is triggered by ... knowledge of the transaction that constituted the alleged violation, not by ... knowledge of the law.”) *Brock v. Nellis*, 809 F.2d 753, 755 (11th Cir.1987) (“To us, section 1113(a)(2)(A) means only that once the Secretary learns of the facts that support his allegation of illegality, he has no more than three years in which to bring his suit.”); *Scott v. Evins*, 802 F.Supp. 411, 416 (N.D.Ala.1992), *aff'd*, 998 F.2d 1022 (11th Cir.1993) ( section 1113(2) “bars an action for violation of [ERISA fiduciary duties] three years after the plaintiff has actual knowledge of the facts, not knowledge of the violation of the law.”)

Citing both of the foregoing distinct lines of cases, in *Caputo v. Pfizer, Inc.*, 267 F.3d 181 (2nd Cir.2001), the Second Circuit appears to have adopted a “hybrid” view of the actual knowledge requirement, extrapolating parts of both the Third and Fifth Circuits' view, and of the view espoused by the Seventh, Ninth and Eleventh Circuits. The *Caputo* court held as follows:

Although this Court has not previously defined the term, we now hold that a plaintiff has “actual knowledge of the breach or violation” within the meaning of ERISA § 413(2), 29 U.S.C. § 1113(2), when he has knowledge of all material facts necessary to understand that an ERISA fiduciary has breached his or her duty or otherwise violated the Act. *Accord Maher v. Strachan Shipping Co.*, 68 F.3d 951, 954 (5th Cir.1995); *Gluck v. Unisys Corp.*, 960 F.2d 1168, 1177 (3d Cir.1992). While a plaintiff

need not have knowledge of the relevant law, *Blanton v. Anzalone*, 760 F.2d 989, 992 (9th Cir.1985), he must have knowledge of all facts necessary to constitute a claim. Such material facts “could include necessary opinions of experts, knowledge of a transaction's harmful consequences, or even actual harm.” *Gluck*, 960 F.2d at 1177....

267 F.3d at 193.

Some courts, in an attempt to resolve the “actual knowledge” inquiry also look to whether the defendant's actions giving rise to the plaintiff's breach of fiduciary claims were “inherently suspect,” or “inherently” a statutory violation. For example, in **\*329** *Fink v. National Savings and Trust Co.*, 772 F.2d 951 (C.A.D.C.1985), the plaintiff's breach of fiduciary claim was predicated upon the ERISA Plan trustee's alleged failure to independently evaluate the Plan's investments, not upon the investment itself. The defendant argued that the plaintiff's claim was time-barred because he had knowledge as of the date of the Plan's filing of forms filed with the Department of Labor which disclosed the investment transaction. The court held that the Department of Labor forms alone were insufficient to constitute knowledge to the Plan beneficiaries of the breach of the fiduciary duty of independent evaluation. “The disclosure of a transaction that is not inherently a statutory breach of fiduciary duty cannot communicate the existence of the underlying breach.” *Id.* at 957. See also, *Waller v. Blue Cross of California*, 32 F.3d 1337, 1338 (9th Cir.1994) (plaintiffs' knowledge of Retirement Plan's purchase of annuities to provide retirement benefits to Plan participants held not to constitute actual knowledge that defendants breached their fiduciary duties by using an infirm bidding process in selecting the annuity providers); *Caputo v. Pfizer, Inc.*, *supra* (plaintiffs' knowledge of defendant's offering of a second voluntary separation offer (VSO) did not constitute actual knowledge of a breach of fiduciary duty claim charging defendants with misrepresentation of future pension benefits for purposes of the § 4113 three-year statute of limitations where the plaintiffs admitted that, when the second VSO was formally announced, although they “suspected” that management had been “fudging it” when it denied that such a package would be offered, they had no knowledge that any individual had knowingly lied to them. 267 F.3d at 186, 193.)

As correctly noted by the Seventh Circuit, “[A]ctual knowledge must be distinguished from constructive knowledge.” *Martin*, 966 F.2d at 1086. The line between actual and constructive knowledge is not a bright and readily distinguishable one. “We know that somewhere between ‘every last detail’ and ‘something was awry’ lies the requisite knowledge of an ERISA violation.... [J]udges, faced with particular contexts and relying on their ‘situation sense,’ must make the determination.” *Id.* at 1086.

