NOT RECOMMENDED FOR FULL-TEXT PUBLICATION

No. 18-5325

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

DAVID MOORE, Plaintiff-Appellant, v. METROPOLITAN LIFE INSURANCE COMPANY; AMERICAN WATER WORKS COMPANY, INC., Defendants-Appellees.	)	ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF KENTUCKY

O R D E R

Before: GUY, STRANCH, and LARSEN, Circuit Judges.

David Moore, proceeding through counsel, appeals the district court's judgment in favor of the defendants in his action brought under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001—1461, against his former employer, American Water Works Company, Inc. ("American Water"), and the Metropolitan Life Insurance Company ("MetLife"). The parties have waived oral argument, and this panel unanimously agrees that oral argument is not needed. *See* Fed. R. App. P. 34(a).

In January and February of 2015, while employed by American Water at a water treatment facility in Kentucky, Moore became disabled when he suffered a stroke and a heart attack. Moore participated in the company's life insurance benefits plan (the "Plan"), which was insured by MetLife. Moore initially received short-term disability benefits for twenty-six weeks, after which MetLife automatically opened a claim under the life insurance portion of the Plan. By letter dated December 7, 2015, MetLife advised Moore that he "met all the requirements that

define Total Disability" under the Plan and that his claim for continued Basic Life and Optional Employee Life insurance coverage had been approved. The letter stated that Moore's basic life coverage of $69,000 and his optional life coverage of $166,000 would continue at no cost for as long as he remained disabled, but that the amount of coverage would drop to $10,000 on March 2, 2033, when Moore turned seventy years old.

According to Moore, during his employment at American Water, he received two summary plan description ("SPD") booklets—one when he first started in 2000 and one in 2002. The SPD dated May 2002 included the following provision on "Permanent and Total Disability":

> If you become eligible for a Permanent and Total Disability benefit and the disability lasts for six months or more, a monthly income of $18 for each $1,000 of the amount of your basic and optional insurance is payable. The monthly income will continue until the amount of your insurance, plus interest as may be declared by Aetna on the unpaid balance, is exhausted.[1]

Believing that he was entitled to monthly disability benefits under the Plan based on that provision and that there was no reduction in benefits at age seventy, Moore and his wife contacted the benefits service center at MetLife numerous times for clarification as to what benefits he was entitled to, but "did not receive any final answer."

In June 2016, Moore's attorney contacted MetLife and American Water to request copies of all documents related to Moore's life insurance and disability insurance benefits. In response, American Water provided a copy of an SPD with an effective date of January 1, 2011, and a life insurance certificate. The 2011 SPD did not provide for monthly disability payments and stated that Permanent and Total Disability Benefits "reduce[] to $10,000 when you reach age 70." The life insurance certificate that American Water provided, on the other hand, included a provision for Disability Life Installment Benefits of $18 per month for every $1000 of life insurance coverage and did not include a reduction in benefits at age seventy. Moore's attorney then sent a letter to MetLife on July 25, 2016, requesting payment of Moore's Disability Installment Life Benefits and clarification of the statement in a December 7, 2015, approval letter that Moore's life insurance benefits would be reduced to $10,000 on March 2, 2033. Counsel attached to his

[1] Aetna was the insurer of the Plan until January 1, 2003, when MetLife became the insurer.

letter a copy of the life insurance certificate that American Water had provided to him. MetLife responded with a letter dated August 18, 2016, which stated, "The customer's certificate you submitted into our office for review is not the applicable customer's certificate that was used for Mr. Moore's claim review." Moore's attorney again wrote to MetLife seeking further clarification and requesting a copy of the certificate that MetLife had used for its review of Moore's claim.

A claims examiner at MetLife began investigating the matter and discovered that American Water had provided Moore's attorney with the wrong life insurance certificate. The following timeline shows how this mistake occurred: The life insurance benefits policy that American Water had through Aetna from 1996 through 2002 included a Disability Installment Life Benefits provision, which provided monthly benefits in the amount of $18 per $1000 of life insurance coverage with no later reduction in the benefit amount, and a waiver of premium benefit. The 2002 SPD that Moore had in his possession and consulted when he became disabled corresponded with this policy. When MetLife began insuring the Plan's benefits in January 2003, it issued a new policy to American Water, which was consistent, in relevant part, with the prior Aetna-insured version of the Plan, in that it included Disability Installment Life Benefits and Continued Death Benefits During Total Disability with no later reduction in the amount. This was the policy that American Water provided to Moore's attorney in July 2016 in response to his inquiry.

