

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

DONNA M. BOKMA and DANIEL
SAMSIL, *on behalf of themselves*
and all others similarly situated,
Plaintiffs,

v.

Civil No. 3:24cv686 (DJN)

PERFORMANCE FOOD GROUP, INC.,
Defendant.

MEMORANDUM ORDER
(Denying Defendant’s Motion to Dismiss)

Plaintiffs Donna Bokma (“Bokma”) and Daniel Samsil (“Samsil”) (collectively, “Plaintiffs”) bring this action against Performance Food Group, Inc. (“Defendant”), asserting three claims for violations of the Employee Retirement Income Security Act (“ERISA”). Specifically, Plaintiffs allege that Defendant (1) unlawfully imposed a discriminatory tobacco surcharge on participants in its employee benefits plan, (2) failed to notify Plaintiffs of a reasonable alternative standard to avoid the tobacco surcharge and (3) breached its fiduciary duty in relation to its imposition of the surcharge. (ECF No. 16 at 17–23.) This matter comes before the Court on Defendant’s Motion to Dismiss, which seeks dismissal of Plaintiff’s First Amended Class Action Complaint with prejudice. (ECF No. 18 (“Motion”).) For the reasons set forth below, the Court hereby DENIES Defendant’s Motion to Dismiss (ECF No. 18).

I. BACKGROUND

A. Statutory and Regulatory Background

Before addressing Plaintiff’s factual allegations and the merits of the arguments raised in Defendant’s Motion, the Court sets out the statutory and regulatory framework governing the

ERISA scheme at issue in this matter. ERISA Section 702(b) prohibits group health plans from discriminating against participants and beneficiaries based on health status. Specifically, ERISA Section 702(b) states the following:

A group health plan . . . may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent.

29 U.S.C. § 1182(b)(1). However, the non-discrimination provision stands limited by Section 702(b)(2), which states that “[n]othing in paragraph (1) shall be construed . . . to prevent a group health plan . . . from establishing premium discounts or rebates . . . in return for adherence to programs of health promotion and disease prevention.” *Id.* § 1182(b)(2)(B). These two provisions allow group health plans to issue discounts or rebates to participants who complete applicable wellness programs.

In 2010, Congress amended the Public Health Safety Act (“PHSA”) to add wellness program requirements and specifically incorporated Section 2705 of the PHSA into ERISA. *See* 29 U.S.C. § 1185d(a)(1) (providing that PHSA provisions “shall apply to group health plans” under ERISA). Under PHSA Section 2705, wellness programs offered by employers must meet certain requirements, including that the program must (1) “be reasonably designed to promote health or prevent disease” (*i.e.*, the program “is not a subterfuge for discriminating based on a health status factor”), (2) make available the “full reward” to all similarly situated individuals and (3) “disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard.” 42 U.S.C. § 300gg-4(j)(3)(B)–(E).

In 2013, the Department of Labor (“DOL”) incorporated these requirements into its regulations for non-discriminatory wellness programs. Incentives for Nondiscriminatory

Wellness Programs in Group Health Plans, 78 Fed. Reg. 33158, 33181–86 (June 3, 2013) (codified at 29 C.F.R. § 2590.702). In issuing these revised regulations, the DOL specified its intent that “every individual participating in [a wellness] program should be able to receive the full amount of any reward or incentive, regardless of any health factor.” *Id.* at 33160.

Under the applicable regulatory scheme, outcome-based wellness programs, such as tobacco cessation programs, must satisfy five conditions. First, participants must receive at least one opportunity per year to qualify for the reward. 29 C.F.R. § 2590.702(f)(4)(i). Second, the reward must not exceed a specified percentage of the “cost of employee-only coverage under the plan.” *Id.* § 2590.702(f)(4)(ii); *see id.* § 2590.702(f)(5) (defining the relevant percentage for tobacco-reduction programs as fifty percent). Third, the program “must be reasonably designed to promote health or prevent disease.” *Id.* § 2590.702(f)(4)(iii). This provision requires that a program have a “reasonable chance of improving the health of, or preventing disease in, participating individuals,” not be “overly burdensome” and not act as “subterfuge for discriminating based on a health factor.” *Id.*

Fourth, “[t]he full reward . . . must be available to all similarly situated individuals,” requiring a “reasonable alternative standard . . . for any individual who does not meet the initial standard.” *Id.* § 2590.702(f)(4)(iv)(A). In determining whether a plan furnishes a reasonable alternative standard, “[a]ll the facts and circumstances are taken into account,” including the time commitment and cost for program completion. *Id.* § 2590.702(f)(4)(iv)(C). The plan must also accommodate the recommendations of an individual’s personal physician if that physician deems a plan standard “not medically appropriate for that individual.” *Id.* Lastly, the plan must “disclose in all plan materials describing the terms of an outcome-based wellness program . . . the availability of a reasonable alternative standard.” *Id.* § 2590.702(f)(4)(v). This disclosure

must include “contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual’s personal physician will be accommodated.” *Id.* However, “[i]f plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.” *Id.* The regulations provide illustrative examples of programs that either satisfy or fail to meet these standards. *Id.* § 2590.702(f)(4)(vi).

B. Factual Background

At this stage, the Court must accept as true the facts set forth in the First Amended Class Action Complaint (ECF No. 16 (“FAC”)). *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Against this backdrop, the Court accepts the following facts for purposes of resolving the instant Motion.

Plaintiff Bokma resides in Northumberland County, Pennsylvania, and constitutes an employee of Defendant and a participant in Defendant’s Employee Benefits Plan (the “Plan”). (FAC ¶¶ 7–8.) Plaintiff Samsil resides in Kentucky and constitutes a former employee of Defendant and a Plan participant from 2021 to 2023. (*Id.* ¶¶ 9–10.) At all times relevant, Defendant sponsored, maintained and managed the Plan and served as its Administrator. (*Id.* ¶ 12 (citing Plan Document § 2.11, which defines Defendant as the “Plan Administrator”).) As of December 31, 2023, the Plan had over 34,000 active participants. (*Id.*)

Plaintiffs allege that Defendant imposed an annual surcharge of \$600 on employees and \$300 on spouses or domestic partners who enrolled in the Plan from 2022 to 2024 and who did not self-certify that they had not used tobacco products within the previous twelve months. (*Id.* ¶¶ 21–22.) The surcharge was prorated and deducted per pay period, with Bokma and Samsil each paying \$23.08 per paycheck. (*Id.* ¶ 22.) Plaintiffs allege that Defendant’s surcharge was unlawful, because it failed to adhere to ERISA and related regulations concerning wellness programs. (*Id.* ¶¶ 2, 25.) These rules mandate that employers cannot charge extra fees based on

tobacco use unless those fees are part of a bona fide wellness program that offers a reasonable alternative standard to all participants. (*Id.* ¶ 2.) While Plaintiffs acknowledge that Defendant offers the “Quit 4 Life” smoking cessation program, they allege several deficiencies with the program that render the surcharge illegal under ERISA and related regulations. (*Id.* ¶¶ 25–42.)

First, Plaintiffs allege that Defendant’s program violates ERISA’s anti-discrimination provision by failing to provide retroactive reimbursement to obtain the “full reward” given to similarly situated individuals. (*Id.* ¶ 25.) While Defendant offers the Quit 4 Life program as part of the Plan’s wellness initiative, Plaintiffs allege that the Plan’s Benefits Guide does not sufficiently explain the process by which employees and spouses can avoid or remove the surcharge retroactively. (*Id.* ¶ 29.) Further, the Guide mentions that the surcharge will be removed only on a prospective basis upon completion of Quit 4 Life, but not for the entire plan year. (*Id.*) Plaintiffs also allege that Samsil attended a meeting in 2023, during which an employee of Defendant informed tobacco users that the surcharge would be “removed *only* on a go-forward basis *after completing the program*.” (*Id.* ¶ 30.) Because Defendant’s program does not offer retroactive reimbursement for participants who complete the program and thus does not provide uniform availability of the “full reward” as required by 29 C.F.R. § 2590.702(f)(4)(iv), Plaintiffs allege that the Plan impermissibly discriminates against tobacco users. (*Id.*)

Plaintiffs further allege that Defendant fails to include sufficient notification of a reasonable alternative standard in all Plan materials, as required under ERISA and governing regulations. (*Id.* ¶¶ 36–37 (citing 29 C.F.R. § 2590.702(f)(4)(v)).) Specifically, Plaintiffs allege that there is no mention of the surcharge or the Quit 4 Life program in either the Plan Document or the summary plan description (“SPD”), reflecting a “systemic disregard for the regulations.” (*Id.* ¶¶ 37–38.) Further, in the Benefits Guide, the only mention of the surcharge and the Quit 4

Life program “is buried at the bottom of a page” and “includes only vague language” that fails to inform participants that they will not receive the “full reward” on a retroactive basis. (*Id.* ¶ 37.) Plaintiffs also allege that Defendant’s materials fail to mention that the Plan’s wellness program will consider “recommendations of an individual’s personal physician” if a participant is unable to complete the program, as required by regulations. (*Id.* ¶ 39.) Plaintiffs allege that Defendant’s failure to adequately disclose a reasonable alternative standard or include the notice regarding physician accommodations deprives employees of the ability to make an informed decision about their health and benefits and imposes an unlawful financial burden. (*Id.* ¶ 40.)