Although in this Circuit, we have yet to firmly establish a rule of law broadly defining “actual knowledge of the breach or violation” under Section 413(2) of ERISA, we have had occasion to examine numerous ERISA claims dealing with the determination of when litigants had “actual knowledge.” For example, in *Tassinare v. American Nat'l Ins. Co.*, 32 F.3d 220, 222–224 (6th Cir.1994), we held that a plaintiff's claim for breach of ERISA fiduciary duties was time-barred because the plaintiff did not file suit within three years after he sent a “protest letter” to the Internal Revenue Service in which he complained about the defendant's conduct with regard to the underpayment of his pension benefits. See also *Farrell v. Automobile Club*, 870 F.2d 1129, 1131 (6th Cir.1989) (holding that but for an unrelated tolling of the statute of limitations, the plaintiffs' claim for breach of ERISA fiduciary duties would have been time-barred because the plaintiffs had not filed suit within three years after “meeting with one another ... to review documents which allegedly prove their claim,” and rejecting the plaintiffs' contention that they did not have the requisite “actual knowledge” until “their attorney gave his opinion on the strength of their claim.”)

In *Ternes v. Tern-Fam, Inc.*, 904 F.2d 708, 1990 WL 80915 (6th Cir.1990) the plaintiff sued his family corporation to recover payment of ERISA and other benefits due to him under the corporation's **\*330** profit-sharing plan. 1990 WL 80915 at \*3. The district court found that the plaintiff was aware that he was entitled to the funds in March of 1983. The district court further held that a December 1984 letter from Ternes to the members of the profit-sharing plan showed his actual knowledge that he had not received the plan benefits to which he claimed to be entitled. On appeal, the plaintiff argued that the three-year statute of limitations did not commence until his application for the benefits was denied. This Court disagreed, holding that to trigger the ERISA statute of limitations, the plaintiff “need only have knowledge of the act and cannot wait until the consequences of the act become painful.” *Id.* at \*11–\*12 (citing *Turner v. Retirement Plan of Marathon Oil Co.*, 659 F.Supp. 534 (N.D. Ohio), *aff'd*, 845 F.2d 327 (6th Cir.1988)). See also, *Rogers v. Millan*, 920 F.2d 34, 1990 WL 61120 (6th Cir.1990) (“The three-year

limitation period began to run only when [the plaintiff] learned of the facts that support his allegation that the [defendants] breached their [ERISA] fiduciary duties.”)

Based on the foregoing discussion of Sixth Circuit law as well as the analysis reflected in the decisions of the Seventh, Ninth and Eleventh Circuits discussed above, we find that view reflected in these decisions is the better view. Accordingly, we join those Circuits in concluding that the relevant knowledge required to trigger the statute of limitations under 29 U.S.C. § 1113(2) is knowledge of the facts or transaction that constituted the alleged violation; it is not necessary that the plaintiff also have actual knowledge that the facts establish a cognizable legal claim under ERISA in order to trigger the running of the statute. This view is not only in accord with our previous ERISA “actual knowledge” decisions but it also furthers the policies underlying statutes of limitations. Among the basic policies served by statutes of limitations is preventing plaintiffs from sleeping on their rights and prohibiting the prosecution of stale claims. *See e.g., Board of Regents of University of State of N.Y. v. Tomanio*, 446 U.S. 478, 487–88, 100 S.Ct. 1790, 1796–97, 64 L.Ed.2d 440 (1980); *Johnson v. Railway Exp. Agency, Inc.*, 421 U.S. 454, 463–64, 95 S.Ct. 1716, 1722, 44 L.Ed.2d 295 (1975). As the Supreme Court explained in *Tomanio, supra*,

Statutes of limitations are not simply technicalities. On the contrary, they have long been respected as fundamental to a well-ordered judicial system. Making out the substantive elements of a claim for relief involves a process of pleading, discovery, and trial. The process of discovery and trial which results in the finding of ultimate facts for or against the plaintiff by the judge or jury is obviously more reliable if the witness or testimony in question is relatively fresh. Thus in the judgment of most legislatures and courts, *there comes a point at which the delay of a plaintiff in asserting a claim is sufficiently likely either to impair the accuracy of the fact-finding process or to upset settled expectations that a substantive claim will be barred without respect to whether it is meritorious.*

