MEMBER ARTICLE

DEMYSTIFYING ERISA LITIGATION

By Robert Armand Perez, Sr., Esq.

ERISA is the Employee Retirement Income Security Act. This 1974 federal statute standardizes the law of employee benefits and pensions. Its core intent was to protect employee pension funds. Other ERISA benefits are called "welfare benefits."[1] ERISA litigation is unique. It has aspects of administrative law with judicial review to adjudicate the availability benefits and/or provide for equitable relief. The related procedural requirements create hazards for the claimant. From the moment of the denial, the claimant must obtain and consider the pertinent plan language, appeal rights, and deadlines.

From the moment of the denial, knowledge of the plan language, appeal rights, and deadlines is mandatory.

Although the ERISA benefit may be funded by insurance, it is unlike other insurance claims. The identification of what is an ERISA claim is complex. All employee benefits – pension benefits, E.S.O.P.s,[2] health, disability, life insurance, apprenticeships, and some severance packages are ERISA plans. By statute, if an employee is employed by a governmental agency,[3] a church entity,[4] or is self-employed, it is not an ERISA benefit. Pension plans are usually a structured as a trust. Many ERISA welfare benefits are insurance-based, but ERISA welfare benefits that appear to be insurance policies may not be. They may be self-insured health plans or disability plans. These are administered by third-party administrators. They may not be easily distinguished from insurance-based benefits.

The Scope of ERISA Preemption

There is a multi-part process to understanding ERISA's relationship with state law. ERISA[5] provides that all state laws that "relate to" employee benefit plans are preempted. This is a broad provision. ERISA also contains a "Saving Clause." Insurance laws regulating insurance may be saved.[6] Nonetheless, a plan does not become insurance merely because the plan provides employee benefits. This is called the "Deemer Clause."[7] The intent of this provision is to allow employers to provide "self-insured" plan benefits without risking exposure to state laws that govern insurance.

There is a two-part "Savings Clause" test to determine what state law is *saved* and may be applied. To be *saved*, a state law must satisfy two requirements to survive pre-exemption.[9] "First, the state law must be specifically directed toward entities engaged in insurance . . . Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured."[10] There has developed a body of federal common law -- both procedural and substantive – interpreting this clause over the past four decades.

ERISA Terminology

There are terms that are unique to ERISA or have particular meaning. Under ERISA, a *plan participant* is "any employee or former employee . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan."[11] A *beneficiary* is "a person designated by a participant, or by the terms of an employee benefit plan . . . ."[12] For clarity sake, we will refer to both as a *claimant*.

Also, key to understanding the enforcement scheme under ERISA is the term fiduciary. A person is a fiduciary with respect to a plan to the extent there is the exercise of any discretionary authority or control in the administration of the plan benefits.[13] There is a functional test that determines fiduciary status.[14] Litigation under ERISA is an equitable action. The payment of benefits is the core recovery.

The Governing Documents

An ERISA benefit must have a written plan.[15] The ERISA *fiduciary* administers the plan. ERISA *fiduciary* duties are statutory.[16] *Fiduciaries* must administer the plan solely in the interest of p*articipants* for the exclusive purpose of providing benefits. They must act with care and prudence and follow the terms of the plan documents, avoiding conflicts of interest.[17]

The plan must be administered "[i]n accordance with the documents and instruments governing the plan . . .."[18] Under ERISA there are two mandated documents, a *Plan* and a *Summary Plan Description* ("SPD"). The Plan document sets forth the rights and responsibilities of the parties. This may be a trust document, as in a pension plan, a self-insured plan, or an insurance policy.[19] It is important to determine what is the *Plan* document because it will control over the *Summary Plan Description*.[20]

Sometimes there are multiple documents that constitute the *Plan*. Each *plan*, whether a trust, policy, or certificate, may vary dramatically. The coverages, the exclusions, and the definitions are all different. Central to ERISA is the ability of an employer to customize the benefit *plan*. Obtaining the *Plan* documents is the crucial first step.

As stated previously, an ERISA *plan* must also have a *Summary Plan Description* ("SPD"). This is a document that summarizes the fundamental plan benefits, qualifications, and limitations in ordinary language.[21] A *Summary Plan Description*, or SPD, is required by statute.[22] The SPD must contain "the plan's requirements respecting eligibility for participants and beneficiaries" and the "circumstances which may result in disqualification, ineligibility, denial, or loss of benefits."[23] SPD's must "be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participant beneficiaries of their rights and obligations under the plan."[24] SPD's must include statements "clearly identifying circumstances which may result in . . . loss . . . of any benefits

that a participant or beneficiary might otherwise reasonably expect the plan to provide."[25] The ERISA practitioner must promptly obtain both of these documents. They should be requested in writing from the *Plan Administrator*. They must be read closely to ascertain the benefits, limitations, exclusions, and contractual provisions limiting the timeframe for suit to be filed.