Plaintiffs also allege that Defendant maintained exclusive control over the surcharge and breached its fiduciary duty as Plan Administrator in several ways. (*Id.* ¶¶ 23, 32, 72–76.) First, Defendant decided whether participants who completed the Quit 4 Life program mid-year would receive retroactive reimbursement for surcharges already paid and retained discretion over whether and how refunds were administered. (*Id.* ¶ 73.) Defendant also managed the conditions under which participants would be considered compliant with the program. (*Id.*) In so doing, Plaintiffs allege that Defendant impermissibly prioritized its financial interests over the interests of plan participants. (*Id.* ¶ 74.) Plaintiffs also allege that Defendant failed to review and monitor the program for compliance with ERISA and regulations and improperly retained the surcharges, using the funds to offset its own contributions to the Plan. (*Id.* ¶¶ 72, 75–76.) Plaintiffs allege that Defendant has a fiduciary duty to ensure that funds earmarked for the Plan are used to support employee health insurance. (*Id.* ¶ 33.) Plaintiffs claim that Defendant’s actions constitute breaches of its fiduciary duties, including the duties of loyalty and prudence. (*Id.* ¶¶ 72–76.) As a direct result of Defendant’s actions, Plaintiffs and class members have suffered financial harm in the form of millions of dollars in unlawful surcharges. (*Id.* ¶ 77.)

This suit is brought by Plaintiffs, for themselves and on behalf of all similarly situated individuals who paid a tobacco surcharge in connection with their participation in the Plan, as a class action pursuant to Federal Rule of Civil Procedure 23. (*Id.* ¶¶ 43–44.) Plaintiffs allege numerosity, commonality and typicality and that they will adequately represent and protect the interests of the class. (*Id.* ¶¶ 48–51.) Plaintiffs further allege that a class action proves superior to any other method for fair and efficient adjudication of the case, and that any injunctive, declaratory or equitable relief would apply generally to the whole class. (*Id.* ¶¶ 52–53.)

On December 4, 2024, Plaintiffs filed the First Amended Class Action Complaint, which raises three Counts against Defendant. (ECF No. 16.) Count I asserts that Defendant violated ERISA Section 702, specifically the anti-discrimination provision contained in 29 U.S.C. § 1182(b), by improperly imposing the tobacco surcharge without offering a compliant wellness program to obtain the full reward. (*Id.* ¶¶ 54–60.) Under Count II, Plaintiffs assert that Defendant violated Section 702 and 29 C.F.R. § 2590.702 by failing to provide both the required notice of a compliant reasonable alternative standard and notice that physician recommendations would be accommodated in developing an alternative standard. (*Id.* ¶¶ 61–69.) Pursuant to ERISA Section 502(a)(3), Plaintiffs seek all available and appropriate remedies to redress violations of ERISA’s anti-discrimination provisions under Counts I and II. (*Id.* ¶¶ 60, 69 (citing 29 U.S.C. § 1132(a)(3)).) Lastly, under Count III, Plaintiffs assert that Defendant breached fiduciary duties as Plan Administrator, in violation of 29 U.S.C. §§ 1004 and 1006, by (1) prioritizing its own financial interest over the interests of Plan participants, (2) dealing with Plan assets for its own benefit, (3) failing to properly disclose information about the Plan, (4) administering a Plan that does not conform with ERISA’s anti-discrimination provisions and (5) failing to act prudently and diligently to ensure program compliance. (*Id.* ¶¶ 70–78.) Plaintiffs

bring Count III on a representative basis on behalf of the Plan pursuant to 29 U.S.C.

§ 1132(a)(2). (*Id.* ¶ 78.)

Based upon the foregoing claims, Plaintiffs seek the following relief: class certification; a declaratory judgment that the Plan’s wellness program is discriminatory and unlawful under ERISA; a declaratory judgment that Defendant breached its ERISA fiduciary duties; orders requiring Defendant to reimburse all persons who paid the unlawful surcharge within the relevant period and to provide an accounting of all prior payments of the surcharge; declaratory and injunctive relief, including enjoining Defendant from continuing to implement an unlawful wellness program; disgorgement of any benefits or profits received; restitution and surcharge from Defendant of all amounts owed to participants and/or the amount of unjust enrichment obtained; relief to the Plan, including restoration of losses to the Plan; pre-judgment interest on any amounts awarded; attorneys’ fees, expenses and/or taxable costs; and any other relief the Court deems proper. (*Id.* at 23–25.)

Defendant timely filed the instant Motion on December 18, 2024. (ECF No. 18.) Plaintiffs filed their Opposition on December 31, 2024, (ECF No. 20), and Defendant filed its Reply on January 6, 2025. (ECF No. 21.) This matter now stands ripe for judicial review.

II. STANDARD OF REVIEW

A motion made pursuant to Federal Rule of Civil Procedure 12(b)(1) challenges the court’s jurisdiction over the subject matter of the complaint. “Generally, challenges to standing fall under Rule 12(b)(1).” *Jarrett v. Experian Info. Sols., Inc.*, 2021 WL 1381132, at *5 (E.D. Va. Apr. 12, 2021). When a defendant asserts that the complaint fails to allege sufficient facts to support subject matter jurisdiction, the court applies a standard patterned on Rule 12(b)(6) and assumes the truthfulness of the facts alleged in the complaint. *Kerns v. United States*, 585 F.3d

187, 193 (4th Cir. 2009). The Court must dismiss an action if it determines that it lacks subject matter jurisdiction. Fed. R. Civ. P. 12(h)(3).

A motion to dismiss pursuant to Rule 12(b)(6) tests the sufficiency of a complaint; it does not serve as the means by which a court will resolve factual contests, determine the merits of a claim or address potential defenses. *Republican Party of N.C. v. Martin*, 980 F.2d 943, 952 (4th Cir. 1992). In considering a motion to dismiss, the Court accepts the well-pleaded allegations in the complaint as true and views the facts in the light most favorable to the plaintiff. *Mylan Lab'ys, Inc. v. Matkari*, 7 F.3d 1130, 1134 (4th Cir. 1993). However, “the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

Under Federal Rule of Civil Procedure 8(a), a complaint must state facts sufficient to “give the defendant fair notice of what the . . . claim is and the grounds upon which it rests.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (quoting *Conley v. Gibson*, 355 U.S. 41, 47 (1957)). Ultimately, the “[f]actual allegations must be enough to raise a right to relief above the speculative level,” rendering the right “plausible on its face” rather than merely “conceivable.” *Id.* at 555, 570. The facts alleged must be sufficient to “state all the elements of [any] claim[s].” *Bass v. E.I. DuPont de Nemours & Co.*, 324 F.3d 761, 765 (4th Cir. 2003). On a motion to dismiss pursuant to Rule 12(b)(6), a court may not consider documents outside of the complaint, “unless the motion is converted into one for summary judgment” under Rule 56. Fed. R. Civ. P. 12(d); *Witthohn v. Fed. Ins. Co.*, 164 F. App’x 395, 396 (4th Cir. 2006). However, a court may consider “documents incorporated into the complaint by reference, and matters of which a court may take judicial notice.” *Tellabs, Inc. v. Makor Issues & Rts., Ltd.*, 551 U.S. 308, 322 (2007).

III. ANALYSIS

Defendant raises several arguments in its Motion. First, Defendant contends that Plaintiffs lack standing to bring this suit, because they have suffered no concrete injury. (ECF No. 19 (“Mem.”) at 4.) Defendant next asserts that the Plan complies with ERISA’s Section 702 anti-discrimination requirements and that Plaintiffs allege violations of DOL regulations that do not provide the “best reading” of Section 702. (*Id.* at 4–7.) Defendant specifically argues that the statute does not require that Plaintiffs receive the “full reward” for mere participation in the program and that therefore Count I should be dismissed. (*Id.* at 7–8.) Further, Defendant asserts that the statute does not require notice of physician accommodations, warranting dismissal of Count II. (*Id.* at 8–9.) Lastly, Defendant argues that Plaintiffs fail to state a claim under Count III, because they fail to allege a fiduciary act or a breach of any fiduciary duty. (*Id.* at 9–11.)

