

**IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA**

No. 35677

**DANNY FISCHER and BRITTANEY FISCHER,  
Plaintiffs Below, Appellants**

vs.

**SWVA, INC., in its capacity as Plan Administrator and Sponsor  
of the SWVA, Inc., Employee Health Care Plan, and SWVA, INC.,  
EMPLOYEE HEALTH CARE PLAN,  
Defendants Below, Appellees**

Hon. F. Jane Husted, Judge  
Circuit Court of Cabell County  
Civil Action No. 07-C-1100

**BRIEF FOR APPELLEES**

**Counsel for Appellants**

Jeffrey V. Mehalic  
WV Bar No. 2519  
P.O. Box 11133  
Charleston, WV 25339-1133  
Telephone 304.346.3462

**Counsel for Appellees**

Ancil G. Ramey  
WV Bar No. 3013  
Sara E. Hauptfuehrer  
WV Bar No. 8931  
Steptoe & Johnson PLLC  
P.O. Box 1588  
Charleston, WV 25326-1588  
Telephone 304.933.8195

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## I. INTRODUCTION

This case arises under the Employee Retirement Income Security Act of 1974 (“ERISA”). The Circuit Court of Cabell County correctly held that plaintiffs’ legal action against defendants SWVA, Inc. (“SWVA”), and SWVA, Inc. Employee Health Care Plan (“Plan”) (“Defendants”) for wrongful denial of benefits was time-barred and that the limitations period was properly applied under Fourth Circuit authority.

Under applicable federal law, plaintiffs’ cause of action accrued on February 27, 2007, when the Plan’s decision denying Brittaney Fischer’s claims for Plan benefits became final. By that time, the Plan also had advised Ms. Fischer’s counsel that she had the right to challenge the denial in court within the time period established by the Plan’s terms. Her right to bring suit challenging the Plan’s benefits denial expired on May 28, 2007. This action was filed on December 17, 2007, nearly seven months later.

Plaintiffs complain, for the first time before this court, that they should have been permitted to engage in discovery “regarding the application of SWVA’s limitations period to Fischer’s claim.”<sup>1</sup> Below, plaintiffs sought discovery of matters relating to the merits of the Plan’s decision to deny benefits. Defendants’ motion for summary judgment, however, was based solely on the threshold issue of timeliness.

Plaintiffs were provided ample opportunity to engage in discovery on that dispositive issue. Nowhere in their Rule 59(f) affidavit did they identify any area of

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<sup>1</sup> Brief of Appellants at 8.

discovery that was relevant *to the issue of timeliness*. And the Circuit Court did not abuse its discretion in permitting additional discovery only on the issue of whether the Plan was self-funded, which was the only *material* issue of fact raised by plaintiffs at the hearing on defendants' summary judgment motion.

Accordingly, this Court should affirm the judgment of the Circuit Court of Cabell County.

## II. PROCEDURAL HISTORY

Plaintiffs filed this action in the Circuit Court of Cabell County on December 17, 2007. In addition to SWVA and the Plan, they named as defendants various providers of medical services for Ms. Fischer.<sup>2</sup>

As to SWVA and the Plan, plaintiffs alleged that they were entitled to relief under 29 U.S.C. § 1132(a)(1)(B) (Section 502(a)(1)(B) of ERISA), which authorizes ERISA plan participants and beneficiaries to bring a cause of action to recover benefits allegedly due under the terms of their plan.<sup>3</sup>

In October 2008, defendants moved for summary judgment on the ground that plaintiffs' claims against them were time-barred under the Plan's 90-day limitations period.

Plaintiffs opposed the motion, arguing that (1) a question of fact existed as to whether the Plan was subject to West Virginia law providing that insurance policies

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<sup>2</sup> Eventually, plaintiffs settled with the medical providers and they were dismissed as defendants.

<sup>3</sup> Complaint at ¶ 37. Federal district courts and state courts of competent jurisdiction have concurrent jurisdiction of ERISA claims arising under § 502(a)(1)(B) of ERISA. See 29 U.S.C. § 1132(e)(1).

issued in West Virginia may not specify a limitations period of less than two years and (2) defendants' application of the Plan's limitations period was legally flawed.<sup>4</sup>

On the question of applicable law, the "fact" that was in dispute, according to plaintiffs, was whether the Plan is "self-funded." The term "self-funded" has legal significance when used to describe an employee benefit plan governed by ERISA.

An ERISA group health plan is either "self-funded" or "fully insured." Under an exception to the general rule of federal preemption, fully insured ERISA plans may be subject to state laws that regulate insurance. Self-funded plans, however, are exempt from the provision in ERISA's preemption section that allows the states to regulate insurance and insurance contracts. 29 U.S.C. § 1144(b)(2); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

Whether the Plan is self-funded or fully insured is relevant for purposes of determining the applicable limitations period. Under West Virginia law, insurance policies issued or delivered in West Virginia may not "limit[] the time within which an action may be brought [against the insurer] to a period of less than two years from the time the cause of action accrues."<sup>5</sup> Under federal law, on the other hand, ERISA plans are free to establish and enforce contractual limitations periods.

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<sup>4</sup> Plaintiffs' Response in Opposition to Defendants SWVA Employee Health Care Plan and SWVA, Inc's Motion for Summary Judgment.

<sup>5</sup> W. Va. Code § 33-6-14.

*Gayle v. United Parcel Service, Inc.*, 401 F.3d 222, 228 (4<sup>th</sup> Cir. 2005) (noting that ERISA plans “can craft their governing principles as they think best”).<sup>6</sup>

If the Plan is fully insured, West Virginia law would override the Plan’s limitations period.<sup>7</sup> If the Plan is self-funded, however, the Plan’s contractual limitations period for challenging denial of a claim for benefits in court (90 days) applies.