446 U.S. at 487–88, 100 S.Ct. at 1796–97 (emphasis added). *See also, Johnson, supra*, (“Although any statute of limitations is necessarily arbitrary, the length of the period allowed for instituting suit inevitably reflects a value judgment concerning the point at which the interests in favor of protecting valid claims are outweighed by the interests in prohibiting the prosecution of stale ones.” 421 U.S. at 463–64, 95 S.Ct. at 1722). If the requisite “actual knowledge of the breach or violation” could only be obtained, as the Plaintiffs suggest, when they learned that they had a claim for violation of ERISA after consulting \*331 with an attorney even though they had actual knowledge years earlier of all of the facts and alleged misdeeds constituting their claim, these policies would be frustrated. If the statute were tolled until an attorney informs the plaintiff that he or she has an ERISA claim, a plaintiff could delay accrual of a claim simply by waiting before consulting an attorney. This would nullify the three-year limitation period of Section 1113(2), something Congress surely did not intend to result when it enacted the statute.

Although the actions complained of in this case may not themselves “communicate the existence of an underlying breach,” the extrinsic facts of which the Plaintiffs had actual knowledge demonstrate that Plaintiffs must have known that they had been wronged long before they consulted with an attorney. Neither *Fink* nor any of its progeny suggest that Plaintiffs were entitled to sit on such knowledge for more than three years.

For the foregoing reasons, we hold that to trigger the running of the statute of limitations under Section 413(2) of ERISA, 29 U.S.C. § 1113(2), it is only the plaintiff's actual knowledge of the underlying conduct giving rise to the alleged violation that is required, rather than the knowledge that the underlying conduct violates ERISA. We reject Plaintiffs' argument that the three-year limitation period is tolled until the plaintiff consults with an attorney and learns from the attorney that he has a claim for breach of ERISA fiduciary duties. In fact, even the Third Circuit has made clear that the running of the three-year statute of limitations is not tolled until an attorney tells the plaintiff that he has a claim. *See, Gluck v. Unisys, supra* (“We emphasize, however, that our holding does not mean that the statute of limitations can never begin to run until a plaintiff first consults with a lawyer.” 960 F.2d at 1177.)

Applying this rule to the facts of the instant case, resolution of the issue presented becomes rather straightforward, as it is beyond serious question that Plaintiffs had “actual knowledge” of the material facts upon which their claims for breach of ERISA fiduciary duties are based more than three years before they filed this action on October 30, 1998.

Wright, Goff and Krantz obtained actual knowledge that Vestax and Heyne allegedly “invested the assets” of the Plan “in high-risk investments” such as “junk bonds”; that Vestax and Heyne allegedly made “investment decisions that were imprudent” including “annuitizing an annuity, investing in certain limited partnerships, and purchasing both “A” and “B” shares of the same investment fund”; that Vestax and Heyne allegedly “caused” the Plan “to invest in and through companies in which the Defendants had a direct financial interest [AFA Financial]”; that Vestax and Heyne allegedly “caused” the “Plan to purchase or sell assets principally for the purpose of earning transaction commissions” for themselves; and that Vestax and Heyne allegedly “paid themselves commissions on certain securities transactions in which they engaged on behalf of the [Plan].” [See Complaint, ¶¶ 10–13; 16]. Further, Plaintiffs were, in several instances, specifically told that Heyne had invested their funds in a manner they had specifically instructed against.

Plaintiffs obtained actual knowledge of all of those alleged facts from their own dealings with Vestax and Heyne during the period from 1992 through 1995 and from their consultations in 1993, 1994 and 1995 with four investment professionals—Phillip Shaffer, Denny Dicky, William Cseplo and Tom Wright—well outside the three-year limitations period established by § 1113(2). Further each of these consultants specifically and unequivocally informed Plaintiffs of the “harmful consequences” \*332 of Vestax's and Heyne's allegedly improper acts and at least one of them (Cseplo) advised that they should “seek legal action” in early 1995. Indeed, it was based upon their actual knowledge of the foregoing material facts that all of the Plaintiffs fully terminated all of their relationships with Defendants by September 11, 1995.<sup>3</sup> Notwithstanding this, Plaintiffs did not file their Complaint in this case until October 30, 1998. Because they did not file their action within three years after obtaining actual knowledge of the alleged facts upon which their claims for breach of ERISA fiduciary duties are based, their claims are time-barred by 29 U.S.C. § 1113(2).

