UNITED STATE DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

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| STEPHEN DEL SESTO, AS RECEIVER AND ADMINISTRATOR OF THE ST. JOSEPH HEALTH SERVICES OF RHODE ISLAND RETIREMENT PLAN, et al | : | |
| Plaintiffs, | : | |
| v. | : | C. A. No. 18-cv-00328-WES-LDA |
| PROSPECT CHARTERCARE, LLC, et al. | : | |
| Defendants. | : | |

**DEFENDANT ANGELL PENSION GROUP, INC.'S MOTION TO DISMISS**

The Angell Pension Group, Inc. ("Angell") hereby moves for dismissal of all claims asserted against it in the Plaintiffs' Complaint pursuant to Fed. R. Civ. P. 9(b) and 12(b). The Complaint should be dismissed as to Angell because:

1. The Plaintiffs have failed to join an indispensable party—the Pension Benefit Guaranty Corporation;
2. The Class Plaintiffs lack standing to assert the claims in the Complaint;
3. The Complaint fails to state a claim upon which relief can be granted as to Angell;
4. The Plaintiffs have failed to plead fraud related claims with the requisite particularity; and
5. The Plaintiffs state law claims are preempted by federal law.

For these reasons, set forth in detail in the accompanying memorandum of law, Angell requests that the Court dismiss all claims asserted against Angell in the Plaintiffs' Complaint.

Angell requests oral argument on this motion and anticipates that argument will take ninety minutes.

THE ANGELL PENSION GROUP, INC.

By its attorneys,

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**CERTIFICATE OF SERVICE**

I hereby certify that on the 14th day of September, 2018, I have caused *Defendant Angell Pension Group, Inc.'s Motion to Dismiss,* and the accompanying memorandum of law, to be filed with the Court via the ECF filing system. As such, this document will be electronically sent to the registered participants identified on the Notice of Electronic Filing (NEF).

*/s/ Steven J. Boyajian*
Steven J. Boyajian

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**MEMORANDUM OF LAW IN SUPPORT OF DEFENDANT THE ANGELL PENSION GROUP, INC.'S MOTION TO DISMISS**

# TABLE OF CONTENTS

# TABLE OF AUTHORITIES

**Page(s)**

**CASES**

**RULES**



**STATUTES**

Comes now, The Angell Pension Group, Inc. ("Angell"), one of the Defendants herein, and submits this memorandum of law in support of its motion to dismiss the Complaint filed by Plaintiff Del Sesto ("Del Sesto") and Plaintiffs Major, Zompa, Bryden, Willner, Short, Boutelle and Levesque (the "Class Plaintiffs") (collectively with Del Sesto, the "Plaintiffs") pursuant to Fed. R. Civ. P. 12(b).

## I. INTRODUCTION

Plaintiffs bring this lawsuit because they believe the St. Joseph Health Services of Rhode Island Retirement Plan (the "Plan") was misclassified as a "Church Plan" exempt from the Employee Retirement Income Security Act of 1974, as amended, ("ERISA").[1] Plaintiffs assert that, because the Plan was misclassified as a Church Plan for years, the Plan is now "grossly underfunded" on an ERISA basis.

Plaintiffs' claims turn on the threshold determination of whether the Plan is properly classified as a Church Plan or an ERISA Plan. It can only be one, or the other. If the Plan is a Church Plan, then it is governed by state law and this Court does not have federal jurisdiction. (Compl. ¶¶ 32-34, 54.) On the other hand, if the Plan is an ERISA Plan, none of the Plaintiffs have, or will have, any injury. The Plan will undergo a distress termination, and the Pension Benefit Guaranty Corporation ("PBGC") will step in and pay the guaranteed benefits owed under the Plan. *No participants will lose any of their pension benefits.* Indeed, none of the Class Plaintiffs actually claim to have been denied any benefit they are owed under the Plan, or assert any immediate, cognizable injury to date.

[1] As used herein, "ERISA Plan" refers to an employee benefit plan governed by ERISA, 29 U.S.C. §§ 1001, *et seq.* "Church Plan" refers to an employee benefit plan exempt from ERISA's requirements because it is established and/or maintained by a church or affiliated organization. 29 U.S.C. § 1003(b)(2); 29 U.S.C. § 1002(33)(A).

Nevertheless, Plaintiffs' 527-paragraph, 21-Count Complaint portrays a soap-operatic tale of wrongdoing. Plaintiffs spin tales of "secret" meetings between and among various parties to supposedly "conspire" to hide the Plan's true status as an ERISA Plan, not a Church Plan. They allege "fraudulent conveyances" to hide assets and purported "false representations" to participants – all in an effort to further this "conspiracy." However, they do not allege that Angell – the Plan's actuary – ever advised on the status of the Plan as a Church Plan or participated in any of these so-called "secret" meetings to hide the Plan's true status as an ERISA Plan. Nor do they allege that Angell had any discretion over what to communicate to participants about the Plan, as opposed to simply conveying the information it was instructed to provide.

Indeed, the facts alleged regarding Angell are extremely limited.[2] Plaintiffs allege that Angell provided St. Joseph Health Services of Rhode Island ("SJHSRI") with the "recommended" contributions to fund the Plan each year, but SJHSRI disregarded Angell's funding recommendations and made no contributions to the Plan. Plaintiffs seek to hold certain defendants, but not Angell, responsible for violating ERISA's minimum funding requirements. Notably,

[2] Plaintiffs repeatedly use the phrase "other Defendants" or "other entities" throughout the Complaint, and it is unclear whether such references are intended to apply to Angell. (*E.g.*, Compl. ¶¶ 57, 58, 66, 194, 205, 207, 224, 292, 309, 326, 404.) In each of these cases where Angell is not specifically mentioned, the Court should assume that Angell is not one of the "other" Defendants or entities. *Laurence v. Wall*, No. CA08-109ML, 2010 WL 4137444, at *2 (D.R.I. Sept. 30, 2010) ("although the Complaint includes allegations against 'defendants' as a group, these sweeping allegations fail to provide adequate specificity to be deemed sufficient allegations against the Moving Defendants") (footnote omitted); *Levi Chicoine v. Gulliver's Tavern Inc.*, No. 15-216 S, 2016 WL 552469, at *3 n.2 (D.R.I. Feb. 10, 2016) ("general 'reference to Defendants throughout 'Amended Complaint No. 2,' does not satisfy the requirement of pleading specific and plausible allegations.' 'Without some semblance of factual allegations and an indication of which Defendant acted and when, that ties the Defendants' specific action to a recognized cause of action,' Plaintiffs have not alleged claims against the individual defendants for which relief can be granted.") (internal citation omitted) (quoting *Schofield v. U.S. Bank N.A.*, No. CA 11-170-M, 2012 WL 3011759, at *5 (D.R.I. July 23, 2012)).

Plaintiffs do not, and cannot, allege that Angell was ever required to make contributions to the Plan. And, nowhere do Plaintiffs suggest, in any way, that any of Angell's calculations were inaccurate, or any specific Actuarial Standards of Practice ("ASOP") were violated.[3] Rather, Plaintiffs simply complain that the amounts calculated by Angell were not actually contributed to the Plan by those who had responsibility to fund the Plan.

Nevertheless, Plaintiffs have added Angell as a defendant to nine (9) of the twenty-one (21) counts alleged.[4] For the reasons set forth in more detail below, the Complaint should be dismissed in its entirety for the failure to join an indispensable party – the PBGC. Further, the Class Plaintiffs lack constitutional standing to assert the claims in the Complaint, and none of the counts specifically asserted against Angell state a plausible claim in any event.

## II. STANDARD OF REVIEW

Fed. R. Civ. P. 8 "demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). A complaint does not "suffice if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.'" *Id.* (citations omitted). Rather, in order "[t]o survive a motion to dismiss, a complaint must contain *sufficient factual matter*, accepted as true, to 'state a claim to relief that is *plausible* on its face.'" *Id.* (emphasis added) (citations omitted).

"The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Iqbal*, 556 U.S. at 678. In short,

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[3] Actuarial Standards of Practice or "ASOPs" are published by the Actuarial Standards Board and can be found at: http://www.actuarialstandardsboard.org/standards-of-practice/.

[4] Including: Count III (Aiding and Abetting Fiduciary Breach under ERISA); Count VII (Fraud through Intentional Misrepresentations and Omissions); Count VIII (Fraudulent Scheme); Count IX (Conspiracy); Count X (Actuarial Malpractice); Count XVI (Rhode Island Hospital Conversion Act); Count XIX (Rhode Island Law, Breach of Fiduciary Duty); Count XX (Rhode Island Law, Aiding and Abetting Breaches of Fiduciary Duty); and Count XXI (Declaratory Judgment, Liability and Turn Over of Funds, State Law).

"Federal Rule of Civil Procedure 8(a)(2) requires a "*showing*, rather than a blanket assertion, of entitlement to relief," and the "*[f]actual allegations* must be enough to raise a right to relief above the speculative level." *Twombly*, 550 U.S. at 555-56, n.3 (emphasis added). "Something beyond the mere possibility [] must be alleged lest a plaintiff with a largely groundless claim be allowed to take up the time of a number of other people, with the right to do so representing an *in terrorem* increment of the settlement value." *Twombly,* 550 U.S. at 557-58 (internal quotations omitted). Indeed, to the extent a complaint fails to meet this threshold level of plausibility, "this basic deficiency should . . . be exposed at the point of minimum expenditure of time and money by the parties and the court." *Id.*

In addition to the face of the complaint, the court may consider documents "integral to or explicitly relied upon in the complaint, even though not attached to the complaint . . ." *Clorox Co. P.R. v. Proctor & Gamble Commercial Co.*, 228 F.3d 24, 32 (1st Cir. 2000) (citation omitted). Moreover, it is well settled that the Court may consider matters susceptible to judicial notice and matters of public record in deciding a Rule 12(b) motion without converting the motion into one for summary judgment. *See Greene v. Rhode Island*, 398 F.3d 45, 48-49 (1st Cir. 2005) (collecting cases); *see also Boateng v. InterAmerican Univ., Inc.*, 210 F.3d 56, 60 (1st Cir. 2000) ("a court ordinarily may treat documents from prior state court adjudications as public records.").