The Court addresses each of these contentions, beginning with Defendant’s standing argument, because “the absence of standing deprives a court of the power to adjudicate anything further about the case.” *Griffin v. Dep’t of Lab. Fed. Credit Union*, 293 F. Supp. 3d 576, 578 (E.D. Va. 2018), *aff’d*, 912 F.3d 649 (4th Cir. 2019).¹ For the reasons discussed below, upon review of the First Amended Class Action Complaint and the parties’ respective arguments, the Court finds that Plaintiffs have standing and sufficiently state all three of their claims against Defendant. Accordingly, the Court DENIES Defendant’s Motion to Dismiss (ECF No. 18).

A. Standing

“There is no ERISA exception to Article III.” *Thole v. U. S. Bank N.A.*, 590 U.S. 538, 547 (2020). To satisfy the case-or-controversy requirement of Article III, the party invoking

¹ Although Defendant does not explicitly cite Rule 12(b)(1) when raising its standing challenge in its Motion, “the Court will review [Defendant’s] assertion through the correct 12(b)(1) lens.” *Jarrett*, 2021 WL 1381132, at *5.

federal jurisdiction must establish his or her standing to sue. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992); *see also Balzer & Assocs., Inc. v. Union Bank & Tr. Co.*, 2009 WL 1675707, at *2 (E.D. Va. June 15, 2009) (“On a motion to dismiss pursuant to Rule 12(b)(1), the party asserting jurisdiction has the burden of proving subject matter jurisdiction.”). The case-or-controversy requirement “ensures that courts exercise power that is judicial in nature,” rather than act as “a forum for generalized grievances.” *Gill v. Whitford*, 585 U.S. 48, 65 (2018). To meet the “irreducible constitutional minimum” requirements for standing, a party bringing a claim must establish three elements: (1) that the plaintiff has sustained an injury in fact; (2) that the injury traces to the defendant’s actions; and (3) that a favorable judicial decision will likely redress the injury. *Uzuegbunam v. Preczewski*, 592 U.S. 279, 285 (2021); *Friends of the Earth, Inc. v. Gaston Copper Recycling Corp.*, 629 F.3d 387, 396 (4th Cir. 2011).

To demonstrate an injury in fact, a plaintiff must suffer an invasion of a legally protected interest that is concrete and particularized to him, as well as actual or imminent and not merely hypothetical. *Friends of the Earth, Inc.*, 629 F.3d at 396; *McBurney v. Cuccinelli*, 616 F.3d 393, 402 (4th Cir. 2010). An injury qualifies as “particularized” if it “affect[s] the plaintiff in a personal and individual way.” *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016). Further, for an injury to be “concrete,” it “must actually exist” and be “real,” rather than “abstract.” *Id.* at 340.

Alleging an injury does not end the standing analysis, as a plaintiff must also establish traceability and redressability. A plaintiff has standing only if the alleged injury is “fairly traceable to the defendant’s allegedly unlawful conduct.” *California v. Texas*, 593 U.S. 659, 669 (2021). Plaintiffs “bear the burden of . . . showing that the defendant’s actual action has caused the substantial risk of harm.” *Clapper v. Amnesty Int’l USA*, 568 U.S. 398, 414 n.5 (2013). Further, a plaintiff must also show that “the injury will be redressed by a favorable decision.”

Lujan, 504 U.S. at 561. “[T]he redressability prong entails that it must be likely, and not merely speculative, that a favorable decision will remedy the injury.” *Friends of the Earth, Inc. v. Gaston Copper Recycling Corp.*, 204 F.3d 149, 154 (4th Cir. 2000). In assessing redressability, a federal court “assumes the merits of a dispute will be resolved in favor of the party invoking [its] jurisdiction.” *Equity in Athletics, Inc. v. Dep’t of Educ.*, 639 F.3d 91, 99 (4th Cir. 2011).

Defendant asserts that Plaintiffs have suffered no concrete injury, as neither Bokma nor Samsil allege that they participated in the Quit 4 Life program or that they would have participated “if the Plan’s notice included additional information.” (Mem. at 4.) Further, Defendant contends that Plaintiffs lack standing, because they fail to demonstrate that payment of the surcharge is “fairly traceable to the wellness program’s alleged violations.” (ECF No. 21 (“Reply”) at 2.) Plaintiffs counter that their injuries arise from Defendant’s non-compliant program, not from their “decision to forgo participation” in that program. (ECF No. 20 (“Opp.”) at 14.) According to Plaintiffs, their injuries “flow[] not from Plaintiffs’ reliance on inadequate notices but from the structural deficiencies of the wellness program itself.” (*Id.*) They further link their payment of the tobacco surcharge to Defendant’s conduct, namely its “refusal to issue retroactive reimbursements, failure to provide required notices, and failure to prudently monitor the wellness program for compliance.” (*Id.*) Overall, Plaintiffs argue that they challenge “the legality of the surcharge itself,” not “their failure to receive a reward,” and that they suffered a concrete monetary injury due to Defendant’s program, which violates ERISA. (*Id.* at 13–14.)

The Court agrees with Plaintiffs and finds that they possess standing to bring this suit. Plaintiffs sufficiently allege that they suffered a real monetary injury that was concrete and particularized to them, in the form of the \$600 annual tobacco surcharge that was periodically deducted from their paychecks over the course of the year. (FAC ¶ 22); *see TransUnion LLC v.*

Ramirez, 594 U.S. 413, 425 (2021) (noting that monetary harms “readily qualify as concrete injuries”). Plaintiffs’ injuries also stand “fairly traceable” to the Defendant’s challenged conduct, because absent Defendant’s alleged administration of its non-compliant wellness program, Plaintiffs would not have had to pay an unlawful surcharge. Lastly, the monetary harm suffered by Plaintiffs and similarly situated class members constitutes a redressable injury, as the requested relief under ERISA can remedy that harm. *See Franklin v. Duke Univ.*, 721 F. Supp. 3d 386, 392–93 (M.D.N.C. 2024) (finding standing for redressable injuries where plaintiff sought declaratory and injunctive relief, restitution and restoration of losses to employee plan).

The Court finds *Mehlberg v. Compass Group USA, Inc.*, Case No. 24-cv-04179, 2025 WL 1260700 (W.D. Mo. Apr. 15, 2025), cited by Plaintiffs, to constitute analogous and compelling persuasive authority. (ECF No. 27 (Notice of Supplemental Authority).) In that case, as here, the plaintiffs seek to bring a class action to challenge a tobacco surcharge, arguing that the defendant violated ERISA and breached fiduciary duties. *Mehlberg*, 2025 WL 1260700, at *1. Like Defendant in the instant matter, the defendant in that case contended that plaintiffs “failed to allege an injury traceable to [its] conduct,” because they “cannot suffer an injury from an allegedly non-compliant program in which they did not participate.” *Id.* at *3. However, the court found that the plaintiffs plausibly alleged that the defendant’s tobacco surcharge “unlawfully deducted money from their wages” in violation of ERISA. *Id.* Because the defendant “caused them monetary loss by imposing an unlawful fee,” the court determined that the plaintiffs satisfied the standing requirement. *Id.* Absent any conflicting case law or compelling argument to the contrary, the Court sees no reason to deviate from the reasoning articulated in *Mehlberg*.

Accordingly, the Court finds that Plaintiffs sufficiently establish standing and proceeds to analyze the merits of their claims as challenged in Defendant’s Motion.

B. ERISA and Regulations

The Court turns to Defendant’s argument that Plaintiffs fail to state a claim under Counts I and II,² “because they do not allege any violation of ERISA” but instead “allege violations of DOL regulations.” (Mem. at 6.) In response, Plaintiffs counter that their “claims strike at the core of [ERISA Section] 702’s anti-discrimination provisions, which prohibit plans from imposing premium differentials based on health status unless they comply with specific regulatory safeguards.” (Opp. at 16.) The Court agrees with Plaintiffs. Counts I and II both explicitly allege violations of ERISA Section 702. (FAC at 17, 19 (listing “violation of 29 U.S.C. § 1182” under the respective headings for Counts I and II).) Plaintiffs’ allegations that Defendant’s wellness program fails to satisfy the regulatory standards codified in 29 C.F.R. § 2590.702 do not undermine the assertion of claims against Defendant for ERISA violations. Rather, Defendant’s alleged failure to satisfy these regulations serves as a means for Plaintiffs to articulate *how* Defendant violates ERISA’s anti-discrimination provision. Accordingly, the Court denies Defendant’s Motion to the extent that it argues that Plaintiffs fail to allege an ERISA violation in Counts I and II. *See Mehlberg*, 2025 WL 1260700, at *4–6 (finding that plaintiffs stated substantially similar claims for violations of 29 U.S.C. § 1182 based on allegations that defendant did not satisfy requirements under 29 C.F.R. § 2590.702).