The Claim Process and Administrative Remedies

When a benefit is denied, the client/claimant must receive a notice of denial that comports with the following: (1) must be in writing; (2) is easily understood by the claimant; (3) contains the specific reason(s) for the denial; (4) refers to the specific *plan* provision on which the denial is based; (5) describes the additional material or information necessary to perfect the claim; (6) tells the claimant what steps are necessary if the claimant wishes to have the denial of the payment of the benefits reviewed; and (7) informs the *claimant* of the right to judicial review.[26]

The *plan administrator* must give the claimant the opportunity to: (1) request a review of the denial of the benefit in writing; (2) read and review pertinent documents; and (3) submit materials in writing to support the payment of his/her claim.[27] The denial notice must comply with the regulations.[28] These core regulations apply to all adverse benefit determinations, both pension and welfare benefits. Providing adequate notice assures the *claimant's* due process in the administrative process. The statute requires a "full and fair review."[29] The failure to comply with these notices and procedural requirements vitiates the process and may toll the time for response.[30] There are additional regulations as well that apply to disability benefits and healthcare benefits.

Disability Regulations

A disability denial must have a full discussion of why there was a denial and what standards were applied.[31] The *claimant* must be informed of his/her right to the entire claim file.[32] The *claimant* has an opportunity to respond to new or additional evidence.[33] If the *plan administrator* fails to strictly comply with the time limits in the regulations, the *claimant* can assert that he or she is "deemed to have exhausted" his or her administrative remedies.[34] The denial notice must contain contractual limitation periods for filing suit, if any.[35] The notification must explain the basis for disagreeing with the opinions presented of the *claimant's* healthcare professionals or vocational professionals. The *administrator* must consider and discuss the determination made by the Social Security Administration if there is one.[36]

Health Claim Regulations

Healthcare claims are subject to additional Patient Protection and Affordable Care Act (ACA) regulations.[37] Scrupulous compliance with the regulations is required with stated exceptions.[38] If the *plan administrator* fails to follow the claim procedures, the *claimant* may be deemed to have exhausted the appeal process. Continued coverage and treatment during the appeal may be required.[39] The claim appeal must be timely processed.[40] The time limits for healthcare claims are complex and depend on the classification of the claim such as urgent care, pre-authorization, or post-claim denial. Each is different. In the case of an adverse benefit determination involving an urgent claim, there must be a description of the expedited review process.[41]

OAJ Member Spotlight

Michelle E. Lanham
The Lanham Law Firm, LLC

Hometown:
I've moved many times in my life, but I generally consider Ohio my home, because it is where most of my loved ones and friends live.

Law School:
Capital University Law School, 2014

Areas of Practice: Employment and Civil Rights

What is your greatest personal success as a trial lawyer?
Starting my own practice which, to be honest, was something that I never thought I'd want to do nor saw myself doing. But oftentimes life goes in an unexpected direction, and while there have been challenges, being open to new opportunities has been worth it.

If you could change one thing about the practice of law what would it be?
More emphasis on self-care and eliminating any stigma of reaching out for help/support when you need it. There is so much stress and pressure in this profession and certainly litigation. You can't pour from an empty cup – take care of yourself first because (1) you're important, and (2) you can be the most effective advocate for your clients.

What is something about you people would be surprised to know?
I was born in Thailand, adopted at 11 months, and came to the States a year later.

If you could meet one person dead or alive, who would it be?
Ghandi or MLK Jr.

If you could have any job, other than a lawyer, for one day what would it be?
I would work at an animal sanctuary or rescue, and if I had more than one day, I would also be a travel writer.

The Administrative Appeal Process

The appeal of a denied claim requires submission of evidence to support the claim. It is inadequate to submit a letter without providing any evidence. Although the denial notice is required to contain a description of the materials necessary to have the claim perfected, in general these notifications are deficient and at best will enumerate some types of evidence such as medical testing, an MRI, or medical records. The ERISA statute does not require exhaustion of administrative remedies, but the common law requires that the administrative remedies be exhausted before suit is filed.[42] Occasionally the plan document will as well. The regulatory timeframes must be strictly followed in the internal appeal. The failure to follow these procedures can be fatal. The claimant's supporting evidence should establish a record with proof sufficient to carry the claimant's burden in litigation. The goal of the claimant should be to establish beyond, at least a clear and convincing level, that the denial or adverse determination should be reversed and the benefit be ordered provided.