An ERISA plan is self-funded for this purpose if the plan itself, or the employer (as opposed to an insurance carrier), is responsible for payment of benefits to the plan’s participants and beneficiaries. Typically, the plan or the employer will secure stop-loss insurance coverage, pursuant to which the insurer reimburses the plan or the employer amounts paid out in benefits under the plan above an “attachment” point. As long as such a policy reimburses the *employer* or the *plan*, and the insurance carrier *does not make benefit payments directly to plan participants*, the plan is self-funded for purposes of ERISA preemption. See, e.g., *Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206, 213-14 (3<sup>d</sup> Cir. 2001) (“the purchase of stop-loss insurance does not make a

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<sup>6</sup> Such “governing principles” can include reasonable contractual limitations periods, and, as *Gayle* itself makes clear, those limitations periods are enforceable, even when enforcement produces a harsh result. See 401 F.3d at 229-30 (dismissing plaintiffs’ claim for benefits *with prejudice* where she failed to meet the plan’s deadline for appeal); see also *White v. Sun Life Assurance Co. of Canada*, 488 F.3d 240, 250 (4<sup>th</sup> Cir. 2007); *Northlake Regional Med. Center v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301, 1303 (11<sup>th</sup> Cir. 1998) (an ERISA plan “is nothing more than a contract, in which the parties . . . are free to include whatever limitations they desire”); *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7<sup>th</sup> Cir. 1997).

<sup>7</sup> This is a much abbreviated summary of an extremely complicated legal issue. The decision below (pp.7-8) explains how ERISA’s preemption provisions work in this context.

self-funded plan an insurance carrier under ERISA's 'savings clause'); *accord American Medical Security, Inc. v. Bartlett*, 111 F.3d 358, 361 (4<sup>th</sup> Cir. 1997); *Lincoln Mutual Casualty Co. v. Lectron Products, Inc., Employee Health Benefit Plan*, 970 F.2d 206, 210 (6<sup>th</sup> Cir. 1992); *Thompson v. Talquin Building Products Co.*, 928 F.2d 649, 652-53 (4<sup>th</sup> Cir. 1991).

In this case, SWVA had a stop-loss policy in place which provided for reimbursement from the insurer to SWVA for benefits paid in excess of a specified deductible.<sup>8</sup>

In opposing defendants' October 2008 motion for summary judgment, plaintiffs contended, "Discovery is required in order to verify the Plan's status," that is, whether or not the Plan is self-funded.<sup>9</sup>

Plaintiffs' second line of attack below, based on the Plan's application of the 90-day limitations period, was purely a legal argument having no evidentiary component. In the court below, plaintiffs argued that under the Plan's application of the 90-day limitations period, the 90 days started to run on their cause of action challenging denial of the benefit claims *before* that cause of action had accrued.<sup>10</sup> That result was impermissible, according to the plaintiffs, under the Fourth

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<sup>8</sup> See Defendants' Supplemental Memorandum in Support of Renewed Motion for Summary Judgment, Exhibit A.

<sup>9</sup> Plaintiffs' Response in Opposition to Defendants SWVA Employee Health Care Plan and SWVA, Inc's Motion for Summary Judgment at 5.

<sup>10</sup> Plaintiffs' Response in Opposition to Defendants SWVA Employee Health Care Plan and SWVA, Inc's Motion for Summary Judgment at 7-8. As explained below, plaintiffs' argument on this point is based on a fundamental mischaracterization of the record.

Circuit's decision in *White v. Sun Life Assurance Co. of Canada*, 488 F.3d 204 (4<sup>th</sup> Cir. 2007).

In December 2008, the Circuit Court (Judge Cummings) denied defendants' motion for summary judgment "at this time for being pre-mature." The court further stated that the motion "may be filed again at the close of discovery." Judge Cummings retired from the bench as of December 31, 2008, and The Honorable F. Jane Husted was elected to the vacant seat.

Thereafter, defendants voluntarily provided additional information to the plaintiffs, including copies of the stop-loss insurance contract, which information put to rest the "fact issue" identified in plaintiffs' response to defendants' October 2008 motion for summary judgment – whether the Plan was "self-funded" for purposes of ERISA preemption. Plaintiffs then served discovery requests that did *not* seek information that was probative of the timeliness/self-funded status issue.<sup>11</sup>

Defendants filed a renewed motion for summary judgment on May 28, 2009, again arguing that the action was time-barred under the Plan's limitations period and that the limitations period had been properly applied.<sup>12</sup>

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<sup>11</sup> Instead of inquiring into the Plan's status for purposes of preemption, Plaintiffs' discovery requests sought wide-ranging information about the individuals who had been involved in the denial of the Fischers' claims for benefits under the Plan, their job titles and compensation, as well as information relating to the decision-making process. As such, plaintiffs' discovery requests plainly were directed at the merits of the denial of the claims for benefits and *not* at the "limitation period issue." *Cf.* Appellants' Brief at 5.

<sup>12</sup> Defendants did not argue, as plaintiffs contended in their petition for appeal, that "Fischer had not submitted his daughter's medical expenses for payment within the time established by the Plan." Petition for Appeal at 5.

In response, plaintiffs insisted that they needed to engage in discovery, filing both a Rule 56(f) affidavit and a motion to compel. But they *still* did not identify what they needed to discover about the only possible disputed fact that was relevant to defendants' timeliness argument – whether the Plan was self-funded. Defendants opposed plaintiffs' efforts to engage in discovery by focusing the court on irrelevance of the discovery requests to the question of the Plan's self-funded status.

On July 20, 2009, Judge Husted held a hearing on defendants' summary judgment motion and on plaintiffs' motion to compel.