## III. ARGUMENT

### A. The PBGC is an indispensable party under Fed. R. Civ. P. 19.

The PBGC's duties "consist primarily of furthering the statutory purposes of Title IV [of ERISA] identified by Congress" which, in pertinent part, are "(1) to encourage the continuation and maintenance of voluntary private pension plans for the benefit of their participants" and "(2) to provide for the timely and uninterrupted payment of pension benefits to participants and beneficiaries under plans to which this subchapter applies." *Pension Ben. Guar. Corp. v. LTV*

*Corp.*, 496 U.S. 633, 648 (1990) (citing 29 U.S.C. § 1302(a)). Thus, when a covered ERISA pension plan terminates with insufficient assets to satisfy its pension obligations, "the PBGC becomes trustee of the plan." *Id.* at 637. After using available plan assets to cover benefit obligations, the PBGC then uses "its own funds to ensure payment of most of the remaining 'non-forfeitable' benefits . . . which participants have earned entitlement under the plan terms as of the date of termination." *Id.* at 637-38 (citing 29 U.S.C. §§ 1301(a)(8), 1322(a) and (b)).

If this Court decides the Plan is an ERISA Plan, then that judicial determination must be binding on the PBGC so the PBGC will step in and pay the guaranteed benefits owed to the Plan participants. Otherwise, all parties – including the Plan participants – bear the risk that the PBGC could conversely claim the Plan is a Church Plan and refuse to pay the benefits owed. Moreover, if Defendants prevail on Plaintiffs' claims, they could still face the same claims being made by the PBGC when it becomes trustee of the Plan, and will have to litigate the same alleged conduct twice. Such risk for inconsistent judgments is exactly what Rule 19 was intended to prevent. Fed. R. Civ. P. 19(a)(1) ("A person who is subject to service of process and whose joinder will not deprive the court of subject-matter jurisdiction ***must be joined as a party*** if: (A) in that person's absence, the court cannot accord complete relief among existing parties; or (B) ***that person claims an interest relating to the subject of the action and is so situated that disposing of the action in the person's absence may***: (i) as a practical matter impair or impede the person's ability to protect the interest; or (ii) ***leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations because of the interest***.") (emphasis added).

Accordingly, the Complaint should be dismissed pursuant to Fed. R. Civ. P. 12(b)(7) for failure to join an indispensable party – the PBGC. *See, e.g., Z & B Enters., Inc. v. Tastee-Freez Int'l, Inc.*, 162 F. App'x 16, 20 (1st Cir. 2006) (affirming dismissal for failure to join an

indispensable party where franchisor's purported agents were necessary parties because "we may not be able to grant complete relief" and defendant "could be subject to inconsistent or double obligations" without such parties).[5]

**B. <u>The Class Plaintiffs lack constitutional standing to bring this lawsuit</u>.**

To have standing under Article III of the Constitution, a plaintiff must satisfy three elements: *First*, "the plaintiff must have suffered an 'injury in fact' – an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Lujan v. Def. of Wildlife*, 504 U.S. 555, 560 (1992) (citations and quotations omitted). An injury is concrete if it "actually exists," and a mere statutory violation, without more, does not amount to a concrete injury. *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1548-49 (2016). *Second,* "there must be a causal connection between the injury and the conduct complained of – the injury has to be 'fairly traceable to the challenged action of the defendant . . .'" *Lujan*, 504 U.S., at 560 (citations omitted). *Third,* it must be "likely," not merely "speculative," that the injury will be "redressed by a favorable decision." *Id.* at 561 (citations omitted).

ERISA does not require that defined benefit plans maintain full funding, instead permitting plans to make contributions designed to address any underfunding over a period of years. 29 U.S.C. § 1082(c). Here, Plaintiffs repeatedly claim that the Plan is "grossly underfunded," but do not identify by how much. (Compl. ¶¶ 57, 65, 271, 344, 404.) Even if the Plaintiffs have adequately alleged that the Plan is technically "underfunded" on an ERISA basis, underfunding alone is not sufficient to establish constitutional standing. *Spokeo,* 136 S. Ct. at 1549 (noting that

[5] A more extensive analysis of the reasons for dismissal pursuant to Fed. R. Civ. P. 12(b)(7) is contained in the memorandum of law to be submitted concurrently with this memorandum by Defendant Prospect Medical Holdings, Inc. and four other defendants (collectively, "Prospect Entities"). To avoid duplication, Angell adopts and incorporates by reference the arguments of Prospect Entities with respect to ripeness and dismissal for failure to join the PBGC.

a "bare procedural violation, divorced from any concrete harm" does not satisfy Article III standing); *Lee v. Verizon Commc'ns, Inc.*, 837 F.3d 523, 530 (5th Cir. 2016) ("We . . . decline to conflate the concepts of statutory and constitutional standing by holding that incursion on a statutorily-conferred interest in proper plan management is sufficient in itself to establish Article III standing.") (citations and quotations omitted).

Plaintiffs speculate that, due to the alleged underfunding, the Class "Plaintiffs pensions ***will be*** lost or at least severely reduced." (Compl. ¶ 435 (emphasis added).)[6] However, the Complaint is devoid of ***any*** allegation that ***any*** Class Plaintiff, or ***any*** participant in the Plan, has actually failed to receive a single penny of benefits due or otherwise has actually been harmed in any way. Significantly, Plaintiffs have not alleged that the Plan has been terminated or that the PBGC will not pay all of the benefits owed in the event of a termination. Such speculative allegations of risk fail to constitute an injury suffered by Class Plaintiffs (or any member of the putative class) – let alone an injury that is concrete and particularized, and actual or imminent. *See, e.g., Lee*, 837 F.3d at 546 ("[Plaintiff's] allegations do not further allege the realization of risks which would create a likelihood of direct injury to participants' benefits. To wit, [Plaintiff] does not allege a plan termination, an inability by Verizon [sic] address a shortfall in the event of a termination, or a direct effect thereof on participants' benefits."); *see also Sheedy v. Adventist Health Sys.*, No. 616CV1893ORL31GJK, 2018 WL 3538441, *4 (M.D. Fla. July 23, 2018) ("[Plaintiff] does not explain what benefit she is entitled to under the [plan], or when that benefit is due. She does not indicate whether the [plan] has ever failed to make a required payment, nor does she indicate when

[6] Plaintiffs allege that the Plan was placed into receivership with the request that the Rhode Island Superior Court approve a "virtually immediate 40% across-the-board reduction in benefits." (Compl. ¶ 56.) But the Complaint does not allege that this "request" was approved, nor that there has been a reduction to a single participant's benefits as a result of this "request."

the [plan] will need additional funding in order to meet its payment obligations. The Plaintiff has not adequately pleaded that she faces a substantial, rather than merely speculative, risk of future injury. Thus, the Plaintiff lacks standing to bring Count III with respect to the [plan].”); *Perelman v. Perelman*, 793 F.3d 368, 374 (3d Cir. 2015) (“[E]ven if the defendants’ dealings resulted in a diminution in Plan’s assets, they are insufficient to confer standing upon [plaintiff] absent a showing of individualized harm.”); *David v Alphine*, 704 F.3d 327, 338 (4th Cir. 2013) (“We find on this record the alleged risk [to plan funding] to be insufficiently ‘concrete and particularized’ to constitute an injury-in-fact for Article III standing purposes.”).

**C. Plaintiffs fail to allege any causation by Angell.**

Moreover, as discussed in more detail below, Plaintiffs have failed to allege any conduct by Angell that caused any “injury in fact” to any of the Plaintiffs. Plaintiffs do not (and cannot) allege that Angell was a fiduciary to the Plan, or that Angell was responsible for funding the Plan.

Plaintiffs allege that Angell prepared various calculations, but was asked at one point to prepare a spreadsheet focusing on only one of those calculations, showing that if $14 million were contributed to the Plan, it would be “stabilized” at a funding ratio of 94.9%. (Compl. ¶¶ 313-324.) According to the Complaint, this spreadsheet failed to disclose that “use of any funding level percentage as a measure of the Plan’s funding progress was contrary to and deviated from the standards of actuarial practice, that according to those standards the funding progress of a pension plan should not be reduced to a funding percentage at a single point in time . . .” (*Id.* ¶ 323.) Plaintiffs also allege that the spreadsheet failed to disclose that 7.75% (the assumed investment return) is 68% more than 4.6% (which the Complaint describes as a “market rate”). (*Id.* ¶ 322.) Then, Plaintiffs allege that, “[t]hese misrepresentations and omissions” were relied upon by

regulators in approving the asset sale. (*Id.* ¶ 324.)[7]

However, Paragraph 324 mischaracterizes the factual allegations of the prior paragraphs, none of which allege any misrepresentation. Rather, it seems clear from the Complaint that Plaintiffs do not contest the *accuracy* of any of the information provided by Angell, but only its *completeness*. Yet, the allegations show that Angell provided numerous scenarios and measures to its client, as well as using multiple projected rates of return. However, the allegations make clear that the *client* (SJHSRI), not Angell, controlled what information was provided to the regulators. So, the *gravamen* of the Complaint seems to be the preposterous proposition that an actuary is never permitted to give a client a single accurate number without including, in the very same communication, a complete treatise on actuarial science and multiple scenarios, even if the actuary has separately provided the client with a multitude of accurate projections. Further, the information presented – that the Plan would be "stabilized" at 94.9% – obviously demonstrates that the Plan will run out of money at some point. Plaintiffs have not explained how the regulators could have thought 94.9% funding is sufficient to pay 100% of Plan benefits.

Thus, Plaintiffs present no plausible way that any alleged action or inaction by Angell *caused* the Plan to be underfunded.