ERISA Claims Demand Early Involvement

Unlike many other types of cases, ERISA claims require early and extensive involvement to investigate the claim and establish a record that the court will eventually review. After a claim for benefits is made and it is denied, in the administrative review process the claimant must have supporting evidence.[43] If the claim is still denied, there is judicial review.[44] It may be tempting in response to a claim denial to fire off a hastily worded letter to a *Plan Administrator* threatening bad faith, attorney fees and extensive discovery; however, such a letter may have the opposite effect intended as it may serve only to telegraph the practitioner's lack of knowledge and experience.

Every circuit has issued decisions limiting the discovery available to *claimants*, as well as the scope of matters subject to review. The scope of judicial review is generally limited to the matters that were presented or available to the *plan administrator/fiduciary* prior to filing suit. Therefore, the claimant's evidence supporting the claim after an initial denial must be presented to the plan administrator prior to litigation. The Sixth Circuit holds that the court is limited to the matters that were available to the claim administrator before a final claim decision.[45] After a final benefit denial, review by the district court is available.[46] The court reviews the record developed during the claim process and the appeal *de novo*, or under the "arbitrary and capricious" standard, depending on the language in the *plan* documents.

If the *plan* has given discretion to the *plan administrator*, then an arbitrary and capricious standard will be applied. The Sixth Circuit standard for what language qualifies for deference is very low.[48] Under the arbitrary and capricious standard, the decision to deny benefits will be sustained if the *administrator/fiduciary's* decision "is the result of a deliberate, principled reasoning process **and it is supported by substantial evidence.**"[49] The court must review the quality and quantity of the medical evidence.[50] The decision will be upheld if there is a "deliberate, principled and reasoned decision."[51] This is a difficult standard for the claimant to overcome. The use of the discretionary clauses that enable the administrator to use the arbitrary and capricious standard is being slowly eroded state-by-state. Approximately twenty states have limited the discretionary clause from insurance policies by statute, insurance regulation, or administrative order. Ohio has not.

There is No Bad Faith Cause of Action

Under ERISA, remedies are limited. The Supreme Court of the United States has held that there is no insurance bad faith claim under ERISA.[52] State law claims of bad faith are preempted by the federal statute and are not available as remedies in ERISA insurance cases. The remedies under ERISA are those in the statute.[53] Some state procedural remedies may be enforceable, such as state mandated review of denials of experimental treatment or mandated coverage issues. But any penalty under state law is preempted.

Where a Benefit Claim Can Be Brought

There is jurisdiction in state court for benefits claim.[54] There is concurrent jurisdiction.[55] But if the claimant files the action in state court, the Plan may remove the case to federal court. The federal court has exclusive jurisdiction of anything oth-

er than a benefit claim,[56] such as an issue of plan language interpretation, a claim for breach of fiduciary duty, or other cause of action other than a claim for benefits. As a matter of practice, all ERISA claims get removed from state court to federal court. After filing a state court complaint, if the case is removed to federal court the plaintiff must amend the complaint to state an ERISA cause of action. If the complaint is not amended to an ERISA claim, the case can properly be dismissed.[57]

Plenary Discovery is Not the Rule

The plaintiff generally has no opportunity for discovery except after the plaintiff makes a showing of bias and prejudice, or *procedural irregularity*. ERISA affords only a very limited scope of discovery. Some decisions state that there must be something other than the bare allegation of bias before the plaintiff can obtain discovery on this type of issue. There is nothing in the ERISA statute that provides for limitations on discovery. But, this policy of limited discovery is to advance "a primary goal of ERISA . . . to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously."[58] An exception to the limitation is when evidence outside the administrative record is necessary to resolve a procedural challenge to a decision. The plaintiff should offer more than a mere allegation in support of the procedural challenge.[59]

There should be factual evidence pled with particularity for a violation of the claim procedures if the claimant hopes to have discovery on *procedural irregularity* issues.[60] In short, discovery may be allowed if *procedural irregularities* affect due process, or demonstrate the defendant's bias and prejudice.[61]

When Discovery is Available

The Supreme Court in *MetLife v. Glenn*[62] addressed two important and closely related issues. Where a plan administrator funds plan benefits and decides a claim's appeal, there is a conflict of interest. MetLife insured benefits under a long-term disability insurance plan. MetLife was vested with discretionary authority to decide the appeal. This conflict of interest must be considered by the reviewing trial court as a factor in deciding whether the claim must be paid. The *MetLife* court recognized the need to protect the integrity of the procedural due process in claim reviews and the administrative appeal.[63]

The threshold issue is whether this dual role creates a "structural conflict." If such a conflict exists, what is the relevance of the conflict to a court reviewing a benefit determination made by the *plan administrator*? How should it be weighed? The reviewing court should consider the conflict as a factor in determining whether the *plan administrator* abused his or her discretion in denying benefits. The significance of the conflict will depend upon the circumstances of the particular facts. The existence of a conflict should be weighed as one of many factors in determining whether there was an abuse of discretion. The court should engage in a "combination of factors" review.[64]