But the policy had long since been changed. Effective January 1, 2006, a new Certificate of Insurance, designated Certificate 11, was issued. Certificate 11 incorporated changes that had been made to the benefits plan pursuant to a 2005-2010 National Benefits Agreement for American Water union employees. It also added the provision for a reduction in benefits to $10,000 at age seventy, but kept the provision for Disability Installment Life Benefits. Certificate 15 replaced Certificate 11 on January 1, 2011, and was retroactively applicable to January 1, 2006. Certificate 15 kept the provision for a reduction in benefits at age seventy but removed the provision for Disability Installment Life Benefits. On March 28, 2011, Certificate 20 replaced Certificate 15, with an effective date of November 17, 2010. Like Certificate 15,

Certificate 20 provided for a reduction in benefits to $10,000 at age seventy and did not provide for Disability Installment Life Benefits. MetLife and American Water maintain that Certificate 20 governs Moore's claim.

Because MetLife had determined that American Water had sent Moore the wrong life insurance certificate, MetLife contacted American Water asking them to confirm that Certificate 20 was the policy applicable to Moore's claim and to provide Moore and his attorney a copy of the certificate. There is no indication in the record that American Water provided Moore with a copy of the applicable policy or that it responded to MetLife.

Moore initially filed this suit against MetLife in state court. MetLife removed the action to federal court and attached a copy of Certificate 20 to its notice of removal. Shortly thereafter, Moore's attorney wrote to American Water attaching copies of the insurance certificate American Water had sent to him in July 2016 and Certificate 20 and asking for clarification as to which certificate was applicable to Moore at the time he was no longer able to work in 2015. American Water responded that Certificate 20 was the correct certificate. Moore then issued a subpoena duces tecum to American Water, demanding production of all documents related to Moore's long-term disability and life insurance benefits. American Water responded by again providing Moore with a copy of the same certificate it had provided in July 2016, not Certificate 20.

In July 2017, Moore filed a second amended complaint, adding American Water as a defendant. Moore moved to compel MetLife to respond to interrogatories and produce documents in order to determine which policy applied to his claim. American Water filed a response to the motion, attaching a copy of Certificate 20 and a declaration from Benefits Manager Sean King, in which he confirmed that Certificate 20 was the applicable policy.

Counts I and II of the amended complaint alleged that MetLife's December 7, 2015, letter, stating that Moore's death benefits were subject to a future reduction, and the improper denial of disability installment benefits were wrong, arbitrary and capricious, against the evidence provided to MetLife, and a breach of fiduciary duty. Pursuant to 29 U.S.C. § 1132(a)(1)(B) and (g), Moore sought clarification of his rights under the Plan, recovery of his

disability installment benefits, interest, and attorney's fees. As an alternative to Counts I and II, Count III sought relief against American Water for its failure to provide copies of applicable plan documents, in violation of 29 U.S.C. § 1024. Pursuant to 29 U.S.C. § 1132(c) and (g), Moore sought penalties in the amount of $110 per day or an amount allowed by ERISA, whichever is greater, and attorney's fees and costs. Count IV—also brought as an alternative to Counts I and II—alleged, pursuant to 29 U.S.C. § 1132(a)(3), that American Water breached its fiduciary duty and sought equitable relief, attorney's fees, and costs.

Moore and MetLife filed cross-motions for judgment, with MetLife seeking judgment on Moore's claim for benefits under 29 U.S.C. § 1132(a)(1)(B) and Moore seeking judgment and an order remanding the matter for a full and fair administrative review of his claim for benefits. Moore asserted that a remand was necessary because MetLife failed to conduct a full and fair review of his claim for benefits as required by 29 U.S.C. § 1133. American Water and Moore filed cross-motions for summary judgment.

The district court entered judgment in favor of MetLife and affirmed its administrative decision. The court found that Certificate 20 was the governing certificate in June 2015 when MetLife applied it to Moore's benefits claim and that American Water's having provided Moore with the wrong certificate did not change that conclusion. The court therefore rejected Moore's claim for benefits under § 1132(a)(1)(B). The court also rejected Moore's argument that MetLife and American Water failed to produce evidence that the amendments to the policy were properly effectuated because Moore failed to raise an invalid-amendment claim under § 1132(a)(3) against MetLife in his amended complaint. The court denied Moore's request for remand, reasoning that, even if Moore had made a claim for benefits within the meaning of ERISA and had been denied a full and fair review of that claim, a remand would serve no useful purpose. As for Counts III and IV, the court found that Moore failed to establish that American Water breached its fiduciary duty but assessed statutory penalties in the amount of $15 per day against American Water for its failure to twice provide Moore with the applicable certificate governing his benefits claim within thirty days of his requests.