**D. Plaintiffs fail to state a claim for relief under ERISA against Angell.**

1. There is no cause of action against a non-fiduciary under ERISA for "aiding and abetting" a fiduciary breach. (Counts III and XX.)

ERISA assigns a number of detailed duties and responsibilities to fiduciaries, makes fiduciaries liable for breach of these duties, and specifies the remedies available against them. 29 U.S.C. §§ 1104, 1109(a). However, these provisions are limited, by their terms, to *fiduciaries.*

[7] To avoid duplication, Angell adopts and incorporates by reference Prospect Entities' arguments relating to statements made to third parties (i.e., not to Plaintiffs).

Plaintiffs do not allege that Angell – the Plan's actuary – is a fiduciary to the Plan.[8]

Instead, Plaintiffs claim that Angell – a non-fiduciary – should be held liable for supposedly "aiding and abetting" breaches of fiduciary duty under ERISA and Rhode Island state law. (*See* Counts III and XX.) However, "no provision [of ERISA] explicitly requires [non-fiduciaries] to avoid participation (knowing or unknowing) in a fiduciary's breach of fiduciary duty." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993); *Reich v. Rowe*, 20 F.3d 25, 26 (1st Cir. 1994) ("Although ERISA may allow for some types of actions against non-fiduciaries, it does not authorize suits against non-fiduciaries charged solely with participating in a fiduciary breach."); *see also Nieto v. Ecker*, 845 F.2d 868, 871 (9th Cir. 1988) ("The plain language of section 409(a) limits its coverage to fiduciaries, and nothing in the statute provides any support for holding others liable under that section.") "It is unlikely [] that this was an oversight, since ERISA *does* explicitly impose 'knowing participation' liability on co-fiduciaries." *Mertens*, 508 U.S. at 254 (citing 29 U.S.C. § 1105(a)) (emphasis in original).

In *Mertens*, the Supreme Court expressly held that a non-fiduciary actuary could not be held liable under ERISA § 502(a)(3) for money damages for knowingly assisting in a breach by a fiduciary. 508 U.S. at 251-53. Though the Supreme Court has not expressly opined on whether ERISA provides for a cause of action against non-fiduciaries who assist in a fiduciary's breach of duty,[9] other courts have held that 29 U.S.C. § 1132(a)(3) simply does not authorize suit against non-fiduciaries for participating in a fiduciary breach. *See, e.g., Renfro v. Unisys Corp.*, 671 F.3d

[8] *See* Compl. ¶ 440 (identifying SJHSRI and CCCB as the Plan's fiduciaries). Further, Angell is not named as a defendant to Count II - ERISA, Breach of Fiduciary Duty.

[9] *Pharm. Care Mgmt. Ass'n v. Rowe,* 429 F.3d 294, 300 n.4 (1st Cir. 2005) ("In *Mertens*, the Supreme Court expressly reserved the question as to whether ERISA provides for a cause of action against non-fiduciaries who assist in a fiduciary's breach of duty. The Court, however, did resolve the question as to whether a non-fiduciary in such a suit would be subject to monetary damages.").

314, 325 (3d Cir. 2011) ("In light of *Reich*, and interpreting identical language, we find *Mertens* persuasive and hold that 29 U.S.C. § 1132(a)(3) does not authorize suit against 'non-fiduciaries charged solely with participating in a fiduciary breach.' Because, as previously discussed, the Fidelity entities did not act as fiduciaries with respect to the alleged breach, they may not be sued under this section for acts taken in a non-fiduciary role.") (citation omitted); *Lash v. Reliance Standard Life Ins. Co.*, No. 16-235, 2016 WL 3362060, at *3 (E.D. Pa. June 17, 2016) ("Plaintiff cannot assert a claim against Matrix under § 1132(a)(3) unless Matrix has acted as a fiduciary.")[10]

2. Plaintiffs have not stated a plausible claim for equitable relief under ERISA § 502(a)(3) against Angell.

Plaintiffs have not stated a claim against Angell that is "plausible on its face." *Iqbal*, 556 U.S. at 678. The Complaint is replete with allegations that Angell affirmatively, and repeatedly, advised the Plan's fiduciaries to comply with the law and make the minimum funding contributions, but these recommendations were ignored or "disregarded."[11] This is fundamentally

[10] The Supreme Court has held that ERISA § 502(a)(3) authorizes suits against non-fiduciaries for participating in a transaction prohibited by ERISA § 406(a). *Harris Tr. & Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000). However, the *Harris Trust* decision is limited to prohibited transaction claims under ERISA § 406(a), and does not specifically address the broader question of whether ERISA § 502(a)(3) provides a cause of action against non-fiduciaries for participating in breaches of fiduciary duty by plan fiduciaries under ERISA §§ 404 or 409. *See, e.g.*, *McDannold v. Star Bank*, 261 F.3d 478, 486 (6th Cir. 2001) (noting the "narrow reach" of *Harris Trust*); *Davidson v. Hewlett-Packard Co.*, No. 5:16-cv-01928-EJD, 2017 WL 106398, at *2 (N.D. Cal. Jan. 11, 2017) (granting motion to dismiss § 502(a)(3) claim because defendants were not fiduciaries under ERISA and plaintiff "has not alleged that the three doctors or Does 1–50 engaged in transactions barred under § 406(a). As such, *Harris Trust* offers no basis for naming them as individual defendants.").

[11] *See* Compl. ¶ 65 ("At various times during the period from 1995 to the present, SJHSRI did not fund the Plan in accordance with the requirements of ERISA and the recommendations of the Plan's actuaries, with the result that the Plan is grossly underfunded."); ¶ 271 (". . . although actuaries throughout the life of the Plan annually calculated the amount of money that SJHSRI should pay into the Plan, based upon the contribution requirements of ERISA and the Plan, SJHSRI routinely disregarded their recommendations and in many years chose to make no annual contributions whatsoever, with the result that the Plan became more and more underfunded over time."); ¶ 303 ("SJHSRI for years had been disregarding Angell's funding recommendations and

inconsistent with any notion that Angell was "aiding," "abetting," or otherwise "participating" in any breach by the Plan's fiduciaries. Similarly, Angell provided its client with numerous calculations and projections – none of which are alleged to be inaccurate – but Plaintiffs attempt to hold Angell responsible for ensuring that its client provide all of the projections to regulators in connection with the asset sale. (Compl. ¶¶ 313-324.) Indeed, if this court were to accept Plaintiffs' theory, then any non-fiduciary lawyer, actuary or consultant who provides advice to a Plan fiduciary that is ignored, could subsequently be liable for "aiding and abetting" a fiduciary breach. *See, e.g., Mellon Bank, N.A. v. Levy*, No. 01-1493, 2002 WL 664022, at *11 (W.D. Pa. Apr. 22, 2002) (noting "the rule prohibiting fiduciary liability against professional service providers who act within the scope of their usual professional duties" and granting motion to dismiss).

Further, Count III purports to state a claim under 29 U.S.C. § 1132(a)(3). That provision only authorizes injunctive or "other appropriate equitable relief" to redress violations, or enforce the provisions, of the terms of the plan or subchapter I of ERISA. *Id.* at *9 n.14. Count III identifies no provisions of the Plan or subchapter I of ERISA that Plaintiffs contend Angell violated. The only apparent violation of ERISA, or the Plan terms, alleged in the Complaint is the assertion that certain Defendants, but not Angell, violated ERISA's minimum funding requirements. Of course, Plaintiffs do not, and cannot, allege that Angell – the Plan's actuary – was ever required to make contributions to the Plan.[12]

Finally, ERISA § 502(a)(3) limits plaintiffs to "appropriate equitable relief." 29 U.S.C. § 1132(a)(3). Here, Plaintiffs' multitude of theories for recovery in Count III fail to state a claim.

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making no contributions."); ¶ 332 (noting that no contributions had been made "contrary to the recommendations of the Plan's actuarial advisors").

[12] *See* Compl. ¶ 432 ("As the employer maintaining the plan, SJHSRI was responsible for making the contributions that should have been made pursuant to 29 U.S.C. § 1082, at a level commensurate with ERISA's requirements.")

Plaintiffs are not seeking identifiable, traceable funds from Angell. Thus, Plaintiffs are not entitled to any monetary recovery from Angell. *See, e.g., Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 214 (2002) ("The basis for petitioners' claim is not that respondents hold particular funds that, in good conscience, belong to petitioners, but that petitioners are contractually entitled to some funds for benefits that they conferred. The kind of restitution that petitioners seek, therefore, is not equitable—the imposition of a constructive trust or equitable lien on particular property—but legal—the imposition of personal liability for the benefits that they conferred upon respondents."); *Montanile v. Bd. of Trs. of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651, 660 (2016) ("as a general rule, plaintiffs cannot enforce an equitable lien against a defendant's general assets"). Furthermore, Plaintiffs' requests for reformation of the Plan and equitable estoppel to fund the Plan do not apply to Angell, which indisputably has no funding obligation with respect to the Plan.

Because Plaintiffs have identified no factual basis for "equitable relief" against Angell for violations of the Plan terms or subchapter I of ERISA, Count III fails to state a claim against Angell.

**E. <u>Plaintiffs fail to state a claim against Angell for actuarial malpractice (Count X)</u>.**

Count X is labelled as a claim for "actuarial malpractice." The actual allegations only assert the conclusion that Angell did not conform to the required "standard of care," without including any factual allegations about what Angell did, or failed to do, that supposedly constituted "negligence."