Relatedly, Defendant argues that “the Court is not beholden to DOL’s regulations as the controlling interpretation of [ERISA]” and therefore must exercise its own judgment without any

² While the Court responds to certain arguments that impact Counts I and II of Plaintiffs’ First Amended Class Action Complaint in this section, it separately addresses the merits of those individual claims in greater detail below. *See infra* Section III.D–E.

regulatory deference. (Mem. at 7.) Specifically, Defendant cites the Supreme Court’s recent decision in *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024), in support. (Mem. at 7.) In that case, the Supreme Court held that “[c]ourts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority.” *Loper Bright Enter.*, 603 U.S. at 412. The Court explicitly overruled the two-step “*Chevron* deference” framework, by which courts previously deferred to agency interpretations of ambiguous statutes if the agency “offered a permissible construction of the statute . . . even if not the reading the court would have reached if the question initially had arisen in a judicial proceeding.” *Id.* at 397, 412 (citing *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984)). The Supreme Court further noted that “there is a best reading all the same—the reading the court would have reached if no agency were involved,” and thus instructed courts to “apply[] all relevant interpretative tools” to determine the “best reading” without agency deference. *Id.* at 400. Here, Defendant contends that, “[b]ecause the DOL regulations do not offer the ‘best read’ of ERISA Section 702, the Court should not rely on these regulations.” (Mem. at 7.)

Plaintiffs counter that Defendant’s reliance on *Loper Bright* “is both misplaced and legally unsound.” (Opp. at 17.) Plaintiffs assert that *Loper Bright* “addressed judicial deference to agency *interpretations of ambiguous statutes*, not the enforceability of duly promulgated regulations,” and thus that case “did not invalidate or undermine” the regulations at issue in this matter. (*Id.*) According to Plaintiff, “*Loper Bright* does not empower courts to disregard duly promulgated regulations . . . nor does it allow Defendant to rewrite statutory requirements to suit

[its] own financial interests.” (*Id.* at 18.) Plaintiffs contend that Defendant cannot utilize *Loper Bright* “to ignore binding regulations” or “excuse noncompliance with ERISA.”³ (*Id.*)

The Court disagrees with Defendant that *Loper Bright* warrants dismissal of Counts I and II. First, the Court notes that the Supreme Court’s decision to overrule *Chevron* only affects agency actions that stem from statutory ambiguity or silence. *Loper Bright Enter.*, 603 U.S. at 379 (discussing former *Chevron* framework, which applied when “the statute [was] silent or ambiguous with respect to the specific issue”). Here, Defendant identifies no case addressing an ambiguity within 29 U.S.C. § 1182 or applying *Chevron* deference to the DOL regulations at issue in this matter. Thus, the lack of any authority applying *Chevron* to defer to the DOL’s regulations when assessing an alleged violation of ERISA Section 702 raises questions as to *Loper Bright*’s relevance to this case.

Even to the extent that 29 U.S.C. § 1182 could be considered ambiguous — an issue that the Court does not decide for the purpose of resolving the instant Motion — *Loper Bright* does not require courts to automatically disagree with an agency’s interpretation of an ambiguous statute. *See id.* at 403 (noting that “Congress expects courts to do their ordinary job of interpreting statutes, with due respect for the views of the Executive Branch [agencies]”). The Supreme Court directed courts to “use every tool at their disposal to determine the best reading of the statute and resolve the ambiguity.” *Id.* at 400. Not only might a court acknowledge an agency’s interpretation as one “tool at [its] disposal,” but the “best reading” of an ambiguous

³ Plaintiffs also assert that “*Auer* deference” remains intact after *Loper Bright* and applicable to the instant matter. (Opp. at 18–19.) In *Auer v. Robbins*, 519 U.S. 452 (1997), the Supreme Court held that courts should defer to reasonable interpretations of an agency’s own ambiguous regulations when such interpretation is consistent with the regulation’s intent. *Id.* at 461–62. To the extent that *Auer* deference is relevant to the instant Motion, the Court addresses the issue where appropriate. *See infra* Section III.D.

statute might also substantially align with the agency’s interpretation, particularly if a given agency decision or regulation has existed unchallenged for a significant period. *Id.* And while Defendant contends that the DOL regulations “are not the ‘best read’ of [ERISA] and should be disregarded,” Defendant does not robustly argue this point, allocating only a brief section of its Motion to the issue. (Mem. at 7–9.) To the extent that it continues to assert that the Court must disregard the regulations, Defendant will have the opportunity to reassert this argument and present relevant post-*Loper Bright* authority at future stages of the litigation.

The Court also takes note of *Hansen v. Laboratory Corp. of America*, 2024 WL 4564357 (E.D. Wis. Oct. 24, 2024), a post-*Loper Bright* decision from the Eastern District of Wisconsin. In that case, the defendant argued that an ERISA payroll practices exemption, codified in DOL regulations, “should be disregarded because the [DOL] lacked statutory authority to promulgate it and the regulation conflicts with the plain language of ERISA.” *Id.* at *5. The court found that the defendant read *Loper Bright* “far too broadly,” noting that the case “does not stand for the proposition that all regulations promulgated by federal agencies must be disregarded.” *Id.* The court cited 29 U.S.C. § 1135, which specifically confers on the DOL the authority to prescribe regulations it finds “necessary or appropriate to carry out the provisions” of ERISA. *Id.* Ultimately, the court determined that the Supreme Court had “already considered and upheld the payroll practices exception” in a case preceding *Loper Bright* and therefore denied the defendant’s argument that the regulation conflicted with the ERISA statute. *Id.* at *6; *see Loper Bright Enter.*, 603 U.S. at 412 (holding that “prior cases that relied on the *Chevron* framework . . . are still subject to statutory *stare decisis*”).

While *Hansen* does not directly map onto the instant case, it proves instructive in these early days of the post-*Loper Bright* world. Like the defendant in *Hansen*, Defendant in this case

contends that the DOL regulations “are inconsistent with [the ERISA] statute . . . and should be disregarded.” (Mem. at 8–9.) Like the court in *Hansen*, this Court also finds that Defendant “reads *Loper* [*Bright*] far too broadly.” *Hansen*, 2024 WL 4564357, at *5. The DOL regulations addressing requirements for outcome-based wellness programs did not suddenly lose their force and effect in the immediate aftermath of *Loper Bright*. This matter also does not stand as a case in which Defendant has sued to challenge the validity of the DOL regulations, and Defendant fails to identify any case, either pre- or post-*Loper Bright*, in which a defendant successfully challenged the DOL regulations within a motion to dismiss. Dismissal of Counts I and II on this basis, at this stage in the litigation and without any authority invalidating the DOL regulations, would therefore be improper.

Lastly, as Defendant itself points out, ERISA incorporates Section 2705 of the PHSA. (Mem. at 5); 29 U.S.C. § 1185d(a)(1) (stating that “the provisions of [Section 2705] . . . shall apply to group health plans”). Like the DOL regulations, Section 2705 contains requirements for wellness programs, including access to the “full reward” for “all similarly situated individuals” and disclosure of “the availability of a reasonable alternative standard” in plan materials. 42 U.S.C. § 300gg-4(j)(3). Defendant expressly cites one of these statutory requirements in its Motion, asserting that its program “need only offer an ‘opportunity to qualify for the reward under the program at least once each year.’” (Mem. at 8 (citing 42 U.S.C. § 300gg-4(j)(3)(C)).) It is counterintuitive, at best, for Defendant to rely on one PHSA condition — offering a single opportunity to qualify per year — in its argument while simultaneously asserting that another condition — access to the “full reward” — should be disregarded “as inconsistent with the plain reading of the statute.” (*Id.*) Regardless of the impact of *Loper Bright* on the DOL regulations, Defendant cannot turn a blind eye to the PHSA mandates incorporated within ERISA.

For all of these reasons, and for the purpose of resolving the instant Motion, the Court finds that *Loper Bright* does not warrant dismissal of Counts I and II.⁴

C. Breach of Fiduciary Duty (Count III)

Before reviewing Counts I and II, the Court first assesses whether Plaintiffs state a claim for breach of fiduciary duty under Count III, because, as Defendant points out, Counts I and II, which Plaintiffs assert pursuant to 29 U.S.C. § 1132(a)(3), also require Plaintiffs to show that Defendant breached a fiduciary duty. (Mem at 6 n.3); *see Moore v. Verizon Commc'ns, Inc.*, 2022 WL 16963245, at *7 (E.D. Va. Nov. 15, 2022), *aff'd*, 2024 WL 399076 (4th Cir. 2024) (noting that, to state a claim under § 1132(a)(3), a plaintiff must show that “(1) the defendant was a fiduciary of the ERISA plan; (2) the defendant breached its fiduciary responsibilities under the plan; and (3) injunctive or other equitable relief is necessary to remedy the breach”). Thus, if Plaintiffs fail to state a claim for breach of fiduciary duty under Count III, Counts I and II must also fail. Defendant contends that Plaintiffs fail to state such a claim for two reasons. (Mem. at 9–11.) First, Defendant asserts that Plaintiffs fail to allege that Defendant performed a fiduciary act. (*Id.* at 9–10.) Second, Defendant argues that even if Plaintiffs establish that Defendant performed a fiduciary act, they fail to allege that Defendant breached any fiduciary duty. (*Id.* at 11.) The Court assesses these two issues in turn, ultimately finding that Plaintiffs sufficiently state a claim under Count III for breach of fiduciary duty.