On appeal, Moore argues that (1) MetLife did not conduct a full and fair review of his claim, (2) the district court should have remanded the matter for a full and fair administrative review process, and (3) American Water breached its fiduciary duty by failing to effectively communicate with him about the changes to his benefits plan. He does not challenge the assessment of statutory penalties against American Water.

Moore's Claims against MetLife

"[We] review[] a district court's judgment in an ERISA case *de novo*, applying the same standard of review to the administrator's action as required by the district court." *Moore v. Lafayette Life Ins.*, 458 F.3d 416, 427 (6th Cir. 2006). Generally, a challenge to the denial of benefits under 29 U.S.C. § 1132(a)(1) is reviewed de novo, *see Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), and review is confined to the administrative record, *see Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 619 (6th Cir. 1998). Here, Moore is raising a procedural violation against MetLife, and the "question of whether the procedure employed by the fiduciary in denying the claim meets the requirements of Section 1133 is a legal question which [we] must review *de novo*." *Kent v. United of Omaha Life Ins.*, 96 F.3d 803, 806 (6th Cir. 1996). In reviewing a procedural claim, a court may consider evidence outside the administrative record. *See VanderKlok v. Provident Life & Accident Ins.*, 956 F.2d 610, 617 (6th Cir. 1992).

On appeal, Moore does not explicitly challenge the district court's finding that Certificate 20 was the certificate that governed his claim for benefits. Instead, he maintains that MetLife failed to comply with ERISA's procedural requirements when it denied his claim for disability installment benefits. The ERISA provision at issue provides as follows:

> In accordance with regulations of the Secretary, every employee benefit plan shall—
>
> > (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. Moore contends that MetLife failed to comply with these requirements because it "did not provide specific, written reasons for its refusal to pay the claim, nor did it offer any opportunity for further discussion or appeal to the appropriate fiduciary under § 1133." MetLife, on the other hand, argues that there was no claim denial to trigger § 1133's requirements in the first place. It contends that, "all of the benefits available to [Moore] under the Plan were *approved* by MetLife," and when Moore inquired about additional benefits that were not available under the Plan, he was not making a "claim for benefits *under the plan*" within the meaning of ERISA and no "benefits *under the plan* [were] denied."

ERISA regulations define a "claim for benefits" as "a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims." 29 C.F.R. § 2560.503-1(e). An "adverse benefits determination" is defined, in relevant part, as

> [a] denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

Id. at § 2560.503-1(m)(4)(i).

As the district court recognized, § 1133 was not implicated because MetLife approved Moore's initial claim for benefits under the Plan. Contrary to Moore's assertion, his subsequent inquiries about disability installment benefits and whether his life insurance benefits would be reduced at age seventy was not a new claim for benefits that triggered the claim-procedure requirements. Indeed, he was not making a request for a benefit that was available to him "under the plan," 29 U.S.C. § 1133(1), and the inquiries here did not constitute a claim for benefits that triggered ERISA's procedural requirements. MetLife's response to his inquiries—that the certificate that Moore had submitted to its office for review was not the applicable certificate that was used for Moore's claim review—was not an "adverse benefits determination" within the

meaning of the regulations because it did not deny him a benefit that was otherwise available under the Plan. Moore asserts that "the regulations undoubtedly consider a request for payment of benefits to constitute a claim, even if the reason for non-payment is based on an eligibility determination." But Moore was not denied disability installment benefits based on a determination that he was not eligible for such benefits. Rather, he did not receive these benefits because they were not available under the version of the Plan in effect at the time he became unable to work. His reliance on *Smith v. Columbia Gas of Ohio Group Medical Benefit Plan*, 624 F. Supp. 2d 844 (S.D. Ohio 2009), is similarly misplaced. In that case, the court rejected the defendants' argument that the termination of the plaintiff's benefits was the result of a "ministerial function" and therefore was not an adverse benefits determination. *Id.* at 863. By virtue of his termination, Smith was denied a plan benefit and the court found that "the termination of Plaintiff's benefits constituted an adjudication of his claim for such continued disability benefits." *Id.* Here, disability installment payments were not a Plan benefit.