At that time, the Circuit Court rejected plaintiffs' argument that the decision in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), authorized discovery in ERISA benefits cases.<sup>13</sup> The Circuit Court also pressed plaintiffs' counsel for an explanation of the facts on which he based his apparent belief that the Plan might not be self-funded.<sup>14</sup> When plaintiffs insisted that they needed to depose the Plan's named fiduciary, the Circuit Court allowed that deposition to go forward and directed that it was to be strictly limited to *the self-funded status of the Plan*,<sup>15</sup>

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<sup>13</sup> Transcript of Hearing on Defendants' Motion for Summary Judgment, Plaintiffs' Motion to Compel ("Tr.") at 15 ("Glenn . . . didn't even address discovery"). Defendants invite the members of this Court to read *Glenn* for themselves to verify that, contrary to plaintiffs' contention, *Glenn* did *not* hold that an ERISA plan administrator's conflict of interest is "a proper subject for discovery in an action arising under ERISA." Appellants' Br. at 6.

<sup>14</sup> Tr. at 7 ("[W]hat leads you to believe that it is not self-funded? . . . What can you give me as a good faith basis to show that there is anything to show that they are not a self-funded plan?").

<sup>15</sup> Specifically, Judge Husted said, "I want to give you the opportunity . . . to do this deposition for the limited purpose only of inquiring whether, or not, it is a self-funded plan." Tr. at 18.

which, again, was the only factual issue material to defendants' renewed motion for summary judgment on timeliness grounds.<sup>16</sup>

The Plan's named fiduciary was deposed on August 3, 2009, and nothing was discovered that cast doubt upon the Plan's self-funded status. The parties then submitted supplemental briefs in support of and in opposition to defendants' renewed motion for summary judgment.

On December 30, 2009, the Circuit Court executed an order granting defendants' motion for summary judgment. The court held that, because the stop-loss policy provided reimbursement to SWVA, rather than benefits to the Plan's participants, the Plan was self-funded for purposes of ERISA preemption analysis. "The Court concludes that the terms of the stop-loss policy . . . establish that the policy provides for reimbursement of SWVA; SWVA remains liable to the Plan's participants and beneficiaries at all times."<sup>17</sup>

For that reason, federal law, and not West Virginia insurance regulations, governed the statute of limitations applicable to the plaintiffs' cause of action.<sup>18</sup> Under the federal law, "ERISA plans are free to establish contractual limitations

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<sup>16</sup> Nowhere in the hearing transcript is there even a hint of the notion that, as plaintiffs' state in their brief, "the court doubted whether it had jurisdiction to adjudicate Fischer's claims at all." Brief of Appellants at 12. Nor was the jurisdiction of the Circuit Court ever questioned in any of the parties' briefing. Plaintiffs' misguided attempt to inject jurisdictional issues into this matter based on a reference in the court's courtesy letter of October 2, 2009 should not distract this Court from the real issues in this case.

<sup>17</sup> Decision Below at 9.

<sup>18</sup> *Id.* at 7.

periods, which are enforceable so long as they are reasonable.”<sup>19</sup> The court held that “[t]he Plan’s 90-day limitations period is reasonable as a matter of law.”<sup>20</sup> Indeed, plaintiffs had never contended otherwise.<sup>21</sup>

The Circuit Court then addressed the plaintiffs’ argument that the Plan’s application of the Plan’s limitations period was legally flawed. But the court did *not*, as plaintiffs’ assert, reject the argument that “the Plan cannot cause the limitations period to begin before the claim has accrued.”<sup>22</sup> That argument does not help the plaintiffs for the simple reason that in this case the Plan did *not* cause the limitations period to begin before the plaintiffs’ cause of action had accrued. Rather, consistently with the authority upon which plaintiffs’ relied, *White v. Sun Life Assurance of Canada*, 488 F.3d 240 (4<sup>th</sup> Cir. 2007), plaintiffs’ cause of action accrued, and the limitations period began to run, when the Plan’s decision denying Ms. Fischer’s claims for benefits became final on February 27, 2007.<sup>23</sup>

Thereafter, plaintiffs filed a motion to alter or amend the judgment under Rule 59(e), but after defendants served plaintiffs with a notice of impending Rule 11 motion, plaintiffs withdrew their Rule 59(e) motion before the hearing date, and the December 30, 2009 order, which was entered on January 6, 2010, stands as the judgment of the court below.

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<sup>19</sup> *Id.* at 10.

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> Brief of Appellants at 1.

<sup>23</sup> See Decision Below at 12.

### III. STATEMENT OF FACTS

The timeliness of plaintiffs' lawsuit is the dispositive issue in this case, and the facts relevant to that issue are (1) the Plan's decision denying plaintiffs' claims for benefits became final on February 27, 2007 and (2) plaintiffs did not file this action until December 17, 2007, well after the Plan's 90-day limitations period has expired. A summary the facts relating to the Plan's processing of plaintiffs' benefit claims, however, is helpful to an accurate understanding of the overall picture of this case.

Plaintiffs alleged that defendants wrongfully denied certain claims for benefits under the Plan. The Plan is an "employee welfare benefit plan" for purposes of ERISA. It is a "plan . . . maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital . . . benefits. 29 U.S.C. § 1002(1). Mr. Fischer is a "participant" under the Plan by virtue of his employment; Ms. Fischer, at the relevant time, was a "beneficiary," generally eligible for benefits under the Plan as Danny Fischer's dependent. 29 U.S.C. § 1002(7), (8).

On January 26, 2006, Ms. Fischer was injured in a motor vehicle accident. The cause of the accident was that the driver of the car in which Ms. Fischer was a passenger lost control of his vehicle.<sup>24</sup> The medical providers that treated Ms. Fischer for her injuries submitted claims for benefits under the Plan on her behalf.

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<sup>24</sup> SWVA0215.