1. <u>The Class Plaintiffs do not have standing to assert an actuarial malpractice claim.</u>

As a preliminary matter, none of the Class Plaintiffs even have the ability to raise an actuarial malpractice claim against Angell. Most courts that have considered this issue have held

that a party must be in privity of contract with a professional, or that a party must be the direct and intended beneficiary of a professional's services, to sue for professional malpractice. *See, e.g., Clark v. Feder Semo & Bard, P.C.,* 634 F. Supp. 2d 99, 108 (D.D.C. 2009) (retirement plan participant was not in privity of contract with actuarial consulting firm hired by employer to provide actuarial services related to employer's retirement plan or a direct and intended beneficiary of the actuarial consulting firm's services, as required to state a claim for professional malpractice against actuarial consulting firm based on actuarial services the firm provided related to the retirement plan); *Dill v. Wood Shovel & Tool Co.*, No. 4110, 1972 WL 795, at *5 (S.D. Ohio Apr. 20, 1972) (noting that a professional is not liable for ordinary negligence to a third person with whom he has no professional contractual relationship and that "this rule is equally applicable to the liability of an actuary for alleged negligence in failing to advise its employer as to the correct amount of contributions required to make a pension fund actuarially sound.").

Here, SJHSRI hired Angell to assist it with the Plan. The Class Plaintiffs were merely participants in the Plan. (Compl. ¶¶ 3-9.) None of the Class Plaintiffs have alleged that they were in privity of contract with Angell, nor have they alleged facts that they were the direct and intended beneficiary of Angell's actuarial services. Accordingly, the Class Plaintiffs do not have standing to sue Angell for actuarial malpractice. *E.g., Clark,* 634 F. Supp. 2d at 108.

2. Plaintiffs have not stated a plausible claim for actuarial malpractice.

The gist of Plaintiffs' Complaint is that the annual maximum and minimum contributions to the Plan recommended by Angell each year were not actually contributed to the Plan by those who had responsibility to fund the Plan. (*See* Compl. ¶¶ 65, 271, 303, 332.) However – to be clear – ***it is not Angell's responsibility, as the Plan's actuary, to ensure that any such funding obligations are met.*** *See, e.g., Bd. of Trs. New Orleans Emp'rs Int'l Longshoremen's Ass'n v. Gabriel, Roeder, Smith & Co.,* 529 F.3d 506 (5th Cir. 2008) (actuary who provided actuarial

services for union pension board did not commit actuarial malpractice under ASOP of the Actuarial Standards Board in failing to affirmatively state her opinion on whether board should adopt proposals for additional benefits; once actuary provided board with estimates regarding actuarial cost of paying the additional benefits, and advised the board it should take into account recent market decline in making its decision, she met her duty under the ASOP). And nowhere do Plaintiffs suggest, in any way, that any of Angell's calculations were inaccurate.

Instead, it appears Plaintiffs challenge particular actions taken when Angell supposedly acted as CCCB's and SJHSRI's actuarial "consultant" in connection with the application for regulatory approval of the conversion of the hospitals to for-profit entities in 2014. (Compl. ¶¶ 312-13.) Specifically:

- Plaintiffs allege that in 2013 Angell had provided CCCB and SJHSRI with calculations demonstrating that – if $14 million were contributed to the Plan, and assuming a future rate of return of 7.75% – the Plan would run out of funds in 2034 with over $99 million in unpaid liabilities. (*Id*. ¶ 314.)

- Plaintiffs allege that in early 2014 Angell provided CCCB and SJHSRI with an *updated* calculation based on slightly higher value of Plan assets at the beginning of 2014 (which showed the Plan would run out of funds in 2036), and also provided an "alternative" calculation that used a lower rate of return of 5.75% (under which the Plan would run out of assets in 2030). (*Id*. ¶ 315.)

- Plaintiffs allege CCCB and SJHSRI "asked Angell to modify that calculation for submission to the Attorney General and the Department of Health" to utilize *only* the higher projected rate of 7.75%, delete all calculations post-2014, and show *only* the stabilization effect in 2014 of the incoming $14 million to the Plan without further information. (*Id*. ¶ 318.)

- Plaintiffs claim that Angell was being asked to present the 2014 funding level in isolation, so that it could be provided *by other defendants* to the Attorney General and the Department of Health, knowing it would be "misleading." (*Id.* ¶¶ 320-21.)

- Plaintiffs allege that Angell did, in fact, provide the "requested new calculation" showing the immediate effect of the $14 million contribution would be to increase the funding percentage of the Plan to 94.9% (the "94.9% Spreadsheet"). (*Id.* ¶ 321.)

Plaintiffs then seemingly challenge three aspects of Angell's conduct in connection with

this request from CCCB and SJHSRI.

- *Use of 7.75% as the rate of return*

First, Plaintiffs contend that the calculation did not disclose that the Plan's projected rate of return (7.75%) was "over 68% greater than the market rate of 4.6%." (*Id.* ¶ 322.) However, Plaintiffs do not allege any ASOP was violated with using 7.75% as the Plan's projected rate. And the Complaint clearly states that the projected rate of return *was* disclosed (*id.* ¶¶ 250, 251, 314, 315), and that Angell also provided projections using a return of 5.75% (*id.* ¶ 315). There is no allegation that supports the proposition that Angell would know, better than anyone else, what future investment returns would be. Angell was hired to perform actuarial calculations, not predict the future of the stock market.

- *94.9% Spreadsheet*

Second, Plaintiffs contend that Angell should not have provided the revised 94.9% Spreadsheet to SJHSRI, unattached to their other calculations, knowing that projection would be given to the regulators. (Compl. ¶¶ 321-22.) In this regard, it appears that Plaintiffs do not contest the accuracy of any of the information provided by Angell, but only its completeness. Yet, the allegations show that Angell provided numerous scenarios and measures to its client, as well as using multiple projected rates of return. (*Id.* ¶¶ 314-316.) And, there is simply no allegation that Angell had discretion or responsibility to decide what information should be provided to the regulators. So, the crux of the Complaint seems to be the preposterous proposition that an actuary is never permitted to give a client a single accurate number without including, in the very same communication, a complete treatise on actuarial science and multiple scenarios, even if the actuary has separately provided the client with a multitude of accurate projections.

Further, the 94.9% funding level plainly and obviously indicates that the $14 million

contribution was nevertheless insufficient to pay 100% of Plan benefits. Thus, it is impossible to see how this revised 94.9% Spreadsheet could have deceived *anyone* into thinking the Plan would *not* run out of money.

- *Funding level*

Third, Plaintiffs assert, in conclusory fashion, that Angell's calculation did not disclose that "any funding level percentage as a measure of the Plan's funding progress was contrary to and deviated from the standards of actuarial practice . . ." (*Id.* ¶ 323.) But, once again, Plaintiffs do not identify any ASOP that was violated. Moreover, Paragraph 323 clearly is intended to say that no *single* funding level percentage should be used as a *complete* measure. No other construction of that sentence makes any sense. Clearly, the Complaint could not be intended to suggest that an actuary is *never* permitted to give a percentage. Setting aside the question of whether giving a single percentage is a violation of any ASOP (it is not), it is abundantly clear from the Complaint that Angell provided multiple scenarios at both 7.75% interest and 5.75% interest. Thus, the warning would have been irrelevant. The Complaint makes it clear that the 94.9% Spreadsheet was given to SJHSRI, which in turn gave it to the regulators. The Complaint does not establish that Angell was in any way responsible for which information was provided by SJHSRI to the regulators.

Plaintiffs simply have not stated a plausible claim against Angell for any actuarial malpractice, and Count X fails.

**F. Plaintiffs' remaining state law claims are preempted by ERISA.**

Plaintiffs contend that the Plan is governed by ERISA. (Compl. ¶ 32.) By its plain terms, ERISA broadly 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); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (ERISA preemption is "conspicuous for its breadth."). "The term 'State law' includes all laws,

decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1). In adopting § 1144(a), Congress deliberately rejected narrower preemption language directed at "state laws relating to the *specific subjects* covered by ERISA," *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 98 (1983) (emphasis added), choosing instead to supplant all state laws that "relate to" ERISA-regulated plans.

In *Shaw*, the Supreme Court observed that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. Indeed, ERISA preempts a state law that has a connection with or refers to an ERISA-regulated benefits plan, "even if the law is not specifically designed to affect such plans, or the effect is only indirect, and even if the law is consistent with ERISA's substantive requirements." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 (1992) (internal quotation marks and citations omitted); *see also Rosario-Cordero v. Crowley Towing & Transp. Co*., 46 F.3d 120, 123 (1st Cir. 1995) ("[A] state law may relate to an employee benefit plan even though the law does not conflict with ERISA's own requirements. . . . ").

While not always clearly specified, Plaintiffs apparently rely on Rhode Island law in bringing the remaining Counts they assert against Angell. (*See* Counts VII, VIII, IX, XVI, XIX, XX, XXI.) However, these Counts all relate to work Angell did for the Plan, including information that Angell provided regarding the Plan's funded status and/or communications between Angell and Plan participants about benefits. (*Id.*) Thus, to the extent Plaintiffs attempt to rely on state law to support these Counts, such laws are preempted as all of the conduct at issue directly "relates to" the Plan, which Plaintiffs claim is subject to ERISA. 29 U.S.C. § 1144(a); *see, e.g., Carlo v. Reed Rolled Thread Die Co.,* 49 F.3d 790, 794 (1st Cir.1995) (misrepresentation claim was preempted by ERISA because a computation of damages would require the court's "inquiry [to]

be directed to the plan."); *Vartanian v. Monsanto Co.*, 14 F.3d 697 (1st Cir.1994) (state-law claim of misrepresentation was preempted by ERISA because in order for the plaintiff to prevail the court would have to find that a plan existed); *Pemental v. Sedgwick Claims Mgmt. Sys., Inc.*, No. 14-45-M, 2014 WL 2048279, at *5 (D.R.I. May 19, 2014) ("the Plan is 'related to' the cause of action and [therefore] ERISA preempts [plaintiff's] fraud claim"); *Lemanski v. Lenox Sav. Bank*, No. 95-30074-MAP, 1996 WL 253315, at *13 (D. Mass. Apr. 12, 1996) ("Plaintiff's breach of contract, declaratory judgment and injunction claims are expressly preempted by ERISA because in order to prevail he must plead, as he has, and the court must find, as it does, that an ERISA plan exists.").