Though Moore argues otherwise, his challenge to the denial of disability installment benefits and the reduction of benefits at age seventy asserts, at its root, a claim that the Plan was improperly amended. Indeed, he ultimately wishes to have the prior version of the Plan enforced and to be awarded benefits that are no longer available. In support of his motion for judgment against MetLife, Moore argued that there was no evidence that any of the amendments to the Plan were "effectuated properly under the terms of the Master Policy." And as one of the bases for his request for remand, he cited the lack of evidence showing that the amendments were "consistent with the terms of the plan." Moore reasserts these arguments in his appellate brief, arguing that "the district court . . . largely ignored the evidence that the certificate was never properly amended." He states, "The evidence reflects that the terms of the plan were not amended, and thus there is no amendment to invalidate." But there is now no dispute that Certificate 20 was the applicable certificate at the time Moore became unable to work, and Certificate 20 did not include disability installment benefits.

At no point in the complaint did Moore allege, as he does now, that the Plan was improperly amended. Moreover, a claim challenging the validity of a plan amendment is

properly brought under 29 U.S.C. § 1132(a)(3), not § 1132(a)(1)(B). "[R]elief that seeks to *change* the terms of a plan is not relief that seeks 'to enforce . . . rights under the terms of the plan,' which is available under § 1132(a)(1)(B)." *Plotnick v. Comput. Sci. Corp. Deferred Comp. Plan for Key Execs.*, 182 F. Supp. 3d 573, 592 (E.D. Va. 2016) (second alteration in original) (citing *CIGNA Corp. v. Amara*, 563 U.S. 421, 435-36, 438-39 (2011)). Given Moore's acknowledgement that Certificate 20 was the applicable certificate and his demand for benefits under the previous version of the Plan, it is clear that he is seeking to change the terms of the current Plan. And the statutory vehicle for doing so is § 1132(a)(3). *See id.*; *see also Ross v. Rail Car Am. Grp. Disability Income Plan*, 285 F.3d 735, 741 (8th Cir. 2002); *Schleben v. Carpenters Pension Tr. Fund—Detroit & Vicinity*, No. 14-cv-11564-LJM, 2014 WL 4604000, at *4-5 (E.D. Mich. Sept. 15, 2014). Although Moore raised a claim under § 1132(a)(3), he did so only against American Water.

The district court properly entered judgment in favor of MetLife.

Moore's Claims against American Water

The district court granted summary judgment in favor of American Water on Moore's claim that American Water breached its fiduciary duty by failing to provide him with accurate plan documents. We review a district court's grant of summary judgment de novo, viewing the facts in the light most favorable to the non-moving party. *Flagg v. City of Detroit*, 715 F.3d 165, 178 (6th Cir. 2013). Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *see Estate of Smithers ex rel. Norris v. City of Flint*, 602 F.3d 758, 761 (6th Cir. 2010).

Moore alleged that American Water breached its fiduciary duty by "failing to apprise Moore of its alleged removal of his disability installment life benefits and of the reduction of his life benefits to $10,000 at age 70." To establish a breach-of-fiduciary-duty claim based upon misrepresentations under ERISA, a plaintiff must show "(1) that the defendant was acting in a fiduciary capacity when it made the challenged representations; (2) that these constituted material misrepresentations; and (3) that the plaintiff relied on those misrepresentations to [his]

detriment." *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 449 (6th Cir. 2002). "[A] misrepresentation is material if there is a substantial likelihood that it would mislead a reasonable employee in making an adequately informed decision in pursuing disability benefits to which []he may be entitled." *Id*. (first alteration in original) (quoting *Krohn v. Huron Mem'l Hosp.*, 173 F.3d 542, 547 (6th Cir. 1999)).

As the Plan administrator, American Water was obligated to provide to Moore an SPD that was "written in a manner calculated to be understood by the average plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a); *see* 29 U.S.C. § 1024(b). ERISA's implementing regulations require that the SPD be furnished using "measures reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals" and "be sent by a method or methods of delivery likely to result in full distribution." 29 C.F.R. § 2520.104b-1(b)(1).

In his affidavit, Moore stated that he recalled receiving two versions of the SPD during his employment at American Water—one when he first started in 2000 and the second sometime in 2001 or 2002. He stated that he does not have any SPDs dated after May 2002, but that it would have been his normal practice to keep such documents. American Water submitted documents showing that, in July 2012, it retained A+ Letter Services, Inc., to handle the mailing of the 2011 SPDs to American Water employees. The evidence included invoices from A+ Letter Services, the cover letter sent with the SPD, a mailing list showing that Moore was included in the list of employees who were sent the SPD, and an affidavit from American Water paralegal Martha B. Mazika.