1. Fiduciary Act

“Before one can conclude that a fiduciary duty has been violated, it must be established that the party charged with the breach meets the statutory definition of ‘fiduciary.’” *Coleman v.*

⁴ As noted above, the Court’s decision here does not foreclose the possibility of Defendant reasserting this argument at a later stage in the litigation, potentially with the guidance of additional post-*Loper Bright* authority pertinent to the issue.

Nationwide Life Ins. Co., 969 F.2d 54, 60–61 (4th Cir. 1992); *see Pegram v. Herdrich*, 530 U.S. 211, 226 (2000) (“In every case charging breach of ERISA fiduciary duty, then, the threshold question is . . . whether that person was acting as a fiduciary . . . when taking the action subject to complaint.”). Under ERISA’s statutory definition, a person operates as a fiduciary when “he exercises any discretionary authority or discretionary control respecting management of [the] plan or . . . management or disposition of its assets . . . or he has any discretionary authority or discretionary responsibility in the administration of such plan.” 29 U.S.C. § 1002(21)(A).

“By the very nature of the position, a plan administrator is a fiduciary with respect to [its] own policy.” *Can. Life Assurance Co. v. Est. of Lebowitz*, 185 F.3d 231, 237 (4th Cir. 1999). An employer that establishes an ERISA plan constitutes a “sponsor.” 29 U.S.C. § 1002(16)(B). When a plan does not designate an administrator, the plan sponsor becomes the plan’s administrator. *Id.* § 1002(16)(A)(ii). A sponsor may act as a fiduciary “to the extent that it exercises any discretionary authority over the management or administration of a plan.” *Sonoco Prods. Co. v. Physicians Health Plan, Inc.*, 338 F.3d 366, 372–73 (4th Cir. 2003).

“ERISA fiduciaries may wear two hats.” *Pender v. Bank of Am. Corp.*, 788 F.3d 354, 362 (4th Cir. 2015). Thus, being a plan sponsor “does not automatically convert the employer into a plan fiduciary.” *Moon v. BWX Techs., Inc.*, 577 F. App’x 224, 229 (4th Cir. 2014) (citing *Beck v. PACE Int’l Union*, 551 U.S. 96, 101 (2007)). Rather, courts scrutinize “the conduct at issue” to determine whether the individual “de facto performs specified discretionary functions with respect to the management, assets, or administration of a plan.” *Wilmington Shipping Co. v. New Eng. Life Ins. Co.*, 496 F.3d 326, 343 (4th Cir. 2007); *Custer v. Sweeney*, 89 F.3d 1156, 1161 (4th Cir. 1996). Ultimately, courts have an “obligation to liberally construe fiduciary status.” *Dawson-Murdock v. Nat’l Counseling Grp., Inc.*, 931 F.3d 269, 278 (4th Cir. 2019).

The Fourth Circuit has held that a plan administrator acts as a fiduciary when it verifies employee eligibility for participation in a plan. *Gordon v. CIGNA Corp.*, 890 F.3d 463, 474 (4th Cir. 2018). Further, an administrator acts as a fiduciary when conveying (or failing to convey) material information to participants regarding maintaining eligibility for ERISA benefits. *Griggs v. E.I. DuPont de Nemours & Co.*, 237 F.3d 371, 381–82 (4th Cir. 2001). By contrast, “[p]lan sponsors who alter the terms of a plan,” without more, “do not fall into the category of fiduciaries.” *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996); see *Curtiss–Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (“[P]lan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.”). An employer also does not act as a fiduciary “simply by performing settlor-type functions such as establishing a plan and designing its benefits.” *Sonoco Prods. Co.*, 338 F.3d at 373. Similarly, mere acceptance of premium payments does not constitute a fiduciary act. *Moon*, 577 F. App’x at 231. Nor does processing claims or “reading a computer screen to determine who is and who is not covered.” *HealthSouth Rehab. Hosp. v. Am. Nat’l Red Cross*, 101 F.3d 1005, 1009 (4th Cir. 1996).

Here, in Defendant’s telling, Plaintiffs only allege that Defendant, “the sponsor of a self-funded group health plan, collected and held the ERISA-authorized tobacco surcharges it deducts from employee paychecks.” (Mem. at 9.) According to Defendant, it acted merely as a settlor “making plan design decisions” while “determining the structure of its wellness program, including imposing the tobacco surcharge.” (*Id.* at 10.) Thus, according to Defendant, Plaintiffs fail to establish that it acted as an ERISA fiduciary. Plaintiffs counter that Defendant conflates settlor plan-design functions with Defendant’s fiduciary role as a plan administrator. (Opp. at 22.) Plaintiffs argue that their allegations “are squarely aimed at Defendant’s discretionary actions in administering and managing a wellness program . . . not the mere act of designing it.”

(*Id.*) Specifically, Plaintiffs challenge Defendant’s discretion in choosing not to retroactively reimburse surcharges to participants who completed the Quit 4 Life program, as well as Defendant’s repeated omission of “critical information about reasonable alternative standards and physician accommodations in plan materials.” (*Id.* at 23.)

Upon review of the First Amended Class Action Complaint, the Court agrees with Plaintiffs and finds that they sufficiently allege that Defendant acted as an ERISA fiduciary. The Court begins by noting that Plaintiffs allege that Defendant serves as the Plan Administrator. (FAC ¶ 12 (citing Plan Document § 2.11 (defining Defendant as “Plan Administrator”))). Defendant does not address this allegation in its Motion or Reply, effectively conceding the point. As noted by the Fourth Circuit, a plan administrator “is a functional fiduciary with respect to plan administration.” *Dawson-Murdock*, 931 F.3d at 276; *see Can. Life Assurance Co.*, 185 F.3d at 237 (“By the very nature of the position, a plan administrator is a fiduciary with respect to her own policy.”) Thus, by alleging that Defendant acts as Plan Administrator, Plaintiffs satisfy the initial threshold to plead that Defendant acts as a fiduciary in administering the Plan.

Even if the Plan had not explicitly named Defendant as Plan Administrator, Defendant would still constitute a fiduciary under ERISA if it performed “specified discretionary functions with respect to the management, assets, or administration of a plan.” *Custer*, 89 F.3d at 1161. Plaintiffs’ allegations plausibly establish Defendant’s fiduciary status under such a rationale as well. Plaintiffs allege that Defendant exercised discretionary authority and control over both the management of the Plan and disposition of its assets by collecting the tobacco surcharges and deciding not to retroactively reimburse those who completed the Quit 4 Life program midyear. (FAC ¶¶ 72–73.) Defendant argues that it acted merely as a settlor in setting the terms of its wellness program and imposing the surcharge on any participants who failed to comply with

those terms. (Mem. at 10.) However, Plaintiffs’ allegations do not focus on Defendant’s selection of the terms that would apply to the Plan. Rather, Plaintiffs challenge Defendant’s repeated discretionary decisions against retroactively reimbursing qualifying participants. (FAC ¶¶ 25, 30, 35, 73.) Plaintiffs highlight a 2023 meeting during which an individual speaking on behalf of Defendant informed Samsil and others that the surcharge could be “removed *only* on a go-forward basis *after completing the program*.” (*Id.* ¶ 30.) This allegation supports Plaintiffs’ claim that Defendant acted as a fiduciary by not merely choosing certain terms for its Plan, but also actively exercising discretionary control throughout the course of the Plan year.

Further, Plaintiffs allege that Defendant failed to “properly disclose material information about the plan to participants, thereby misleading or depriving them of the ability to make informed decision[s].” (FAC ¶ 76.) Specifically, Plaintiffs allege that Defendant failed to disclose a reasonable alternative standard or that the recommendations of a participant’s physician would be considered in crafting such a standard. (*Id.* ¶¶ 40, 66–67.) Plaintiffs contend that this failure “was not a one-time plan design choice but a repeated failure, year after year, of plan administration, which is a quintessential fiduciary duty.” (Opp. at 23.) The Court agrees. Once again, Plaintiffs’ allegations do not pertain merely to settlor-type, one-time decisions of a plan sponsor, but rather challenge Defendant’s ongoing discretionary administrative decisions to omit material information from Plan documents. As the Fourth Circuit has held, “a plan administrator acts in a fiduciary capacity when it conveys (or fails to convey) material information to a plan participant concerning the retention of eligibility for a benefit plan.” *Dawson-Murdock*, 931 F.3d at 279. Here, Plaintiffs’ allegations sufficiently establish that Defendant acted as a fiduciary in similarly failing to convey relevant information regarding the tobacco surcharge and reasonable alternative standard.