The *MetLife* court held that plan administrators are required to perform with the utmost duty of loyalty and good faith to the claimant.[65] ERISA imposes "higher-than-marketplace" quality standards on insurers to "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of participants and beneficiaries" of the plan[66] with accurate claim processing and to "provide a full and fair review" of claim denials[67] with judicial review of individual claim denials.[68]

Relief in a Benefits Claim

When there is a *de novo* review, the court should determine benefits. "When applying a *de novo* standard in the ERISA context, the role of the court reviewing a denial of benefits 'is to determine whether the administrator . . . made a correct decision.' The administrator's decision is accorded no deference or presumption of correctness."[69]

When the arbitrary and capricious standard applies, and the denial of benefits is determined to be arbitrary and capricious, the Sixth Circuit has taken two alternative routes: award benefits to the claimant or remand to the plan administrator. The rule is that "where the problem is with the integrity of the plan's decision-making process, rather than that a claimant was denied benefits to which he was clearly entitled, the appropriate remedy generally is remand to the plan administrator."[70] In contrast, when a remand to the administrator would be a useless formality and the claimant is clearly entitled to the benefits, the benefits may be immediately awarded.[71]

Benefits and Equitable Relief are Available

ERISA's text, structure, and purpose are to allow a plaintiff who asserts a denial-of-benefits claim[72] to also assert an equitable relief claim if the plaintiff alleges distinct injuries cognizable under a catchall provision for equitable recovery,[73] or if the award of benefits would be an inadequate form of relief.[74]

ERISA's text[75] makes clear that the two statutory provisions authorize distinct actions to remedy distinct injuries. The *benefits recovery* provision authorizes a plaintiff to bring a claim "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."[76]

In contrast, the *catchall equitable relief* section broadly authorizes a plaintiff to "obtain other appropriate equitable relief" to redress ERISA violations or enforce "any provisions" of the statute or plan.[77] These provisions are not mutually exclusive. To the contrary, the language creates separate causes of action to remedy separate injuries and ensure that a plaintiff receives adequate relief.

The structure of the statute reinforces that construction. The *benefits recovery* section[78] "focus[es] upon . . . [the] wrongful denial of benefits…." In contrast, there is what it is termed a *catchall equitable* provision that "act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that [the benefits section] does not elsewhere adequately remedy."[79] Thus, "where Congress . . . provided adequate relief for a beneficiary's injury" in the *benefits recovery* section, the *catchall* section[80] is thought to be unnecessary as "there will likely be no need for further equitable relief" under the catchall equitable section.[81] But where the beneficiary asserts a different injury or shows that the *benefits recovery* section would not "provide adequate relief," nothing precludes a separate claim under the *equitable catchall* section.

In *CIGNA Corp. v. Amara*,[84] ERISA plan participants brought claims for benefits[85] on the theory that plan administrators provided inaccurate Summary Plan Descriptions.[86] The district court awarded the benefits that plan administrators had allegedly promised.[87] Having awarded adequate relief under the benefits section,[88] the district court did not consider providing additional relief under the *catchall* provision.[89]

The *CIGNA* court concluded that the relief the district court granted was not available under the benefits section.[90] The Supreme Court stated that the district court should consider whether equitable relief was available under the catchall section.[91] A request for relief in "the form of a money payment does not [necessarily remove such a request] from the category of traditionally equitable relief, [because equity courts] possessed the power to provide relief in the form of monetary 'compensation' for a loss resulting from a trustee's breach of duty" through a "surcharge" remedy.[92] *CIGNA* thus clarified that a plaintiff's pursuit of a claim for benefits under the *benefits recovery* section[93] does not preclude appropriate equitable relief for a fiduciary breach under the *equitable catchall* section.[94]

The Sixth Circuit precedent addressing the relationship between the benefits *recovery section*[95] and the *catchall equitable* section[96] is not entirely clear. The Sixth Circuit in *Rochow v. Life Insurance Co. of North America*[97] addressed the availability of claims under the *benefits recovery* section and the *catchall equitable* section.[98] There, an ERISA plan participant who successfully recovered disability benefits under the *benefits recovery* section[99] also sought to recover disgorged profits under the equitable catchall section[100] "based on the claim that the wrongful denial of benefits also constituted a breach of fiduciary duty."[101] The *Rochow* court rejected the plaintiff's equitable disgorgement recovery[102] claim as an attempt to secure "an impermissible duplicative recovery." The court determined that the payment of benefits under the *benefits recovery* section[103] constituted "an adequate remedy," and that equitable relief under the *catchall equitable* provision[104] was therefore unwarranted.[105] The *catchall* provision[106] provides a remedy for "violations that [the benefits section] does not elsewhere adequately remedy."[107] This is also in accord with decisions of other Courts of Appeals emphasizing that the *benefits recovery* section[108] and the *catchall equitable* section[109] do not authorize "duplicate" recoveries.[110]