The Plan limits benefits payable for expenses incurred in connection with injuries sustained as a result a third-party's negligence. Generally, the Plan prohibits payment for "expenses incurred for injuries received in, or as the result of, an accident for which a third party may be liable."<sup>25</sup>

Where the Plan Administrator determines there is a reasonable opportunity for the injured party (and thus the Plan) to obtain a reasonable recovery from the culpable third party, however, the Plan can enter into a reimbursement agreement with the injured party and pay benefits up to the amount of the anticipated recovery.<sup>26</sup>

Upon receiving notice of the claims for Ms. Fischer's accident-related expenses, the Plan Administrator undertook to determine whether there was a reasonable opportunity for the Plan to secure a recovery from the driver of the vehicle.

In September 2006, following denial of the claims by the Plan Administrator due to plaintiffs' failure to furnish specifically requested information about the accident, plaintiffs' attorney asked for reconsideration of the denial and submitted supporting documentation.<sup>27</sup>

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<sup>25</sup> SWVA0068.

<sup>26</sup> SWVA0069; SWVA0228 (final denial letter).

<sup>27</sup> SWVA0205-06.

On November 29, 2006, the “named fiduciary” designated by the Plan for claims adjudication upheld the denial based on the absence of evidence that a reasonable recovery for the Plan would be possible.<sup>28</sup>

With that decision denying plaintiffs’ appeal, ordinarily the Plan’s 90-day limitation period for bringing a lawsuit to challenge the denial would have begun to run. The Plan expressly states, “No legal action concerning the denial of benefits under this Plan may be commenced or maintained against the Plan or the Employer more than ninety (90) days after your receipt of notice of a decision on review of your appeal . . . .”<sup>29</sup>

Under the Plan’s terms, the limitations period for seeking judicial review of the denial of benefits would have expired on *February 27, 2007*. The Plan Administrator, however, determined to toll the limitations period for the purpose of allowing the Fischers to submit additional information.<sup>30</sup>

The Plan’s named fiduciary set the February 27, 2007 date as the deadline for the submission of additional supporting evidence and gave notice that, “*[i]f by that date the Plan has not received any such evidence, then the Plan’s denial of Mr. Fischer’s appeal will hereby and automatically become final without further action of the Plan.*”<sup>31</sup>

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<sup>28</sup> SWVA0227-30.

<sup>29</sup> SWVA0063.

<sup>30</sup> SWVA0229-30.

<sup>31</sup> SWVA0230.

The Plan's 90-day limitations period would then begin to run on February 27, 2007, meaning that plaintiffs had until **May 28, 2007** to file their lawsuit.

In December 2006, plaintiffs, by counsel, requested copies of relevant documents, which were provided.<sup>32</sup> In January 2007, in response to a letter from counsel for one of Ms. Fischer's medical providers, Plan counsel again stressed the need for prompt submission of additional information.<sup>33</sup>

Nothing more happened until August 29, 2007, when plaintiffs' new counsel, Mr. Mehalic, sent a letter to the Plan's attorney.<sup>34</sup> Mr. Mehalic implicitly acknowledged the possibility that the 90-day limitations period had expired, but attempted to revive the claim:

Under the circumstances, the deadline imposed by the Plan must be extended so as to allow for the conditions to be fulfilled, which are, by Plan definition, imposed on establishing claim eligibility, *i.e.*, investigation of third party liability. Otherwise the claim limitations period would begin to run before the claim accrues.<sup>35</sup>

Thereafter, counsel for the Plan and for plaintiffs exchanged additional correspondence regarding plaintiffs' claims, which correspondence is not material to the issues presented here. What is important is that this action was not filed until

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<sup>32</sup> SWVA0232-33.

<sup>33</sup> SWVA0420-22.

<sup>34</sup> SWVA0437-38.

<sup>35</sup> SWVA0438. Counsel's argument missed the point. No "investigation" was needed to determine whether a third party was liable for causing the accident. No one questioned the fact that the driver of the vehicle was liable for the accident as it was a single-car accident in which Ms. Fischer was a passenger and police reports showed that the driver simply lost control of his vehicle. SWVA0207-17.

December 17, 2007, nearly seven months after the Plan's 90-day limitations period had expired.

#### IV. DISCUSSION OF LAW

##### A. Standard of Review

Plaintiffs' brief addresses two issues: (1) did the Circuit Court err in ruling, as a matter of law, that plaintiffs' suit was time-barred and (2) did the Circuit Court err in "refusing" to permit discovery regarding the application of SWVA's limitations period to Fischer's claim (which discovery was not identified in plaintiffs' Rule 56(f) motion)?

First, with respect to the Circuit Court's award of summary judgment, the standard of review is *de novo*. Syl. pt. 1, *Painter v. Peavy*, 192 W. Va. 189, 451 S.E.2d 755 (1994) ("A circuit court's entry of summary judgment is reviewed *de novo*"). Because plaintiffs are simply wrong in their assertion that SWVA applied the Plan's limitations period in such a way that the period [began] to run before Fischer's cause of action accrue[d], Brief of Appellants at 9, the Circuit Court correctly awarded summary judgment to defendants.

Second, with respect to the Circuit Court's ruling on plaintiffs' Rule 56(f) affidavit, the standard of review is abuse of discretion." *Drake v. Snider*, 216 W. Va. 574, 577, 608 S.E.2d 191, 194 (2004) ("As to the circuit court's denial of Ms. Drake's Rule 56(f) motion for discovery, '[a] trial court's decision not to allow further discovery under Rule 56(f) is reviewed on appeal for an abuse of discretion.' Franklin D. Cleckley, et al., LITIGATION HANDBOOK ON WEST VIRGINIA RULES OF

CIVIL PROCEDURE, § 56(f), at 104 (Supp. 2004) (citing *United States v. Kitsap Physicians Serv.*, 314 F.3d 995 (9th Cir. 2002)).” Here, as the Circuit Court allowed ample discovery, including deposition of the Plan’s named fiduciary, on the only factual issue identified by plaintiffs in response to defendants’ motion for summary judgment, the Circuit Court did not abuse its discretion in declining to allow additional discovery.