## V. CONCLUSION

For the foregoing reasons, the District Court's grant of Defendants' Motion for Summary Judgment is AFFIRMED.

### All Citations

349 F.3d 321, 31 Employee Benefits Cas. 2098, 2003 Fed.App. 0405P, Pens. Plan Guide (CCH) P 23986E

---

### Footnotes

- \* The Honorable Gerald E. Rosen, United States District Judge for the Eastern District of Michigan, sitting by designation.
- 1 The name of the corporation has changed from time to time to reflect the names of the physicians affiliated with the practice.
- 2 Section 413 of ERISA, 29 U.S.C. § 1113, states:

No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—

31 Employee Benefits Cas. 2098, 2003 Fed.App. 0405P...

(1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission, the latest date on which the fiduciary could have cured the breach or violation, or

(2) three years after the earliest date of which the plaintiff had actual knowledge of the breach or violation;

except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1113.

3 Goff terminated his relationship with Defendants on March 25, 1995. Krantz terminated his relationship with them on May 2, 1995. Defendants' relationship with the Plan's general account was terminated on July 20, 1995, and on September 11, 1995, Plaintiff Wright terminated his relationship with Defendants, as well.

---

End of Document

© 2025 Thomson Reuters. No claim to original U.S. Government Works.

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION**

WESCO, INC., WESCO, INC. CAFETERIA  
PLAN AND EMPLOYEE BENEFIT PLAN,  
FRANKENMUTH BAVARIAN INN, INC.,  
FRANKENMUTH BAVARIAN INN, INC.  
EMPLOYEE HEALTH BENEFIT PLAN &  
TRUST, OPUS PACKAGING GROUP INC.,  
and OPUS PACKAGING GROUP HEALTH  
INSURANCE PLAN, on  
behalf of themselves and a class of all others  
similarly situated,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF  
MICHIGAN,

Defendant.

Civil Action No.: 2:25-cv-11712

Judge: Hon. Susan K. DeClercq

Magistrate Judge: David R. Grand

**INDEX OF EXHIBITS TO  
DEFENDANT'S REPLY BRIEF IN SUPPORT OF ITS MOTION TO  
DISMISS PLAINTIFFS' AMENDED COMPLAINT FOR  
FAILURE TO STATE A CLAIM**

1.	<i>Arnold v. Paredes</i> , 714 F. Supp. 3d 962 (M.D. Tenn. 2024)
2.	<i>Cataldo v. U.S. Steel Corp.</i> , 676 F.3d 542 (6th Cir. 2012)
3.	<i>Fleming v. Kellogg Co.</i> , No. 23-1966, 2024 WL 4534677 (6th Cir. 2024)
4.	<i>Grand Traverse Band of Ottawa &amp; Chippewa Indians v. Blue Cross Blue Shield of Mich.</i> , 146 F.4th 496 (6th Cir. 2025)
5.	<i>Hall v. Small</i> , 705 N.W.2d 741 (Mich. Ct. App. 2005)
6.	<i>Hawkins v. Cintas Corp.</i> , 32 F.4th 625 (6th Cir. 2022)
7.	<i>Parker v. Tenneco, Inc.</i> , 114 F.4th 786 (6th Cir. 2024)
8.	<i>Rosenbaum v. Davis Iron Works</i> , 871 F.2d 1088, 1989 WL 36897 (6th Cir. 1989)
9.	<i>Taylor v. Visteon Corp.</i> , 149 F. App'x 422 (6th Cir. 2005)
10.	<i>Tiara Yachts, Inc. v. Blue Cross Blue Shield of Mich.</i> , 138 F.4th 457 (6th Cir. 2025)
11.	<i>Wright v. Heyne</i> , 349 F.3d 321 (6th Cir. 2003)