Further, it is well established that ERISA's civil remedies provision provides the exclusive remedies for violations of the conduct regulated by ERISA. In *Pilot Life Ins. Co. v. Dedeaux*, the Supreme Court concluded that "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." 481 U.S. 41, 54 (1987). The Supreme Court explained:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

*Id.* (state law claims for, *inter alia*, breach of fiduciary duties and fraud in the inducement were preempted by ERISA).

In this regard, courts within this Circuit have routinely found that state common law claims (such as those specific claims asserted against Angell here) fall within ERISA's exclusive civil

enforcement regime and are preempted. *See, e.g., Mauser v. Raytheon Co. Pension Plan for Salaried Emps.*, 239 F.3d 51, 58 (1st Cir. 2001) (ERISA preempted breach of fiduciary duty claim); *Stamp v. Metro. Life Ins. Co.*, 466 F. Supp. 2d 422, 429 (D.R.I. 2006) ("to the extent Plaintiff asserts a common law breach of fiduciary duty claim, that claim is preempted by ERISA"); *Stenmark v. Bank of Am. Corp.*, No. 05-312 ML, 2006 WL 2474871, at *2 (D.R.I. Aug. 24, 2006) (state-law claims of fraud and negligent misrepresentation preempted by ERISA); *Simmons v. Serv. Credit Union*, No. 17-cv-159-PB, 2018 WL 1251628, at *4 (D.N.H. Mar. 12, 2018) ("Because [plaintiff's] breach of contract and declaratory judgment claims seek to enforce rights provided under that plan, his claims are completely preempted by ERISA.").[13]

**G. Plaintiffs' fraud-related claims fail as a matter of law.**

Even if not preempted, Plaintiffs' fraud-related claims (Counts VII-IX) fail to meet the heightened pleading standard of Fed. R. Civ. P. Rule 9(b). *N. Am. Catholic Educ. Programming Found., Inc. v. Cardinale*, 567 F.3d 8, 15 (1st Cir. 2009) (Rule 9(b) governs a claim "where the core allegations effectively charge fraud."). Rule 9(b) requires Plaintiff to state with particularity "the circumstances constituting fraud or mistake." *Id.* at 13. "[M]ere allegations of fraud, corruption or conspiracy, averments to conditions of mind, or referrals to plans and schemes are too conclusional to satisfy the particularity requirement, no matter how many times such accusations are repeated." *Hayduk v. Lanna*, 775 F.2d 441, 444 (1st Cir. 1985).

Counts VII, VIII, and IX contain absolutely no factual allegations against Angell at all. Even attempting to look elsewhere in the Complaint for factual allegations against Angell that might relate to these claims, Plaintiffs do not provide the required specificity.[14]

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[13] To avoid duplication, Angell also adopts and incorporates by reference the arguments of Prospect Entities with respect to ERISA preemption.

[14] As receiver to the Plan, Plaintiff Del Sesto has access to 800,000 pages of documents

1. Plaintiffs fail to assert a claim against Angell for fraudulent misrepresentation (Count VII).

In Paragraph 260 of the Complaint, Plaintiffs generally allege that a group of Defendants:

> . . . made or provided statements to Plan participants, on different occasions, in many different contexts, over many years, and using plain language, that assured Plan participants that the Plan was an earned benefit of their employment, that the contributions necessary to properly fund the Plan were being made, that it was management's policy, practice and duty to do so, and that SJHSRI and not the Plan participants bore the risk of Plan assets not earning expected returns or incurring investment losses.

(Compl. ¶ 260.) However, Plaintiffs do not include any specific factual allegations tying these "statements" made "on different occasions, in many different contexts" to any particular Defendant(s). (*Id.* at ¶¶ 260, 284; *see also* ¶ 280 (discussing a pamphlet provided to Plan participants without identifying the sender).) Plaintiffs' generalized references to "statements" or other types of communications without specifically identifying the pertinent facts surrounding the "who, what, where, and when" the communication was sent (and by whom), does not meet the heightened pleading standards for fraud under Rule 9(b). *Doyle v. Hasbro, Inc.*, 103 F.3d 186, 194 (1st Cir. 1996). Further, grouping the Defendant(s) together in this manner fails to satisfy the requirement that the "who" be pled with specificity. *See King v. Wells Fargo Home Mortg.*, No. 11-10781-GAO, 2013 WL 1196664, at *2 (D. Mass. Mar. 25, 2013) (lumping parties all together as "defendants" is not sufficient.); *Archdiocese of San Salvador v. FM Int'l, Inc.*, No. 05-cv-237-JD, 2006 WL 437493, at *7-8 (D.N.H. Feb. 23, 2006) (noting that when a the complaint "group[s] all claimed wrongdoers together in a single set of allegations," it is insufficient under Rule 9(b)).

In this regard, the vast majority of the supposedly misleading statements were allegedly made by individuals and entities *other* than Angell. (*See* Compl. ¶¶ 266-288.) For example, Plaintiffs' allege that certain representations were made in various "booklets" (*id.* ¶¶ 266-67, 269-

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regarding the Plan and its administration. *See* Request for Judicial Notice filed concurrently herewith. It is telling that he is unable to state a plausible claim with the requisite specificity.

270), but these "booklets" were allegedly drafted and revised by SJHSRI (*id.* ¶ 272), *not* Angell. Plaintiffs also allege various other statements or representations were made by SJHSRI (*id.* ¶¶ 274, 281, 282, 285, 286, 287, 288), SJHSRI's Presidents (*id.* ¶¶ 268, 275-276), the Diocese Retirement Board (*id.* ¶ 273), the Bishop (*id.* ¶¶ 277-279) and the Diocese (*id.* ¶¶ 277-279). None of these statements allegedly made by other individuals and entities can be "attributed" to Angell simply by implication.[15]

There are just ***three*** specific communications alleged in the Complaint that even remotely reference Angell, and none of them meet the elements for a "fraudulent misrepresentation." *See Francisco v. U.S. Marshalls Serv.*, No. 11-23IL, 2014 WL 652147, at *13 (D.R.I. Feb. 19, 2014) (elements for fraudulent misrepresentation are "a [misrepresentation] intending thereby to induce plaintiff to rely thereon' and that the plaintiff justifiably relied thereon to his or her damage.").

- *Participant Statements*

Plaintiffs allege that *Angell* provided Plan participants with "statements" setting forth "specific projected lifetime benefits," despite knowing that the Plan was underfunded. (Compl. ¶ 292.) However, as alleged in the Complaint, and shown in in Exhibit A,[16] the statements begin by saying, "*St. Joseph Health Services of Rhode Island* is pleased to give you this statement showing your estimated benefits." (Compl. ¶ 281.) (emphasis added). There is no allegation that Angell was in in any way responsible for the text in the statements provided *by SJHSRI*.

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[15] *E.g., Potter v. Retail Automation Prods.*, Inc., No. 13-cv-4506 (GBD), 2014 WL 494521, at *2 (S.D.N.Y. Feb. 5, 2014) ("Where allegations of fraud involve multiple defendants, the complaint must set forth allegations specifically attributable to each individual defendant."); *Angermeir v. Cohen*, 14 F. Supp. 3d 134, 147 (S.D.N.Y. 2014) ("a bare allegation of an individual defendant's affiliation with entities allegedly committing fraudulent acts is not enough to satisfy Rule 9(b).").

[16] A sample participant statement (as referenced in Paragraph 292 of the Complaint) is attached as Exhibit A to the Request for Judicial Notice filed concurrently herewith. *Clorox Co. P.R.*, 228 F.3d at 32.

Further, Plaintiffs highlight the fact that these participant statements included the following language: "Benefits are paid from a secure trust fund" and "The Plan is entirely paid for by St. Joseph Health Services of RI. There is no cost to you." (Compl. ¶ 281.) Such statements are accurate and, therefore, cannot form the basis of any misrepresentation claim. And, as shown in Exhibit A, the statements expressly state: "These figures are not a promise or guarantee of any future benefits." *See* Exhibit A. Such language was conveniently omitted from Plaintiffs' Complaint. Plaintiffs cannot seriously contend these participant statements were part of a conspiracy to fraudulently convince participants that their benefits *are* guaranteed.[17]

Finally, as shown in Exhibit A, the statements also clearly identified that the projections were "estimates." Such "estimates" are merely "opinions" and "cannot form the basis for a misrepresentation claim" as a matter of law. *In re Frusher*, 146 B.R. 594, 597 (Bankr. D.R.I. 1992), *aff'd sub nom., Frusher v. Baskin-Robbins Ice Cream Co.*, 43 F.3d 1456 (1st Cir. 1994); *see also 514 Broadway Inv. Tr., UDT 8/22/05 ex rel. Blechman v. Rapoza,* 816 F. Supp. 2d 128, 139 (D.R.I. 2011) ("[an] action for common-law fraud, or deceit, requires a showing of a false statement of fact, not an opinion or estimate . . ."); *St. Paul Fire & Marine Ins. Co. v. Russo Bros.,* 641 A.2d 1297, 1299, n.2 (R.I. 1994) ("The general rule is that a misrepresentation should take the

[17] Plaintiffs' contention that it is fraudulent to reference lifetime benefits is entirely disingenuous. To this day, Plaintiff Del Sesto continues to provide participants with election forms allowing them to make the following election: "Life Annuity – this type of pension pays you level monthly payments for as long as you live. Payments stop when you die. This is not an Eligible Rollover Distribution. I elect to receive my pension commencing on my Pension Starting Date equal to $XXX per month for my lifetime. I understand that payments will stop when I die." *See* Request for Judicial Notice filed concurrently herewith. The same election form, which Plaintiff Del Sesto is still using, also allows for six other payment options which are described as lasting as long as the participant lives, with additional payments to a beneficiary beyond the lifetime of the participant. The form also permits the participant to elect to postpone payment to a later date, with no notice that the plan could, by then, have run out of money. Thus, it is clear even Plaintiff Del Sesto gives no credence to the premise that a reference to lifetime benefits is fraudulent.

form of an expression of fact and not the offering of an opinion or estimate."). Nor can Plaintiffs plausibly demonstrate any reasonable reliance on such "estimates." *Livick v. The Gillette Co.,* 524 F.3d 24, 32-33 (1st Cir. 2008) (affirming defense summary judgment on basis that employee could not reasonably rely on erroneous pension benefit "estimates"); *Green v. ExxonMobil Corp.,* 413 F. Supp. 2d 103, 113 (D.R.I. 2006) (". . . no reasonable person would have depended on the prospect of a payment labeled an 'estimate.' Accordingly, there was no reasonable detrimental reliance by Plaintiffs on the April 11th letter.").