Consequently, the Circuit Court properly awarded summary judgment to the defendants.

**B. The Trial Court Did Not Err, as a Matter of Law, by Ruling that Plaintiffs’ Suit Was Barred by the Applicable Period of Limitations Where it Was Undisputed That Plaintiffs Did Not File Suit Until More Than 90-Days from the Date of the Plan’s Decision Denying Plaintiffs’ Claims Became Final**

Initially, it is important to understand what plaintiffs are *not* challenging. As explained above, the parties’ battleground in the proceedings below was over the Plan’s self-funded status.

Plaintiffs conceded from the outset that if the Plan was self-funded, then ERISA preempted West Virginia’s insurance law restricting insurance policies’ limitations period.<sup>36</sup> They further conceded that, under ERISA, plan-prescribed limitations periods are enforceable if they are reasonable,<sup>37</sup> and they never contended that *this* Plan’s imitations period was *not* reasonable.

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<sup>36</sup> See Plaintiffs’ Response in Opposition to Defendants SWVA Employee Health Care Plan and SWVA, Inc’s Motion for Summary Judgment at 5.

<sup>37</sup> *Id.* at 7.

In their appeal, plaintiffs have abandoned their attempt to argue that the Plan is not self-funded. It follows that the following points are not contested:

- ERISA preempts state law regulating the allowable limitations periods in insurance policies.
- The Plan's limitations period is enforceable if it is reasonable.
- The Plan's limitations period is reasonable.<sup>38</sup>

What is left of plaintiffs' arguments with respect to the timeliness issue is that the Plan's *reasonable* limitations period was not properly applied.

**1. The Plan's Limitations Period Did Not Begin to Run before Ms. Fischer's Cause of Action Accrued**

Plaintiffs' argument with respect to application of the Plan's limitations period is based on the Fourth Circuit's decision in *White*. An understanding of that argument requires a brief discussion of ERISA's legal principles.

Causes of action for benefits under an ERISA plan, like plaintiffs' claim against these defendants, arise under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). It is well settled that such actions may not be commenced until the claimant has exhausted his remedies under the Plan's internal claims review procedures. *White*, 488 F.3d at 247 (citing cases).

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<sup>38</sup> Of course, any claim that the Plan's 90-day limitations period is unreasonable would be without merit as this Court has affirmed denial of relief where a party failed to comply with such period. *See Ashby v. City of Fairmont*, 216 W. Va. 527, 532, 607 S.E.2d 856, 861 (2004) ("The Legislature has set the appeal time frame of ninety days, and, insofar as the statutory language is plain and mandatory, we must apply the statute as written. Applying the clear and unambiguous language of the statute, the petition for appeal to the circuit court was untimely filed because it was filed more than ninety days after the Commission's decision was entered in its order book. Therefore, we affirm the circuit court's ruling dismissing Mr. Ashby's petition for appeal as untimely filed.").

The exhaustion requirement is derived from ERISA's mandate that all employee benefit plans must "provide internal dispute resolution procedures for participants whose claims for benefits have been denied." *Makar v. Health Care Corp.*, 872 F.2d 80, 83 (4<sup>th</sup> Cir. 1989) (citing 29 U.S.C. § 1133). As contemplated by the statute, the Department of Labor has promulgated extensive regulations governing plan-based administrative procedures. See 29 C.F.R. § 2560.503-1. In general, whenever a claim for benefits is denied in whole or in part, the participant must be notified in writing of the denial and the reasons for the denial and given an opportunity to appeal the adverse decision to the appropriate plan decision-maker.

This scheme reflects "the strong federal interest encouraging private resolution of ERISA disputes." *Makar*, 872 F.2d at 82 (citing *Kross v. Western Elec. Co.*, 701 F.2d 1238, 143-45 (7<sup>th</sup> Cir. 1983)). Courts help promote that "strong federal interest" by requiring benefit plan claimants to pursue and exhaust their remedies under their plan's claims procedures as a prerequisite to bringing a legal action under 29 U.S.C. § 1132(a)(1)(B) seeking to "recover benefits due . . . under the terms of his plan." The general rule, then, is ERISA plan participants and beneficiaries may not bring a cause of action for plan benefits until the plan's administrative procedures have produced a final decision on the claim by the plan's administrator.<sup>39</sup>

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<sup>39</sup> The Plan provides, "Before you file a civil action under Section 502(a) of ERISA in federal court, you must have filed a claim with American Benefit Corporation and appeal of the initial claim with the V.P. Administration as described herein, and the claim for benefits and subsequent appeal must have been denied in whole or in part." SWVA0068.

In *White*, the court held that in light of the exhaustion requirement a claimant's claim for benefits does not "accrue" for purposes of triggering the limitations period until the plan's administrator has issued its final decision. 488 F.3d at 246. "This means," the court continued, "that the statute of limitations begins to run at the moment when the plaintiff may seek judicial review, because ERISA plaintiffs must generally exhaust administrative remedies before seeking judicial relief." *Id.*

*White* involved Sun Life's application of the plan's provision specifying that "[n]o legal action may start . . . more than 3 years after the time Proof of Claim is required," which the court referred to as the plan's "accrual rule." *Id.* at 242. The date on which proof of claim on White's claim was required is not clear from the decision, but her application for benefits was dated May 5, 2000. *Id.* at 244. Sun Life's final decision denying the claim was dated March 28, 2001. The lawsuit was filed on March 26, 2004, *within 3 years of denial of White's claim.* *Id.* at 245.

Hence the problem – the lawsuit was timely if the Plan's accrual rule was overridden by the legal principle that a cause of action for ERISA plan benefits does not accrue until the Plan issues a final decision. Under that principle, White's cause of action under § 502(a)(1)(B) of ERISA accrued on March 28, 2001, the date of the Sun Life's final decision. The action was not timely, however, if (as argued by Sun Life) the three-year limitations period began to run when "proof of claim was required," in or about May 2000.