Lastly, the Court notes Plaintiffs’ allegations that Defendant unlawfully held the tobacco surcharges “in its own accounts” and thereby acted in its own self-interest and at participants’ expense by failing to “contribute as much of its own assets to the Plan.” (FAC ¶¶ 72, 75–76.) This alleged retention of Plan assets also constitutes a sufficient allegation of a fiduciary act, as Defendant exercised discretion over “management or disposition of [Plan] assets” by choosing to commingle those assets for its own benefit. 29 U.S.C. § 1002(21)(A).

In sum, as alleged, Plaintiffs’ First Amended Class Action Complaint focuses on Defendant’s various discretionary actions as Plan Administrator, not merely Defendant’s “settlor-type functions” or “modifying the terms of a plan.” *Sonoco Prods. Co.*, 338 F.3d at 373; *Pegram*, 530 U.S. at 225. At this stage, Plaintiffs thus plausibly plead that Defendant exercised discretionary authority in its role as Plan Administrator. Accordingly, the Court hereby denies Defendant’s Motion to the extent that it asserts that Plaintiffs fail to allege a fiduciary act.

2. Fiduciary Breach

Having determined that Plaintiffs sufficiently allege that Defendant acted as a fiduciary, the Court now examines whether Plaintiffs plausibly plead that Defendant breached a fiduciary duty. Under the ERISA statutory scheme, a fiduciary must “discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries,” “with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use” and “in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with” ERISA. 29 U.S.C. § 1104(a)(1). An ERISA fiduciary also may not “deal with the assets of the plan in [its] own interest or for [its] own account” or act on behalf of any party “whose interests are adverse to the interests of the plan or the interests of its participants.” *Id.* § 1106(b). An

ERISA fiduciary that breaches its duty “shall be personally liable to make good to such plan any losses to the plan . . . to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan . . . and shall be subject to such other equitable or remedial relief as the court may deem appropriate.” *Id.* § 1109(a). Pursuant to 29 U.S.C. § 1132(a)(2), a participant may assert a civil action for appropriate relief under 29 U.S.C. § 1109, which imposes liability for breach of fiduciary duties under ERISA.

The Supreme Court previously held that 29 U.S.C. § 1104(a)(1)(D) “makes clear that the duty of prudence trumps the instructions of a plan document.” *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 421 (2014). The provision “would make little sense if . . . the duty of prudence is defined by the aims of a particular plan.” *Id.* Further, “[b]ecause the content of the duty of prudence turns on the circumstances . . . prevailing at the time the fiduciary acts . . . the appropriate inquiry will necessarily be context specific.” *Id.* at 425.

Knowingly retaining and failing to remit employee contributions, “which are considered plan assets,” can violate both the duties of prudence and loyalty and constitute a violation of 29 U.S.C. § 1106 by using plan assets for the fiduciary’s own interest. *Scalia v. Marzett*, 2020 WL 6059865, at *6–7 (E.D. Va. June 19, 2020), *report and recommendation adopted*, 2020 WL 4365535 (E.D. Va. July 30, 2020); *see also Hammer v. Johnson Senior Ctr., Inc.*, 2020 WL 7029160, at *10 (W.D. Va. Nov. 30, 2020) (finding that “failure to remit employee contributions to the Plan” and commingling of assets violated fiduciary duties under 29 U.S.C. § 1104(a)). In *Chao v. Malkani*, 452 F.3d 290 (4th Cir. 2006), the Fourth Circuit found that the fiduciaries’ “repeated efforts to plunder the Plan’s assets and minimize their own liabilities demonstrate[d] that they were administering the Plan neither for the sole benefit of Plan participants . . . nor with the skill and care of a prudent person.” *Id.* at 294. The court noted that, “[w]hile a mistaken

interpretation of plan terms hardly proves a fiduciary breach,” the defendants’ “bizarre reading” violated the duties of loyalty and prudence. *Id.* at 295.

“A claim alleging a breach of fiduciary duty may survive a motion to dismiss if the court, based on circumstantial factual allegations, may reasonably infer from what is alleged that the process was flawed.” *Feinberg v. T. Rowe Price Grp., Inc.*, 2018 WL 3970470, at *5 (D. Md. Aug. 20, 2018). Because “ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences,” the allegations “need not directly address[] the process by which the Plan was managed.” *Id.*; *cf. Reetz v. Aon Hewitt Inv. Consulting, Inc.*, 74 F.4th 171, 179–82 (4th Cir. 2023) (reviewing claims for breaches of the duties of loyalty and prudence by assessing the evidentiary record presented in bench trial). To state a claim for a fiduciary breach, plaintiffs must also plausibly allege that the defendant’s breach caused a loss to the plan. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985).

Here, Defendant contends that Plaintiffs fail to allege disloyalty, imprudence or a violation of ERISA or the Plan terms. (Mem. at 11.) Defendant argues that its acts stand “consistent with Plan terms and ERISA” and therefore “do not constitute a fiduciary breach.” (*Id.*) Further, Defendant contends that Plaintiffs do not allege that Defendant acted disloyally, as ERISA does not mandate that Plaintiffs receive their desired benefits. (*Id.*) Lastly, Defendant asserts that Plaintiffs fail to allege imprudence, because they do not present “an alternative action Defendant could have taken.” (*Id.*) Plaintiffs counter that “plan terms are not sacrosanct” and therefore Defendant “cannot blindly follow plan documents if doing so results in violating” ERISA. (Opp. at 24–25.) Plaintiffs also assert that Defendant “cannot sidestep its fiduciary obligations by framing its failures as mere disagreements over benefits.” (*Id.* at 25.) Plaintiffs

ultimately contend that Defendant’s actions do not constitute “technical oversights” but rather represent “core breaches” of ERISA fiduciary duties. (*Id.*)

Review of the allegations demonstrates that Plaintiffs plausibly plead breaches of Defendant’s fiduciary duties. Plaintiffs allege that Defendant collected and held Plan assets, in the form of unlawful tobacco surcharges, “in its own accounts” and failed “to contribute as much of its own assets to the Plan.” (FAC ¶ 72.) Plaintiffs also allege that Defendant “prioritiz[ed] its financial interests over the interests of plan participants” by retaining the surcharges without administering retroactive refunds. (*Id.* ¶ 74.) “Rather than placing these funds in a trust account, Defendant retained the amounts collected as part of its own assets” and “mixed those funds into its general assets.” (*Id.* ¶¶ 23, 68.) In so doing, Defendant “increased its own monies and saved the money it would have had to contribute to the Plan,” thereby “deal[ing] with Plan assets for its own benefit.” (*Id.* ¶ 75.) These allegations plausibly plead that Defendant violated (1) its duty of loyalty under 29 U.S.C. § 1104(a)(1)(A) to act “solely in the interest of the participants” and (2) its duty pursuant to 29 U.S.C. § 1106(b) to not deal with Plan assets in its own self-interest. *See Hammer*, 2020 WL 7029160, at *10 (finding that “failure to remit employee contributions to the Plan” and commingling assets violated duties). Defendant’s efforts to “minimize [its] own liabilities” by retaining funds suggest that it “administer[ed] the Plan neither for the sole benefit of Plan participants . . . nor with the skill and care of a prudent person.” *Chao*, 452 F.3d at 294.

Furthermore, Plaintiffs allege that Defendant’s failure to provide participants with the “full reward” as required under ERISA and to properly disclose material information about the Plan deprived them of the ability to make informed decisions regarding their benefits.⁵ (FAC

⁵ The Court separately addresses the merits of these specific allegations in greater detail as they pertain to Counts I and II. *See infra* Section III.D–E.

¶¶ 75–76.) The Court finds that these allegations plausibly state a violation of the duty of loyalty, because, in denying Plaintiffs the “full reward” and failing to adequately inform them, Defendant failed to act “solely in the interest of the participants.” 29 U.S.C. § 1104(a)(1)(A). At this stage, the Court also finds that Plaintiffs plausibly plead a violation of the duty of prudence, as the allegations allow a reasonable inference “that a prudent man acting in a like capacity” under the circumstances would have made the alleged disclosures to ensure that Plan participants were adequately informed. *Id.* § 1104(a)(1)(B).