- *Powerpoint Presentations*

Plaintiffs allege that Angell, and other Defendants, "participated" in PowerPoint presentations to SJHSRI employees intended to reassure them that the sale of the hospital to Prospect Medical would not affect their pension benefits. (Compl. ¶¶ 293, 305.) However, the only statements cited from these presentations are that "your pension benefit is an important part of your future retirement income," and "the Hospital pays the entire cost of the Plan." (*Id.*) Both of these statements are patently true. Even if these statements were false, Plaintiffs allege only that Angell "participated" in the presentation, but do not allege that Angell actually made any particular statements. This is insufficient to state a claim against Angell under Rule 9(b). *See* cases cited *supra,* at pp. 20-22.

- *Telephone Calls*

Plaintiffs allege that the Prospect Entities "instructed" Angell not to provide Plan participants with the information they were seeking concerning the solvency of the Plan. (Compl. ¶ 302.) According to Plaintiffs, the Prospect Entities "instructed" Angell to tell Plan participants that:

> . . . while we [Angell] can't speak to the future solvency of the plan, we can share that the plan administrators review the annual recommended funding as advised by the

> plan's actuaries each year. There is also an investment committee that reviews and monitors the plan on an ongoing basis.

(*Id.*)

Plaintiffs do not identify any specific individual or participant who was "told" this statement, or specific contents of any such conversation. Therefore, this allegation cannot form the basis of any "fraudulent misrepresentation" claim because Plaintiffs have not alleged the "who, what, where, and when" to meet the heightened pleading standards for fraud under Rule 9(b). *Doyle*, 103 F.3d at 194.

Furthermore, despite Plaintiffs' conclusory allegation to the contrary (Compl. ¶ 303), these statements are demonstrably true. Angell could not speak to the future solvency of the Plan, because it was instructed not to do so. The Plan administrators did review the annual recommended funding as advised by the Plan's actuaries each year and there was an investment committee that reviews and monitors the Plan on an ongoing basis. (*Id.* ¶¶ 234, 241-248), Furthermore, the three representations taken together are more likely to be alarming than comforting. They pointedly do not suggest the Plan will be solvent, or even that the Hospital was making the recommended contributions.

2. Plaintiffs fail to assert a claim against Angell for fraudulent omissions (Count VII).

Plaintiffs also claim that Angell "never" informed participants about the Plan's underfunded status. (Compl. ¶¶ 289-291). However, Angell had no legal duty to inform participants of anything. *Francisco*, 2014 WL 652147, at *13 ("Fraudulent concealment also requires intent to induce reliance and detrimental reliance, but it is grounded on the failure to disclose a material fact as opposed to an affirmative misrepresentation. A claim of fraudulent concealment is not actionable absent a duty to disclose."). Plaintiffs do not allege that Angell is a fiduciary to the Plan and, therefore, Angell does not have a fiduciary duty to make "disclosures"

concerning the Plan. (Compl. ¶ 290.). And Angell does not have a contract with the participants such that they are owed any "duty [by Angell] to exercise reasonable care." (*Id.*) Further, Plaintiffs do not allege that Angell had any discretion over what to communicate to participants about the Plan, as opposed to simply conveying the information it was instructed to provide. (*Id.* ¶ 301 (noting that Angell "sought *instructions* from the Prospect Entities as to how Angell should respond to Plan participants who were seeking information concerning the solvency of the Plan.").) Furthermore, the alleged telephonic response ("we can't speak to the future solvency of the plan") (*id.* at ¶ 302) *explicitly* put participants on notice of what was *not* being disclosed – the future solvency of the Plan. So, there was no concealment.

Finally, Plaintiffs have not alleged any particular damage resulting from any of these communications. Plaintiffs have not alleged that any of them would have gotten a different job with a more secure pension, or taken any other alternative action, had they known more about the funding status of the Plan. Any such allegation would be purely speculative in any event.

3. Plaintiffs fail to assert a claim against Angell for conspiracy (Count IX).

Plaintiffs' attempt to plead a "conspiracy" claim against Angell is equally deficient. (*See* Count IX.) A civil conspiracy is an "agreement between two or more parties . . . to accomplish an unlawful objective or to accomplish a lawful objective by unlawful means." *Smith v. O'Connell*, 997 F. Supp. 226, 241 (D.R.I. 1998), *aff'd sub nom. Kelly v. Marcantonio*, 187 F.3d 192 (1st Cir. 1999). "A civil conspiracy claim requires the specific intent to do something illegal or tortious." *Guilbeault v. R.J. Reynolds Tobacco Co.*, 84 F. Supp. 2d 263, 268 (D.R.I. 2000). Civil conspiracy is "not an independent basis of liability. It is a means for establishing joint liability for other tortious conduct; therefore, it requires a valid underlying intentional tort theory." *Read & Lundy, Inc. v. Washington Tr. Co. of Westerly*, 840 A.2d 1099, 1102 (R.I. 2004) (internal quotation marks and citation omitted). Without a legally viable claim for fraudulent misrepresentation or

omission, Plaintiffs' conspiracy claim should also be dismissed. *E.g.*, *Francisco*, 2014 WL 652147, at *13.

Further, Plaintiffs are seemingly alleging a conspiracy to misrepresent the Plan's status as an ERISA Plan. (Compl. ¶¶ 57, 67.) However, any such conspiracy claim fundamentally fails as a matter of law against Angell because there are no factual allegations that Angell participated in any "agreement" to violate the law. Plaintiffs provide detailed allegations regarding a number of "secret meetings" between and among various individuals and entities to further a purported conspiracy to misrepresent the Plan's status, and Plaintiffs specifically identify which parties were supposedly present at each of these meetings. (*E.g.*, Compl. ¶¶ 117, 140, 142-145, 155, 160-161, 165, 168-170, 183, 240, 413) Angell is not identified at any of them. (*Id.*)

Plaintiffs only allege that – on one occasion – CCCB asked Angell how the Plan could remain a Church Plan if SJHSRI became a shell corporation. (*Id.* ¶ 139.) However, Plaintiffs do not allege that Angell ever provided an opinion on this issue. Nor do Plaintiffs allege that Angell ever provided any opinion regarding the legality of characterizing the Plan as a Church Plan instead of an ERISA Plan. Nor could it. Angell is an *actuary*, not legal counsel. It does not make such legal determinations about ERISA coverage. That is not what it was hired to do, and not its responsibility. There is simply no allegation from which it could plausibly be inferred that Angell knew that the Plan was not properly classified as a Church Plan.

Plaintiffs allege that "SJHSRI and other Defendants conspired to conceal [that SJHSRI was not making necessary contributions] from Plan participants through fraudulent misrepresentations and material omissions…" (Compl. ¶ 57.) However, as discussed above, Plaintiffs have not alleged any specific misrepresentation by Angell at any specific time or to any specific person, nor have Plaintiffs alleged any particular omission by Angell at any time, to any person; nor have

Plaintiffs plausibly alleged any reason that Angell would be obligated to inform anyone other than its own client, which knew that it was not making contributions.

Rather, Plaintiffs' only factual allegations demonstrate that Angell *advised* SJHSRI to meet necessary funding obligations to *comply* with the law, not *disobey* it. (Compl. ¶¶ 65, 66, 234, 241, 245-248, 274, 302, 303, 332, 335.) It is disingenuous to suggest that Angell was involved in any "conspiracy to violate the law" when it was, in fact, advising its client to comply with the law. Indeed, Plaintiffs have alleged no facts that Angell had any "specific intent" to violate any law or accomplish any unlawful objective. Thus, Plaintiffs' claim for "conspiracy" against Angell fundamentally fails.

4. Plaintiffs fail to assert a claim against Angell for "fraudulent scheme" (Count VIII).

Count VIII purports to state a claim for "fraudulent scheme." However, Plaintiffs fail to identify any supporting legal authority that this is a stand-alone cause of action, independent from their claims for fraud (Count VII) and conspiracy (Count IX). Rather, any supposed "fraudulent scheme" is simply an element of, and subsumed by Counts VII and IX. *See, e.g. Sheet Metal Workers Local No. 20 Welfare & Benefit Fund v. CVS Health Corp.*, 221 F. Supp. 3d 227, 239 (D.R.I. 2016) ("Because the Court finds that Plaintiffs have sufficiently alleged a fraudulent scheme, the unjust enrichment claim may also go forward."); *W. Reserve Life Assur. Co. of Ohio v. Caramadre*, 847 F. Supp. 2d 329, 341 (D.R.I. 2012) ("Plaintiffs are correct that the Sponsors' orchestration of the fraudulent scheme may support a claim for civil conspiracy."). Thus, Count VIII should be dismissed for this reason alone.

In any event, for the reasons set forth above, Plaintiffs have not alleged with any particularity Angell's role in any "fraudulent scheme" to satisfy Rule 9(b). *See* Sections G 1-3, *supra*.