The Fourth Circuit rejected Sun Life's argument. The court reasoned that if the limitations period began to run when proof of the claim was required, the period could expire before the claimant was able to bring an action on the claim – that is, before the claimant had exhausted the Plan's internal claims review procedures. White's cause of action under ERISA arguably would have been extinguished before she was entitled to bring the action in court. *Id.* at 247-48.

Finding that result untenable, the court applied the federal common law accrual rule, holding that the cause of action accrued *only upon exhaustion of the Plan's claims review procedures*. Because that was when White's cause of action accrued, that was also when the applicable limitations period began to run. Because White's lawsuit was filed within three years of Sun Life's *final decision denying her claim*, the plaintiff was not time-barred from seeking judicial review of the denial.

The circumstances of this case are the opposite of *White*. In this case, plaintiffs' cause of action for judicial review was *not* deemed to have accrued when claims for benefits were submitted under the Plan in the first instance. That happened at the time of Ms. Fischer's treatment for injuries sustained in the January 2006 accident.<sup>40</sup> Rather, consistent with the federal common law accrual rule as applied in *White*, the 90-day limitations period ran from *the date of the Plan's decision denying plaintiffs' claims became final*.

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<sup>40</sup> Under the Plan, beneficiaries are directed to "file a claim . . . when you receive . . . services . . . ." SWVA0062. With respect to claims arising from accidents, the Plan provides, "Written notice of a claim must be submitted within thirty (30) days after the occurrence . . . ." *Id.*

The Plan's decision denying the claims was issued on November 29, 2006 and became final 90 days later (February 27, 2007) when the plaintiffs failed to provide any additional information despite the Plan's invitation in the November 29, 2006 letter to do so. The Plan's 90-day limitations period began to run on February 27, 2007 and expired on May 28, 2007. But plaintiffs waited until December 17, 2007 to file suit.

Moreover, unlike the plaintiff in *White*, these plaintiffs had "fair notice" that their cause of action for judicial review had accrued. See 488 F.3d at 250. The November 29, 2006, denial letter stated: "With this denial of [her] appeal, Ms. Fischer has exhausted her administrative remedies under the Plan's claims review procedures. Accordingly, ***Ms. Fischer has the right to bring a lawsuit against the Plan challenging the denial.***"<sup>41</sup> The plaintiffs had until May 28, 2007 (November 29, 2006 plus 180 days) to file a lawsuit and were so advised in the final denial letter.

Thus, plaintiffs' argument that their cause of action could not accrue until litigation brought by the Fischers against the tortfeasors is resolved,<sup>42</sup> is flatly contradicted by the very authority on which plaintiffs rely – *White v. Sun Life*.

If plaintiffs disagreed with the reasons underlying the Plan's decision to deny the claims, which were fully explained in the denial letter, their recourse was to file a lawsuit on or before May 28, 2007. Having failed to do so, the merits of their

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<sup>41</sup> SWVA0229 (emphasis supplied).

<sup>42</sup> Brief of Appellants at 10.

possible suit are irrelevant, and they simply forfeited their right to judicial review under the Plan and under ERISA.

## **2. Failure to Timely Challenge a Decision Bars Consideration of the Merits**

This Court has consistently held that the failure to timely challenge a decision in accordance with the applicable time frames bars consideration of the merits of a case.

In *State ex rel. Maple Creative LLC v. Tinch*, 226 W. Va. 118, 697 S.E.2d 154 (2010), the unsuccessful bidder on a lucrative state contract for advertising services failed to file a timely protest of award of the contract to another bidder. Although it acknowledged that the unsuccessful bidder's claims might be meritorious, this Court nevertheless denied a petition for writ of mandamus seeking reconsideration of the award of the contract, stating as follows:

[W]e conclude that the petitioner's protest of the award of the contract at issue was untimely in that it was filed later than five working days after the award. Because of the untimeliness of the protest, the respondent had the option, pursuant to 148 C.S.R. § 1-8.1.1, to reject the protest. As a result, the petitioner does not have a clear legal right to the relief which it sought, and the respondent does not have a legal duty to do the thing which the petitioner seeks to compel.

226 W. Va. 122, 697 S.E.2d at 154.

Similarly, in *Moten v. Stump*, 220 W. Va. 652, 656, 648 S.E.2d 639, 643 (2007), this Court dismissed an appeal as improvidently awarded where a driver failed to file a timely appeal from an order affirming revocation of his license, stating as follows:

The circuit court's order of December 15 was a final and appealable order. See Syl. pt. 3, in part, *James M.B.*, 193 W. Va. 289, 456 S.E.2d

16 (“A case is final only when it terminates the litigation between the parties on the merits of the case and leaves nothing to be done but to enforce by execution what has been determined.”). As such, Mr. Moten had four months within which to file an appeal of that order. Mr. Moten did not file an appeal of the December 15 order. Instead, on April 14, 2005, he filed a motion styled “Motion for Relief from Judgment and/or in the Alternative Motion for Reconsideration.” In the body of the motion it was alleged that the motion was filed pursuant to Rule 60(b) of the West Virginia Rules of Civil Procedure. It has been recognized that “[a] motion made pursuant to Rule 60(b) does not toll the running of the appeal period.” Franklin D. Cleckley, Robin J. Davis, & Louis J. Palmer, Jr., LITIGATION HANDBOOK ON WEST VIRGINIA RULES OF CIVIL PROCEDURE § 60(b), at 1330 (2d ed. 2006). Consequently, the Rule 60(b) motion did not toll the appeal period for the December 15 order. Therefore, ***as a result of Mr. Moten's failure to appeal the December 15 order, the substantive matters decided by that order cannot be addressed by this Court in this appeal.***

(Emphasis supplied.) *See also Mary R. v. Billy D.*, 219 W. Va. 520, 523, 637 S.E.2d 618, 621 (2006) (“With respect to Billy D.'s contention that he is entitled to reimbursement for child support he paid while Serena was in his custody, for medical expenses he incurred for Serena from 1999 to 2001, and for his psychological evaluation, we find his appeal of these issues to be untimely. The record shows that these issues were the subject of an order entered by the family court on May 21, 2003, which was affirmed upon the appeal of Mary R. by the circuit court on June 19, 2003. Billy D. filed an appeal of the May 21, 2003, order with the circuit court on June 30, 2003, which was denied as untimely on July 22, 2003. Those orders are now final and unappealable, and therefore, these issues cannot be raised again in this appeal.”)