Separate from its discussion of duplicative recovery, *Rochow* explained that a claimant could "pursue a breach-of-fiduciary-duty claim under the equitable catchall section[111] irrespective of the degree of success obtained on a claim for recovery of benefits under the benefits section"[112] if "the breach of fiduciary duty claim is based on an *injury* separate and distinct from the denial of benefits."[113] *Rochow* concluded on the facts before it that the asserted injuries were not "separate and distinct," but rather "one and the same."[114] The Sixth Circuit's recognition that a plaintiff alleging separate and distinct injuries could bring claims under both provisions, however, is consistent with the approach adopted by other Courts of Appeals addressing the same question.[115]

An ERISA plaintiff may pursue a breach-of-fiduciary-duty claim under the equitable catchall section[116] "irrespective of the degree of success obtained on a claim for recovery of benefits under the benefits section[117] if "the breach of fiduciary duty claim is based on an *injury* separate and distinct from the denial of benefits."[118] *Rochow* precludes relief on "one and the same injury," not in the context of claims that allege "separate and distinct" injuries.[119] The availability of relief is based on the relief sought and pled.[120] In contrast, the Second Circuit similarly recognizes pleading in the alternative under both sections with limitations on "duplicate recovery." Duplicate recoveries "do not limit the number of ways a party can initially seek relief . . . ."[121] This creates a thorny pleading challenge in the Sixth Circuit. Care in pleading these issues is required. Traditional equitable forms of relief besides the mentioned surcharge are restitution, disgorgement, accounting, and injunction.

The fundamental problem with the Sixth Circuit's holding is that there is a split in the circuits on the pleading issue. Other circuits permit pleadings in the alternative consistent with the rule[122] that provides that relief may be pled in the alternative.

Attorney Fees May Be Available

Attorney fees under the statute may be available.[123] It is not necessary to be a prevailing party. Full success on the merits is unnecessary.[124] A claimant seeking fees must show "some degree of success on the merits" before a court may award attorney's fees.[125] The award of fees is not mandatory and is also not as readily obtainable as in civil rights or discrimination actions. Because they are discretionary, there are many factors that the court must review to determine whether fees should be awarded.[126] The court should consider the following factors: (1) the degree of the opposing party's culpability or bad faith; (2) the opposing party's ability to satisfy an award of attorney's fees; (3) the deterrent effect of an award on other persons under similar circumstances; (4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA, and (5) the relative merits of the parties' positions.[127] All of these factors need not be considered or present, but they provide a framework for analysis.[128] And no single factor is determinative.[129] The court should consider each factor before exercising its discretion.[130] The factors themselves are not statutory.[131] There is no requirement that the attorney fees

awarded be proportional to the benefits award, rather the attorney fees amount must be reasonable in accordance with the traditional "lodestar" approach.[132] The lodestar approach involves multiplying the number of hours reasonably expended on the litigation by a reasonable hourly rate.[133] "The primary concern in an attorney fee case is that the fee awarded be reasonable, that is, one that is adequately compensatory to attract competent counsel yet which avoids producing a windfall for lawyers."[134] A reasonable hourly rate is generally calculated according to the "prevailing market rates in the relevant community."[135]

Time Limitations on Filing Suit

The determination of when suit must be filed is perhaps one of the most confusing and challenging issues in ERISA. It can be a minefield. There must be an initial determination of what type of action is being contemplated. The ERISA statute of limitations for a breach of fiduciary duty claim is either three or six years. The three-year statute applies if the plaintiff had "actual knowledge of the breach of the violation." In cases of fraud or concealment by the fiduciary, it is "six years after the date of the discovery or of the breach or violation."[136]

However, most claims are not fiduciary breaches but rather benefit claims that have an even more complex determination on when a claim can be filed. There is no ERISA statutory limitation for benefit claims.[137] The claim is limited by the most appropriate state statute of limitations. "[I]n the absence of a federally mandated statute of limitations, the court should apply the most analogous state law statute of limitations."[138] In an ERISA case, a cause of action accrues "when a fiduciary gives a claimant clear and unequivocal repudiation of the benefits."[139] The Sixth Circuit has held that in Ohio,[140] the most analogous state limitation period is for a breach of contract.[141] Therefore, the claim must be brought within eight years after the cause of action accrued. In contrast, the Sixth Circuit has ruled that in Kentucky, it is not the contract statute of limitation that controls. In an action brought in Kentucky, it is the "another action"[142] limitation statute that applies, and it is five years.