**H. Plaintiffs fail to state a claim for violation of the Rhode Island Hospital Conversions Act (Count XVI).**

Count XVI purports to state a claim against Angell under R.I. Gen. Laws § 9-1-2 which creates a civil cause of action, against an "offender," for damages suffered as a result of the commission of a crime. The Complaint alleges that "Defendants' conduct constituted crimes or offenses under R.I. Gen. Laws § 23-17.14-30" for failure to comply with Rhode Island's Hospital Conversions Act (the "HCA"). (Compl. ¶ 510.) Notwithstanding this general allegation, Count XVI fails because the Plaintiffs do not allege any violation of the HCA ***by Angell***.[18]

As set forth in more detail above, the Complaint alleges that Angell: (1) acted as a "consultant" to SJHSRI and CCCB in connection with the application for approval of the conversion of Fatima and Roger Williams Hospitals to for-profit facilities (Compl. ¶ 312); (2) prepared a March 27, 2014 calculation estimating that, after a $14,000,000 contribution to the Plan and at an assumed rate of return of 7.75%, the Plan would run out of assets in 2036 with $98 million in remaining liabilities (*id.* ¶ 315);[19] and (3) as requested, provided this calculation to SJHSRI and CCCB independently of other calculations that had been provided previously (*id.* ¶¶ 318, 321). The Complaint goes on to allege that SJHSRI, CCCB and certain of their officers made intentionally misleading statements regarding the Plan's funding status to the Project Review Committee evaluating the HCA applications. (*Id.* ¶¶ 325, 327, 330.) Critically, the Complaint does not identify a single statement made by Angell to any regulator, let alone an intentionally

[18] A more extensive analysis of the reasons that Plaintiffs have no claim relating to HCA is contained in the memorandum of law to be submitted concurrently with this memorandum by Defendants Roman Catholic Bishop of Providence, Diocesan Administration Corporation, and Diocesan Service Corporation (collectively, "Diocesan Defendants"). To avoid duplication, Angell adopts and incorporates by reference the arguments of Diocesan Defendants with respect to Count XVI and the HCA.

[19] As explained below, state regulators were well aware that the rate of return on Plan assets could be less than 7.75%.

false or incorrect statement which would constitute a violation of the HCA. *See* R.I. Gen. Laws § 23-17.14-30. Indeed, according to the Complaint the alleged false statements made to regulators were made by Defendants *other than Angell* who indicated that they would comply with ***Angell's*** Plan funding recommendations while not intending to do so. (*Id.* ¶¶ 331, 335, 336 337.)

These allegations, held alongside the HCA, show that the Plaintiffs' have failed to state a claim against Angell under R.I. Gen. Laws § 9-1-2. The HCA criminalizes three types of conduct: 1) knowing violations of the act; 2) willingly or knowingly providing false or incorrect information to regulators; and 3) the giving of false testimony under oath to the legislature, the Department of Health or the Attorney General in connection with a conversion application. *See* R.I. Gen. Laws §§ 23-17.14-17 and 23-17.14-30.

There is no allegation that Angell provided sworn testimony to the legislature, the Attorney General or the Department of Health in connection with the HCA proceedings, and, therefore, Angell could not have violated R.I. Gen. Laws § 23-17.14-17. The only conceivably remaining predicate act to support a claim under RI. Gen. Laws § 9-1-2 would be that Angell willingly or knowingly provided false of incorrect information. *See* R.I. Gen. Laws § 23-17.14-30. However, such a claim necessarily fails for two reasons: (1) the Complaint does not allege that Angell gave any information to regulators in connection with the HCA proceedings, let alone information that was known to be false or inaccurate; and (2) the Complaint does not allege that any calculation performed by Angell was inaccurate.

With respect to information that was given to regulators, the Complaint only alleges that on April 9, 2014, CCCB asked Angell for assistance in answering an inquiry from the Attorney General who had asked for "documentation as to the determination that $14 m will stabilize the plan." (Compl. ¶ 313). The next day, CCCB and SJHSRI requested that Angell "show only the

stabilization effect of the incoming $14M to the plan with no other information shown," (Compl. ¶ 318), which, stripped of histrionics, is simply a request that Angell perform the calculation necessary for the HCA applicants to answer a direct and specific question. Angell is not alleged to have given this calculation to any regulator reviewing the pending applications under the HCA.

With respect to whether Angell's calculations were knowingly false or inaccurate, Angell accurately showed that the contribution of $14 million to the Plan would result in the Plan being less than fully funded such that it would necessarily run out of money if the assumptions used in the calculations proved correct. (Compl. ¶¶ 321, 328.) The Plaintiffs complain that Angell did not specifically disclose that the assumed rate of return used in its calculation was higher than that used to calculate the unfunded liability of other pension plans. (Compl. ¶ 322). However, the Complaint itself shows that this does not make the calculation provided false or inaccurate. The assumed rate of return was disclosed, and the committee of regulators evaluating the HCA applications specifically inquired regarding the "investment risk" that is inherent in any calculation of future Plan liabilities, and asked what would happen if "investment returns don't match up to ***predictions***." (Compl. ¶ 337.) (emphasis added). A prediction cannot be knowingly false or incorrect since it is, by its very nature, an unknown. *See In re Frusher,* 146 B.R. at 597; *see also 514 Broadway Inv. Tr., UDT 8/22/05 ex rel. Blechman,* 816 F. Supp. 2d at 139; *St. Paul Fire & Marine Ins. Co.,* 641 A.2d at 1299, n.2 ("The general rule is that a misrepresentation should take the form of an expression of fact and not the offering of an opinion or estimate.").

In short, and despite the Plaintiffs' efforts to impute wrongful acts to "the Defendants" generally, there is not a single factual allegation to support a claim that *Angell* violated the HCA. For these reasons, the Plaintiffs have failed to state a claim against Angell under the HCA and R.I. Gen. Laws § 9-1-2.

**I. Plaintiffs fail to state a claim for breach of fiduciary duty or aiding and abetting a breach of fiduciary duty (Counts XIX and XX).**

Count XIX purports to state a claim against Angell for "breach of fiduciary duty," presumably under Rhode Island law. Plaintiffs do not explicitly allege that Angell is a "fiduciary" but simply allege, in conclusory fashion, that Angell "owed Plaintiffs fiduciary duties." (Compl. ¶¶ 520-522.) Such bare allegations are insufficient under *Iqbal/Twombly*.

Moreover, it is well-established that actuaries are *not* fiduciaries as a matter of law. *Geo. Knight & Co., Inc. v. Watson Wyatt & Co.*, 170 F.3d 210, 217 n.14 (1st Cir. 1999); *cf. United Teachers Assocs. Ins. Co. v. MacKeen & Bailey, Inc.*, 99 F.3d 645, 646–50 (5th Cir. 1996) (rejecting the notion that actuaries are, as a matter of law, fiduciaries). Rather, something "more" needs to be established "before elevating actuaries and accountants to fiduciary or other special status." *Erlich v. Oulette, Labonte, Roberge and Allen, P.A.*, 637 F.3d 32, 36 (1st Cir. 2011) (citing *Watson Wyatt & Co.*, 170 F.3d at 215–16 (holding, under Massachusetts law, that an actuary did not occupy a position of trust and confidence with its client retirement plan in part because there was "nothing in the record to suggest that [the plan's] trust in [the actuary] resulted in its ceding control of [the plan's] management or assets to [the actuary]")); *Fleet Nat'l Bank v. H & D Entm't, Inc.*, 926 F. Supp. 226, 242 (D. Mass. 1996), *aff'd*, 96 F.3d 532 (1st Cir. 1996) (stating that, in the context of accountant-client relationship under Massachusetts law, "the weight of legal precedent — and common sense — stands for the proposition that an accountant takes on fiduciary obligations only where he or she recommends transactions, structures deals, and provides investment advice, such that he or she exercises some managerial control over the assets in question," not merely when "tasks performed . . . were ministerial in nature" and did not involve "management advice" or "discretionary control") (internal quotation marks, citations, and brackets omitted).

For all of the reasons discussed above, Plaintiffs have not alleged that Angell had any control over the Plan's management or assets to "elevate" Angell to fiduciary status. Angell did not fund the Plan, make decisions regarding the Plan's administration, or have any discretionary control over participant communications. Thus, Count XIX for fiduciary breach fails as alleged against Angell.

Moreover, as discussed above: (1) Angell had no "duty" other than to its client (SJHSRI) which it fully informed about the funding status of the Plan; (2) Angell was not involved in any secret "meetings" or decisions; and (3) Angell had no discretion over communications with participants. Thus, Count XX for "aiding and abetting a fiduciary breach" similarly fails as alleged against Angell.

**J. Plaintiffs fail to state a claim for declaratory judgment (Count XXI).**

Plaintiffs have no right to a declaratory judgment under Rhode Island law (Count XXI) because this action was filed in federal court. Federal courts proceeding under diversity or supplemental jurisdiction apply federal procedural law and state substantive law. *E.g.*, *Essex Ins. Co. v. Westerly Granite Co.*, No. 14-241 ML, 2014 WL 4996693, at *1 (D.R.I. Oct. 7, 2014); *Keating v. Diamond State Ins. Co.*, No. 11-179S, 2013 WL 638929, at *2 (D.R.I. Feb. 20, 2013); *Duclerc v. Mass. Dep't of Correction*, No. 10-12050-DJC, 2012 WL 6615040, at *5, n. 3 (D. Mass. Dec. 18, 2012). "'Since the Declaratory Judgment Act is procedural in nature, federal law controls the question of whether a district court may grant declaratory relief in a given case.' Thus, the Court need not address the parties' contentions made pursuant to the Rhode Island Declaratory Judgment Act, R.I. Gen. Laws § 9–30–1 et seq." *Essex Ins. Co.*, 2014 WL 4996693, at *1 (internal citations omitted). Plaintiffs have already pled a claim for declaratory relief under federal law (Count IV, ERISA, Declaratory Relief), and such claim is their only possible declaratory relief claim. *See Sidou v. Unumprovident Corp.*, 245 F. Supp. 2d 207, 220 (D. Me. 2003) (construing

declaratory judgment claim as a request for declaratory relief pursuant to ERISA). Accordingly, Count XXI (Declaratory Judgment, Liability and Turn Over of Funds, State Law) should be dismissed with prejudice.