To the extent that Defendant contends that Plaintiffs fail to allege a breach because Defendant’s “actions [were] consistent with Plan terms,” the Court notes that this defense bears limited value. (Mem. at 11.) As the statute itself dictates, fiduciaries must act “in accordance with the documents and instruments governing the plan” only if those documents “are consistent with the provisions” of ERISA. 29 U.S.C. § 1104(a)(1)(D). Stated another way, “the duty of prudence trumps the instructions of a plan document.” *Fifth Third Bancorp*, 573 U.S. at 421. Thus, because Plaintiffs specifically allege that Defendant breached the duties of prudence and loyalty by collecting an unlawful surcharge, commingling Plan assets with its own funds and failing to disclose material information about the Plan, Defendant cannot rely on its adherence to the Plan’s terms as a defense. If either the Plan’s terms or Defendant’s administration of the Plan violates ERISA, Defendant may not lean on its adherence to the Plan as a shield from liability.⁶

⁶ The Court acknowledges that Defendant may very well be able to raise defenses and present evidence to prove that it acted prudently and in the best interest of all Plan participants. However, that assessment stands appropriate at a later stage in the litigation, after the parties have an opportunity to engage in discovery. *See Feinberg*, 2018 WL 3970470, at *5 (noting that “ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences”). Because fiduciary duties are “context-specific,” the presentation of evidence will be particularly critical to the Court’s assessment of Defendant’s alleged breaches. *Reetz*, 74 F.4th at 179–82 (reviewing bench trial evidentiary record in assessing breaches of fiduciary duties). Nevertheless, for the purpose of resolving the instant

Lastly, the Court finds that Plaintiffs plausibly plead a loss to the entire Plan, as required in order to obtain relief under 29 U.S.C. § 1109, by alleging that “Plaintiffs and members of the Class lost millions of dollars in the form of unlawful surcharges that were deducted from their paychecks.” (FAC ¶ 77); *see Russell*, 473 U.S. at 144 (noting that “Congress did not intend [29 U.S.C. § 1109] to authorize any relief except for the plan itself”).

For all of these reasons, the Court finds that Plaintiffs plausibly plead that Defendant breached its fiduciary duties to Plan participants. Accordingly, the Court denies Defendant’s Motion as to Count III.

D. Unlawful Imposition of Discriminatory Surcharge (Count I)

The Court has already addressed some of Defendant’s general challenges to Counts I and II and found those arguments unpersuasive at this stage. *See supra* Section III.B. Further, based on its finding that Plaintiffs plausibly plead a breach of Defendant’s fiduciary duties, the Court finds that Plaintiffs can assert claims against Defendant pursuant to 29 U.S.C. § 1132(a)(3). *See supra* Section III.C; *Moore*, 2022 WL 16963245, at *7 (noting that to state a § 1132(a)(3) claim, a plaintiff must demonstrate a fiduciary breach). Thus, the Court now proceeds to review Count I, which Plaintiffs bring under 29 U.S.C. § 1132(a)(3) for violation of 29 U.S.C. § 1182(b)’s anti-discrimination provision. Specifically, under Count I, Plaintiffs challenge Defendant’s unlawful imposition of the tobacco surcharge, which they allege violates 29 U.S.C. § 1182(b) by failing to provide a reasonable alternative standard to obtain the “full reward,” including on a retroactive basis. (FAC ¶¶ 54–60.)

Motion, the Court can “reasonably infer from what is alleged” that Defendant violated its fiduciary duties to Plaintiffs. *Feinberg*, 2018 WL 3970470, at *5; *see also Mehlberg*, 2025 WL 1260700 at *7 (finding that, “[a]t the motion to dismiss stage,” plaintiffs’ allegations that defendant collected and used unlawful tobacco surcharges to offset its own plan contributions “sufficiently allege that [d]efendant acted as a fiduciary and engaged in prohibited transactions”).

Defendant contends that its wellness program satisfies ERISA’s requirements by providing an “opportunity to qualify for the reward under the program at least once each year” in exchange for “adherence” to the program’s terms. (Mem. at 8 (citing 29 U.S.C. § 1182(b)(2)(B); 42 U.S.C. § 300gg-4(j)(3)(C)).) Defendant further asserts that Plaintiffs’ interpretation would allow a full refund even if a participant “did not ‘adhere’ to the terms of the wellness program for 364 days of that plan year,” which does not constitute the “best read” of the statute. (*Id.*) Defendant relies on a 2014 FAQ, jointly issued by the DOL, the Department of Health and Human Services and the Department of the Treasury, which states that an individual who participates mid-year “may receive a pro-rated reward.” (*Id.* (citing U.S. Dep’t. of Lab., *FAQs About Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation*, at 6 (Jan. 9, 2014), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/affordable-care-act-implementation-faqs-part-xviii-mental-health-parity.pdf> [hereinafter “2014 FAQ”])). Overall, Defendant argues that an interpretation of ERISA that requires the “full reward” at any point in the year is “inconsistent with the plain reading of [the] statute.” (*Id.*)

Plaintiffs counter that Defendant’s position — “that participants must ‘adhere’ to the terms of a wellness program to receive the full reward” — “ignores the clear language” of the regulations and interpretative guidance, which require the provision of the “full reward” to all who satisfy a reasonable alternative standard. (Opp. at 19.) Plaintiffs contend that “[t]his requirement exists regardless of when participants satisfy the alternative standard during the plan year,” and that Defendant’s denial of retroactive reimbursement for surcharges already paid in a given year therefore violates the law. (*Id.*) Plaintiffs also assert that Defendant conflates two distinct regulatory requirements. (*Id.* at 20.) Specifically, they argue that the 2014 FAQ cited by

Defendant addresses whether plans must offer multiple opportunities for enrollment after a participant declines an initial invitation to enroll. (*Id.*) However, that FAQ does not override the distinct requirement that plans provide the “full reward” to those who ultimately complete the reasonable alternative standard during the year. (*Id.*) Citing the DOL’s position as advanced in a 2018 opposition brief,⁷ Plaintiffs contend that denial of retroactive reimbursement “allow[s] plans to discriminate for a portion of the plan year.” (*Id.* at 20–21 (quoting *Sec’y of Lab. v. Macy’s Inc.*, 1:17-cv-00541, ECF No. 41 at 13 (S.D. Ohio Oct. 31, 2018)).)

In assessing the parties’ arguments, the Court again turns to *Mehlberg v. Compass Group USA, Inc.*, Case No. 24-cv-04179, 2025 WL 1260700 (W.D. Mo. Apr. 15, 2025) as analogous persuasive authority. In that case, as in the instant matter, Count I asserted a claim pursuant to 29 U.S.C. § 1132(a)(3) for a violation of 29 U.S.C. § 1182(b)’s anti-discrimination provision. *Mehlberg*, Case No. 24-cv-04179, ECF No. 1 ¶¶ 52–58. Plaintiffs in that case, like here, alleged that the defendant imposed a discriminatory surcharge by not providing a reasonable alternative standard that allowed for retroactive reimbursement to obtain the “full reward” during the plan year. *Id.* ¶¶ 53–54. The defendant in *Mehlberg*, like Defendant here, argued that ERISA does not require retroactive reimbursement. *Mehlberg*, 2025 WL 1260700, at *4.

The court disagreed with the defendant, finding that the plaintiffs “adequately alleged that [d]efendant’s tobacco surcharge violated ERISA because it did not offer a retroactive reimbursement of the surcharge.” *Id.* at *5. The court specifically rejected the defendant’s *Loper Bright* argument that the plaintiffs’ interpretation “does not comport with the best reading of the statute and thus is owed no deference.” *Id.* Further, the court agreed with the plaintiffs’

⁷ See *Mass. Mut. Life Ins. Co. v. United States*, 782 F.3d 1354, 1366 (Fed. Cir. 2015) (noting that “[d]eference can even be afforded to an agency’s interpretation when . . . advanced in a legal brief.”).

view that the addition of the qualifying word “full” before “reward” in both the DOL regulation and Section 2705 of the PHSA “removed any doubt that the ‘reward’ was intended to apply retroactively.” *Id.* The court also agreed that the preamble to the DOL regulations, which states that the “same, full reward” must be provided to all who satisfy a reasonable alternative standard, “reflects the agency’s interpretation of its own regulations” and stands entitled to *Auer* deference. *Id.*; 78 Fed. Reg. 33158, 33163. Lastly, the court found “no conflict” between ERISA’s statutory requirement of “adherence” to a wellness program to become eligible for the full reward and the separate requirement that participants “be refunded the full amount of the annual surcharge if they do so.” *Mehlberg*, 2025 WL 1260700, at *6.⁸

The Court finds that the reasoning of the Western District of Missouri’s opinion in *Mehlberg* provides compelling, persuasive authority in this case, which deals with substantially similar claims and arguments. Further, the Court agrees with Plaintiffs that Defendant “conflates two distinct regulatory requirements.” (Opp. at 20.) The 2014 FAQ cited by Defendant states that plans need not “provide another opportunity to avoid the tobacco premium surcharge until renewal or reenrollment for coverage for the next plan year.” 2014 FAQ at 6. However, this guidance places a limitation on opportunities for *enrollment* in a wellness program. By contrast, Plaintiffs allege that Defendant fails to satisfy the separate requirement that plans provide