Moore argues that American Water's evidence was not admissible and that it therefore could not be used to prove that the SPD was, in fact, mailed to Moore. Relying on *Perkins v. Rock-Tenn Services*, 190 F. Supp. 3d 720, 731 (W.D. Mich. 2016), Moore argues that "an administrator cannot simply rely on [hearsay] documents kept by a third party." *Perkins* also involved documents from a third party to show that Rock-Tenn had sent a required notice to the plaintiff. But in that case, the third-party records were rejected because the supporting affidavit

from the Rock-Tenn human resources director did not establish that the record was kept in the ordinary course of Rock-Tenn's business to allow it to come in under the business-records exception to the rule against hearsay. *Id.*; *see* Fed. R. Evid. 803(6)(b).

Federal Rule of Evidence 803(6)(b)—the business-records exception—does not require that the business entity offering the record be the one that actually prepared the record. *See Fambrough v. Wal-Mart Stores, Inc.*, 611 F. App'x 322, 329 (6th Cir. 2015). Documents prepared by a third party can be incorporated into an entity's business records. *Id.* However, a business entity can do so "only *through foundation testimony of the record keeping practices that establish such incorporation and reliance*." *Id.* Unlike the affidavit in *Perkins*, Mazika's affidavit provided this foundation. Mazika affirmed, inter alia, that the documents regarding A+ Letter Services's mailing were "maintained or prepared by employees with knowledge of the facts underlying their contents" and "in the course of a regularly conducted activity of American Water" and that "[i]t is a regular part of American Water's practice to keep and maintain [such] records." The district court properly held that American Water's evidence was sufficient to establish that it satisfied its obligations under 29 U.S.C. §§ 1022 and 1024 and 29 C.F.R. § 2520.104b-1 to distribute the 2011 SPD and that Moore's assertion that he did not recall ever receiving the SPD failed to create a genuine issue of material fact. *See* Fed. R. Civ. P. 56(e).

Moore next argues that, even if American Water did comply with its ERISA obligations by sending him the 2011 SPD, the SPD "was insufficient to reflect a consequential removal of disability benefits." ERISA authorizes district courts "to remedy 'false or misleading' statements in summaries with 'appropriate equitable relief'" under 29 U.S.C. § 1132(a)(3). *Butler v. FCA US, LLC*, 706 F. App'x 256, 258 (6th Cir. 2017) (quoting *Amara*, 563 U.S. at 438-42).

Moore points to the fact that the 2011 SPD retained a section titled "Total Disability Benefits" and that the prior SPDs, which provided for disability installments benefits, included "Permanent and Total Disability" sections. Moore argues that "the continued use of nearly the same language in the 2011 SPD is not notice that those important benefits were being removed" and that "[t]he 2011 SPD was not written in a manner to inform a participant that disability

installment benefits had been removed." In *Butler*, the plaintiff presented a similar argument, asserting that certain parts of the SPD led him to believe that a total and permanent disability benefit, which had previously been part of the plan, remained part of the plan after it had been amended. *Id*. This court rejected the plaintiff's assertion that the SPD was misleading, explaining, "The total-permanent-disability benefit is not mentioned, much less explained. That should have alerted participants that the benefit was no longer part of the policy." *Id*. Like the SPD in *Butler*, the 2011 SPD did not include any language about disability installment benefits. And while it included a "Total Disability Benefits" section, that section clearly outlined the total disability benefit to which Moore was entitled and which he actually received. The absence of any language about disability installment benefits should have made it "reasonably clear that [American Water] removed the [installment] benefit[s] deliberately." *Id*. at 259.

To the extent Moore argues that American Water was obligated to state explicitly that disability installment benefits had been removed, he cites no authority to support this assertion. It is "presume[d] that participants read the entire [SPD], interpreting provisions in context." *Id*. at 258. Although the 2011 SPD had a "Total Disability Benefits" section, a reading of that section and the SPD as a whole makes clear that disability installment benefits were no longer a part of the Plan and that a benefit reduction would take place at age seventy. The district court properly granted summary judgment to American Water on Moore's claim for equitable relief.

Accordingly, we **AFFIRM** the district court's judgment.

ENTERED BY ORDER OF THE COURT

Deborah S. Hunt, Clerk