CASE No. 15-2340

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

JOSEPH Di BIASE, JOHN PRODORUTTI, DAVID BRASS, RON BEEGLE, DAVID BOBCOCK and CARL VAN LOON as individuals, on behalf of themselves and all persons similarly situated, and INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW,

Plaintiffs-Appellants,

v.

SPX CORPORATION,

Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF NORTH CAROLINA, CHARLOTTE DIVISION

Case No. 3:14-cv-656-RJC-DSC

OPENING BRIEF OF APPELLANTS

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Counsel for Appellants

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
DISCLOSURE OF CORPORATE AFFILIATIONS AND OTHER INTERESTS

Disclosures must be filed on behalf of all parties to a civil, agency, bankruptcy or mandamus case, except that a disclosure statement is **not** required from the United States, from an indigent party, or from a state or local government in a pro se case. In mandamus cases arising from a civil or bankruptcy action, all parties to the action in the district court are considered parties to the mandamus case.

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No. 15-2340 Caption: Joseph Di Biase, et al. v. SPX Corporation

Pursuant to FRAP 26.1 and Local Rule 26.1,

Ron Beegle
(name of party/amicus)

who is APPELLANT, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

2. Does party/amicus have any parent corporations? ☐ YES ☑ NO
If yes, identify all parent corporations, including all generations of parent corporations:

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation (Local Rule 26.1(b))? ☐YES ☑NO
If yes, identify entity and nature of interest:

5. Is party a trade association? (amici curiae do not complete this question) ☐ YES ☑NO
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:

6. Does this case arise out of a bankruptcy proceeding? ☐ YES ☑NO
If yes, identify any trustee and the members of any creditors' committee:

Signature: s/ Narendra K. Ghosh Date: 11/12/2015

Counsel for: Appellants

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I certify that on November 12, 2015 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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Pursuant to FRAP 26.1 and Local Rule 26.1,

David Bobcock
(name of party/amicus)

who is APPELLANT, makes the following disclosure:
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No. 15-2340 Caption: Joseph Di Biase, et al. v. SPX Corporation

Pursuant to FRAP 26.1 and Local Rule 26.1,

David Brass
(name of party/amicus)

who is APPELLANT, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

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No. 15-2340 Caption: Joseph Di Biase, et al. v. SPX Corporation

Pursuant to FRAP 26.1 and Local Rule 26.1,

Joseph Di Biase
(name of party/amicus)

who is APPELLANT, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

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Counsel for: Appellants

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Pursuant to FRAP 26.1 and Local Rule 26.1,

John Prodorutti
(name of party/amicus)

who is APPELLANT, makes the following disclosure:
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Counsel for: Appellants

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Pursuant to FRAP 26.1 and Local Rule 26.1,

International Union, United Automobile, Aeropsace and Agricultural Implement Workers of
(name of party/amicus)

America, UAW

who is APPELLANT, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

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Counsel for: Appellants

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Pursuant to FRAP 26.1 and Local Rule 26.1,

Carl Van Loon
(name of party/amicus)

who is APPELLANT, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

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Counsel for: Appellants

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s/ Narendra K. Ghosh (signature) 11/12/2015 (date)

Table of Contents

Page

Table of Authorities

Page(s)

Cases:

Statutes:

Other Authorities:

Statement of Jurisdiction

On November 25, 2014, the individual plaintiffs, on behalf of themselves and others similarly situated, and plaintiff International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW ("UAW"), brought claims against defendant SPX Corporation ("SPX") pursuant to Section 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185, and Section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1132(a)(1)(B). (JA 11-23). Plaintiffs alleged that, effective January 1, 2015, SPX would breach court-approved settlement agreements that provided retirees with lifetime health insurance coverage. (JA 19-22). The District Court had jurisdiction over the claims pursuant to 28 U.S.C. § 1331, 29 U.S.C. § 185, and 29 U.S.C. §1132(e).