⁸ The *Mehlberg* court also cited *Lipari-Williams v. Missouri Gaming Co.*, 339 F.R.D. 515 (W.D. Mo. 2021), in which the same court undertook a plain language analysis of the ERISA statute. *Mehlberg*, 2025 WL 1260700, at *6. In *Lipari-Williams*, the court found that, while the plain language of 29 U.S.C. § 1182(b)(2) allows for “premium *discounts* or *rebates*,” which in their ordinary usage “refer to a reduction in cost,” a tobacco surcharge does not constitute a discount or rebate, because it “imposes an increase in cost.” 339 F.R.D. at 524. The *Mehlberg* court thus found that, because *Lipari-Williams* resolved the issue without reliance on *Chevron*, “*Loper Bright* does not apply under these circumstances.” *Mehlberg*, 2025 WL 1260700, at *6. Here, because the Court finds that Plaintiffs plausibly plead a claim under Count I for the reasons addressed above, it does not reach the issue of *Loper Bright*’s possible application to this case.

participants with the “full reward” upon *completion* of a program, which may occur at any point during the plan year. (FAC ¶¶ 29–31, 35.) The preamble to the DOL regulations and the 2018 DOL position cited by Plaintiffs both state that the “full reward” must be granted to all individuals who satisfy the reasonable alternative standard. 78 Fed. Reg. 33158, 33163; *Macy’s Inc.*, ECF No. 41 at 13. Affording *Auer* deference to the 2014 FAQ, preamble and 2018 position as reasonable interpretations of the DOL’s regulations, the Court finds that Plaintiffs plausibly plead that Defendant violated ERISA Section 702 by impermissibly discriminating against participants in denying retroactive reimbursement during a plan year.⁹

For all of these reasons, the Court finds that Plaintiffs state a claim under Count I. Thus, the Court denies Defendant’s Motion as to that count.

E. Failure to Notify of Reasonable Alternative Standard (Count II)

Under Count II, Plaintiffs assert another claim pursuant to 29 U.S.C. § 1132(a)(3) for violation of 29 U.S.C. § 1182(b)’s anti-discrimination provision. Specifically, Plaintiffs contend that Defendant violated ERISA Section 702 by failing to provide the required notice of a compliant reasonable alternative standard, including a statement that the recommendations of a participant’s physician would be accommodated in developing such a standard. (FAC ¶¶ 61–69.)

Defendant asserts that Count II should be dismissed, because “the statute does not require any disclosure regarding accommodating [recommendations] of a participant’s physician.” (Mem. at 9.) Further, Defendant contends that Section 2705 of the PHSA provides that disclosures regarding the reasonable alternative standard “shall not be required” as long as plan

⁹ To the extent that the 2014 FAQ and 2018 DOL position conflict, the Court finds that the more recent guidance reflects the DOL’s reasonable interpretation. Thus, the Court affords *Auer* deference to the DOL’s 2018 statement that denying retroactive reimbursement violates ERISA’s regulatory scheme “because it would allow plans to discriminate for a portion of the plan year.” *Macy’s Inc.*, ECF No. 41 at 13.

materials disclose the availability of a wellness program “without describing its terms.” (*Id.* (quoting 42 U.S.C. § 300gg-4(j)(3)(E)).) Defendant thus argues that the DOL regulations do not constitute “the ‘best read’ of [the] statute and should be disregarded” to the extent that they require disclosures which the statute states “shall not be required.” (*Id.*)

Plaintiffs counter that while the statutory text may not require notice regarding physician recommendations, the DOL regulations, “which have the force of law as properly promulgated legislative rules,” do. (Opp. at 21.) Plaintiffs contend that the regulations “fall squarely within the agency’s authority granted by 29 U.S.C. §§ 1135 and 1191c” and “have been in place for over a decade” with Congress taking “no action to override or amend them.” (*Id.* n.8.) Plaintiffs cite the preamble to the regulations, which explicitly states that “a plan disclosure that references a premium differential based on tobacco use . . . is a disclosure describing the terms of a health-contingent wellness program and, therefore, must include this disclosure.” (*Id.* (citing 78 Fed. Reg. 33158, 33166).) Plaintiffs contend that Defendant’s “Benefits Guide fails to include this critical disclosure,” despite describing the terms of the Quit 4 Life program, including details about the tobacco surcharge. (*Id.* at 22.) Thus, by “includ[ing] a description of the program’s terms,” Defendant triggered the full disclosure requirements and its failure to include the notice constitutes an ERISA violation. (*Id.*) Ultimately, Plaintiffs contend that Defendant “attempt[s] to manufacture a conflict between ERISA and [the] [r]egulations,” but its failure to include the physician recommendation notice “constitutes a clear, standalone violation.” (*Id.*)

Again, the Court finds compelling the persuasive authority presented in *Mehlberg*. As with Count I, Count II in this matter substantially mirrors Count II in that case. The plaintiffs in *Mehlberg*, like Plaintiffs here, asserted a claim for violation of 29 U.S.C. § 1182(b) pursuant to 29 U.S.C. § 1132(a)(3) and specifically alleged that the plan’s materials “discussed the tobacco

surcharge but did not include a statement that recommendations of an individual’s personal physician will be accommodated in conjunction with the formation of a reasonable alternative standard.” *Mehlberg*, Case No. 24-cv-04179, ECF No. 1 ¶¶ 59–65. As the court in that case noted, under the DOL regulations, a wellness program must disclose the availability of a “reasonable alternative standard . . . in all plan materials,” including “a statement that recommendations of an individual’s personal physician will be accommodated.” *Mehlberg*, 2025 WL 1260700, at *6 (quoting 29 C.F.R. § 2590.702(f)(4)(v)). The court concluded that, “[a]t the motion to dismiss stage,” the plaintiffs “adequately state[d] a claim” under Count II by alleging that the defendant’s plan materials failed to include the physician recommendation notice. *Id.* The court thus denied the defendant’s motion to dismiss as to that count. *Id.*

The Court sees no reason to deviate from the *Mehlberg* court’s reasoning at this early stage in the litigation, where Plaintiffs, like plaintiffs in that case, allege that Defendant’s materials “fail[] to provide participants with the necessary statement that recommendations of a participant’s physician will be accommodated.” (FAC ¶ 67.) The Court agrees with Plaintiffs that, by describing certain details about the Quit 4 Life program in its materials, Defendant triggers the full disclosure requirements, to include the physician recommendation notice. Specifically, Plaintiffs allege that the Benefits Guide “mentions that participants can complete the Quit 4 Life program, but the surcharge will be removed only on a *prospective* basis, not for the entire plan year.” (*Id.* ¶ 29.) Plaintiffs also allege that the Guide’s “ambiguous and misleading language . . . does not clearly notify participants that they are entitled to a full reward, including retroactive reimbursement” and thereby “fails to adequately communicate a reasonable alternative program.” (*Id.* ¶ 34.) Additionally, Plaintiffs allege that the “vague language stating that the surcharge ‘can be removed’ by completing the Quit 4 Life program” appears “at the

bottom of a page in a document exceeding 30 pages in length.” (*Id.* ¶ 37.) These allegations sufficiently plead that Defendant’s materials “describe [the plan’s] terms,” thus triggering the full notice requirements concerning a reasonable alternative standard, including the physician recommendation notice. 42 U.S.C. § 300gg-4(j)(3)(E).

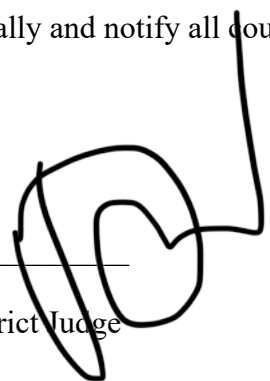
At this stage in the litigation, Defendant identifies no valid reason why the Court must determine that the applicable DOL regulatory requirements, which have existed without amendment for more than a decade, should no longer apply. The Court finds no contradiction or conflict between the ERISA statute, which explicitly incorporated Section 2705 of the PHSA, and the DOL regulations, which also address the wellness program requirements articulated in Section 2705. *See* 29 U.S.C. § 1185d(a)(1) (providing that PHSA provisions “shall apply to group health plans”). For all of these reasons, Plaintiffs adequately state a claim under Count II and the Court therefore denies Defendant’s Motion as to that count.

IV. CONCLUSION

For the reasons set forth above, the Court hereby DENIES Defendant’s Motion to Dismiss (ECF No. 18). This case shall proceed on all Counts presented in Plaintiffs’ First Amended Class Action Complaint.

Let the Clerk file a copy of this Memorandum Order electronically and notify all counsel of record.

It is so ORDERED.


_____/s/_____
David J. Novak
United States District Judge

Richmond, Virginia
Dated: May 20, 2025