Likewise, in this case, under federal law once the Plan's decision denying Ms. Fischers' claims became final, she had 90 days to file suit and, once that period

expired, neither the Circuit Court nor this Court can reexamine the substantive matters decided. Rather, the only issues are whether the Plan's decision was final, which is undisputed, and whether suit was filed in 90 days, which is also undisputed. Consequently, the Circuit Court's award of summary judgment finding that the suit was not timely filed should be affirmed.

**C. The Trial Court Did Not Abuse Its Discretion by Entering Summary Judgment Where Plaintiffs' Rule 56(f) Affidavit Identified No Discovery Related to the Dispositive Issue of Expiration of the Limitations Period**

Plaintiffs' second assignment of error is that "the court erred in refusing to permit discovery regarding the application of SWVA's limitations period to Fischer's claim."<sup>43</sup> According to the plaintiffs, "genuine issues of material fact exist regarding the Plan's application of its limitations period to Fischer's claim."<sup>44</sup> Tellingly, however, plaintiffs do not identify a single issue of material fact "regarding the application of SWVA's limitations period to Fischer's claim" that is supposedly in dispute. Nor did they do so below. There was no error in this regard.

"A trial court does not abuse its discretion in denying Rule 56(f) discovery when the discovery requested would be irrelevant to the underlying issue to be decided." F. Cleckley, R. Davis & L. Palmer, *LITIGATION HANDBOOK ON WEST VIRGINIA RULES OF CIVIL PROCEDURE* 3D § 56(f)[2] (2008) (footnote omitted) [hereinafter *CLECKLEY*]. The "underlying issue to be decided" for purposes of resolving defendants' renewed motion for summary judgment was whether

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<sup>43</sup> Brief of Appellants at 8.

<sup>44</sup> *Id.* at 12.

plaintiffs' lawsuit was time-barred. The underlying issue was not, as plaintiffs imply, whether the Plan Administrator's decision denying the claims for benefits was an abuse of discretion.

In connection with their renewed motion for summary judgment, defendants pointed out that the stop-loss insurance policy provided for reimbursement to SWVA for amounts that had previously been paid to Plan participants (or their providers) from SWVA's general assets in the form of benefits. For that reason, the Plan is self-funded for purposes of ERISA preemption. For that reason, federal law, and not West Virginia's insurance regulations, controlled the applicable limitations period. Under federal law, the Plan's 90-day limitations period is enforceable, and under a proper application of that limitations period plaintiffs' lawsuit was time-barred.

Plaintiffs opposed the motion and filed a Rule 56(f) affidavit, which stated, among other things, that "the plaintiffs are unable to present facts sufficient to justify their opposition to the defendants' motion because the defendants refuse to conduct discovery." Plaintiffs further contended, "Accordingly, the plaintiffs have not had a sufficient opportunity for discovery in this action and cannot adequately oppose the defendants' renewed summary judgment motion."<sup>45</sup>

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<sup>45</sup> Plaintiffs' Response in Opposition to Defendants' Renewed Motion for Summary Judgment, Exhibit I.

At the hearing on defendants' motion, plaintiffs focused on the fact issue "that this plan is self-funded versus whether this is an insurance policy."<sup>46</sup> The following exchange between the Court and plaintiffs' counsel ensued:

THE COURT: Have you not received all the documents from them concerning the plan, itself?

MR. MEHALIC: I have received certain documents from them, and some affidavits.

THE COURT: What do you have to dispute that it is not self-funded?

MR. MEHALIC: Well, the Plaintiffs have been unable to engage in any discovery. I don't believe, Your Honor, that the Plaintiffs are required to accept simply what the Defendants offer them and tell them, "This is it. We believe this is dispositive of the issue, and we expect you to agree."

THE COURT: But, I mean, based on your perusal of the documents, is there anything in them that leads you to believe that they are not self-funded, that this is not just stop-loss coverage they have?"

MR. MEHALIC: Not without further inquiry. The Plaintiffs aren't prepared to accept that.

THE COURT: What inquiry do you anticipate that would change your view?

MR. MEHALIC: The depositions of the affiants: Mr. Gue, Mr. Childers, Ms. Sites.

THE COURT: Well, if Mr. Gue has already filed an affidavit – and they all three have filed the affidavits stating that they are – and you've compared that with the plan's wording, what leads you to believe that it is not self-funded? I mean, other than a fishing expedition to get them deposed? What can you give me as a good faith basis to show that there is anything to show that they are not a self-funded plan?

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<sup>46</sup> Tr. at 6.

MR. MEHALIC: It would not be a fishing expedition, Your Honor. The Plaintiffs' position that they ought not to be limited in asking about how the plan is administered –

THE COURT: You're not answering my question. Can you give me any facts?

MR. MEHALIC: Well, the Court is asking me to give facts on something that I haven't been able to conduct any discovery on, other than what I've set forth in the motion about the self-funded versus insurance status. There are ambiguities in the policy, the plan document.

THE COURT: Such as?

MR. MEHALIC: Such as, it refers to itself as an insurance policy. It refers to plan beneficiaries as insureds.

THE COURT: Well, isn't it true that many of these plans borrow insurance language? I mean, what else are they supposed to call themselves other than just the plan?