To make matters even more complex, the ERISA plan or the underlying policy -- if it is an *insured benefit plan* -- may have a contractual limitation period in the document. If it does, this may shorten the time period. These types of contractual limitations may be enforceable. Absent a controlling statute to the contrary, an ERISA plan may have a shorter contractual limitation period for bringing suit for a judicial review of the denial of benefits than the state statute as long as the period is reasonable.[144] If a *plan administrator* causes a *claimant* to miss a deadline for judicial review, waiver or estoppel may prevent the administrator from invoking a contractual limitations provision as a defense.[145] A typical insurance policy in Ohio that covers an ERISA benefit may provide that an action for judicial review must be brought within three years after "proof of loss" is due.[146] The calculation of this period can be complicated.

The most recent ERISA disability regulations require notification to the *claimant* of the time limits for bringing a civil suit.[148] The Sixth Circuit has provided all *claimants* some relief by requiring that the "adverse benefit determination letter must contain the time limits for judicial action if it is established under the plan or policy."[149] Given the complexity of the area of limitations on filing suit, the matter must be analyzed closely, carefully, and suit filed early if there is any question as to when the limitation period commences.[150]

CONCLUSION

ERISA is complicated and full of traps for the uninformed and inexperienced. The complexity of the statute, the administrative process, and the judicial review provide challenges to the practitioner. The decisions in the case law are often inconsistent, which makes the area ever changing and complex. Knowledge, early involvement and timely action are mandatory for a successful result.

Robert Armand Perez, Sr., M.S., J.D., limits his practice to representing individuals with disability, health, life insurance, and pension issues mostly under ERISA. He graduated Indiana University School of Law with his J.D. and the University of Cincinnati with a B.A. and M.S. in health administration. He is a member of the Ohio Association for Justice and was previously a trustee. He is a member the American Association for Justice and was the chair of the insurance section. He is a member of the American Bar Association, The Ohio State Bar Association, the Federal Bar Association and the Cincinnati Bar Association. He is admitted to practice in the Supreme Court of Ohio, both the Northern and Southern Districts of Ohio, the Sixth Circuit Court of Appeals and the United States Supreme Court.

End Notes

1. 29 U.S.C. §§ 1001, *et seq*.
2. Employee Stock Option Plans.
3. 29 U.S.C. § 1002(32).
4. 29 U.S.C. § 1002(33)(A).
5. 29 U.S.C. § 1144(a).
6. 29 U.S.C. § 1144(b)(2)(A).
7. 29 U.S.C. § 1144(b)(2)(B).
8. *Kentucky Ass'n. of Health Plans v. Miller*, 538 U.S. 329 (2003). (The court voided the old *McCarran-Ferguson* test. 15 U.S.C. § 1011-1015).
9. 29 U.S.C. § 1144(b)(2)(A).
10. *Id*. at 341-42.
11. 29 U.S.C. § 1002(7).
12. 29 U.S.C. § 1002(8).
13. 29 U.S.C. § 1002(21)(A).
14. See *Hamilton v. Carell*, 243 F.3d 992, 998 (6th Cir. 2001); *Mertens v. Hewitt Assocs*., 508 U.S. 248, 262 (1993).
15. 29 U.S.C. § 1102.
16. 29 U.S.C. § 1104.
17. *Id.*
18. 29 U.S.C. § 1104(a)(1)(D).
19. Although an insurance policy is not a plan, it is many times treated as such.
20. *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011).
21. 29 U.S.C. § 1122(a)(1).
22. 29 U.S.C. § 1022(a).
23. 29 U.S.C. § 1022(b).
24. 29 C.F.R. § 2520.102-2(a).
25. 29 C.F.R. § 2520-102-3(1).
26. 29 C.F.R. § 2560.503-1(g)(i-iv).
27. 29 C.F.R. § 2560.503-1.
28. 29 C.F.R. § 2560.503-1(g)(i-iv).
29. 29 U.S.C. § 1133.
30. *Vanderklok v. Provident Life and Accident Insurance Co*., 56 F.2d 610 (6th Cir. 1992).
31. 29 C.F.R. § 2560.503-1(g)(l).
32. 29 C.F.R. § 2560.503-1(g)(1)(vii)(A)(iii)(D).
33. 29 C.F.R. § 2560.503-1(h)(4).
34. 29 C.F.R. § 2560.503-l (2).
35. 29 C.F.R. § 2560.503-1(j)(4)(ii).
36. See 29 C.F.R. § 2560.503-1(j)(6).