Moreover, to the extent Plaintiffs bring this claim pursuant to the Rhode Island Declaratory Judgment Act ("RIDJA"), then the PBGC must be joined as a party to this action. R.I. Gen. Laws § 9-30-11 (requiring that "all persons shall be made parties who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding.") To that end and, for the reasons discussed in Section A *supra*, this case should be dismissed pursuant to Fed. R. Civ. P. 12(b)(7) and 19 for failure to join the PBGC as a necessary party.

## IV. CONCLUSION

For all of the foregoing reasons, the Complaint should be dismissed as to Angell.

This 14th day of September, 2018.

THE ANGELL PENSION GROUP, INC.

By its attorneys,

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-and-

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# EXHIBIT A

[redacted]

Social Security #:
Date of Birth: [redacted]
Date of Hire: April 7, 1980
Normal Retirement Date: August 1, 2013
Credited Service: 24.17

St. Joseph Health Services of Rhode Island

St. Joseph Health Services of Rhode Island is pleased to give you this statement showing your estimated benefits in the Retirement Plan as of July 1, 2004. Your pension benefit is an important part of your future retirement income, along with Social Security, your 403(b) savings, and your other personal savings. You automatically become a participant in the plan once you have completed 12 months of employment and worked at least 1,000 hours. Some key features of this plan are:

- ***Simplicity***—Participation in the plan is automatic. You do not have to enroll or do anything until you retire.
- ***Security***—Benefits are paid from a secure trust fund.
- ***Company Paid***— The plan is entirely paid for by St. Joseph Health Services of RI. There is no cost to you.

You may retire on your Normal Retirement Date and receive a benefit, which is payable at age 65 and 5 years of service. The monthly amount of pension benefit that you have earned to date and the amount you are projected to receive if you continue to work until your Normal Retirement Date, August 1, 2013, are shown below.

**It is important to note that your benefit has been calculated using the plan's definition of highest one year of the last five years for Social Security purposes. Your benefit *may* be higher after submitting *actual* Social Security earnings.**

[redacted]

| $1,532 | $2,022 |
|---|---|
| August 1, 2013 | August 1, 2013 |

As of July 1, 2004, you are 100% vested in this benefit, which means that you may receive this benefit at retirement even if you terminate employment before then.

You may retire early when you have met the requirements for Early Retirement, as described in the Plan. Estimated ***monthly*** benefit amounts begin when you retire and continue for the rest of your life.

**For any participant who has experienced a prior termination from the plan and has since been rehired, the following information may not be exact.** The following reflects the data as of July 1, 2004:

| | Age | Projected Monthly Benefit |
|---|---|---|
| ■ At age 55 with 5 years of service: | 55.92 | $ 813 |
| ■ When you accumulate 85 "points": | 58.42 | $ 1,786 |
| ■ At the later of age 60 or 30 years of service or Normal Retirement Age: | 61.75 | $ 2,011 |

This statement has been prepared to let you know the status and value of your pension plan benefit. These figures are not a promise or guarantee of any future benefits. They are only estimates based on the assumption that you continue to work and earn service credit each year until the indicated retirement date at your current compensation rate. Information in this statement is subject to provisions of the plan document in effect on July 2004. At retirement, your benefit will be calculated exactly based on the plan provisions in effect at that time. Since there is always the possibility of error in data, you should contact the Human Resource Department if any information appears incorrect.

Prepared especially for:

[redacted]
Portsmouth RI 02871

**SUMMARY OF PLAN PROVISIONS:**

St. Joseph Health Services of Rhode Island Retirement Plan provides you with:

a) A monthly income payable for life when you retire, in addition to your Social Security benefits.

b) The right to retire as early as age 55 if you have completed at least 5 years of continuous service.

c) The right to future pension benefits if you leave the Hospital after 5 or more years of continuous service.

d) Death benefits payable to your surviving spouse or beneficiary if you die while still employed after completing 5 years of continuous service.

The Hospital pays the entire cost of the plan. In addition, the Hospital pays into the Social Security System an amount equal to what you pay.

Your Accrued Normal Retirement Benefit is 50% of Final Average Earnings (five highest consecutive rates of annual earnings over the last ten years of employment) minus 50% of Social Security Benefit, all multiplied by a fraction but not greater than one, the numerator being the number of years and months of Credited Service and **the denominator being the greater of thirty or number of years of Credited Service as of age 60.**

You may begin to receive benefits on your:

a) Normal Retirement Date: The first day of the month following the later of your 65th birthday or your fifth anniversary of participation.

b) Late Retirement Date: If you continue to work for the Hospital past your Normal Retirement Date, you may not begin to collect retirement benefits until you actually retire.

c) Early Retirement Date: You can retire any time after age 55 if you have 5 or more years of continuous service. You will receive payments in a reduced amount to reflect the fact that benefits are paid prior to Normal Retirement, unless you meet the Rule of 85 requirements.

For early retirement, the above benefit is reduced by 5/9 of 1% for each month prior to age 65 for the first 60 months and by 5/18 of 1% for each additional month by which commencement of benefits precedes Normal Retirement Date. If your age plus continuous service is at least 85 as of your termination date, no reduction will be applied to your benefit for starting payments prior to your Normal Retirement Date.

If you terminate employment with the Hospital before you are eligible for a retirement benefit and you have 5 years of continuous service, you are eligible for a Normal Retirement benefit using earnings, service, and Social Security offset calculated as of your Termination Date. You can begin receiving this benefit at Normal Retirement Date or in a reduced amount after you have attained age 55 and have completed at least 5 years of continuous service.

The spouse of an active participant (employee) who dies after completing 5 or more years of continuous service shall be eligible to receive a benefit commencing on the participant's Normal Retirement Date. The amount of benefit is equal to 50% of the benefit the participant would have received if he or she terminated employment on the date of death, survived to age 65, and elected benefits in the form of a 50% joint and survivor annuity.

For Social Security benefit information, refer to the estimated benefits statement provided by the Social Security Administration, which is mailed approximately three months prior to your birthday each year once you attain age 25 and is based on your actual lifetime work history.

All possible care was taken in completing this statement. However, the benefits actually payable under any circumstance shall be based on the governing provisions of the plan and on complete and accurate information obtained at the time of final determination of the benefit. Should you have any questions about the Retirement Plan, please contact the Human Resources Department.

# EXHIBIT B

# St. Joseph Health Services of Rhode Island Retirement Plan

## Participant Election and Certification Form

| | | | |
|---|---|---|---|
| Name: | [redacted] | Beneficiary's Name: | [redacted] |
| SSN: | | Beneficiary's SSN: | |
| Date of Birth: | | Beneficiary's Date of Birth: | |
| Pension Starting Date: | | Type of Retirement: | **Early Retirement** |

***Instructions***: *Please make one selection in each Section by initialing your choice and supplying such other information as requested. This form requires that: (Section 1) you choose the form of payment; (Section 2) decide the payment method and amount of voluntary income tax to be withheld (for **Non-Eligible Rollover Distribution** payments only); and (Section 3) certify your acceptance of the terms of these elections and supply personal identification information. Your payment will be processed when you return the completed copies of this form. Failure to complete all pertinent sections can cause a delay in payment. Keep one copy of this form for your personal records.*

### Section 1 - Election of Form of Benefit Payment

*LIFE ANNUITY* - This type of pension pays you level monthly payments for as long as you live. Payments stop when you die. **This is not an Eligible Rollover Distribution.**

[✓] I elect to receive my pension commencing on my Pension Starting Date equal to $460.16 per month for my lifetime. I understand that payments will stop when I die.

*LIFE ANNUITY WITH GUARANTEE OF 120 MONTHLY PAYMENTS* - This type of pension pays you level monthly payments for as long as you live. If you die before receiving at least 120 monthly payments, payments will continue to the beneficiary you select until a total of 120 payments have been made to you and your beneficiary. **This is not an Eligible Rollover Distribution.**

[ ] I elect to receive my pension commencing on my Pension Starting Date equal to $441.75 per month for my lifetime. If I die before I receive 120 monthly payments, pay the remainder of the 120 payments to the following person. This beneficiary election revokes all prior beneficiary designations made by me for any benefits under the Plan.

Please insert beneficiary's name _____

Social Security # _____ and date of birth _____

*JOINT AND SURVIVOR ANNUITY* - This type of pension pays you level monthly payments for your lifetime. If your beneficiary outlives you, your beneficiary would receive monthly payments for life in accordance with your election. Your pension under this option will be determined if you have supplied the name and date of birth of your beneficiary. **This is not an Eligible Rollover Distribution.**

☐ I elect to receive my pension commencing on my Pension Starting Date equal to $414.14 for my lifetime with $207.07 (50% of my pension) continuing to my beneficiary if my beneficiary outlives me.

☐ I elect to receive my pension commencing on my Pension Starting Date equal to $401.87 for my lifetime with $267.89 (66.66% of my pension) continuing to my beneficiary if my beneficiary outlives me.

☐ I elect to receive my pension commencing on my Pension Starting Date equal to $395.74 for my lifetime with $296.81 (75% of my pension) continuing to my beneficiary if my beneficiary outlives me.

☐ I elect to receive my pension commencing on my Pension Starting Date equal to $377.33 for my lifetime with $377.33 (100% of my pension) continuing to my beneficiary if my beneficiary outlives me.

☐ Monthly joint & survivor annuity with non-spouse beneficiary

Please insert non-spouse beneficiary's name _____

Social Security # _____ and date of birth _____

*POSTPONED PAYMENT* - You are eligible to postpone payment and election of your benefit to a later date. If you elect this option, you should notify the Plan Administrator of 1) any change in your address and 2) the date you wish to have payment commence.

☐ I wish to postpone the payment and election of my benefit option to a later date. I will notify the Plan Administrator of any changes in my address and notify the Plan Administrator when I wish to have payment commence.