MR. MEHALIC: Well, the plan. I mean, Your Honor, to be clear, they're insurance policies or they're not. They are not a hybrid. The fact that there may be in their conception, or in their design, they borrow some concepts from insurance law or from trust law. It's a self-funded plan under purposes of ERISA, or it isn't. The plan says it is primarily self-funded. It doesn't say that it's exclusively self-funded.

These are ambiguities, Your Honor, in the plan language. They weren't created by the Plaintiffs. This is the way the plan is written. The Defendants write the plan, have control over what language is in it. The plaintiffs' position is that that language creates an ambiguity that they're entitled to inquire into.

THE COURT: You're on real thin ice on that one. I mean, I don't see anything in that plan that it goes to anything other than the fact that it's self-funded and that they purchased stop-loss insurance. .

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<sup>47</sup> Tr. at 6-9.

The court was not persuaded by plaintiffs' argument, but prevailed upon the defendants to allow plaintiffs to take the deposition of Larry Gue, who plaintiffs believed to be the Plan's "named fiduciary."<sup>48</sup>

Upon clarification that Mr. Gue was not the plan's named fiduciary (and was not the named fiduciary at the time of the denial of plaintiffs' claims for benefits) it was agreed that plaintiffs could depose John O'Connor, who was the Plan's named fiduciary, on the issue of the Plan's self-funded status.<sup>49</sup>

THE COURT: Mr. Mehalic, if I granted you the opportunity to take the deposition of Mr. O'Connor, would you agree to limit it to the issue of whether, or not, this plan is self-funded?

MR. MEHALIC: Mr. O'Connor, or Mr. Gue?

THE COURT: Mr. O'Connor now, since he's the present one. I mean, I don't think it's changed, has it, since the time that Mr. Gue – so, it would be the same answers, regardless. I mean, if you're inquiring into the plan itself, I mean, it's black and white.

MR. MEHALIC: Right.

THE COURT: It either is, or it isn't. So, would that satisfy you?

MR. MEHALIC: Yes. To that issue, yes.<sup>50</sup>

Mr. O'Connor was duly deposed on August 4, 2009.

To allow a trial court to make a reasoned decision on whether to defer ruling on a pending summary judgment motion, it has been noted, the opposing party

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<sup>48</sup> A ERISA plan's "named fiduciary" has "authority to control and manage the operation and administrative of the plan." ERISA § 402(a)(1), 29 U.S.C. § 1102(a)(1).

<sup>49</sup> Tr. at 11-14.

<sup>50</sup> Tr. at 14.

needs to “articulate some plausible basis for the party’s belief that *specified* ‘discoverable’ material facts *likely exist* which have not yet become accessible to the party.” CLECKLEY § 56(f)[2] (emphasis supplied and footnote omitted). Plaintiffs did not do that before the Circuit Court, either in counsel’s Rule 56(f) affidavit or when pressed at the hearing.

Nevertheless, the court allowed discovery to go forward on the issue that Plaintiffs contended, without explanation, was in dispute – the self-funded status of the Plan.

Before this Court, plaintiffs switch gears and contend, *for the first time*, that “genuine issues of material fact exist regarding the Plan’s application of its limitations period to Fischer’s claim.”<sup>51</sup> Plaintiffs have waived that contention by failing to assert it below. *See, e.g., Zaleski v. West Virginia Mut. Ins. Co.*, 224 W. Va. 544, 550, 687 S.E.2d 123, 129 (2009); Syl. pt. 2, *State ex rel. Cooper v. Caperton*, 196 W. Va. 208, 470 S.E.2d 192 (1996) (“to preserve an issue for appellate review, a party must articulate it with such sufficient distinctiveness to alert a circuit court to the nature of the claimed effect”). The argument would fail even if it had been preserved, as even now the plaintiffs have failed to “articulate some plausible basis for [their] belief that specified ‘discoverable’ material facts likely exist,” much less that such material facts would “suffice to engender an issue both genuine and material.” CLECKLEY § 56(f)[2].

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<sup>51</sup> Brief of Appellants at 12.

## V. CONCLUSION

Plaintiffs' counsel was advised, in writing, that a final decision had been made on the application for benefits and that any suit needed to be filed within 90 days after that decision became final. For whatever reason, however, suit was not filed within the period prescribed by the Plan.

Plaintiffs then argued that the Plan was not self-funded and, even if self-funded, the Plan improperly interpreted and applied the provisions of the Plan.

After discovery revealed that the Plan is self-funded, plaintiffs abandoned that issue, leaving nothing but the argument that the Plan improperly interpreted and applied the provisions of the Plan. As explained above, that argument lacks merit.

Finally, there is no legitimate dispute regarding the premature award of summary judgment where plaintiffs' Rule 56(f) affidavit did not satisfy the requirements of state law.

WHEREFORE, appellees, SWVA, Inc., and SWVA, Inc. Employee Health Care Plan, respectfully request that the judgment of the Circuit Court of Cabell County be affirmed.

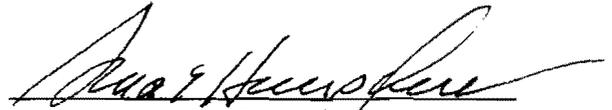


Ancil G. Ramey  
WV Bar No. 3013  
Sara E. Hauptfuehrer  
WV Bar No. 8931  
Steptoe & Johnson PLLC  
P.O. Box 1588  
Charleston, WV 25326-1588  
Telephone 304.933.8195  
*Counsel for Appellees*

**CERTIFICATE OF SERVICE**

I certify that on February 21, 2011, I served the foregoing BRIEF FOR THE APPELLEES by Federal Express addressed to their counsel as follows:

Jeffrey V. Mehalic  
P.O. Box 11133  
Charleston, WV 25339-1133  
Counsel for Appellants



Sara E. Hauptfuehrer  
WV Bar No. 8931