37. 29 C.F.R. § 2590.715-2719(b).
38. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(2).
39. 29 C.F.R. § 2590.715-2719(b)(2)(iii).
40. 29 C.F.R. § 2560.503-1(f)(2)(iii)(A) and (B).
41. 29 C.F.R. § 2560.503-1(j)(5).
42. *Miller v. Metropolitan Life Ins. Co*., 925 F.2d 979, 986 (6th Cir. 1991).
43. 29 U.S.C. § 1133.
44. 29 U.S.C. § 1132.
45. *Wilkins vs. Baptist Healthcare System*, 150 F.3d 609 (6th Cir. 1998).
46. 29 U.S.C. § 1132(a).
47. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).
48. *Perez v. Aetna Life Ins. Co*., 150 F.3d 550 (6th Cir. 1997).
49. *Baker v. United Mine Workers of Am. Health & Ret. Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991).
50. *Glenn v. MetLife*, 461 F.3d 660 (6th Cir. 2006).
51. *Elliott v. Metro. Life Ins. Co*., 473 F.3d 613 (6th Cir. 2007).
52. *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987).
53. *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).
54. *Richland Hospital, Inc. v. Raylon, Inc*., 33 Ohio St. 3d. 87 (1987). (Benefit claims may be brought in state court).
55. 29 U.S.C. § 1132 (e)(1).
56. 29 U. S. C. § 1132(a)(1)(B).
57. *Van Camp v. AT&T Information Systems*, 963 F.2d 119 (6th Cir. 1992).
58. *Perry v. Simplicity Eng'g*., 900 F.2d 963, 967 (6th Cir. 1990).
59. *Johnson v. Conn. Gen. Life Ins. Co*., 324 Fed. Appx. 459, 457 (6th Cir. 2009); see also *Jones v. Allen*, No. 2:11-cv-380, 2014 U.S. Dist. LEXIS 40536, at *5 (S.D. Ohio Mar. 25, 2014). ("[U]ntil a due process violation is at least colorably established, additional discovery beyond the administrative record into a plaintiff's denial of benefits claim is impermissible.")
60. *Calvert v. Firstar Financial, Inc*., 409 F.3d 286 (6th Cir. 2006). (Additional evidence for procedural challenge or bias).
61. *Moore v. LaFayette Life Ins. Co.*, 458 F.3d 416 (6th Cir. 2006).
62. *MetLife v. Glenn*, 562 U.S. 1161 (2008).
63. *Id.*
64. *Id.*
65. 29 U.S.C. § 1104(a)(1), *et seq*.
66. 29 U.S.C. § 1104(a)(1).
67. *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 113 (1989).
68. See 29 U.S.C. § 1132(a)(1)(B). *Glenn* at p. 7.
69. *Hoover v. Provident Life & Acc. Ins. Co*., 290 F.3d 801, 808 (6th Cir. 2002).
70. *Elliott v. Metropolitan Life Ins. Co*., 473 F.3d 613, 621–22 (6th Cir. 2006).
71. *Kalish v. Liberty Mut./Liberty Life Assurance Co. of Boston*, 419 F.3d 501, 513 (6th Cir.2005).
72. 29 U.S.C. § 1132(a)(1)(B).
73. 29 U.S.C. § 1132(a)(3).
74. 29 U.S.C. § 1132(a)(1)(B).
75. 29 U.S.C. § 1132(a)(1)(B); 29 U.S.C. § 1132(a)(3).
76. 29 U.S.C. § 1132(a)(1)(B).
77. 29 U.S.C. § 1132(a)(3).
78. 29 U.S.C. § 1132(a)(1)(B).
79. 29 U.S.C. § 1132(a)(3); *Varity Corp. v. Howe*, 516 U.S. 489 (1996).
80. 29 U.S.C. § 1132(a)(3).
81. *Howe* at 515; see *LaRue v. DeWolff, Boberg & Assocs., Inc*., 552 U.S. 248, 257 (2008).
82. 29 U.S.C. § 1132(a)(1)(B).
83. 29 U.S.C. § 1132(a)(3). *Varity*, 516 U.S. at 515.
84. 563 U.S. 421 (2011).
85. 29 U.S.C. § 1132(a)(1)(B).
86. *Id.* at 429-432.
87. *Id*. at 433-434.
88. 29 U.S.C. § 1132(a)(1)(B).
89. 29 U.S.C. § 1132(a)(3).
90. 29 U.S.C. § 1132(a)(1)(B).
91. 29 U.S.C. § 1132(a)(3). *Amara*, 563 U.S. at 438-442.
92. *Id*. at 441.
93. 29 U.S.C. § 1132(a)(1)(B).
94. 29 U.S.C. § 1132(a)(3).
95. 29 U.S.C. § 1132(a)(1)(B).
96. 29 U.S.C. § 1132(a)(3).