On December 15, 2014, plaintiffs filed a motion for preliminary injunction, seeking to bar SPX from replacing the health insurance coverage it had been providing to retirees. (JA 239-42). On September 29, 2015, the District Court denied plaintiffs' motion. (JA 822-29). On October 27, 2015, plaintiffs timely filed a notice of appeal from the District Court's order denying the motion for a preliminary injunction. (JA 830-32). This Court, therefore, has jurisdiction over this appeal pursuant to 28 U.S.C. § 1292(a)(1).

Statement of the Issue

Did the District Court err in denying plaintiffs' motion for preliminary injunction?

Statement of the Case

I. SPX and Its Retirees Enter Into Settlement Agreements Obligating SPX to Provide Lifetime Health Insurance Coverage.

In 2001, individual retirees and UAW brought two suits against SPX alleging that it had violated provisions regarding retiree health insurance benefits in its collective bargaining agreements with UAW. One case, *Di Biase v. SPX Corp.*, No. 1:01-cv-624 (W.D. Mich.), concerned retirees, as well as their spouses and dependents, who worked at two Leeds & Northrup ("L&N") plants located near Philadelphia, Pennsylvania. (JA 470). The L&N plants had been owned by a predecessor to SPX and were closed in 1997. (JA 470). The other case, *Pedler v. SPX Corp.*, No. 1:01-cv-623 (W.D. Mich.), concerned retirees, as well as their spouses and dependents, who worked at SPX facilities in Muskegon, Michigan. (JA 470).

In 2003, the parties reached settlement agreements in both cases, which were approved by the court. (JA 24-170, 470).[1] The settlement agreement in *Di Biase*

[1] *Pedler v. SPX Corp.*, No. 1:01-cv-623, Amended Judgment, Dkt. No. 90 (W.D.

(the "L&N Settlement") and the settlement agreement in *Pedler* (the "Muskegon Settlement"; collectively the "Settlement Agreements") each obligated SPX to provide specific health insurance coverage to the retirees and their spouses or dependents (the "Settlement Class Members") "for the remainder of their lives." (JA 33-35, 114-16). In exchange, the retirees released any claims to health care benefits other than those specified in the Settlement Agreements. (JA 33, 114).

Each Settlement Agreement identified specific health insurance plans that SPX was obligated to provide to the Settlement Class Members, with detailed benefit levels of the plans specified in the agreements. (JA 33-35, 70-100, 114-16, 154-70). For example, Medicare-eligible class members in the L&N Settlement who resided in the Philadelphia area received health insurance coverage to supplement Medicare under the Keystone 65 Standard Medical Plan. (JA 33, 70-83). Those members in the South New Jersey area received the AmeriHealth 65 Plan. (JA 33). All other Medicare-eligible L&N Settlement members received the Hartford Senior Medical Insurance Plan. (JA 33-34, 87-88). For the Muskegon Settlement, all Medicare-eligible class members received the Hartford Senior Medical Insurance Plan to supplement Medicare. (JA 115-16, 159-60). And all

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Mich. Jan. 30, 2004); *Di Biase v. SPX Corp.*, No. 1:01-cv-624, Amended Judgment, Dkt. No. 85 (W.D. Mich. Jan. 29, 2004).

Medicare-eligible class members under both Settlement Agreements also received the SPX Prescription Drug Plan. (JA 35, 89-97, 116).

Because the Settlement Agreements extended far into the future and particular carriers may stop providing certain plans or even cease to exist, the agreements contemplated that SPX would not be required to use a particular carrier or a specific plan in perpetuity. Rather, in specifying the health insurance benefits for Medicare-eligible class members, the Settlement Agreements obligated SPX to "provide coverage under" a particular group health insurance plan "or its substantial equivalent." (JA 33-35, 114-16). The Settlement Agreements then defined providing coverage under a "substantial equivalent":

> Notwithstanding any other provision hereof, any obligation on the part of SPX to provide coverage under a specified plan or its substantial equivalent shall be deemed to require only that SPX provide coverage which is substantially equivalent in benefits and it shall not be deemed to obligate SPX to provide such coverage through an HMO, to maintain or replicate coverage in a particular network, to provide benefits through a structure under which the patient designates a primary care physician or otherwise to regulate or affect the manner in which SPX makes such substantially equivalent benefits available.