97. 780 F.3d 364, cert. denied, 136 S.Ct. 480 (2015) (*en banc*).
98. 29 U.S.C. § 1132(a)(1)(B); 29 U.S.C. § 1132(a)(3).
99. 29 U.S.C. § 1132(a)(1)(B).
100. 29 U.S.C. § 1132(a)(3).
101. *Rochow* at 371.
102. 29 U.S.C. § 1132(a)(3).
103. 29 U.S.C. § 1132(a)(1)(B).
104. 29 U.S.C. § 1132(a)(3).
105. *Rochow* at 372.
106. 29 U.S.C. § 1132(a)(3).
107. 516 U.S. at 512.
108. 29 U.S.C. § 1132(a)(1)(B).
109. 29 U.S.C. § 1132(a)(3).
110. *Silva v. Metropolitan Life Ins. Co*., 762 F.3d 711 at 726 (8th Cir. 2014); see *Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948 at 961 (6th Cir. 2016).
111. 29 U.S.C. § 1132(a)(3).
112. 29 U.S.C. § 1132(a)(1)(B).
113. 780 F.3d at 372.
114. *Id*. at 373-374.
115. See, *e.g., Jones v. Aetna Life Ins. Co*., 856 F.3d 541 at 547 (8th Cir. 2017).
116. 29 U.S.C. § 1132(a)(3).
117. 29 U.S.C. § 1132(a)(1)(B).
118. *Rochow*, 780 F.3d at 372.
119. *Rochow*, 780 F.3d at 373.
120. See *Silva v. Metropolitan Life Ins. Co*., 762 F.3d 711, 726 (8th Cir. 2014) (permitting claim under 29 U.S.C. § 1132(a)(1)(B) and 29 U.S.C. § 1132(a)(3) seeking the same).
121. *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2nd Cir. 2003).
122. Fed. Civ. Rule 8(a)(3).
123. 29 U.S.C. § 1132(g)(1).
124. *Hardt v. Reliance Standard Life Ins. Co*., 560 U.S. 242, 130 S.Ct. 2149 (2010).
125. See *Id.* at 694.
126. *Foltice v. Guardsman Prods., Inc*., 98 F.3d 933, 936 (6th Cir. 1996).
127. *Secretary of Department of Labor v. King*, 775 F.2d 666, 669 (6th Cir. 1985). See also, *Schwartz v. Gregori*, 160 F.3d 1116, 1119 (6th Cir. 1998).
128. *Ciaramitaro v. UNUM Life Ins. Co. of America*, 521 Fed. Appx. 430, 2013 WL 1339076 (6th Cir. 2013). (Remanded attorney fee issue because low award not adequately explained).
129. See *Schwartz v. Gregori*, 160 F.3d 1116, 1110 (6th Cir. 1998).
130. *Wells v. United States Steel*, 76 F.3d 731, 736 (6th Cir. 1996).
131. *First Trust Corp. v. Bryant*, 410 F.3d 842, 851 (6th Cir. 2005).
132. *Bldg. Serv. Local 47 Cleaning Contractors Pension Plan v. Grandview Raceway*, 46 F.3d 1392, 1401 (6th Cir. 1995).
133. *Hensley v. Eckerhart*, 461 U.S. 424, 433 (1983).
134. *Geier v. Sundquist*, 372 F.3d 784, 791 (6th Cir. 2004).
135. *Blum v. Stenson*, 465 U.S. 886, 895, 104 S.Ct. 1541, 79 L.Ed.2d 891 (1984).
136. 29 U.S.C. § 1113. *Tibble v. Edison Intern*., 135 S.Ct. 1823(2015).
137. 29 U.S.C. § 1132(a)(1)(B).
138. *Meade v. Pension Appeals & Review Comm*., 966 F.2d 190, 194-95 (6th Cir. 1992).
139. *Morrison v. Marsh & McLennan Cos*., 439 F.3d 295, 302 (6th Cir. 2006).
140. *Meade v. Pension Appeals & Review Committee*, 966 F.2d 190 (6th Cir. 1992).
141. Ohio Revised Code § 2305.06. It should be noted that as of the writing of this article, H.B. 251 is currently pending in the Ohio General Assembly, which if passed, would shorten this statute of limitations to three years.
142. KRS § 1113.120(2).
143. *Redmon v. Sud-Chemie, Inc., Retirement Plan for Union Employees*, 547 F.3d 531 (6th Cir. 2008).
144. *Heimeshoff v. Hartford Life & Acc. Ins. Co*., 134 U.S. 604 (2013).
145. *Id.*
146. See Ohio Rev. C. § 3923.04(K).
147. See *Redmon, supra*.
148. 29 C.F.R. § 2560.503-1(g)(1)(iv).
149. *Moyer v. Metropolitan Life Ins. Co*., 762 F.3d 503, 505-06 (6th Cir. 2014).