(JA 38, 117).

Except to the extent SPX was obligated to provide coverage under a specified plan or its substantial equivalent, SPX retained the right to (a) "amend or modify the provisions of any plan;" (b) "change the plan administrator, carrier, [or]

trustee;" (c) "merge the plan with any other plan or split up or spin off any portion of any plan;" and (d) "make any change to any plan" required by law or for tax purposes. (JA 38-39, 117).

L&N Settlement Class Members were required to pay a "premium co-payment" for the provided health insurance plans, which was a specific percentage between 0% to 75% of the premium, depending on the member's retirement date and years of service. (JA 36-37). The L&N Settlement Agreement defined the amount of the "premium" in terms of the "cost of the benefits provided." (JA 36-37). In doing so, the Agreement contemplated only two possible scenarios: SPX provided benefits "under a plan which is not self-funded by SPX," such as the AmeriHealth 65 Plan, or it did so "under a plan which is self-funded by SPX," such as the SPX Prescription Drug Plan. (JA 36-37.)

Under the Muskegon Settlement Agreement, only members who had formerly participated in the "Beneflex Plan" were required to pay a premium co-payment. (JA 117-18). Those members had to pay 50% of the "costs of benefits provided." (JA 117-18). As with the other agreement, the Muskegon Agreement contemplated only two possible scenarios in defining the "cost of the benefits provided": SPX provided benefits "under a plan which is not self-funded by SPX" or it did so "under a plan which is self-funded by SPX." (JA 115.)

SPX was obligated to provide health insurance benefits to each Settlement Class Member until the member ceased to be a class member, or until the member failed to pay the applicable premium co-payment. (JA 36, 116). SPX was required to provide notice to the member before terminating benefits. (JA 36, 116). This was the only provision in the Settlement Agreements permitting the termination of benefits. (JA 36, 116).

As permitted by the Settlement Agreements, SPX had over the years discontinued certain health insurance plans it provided to class members and replaced the plans with substantially equivalent group insurance plans. Effective January 1, 2007, SPX created self-funded medical and prescription drug plans that replaced the pre-65 Blue Care Network HMO plans for Muskegon Settlement Class Members. (JA 301, 473-74). SPX represented that the change provided "substantially equivalent coverage" to class members. (JA 301). Effective January 1, 2009, SPX discontinued use of the Keystone and AmeriHealth Plans for L&N Settlement Class Members and moved all of those members to the Aetna Medical Plan PFFS. (JA 303-15, 474). SPX represented that the change provided a "substantially equivalent medical plan" to class members. (JA 303). Effective January 1, 2011, SPX discontinued use of the Aetna Medical Plan PFFS for L&N Settlement Class Members and moved all of those members to the Aetna Medical

Plan PPO. (JA 317-18, 474). SPX represented that the change provided a "substantially equivalent medical plan" to class members. (JA 317).

II. In 2015, SPX Provides Benefits Through Health Reimbursement Accounts Instead of Health Insurance Plans.

In 2014, SPX adopted a "new approach" for the Medicare-eligible L&N and Muskegon Settlement Class Members to take effect January 1, 2015. (JA 702). Effective that date, SPX cancelled all of the group health insurance plans providing coverage to the Medicare-eligible class members. (JA 479-80, 703).[2] In the place of those plans, SPX created a health reimbursement account ("HRA") for each class member. (JA 702). An HRA is a notional account from which individuals can obtain reimbursement for health-related expenditures, including premiums for health insurance plans, Medicare advantage plans, or prescription drug plans, or for certain other medical expenses.[3] (JA 214-38, 702-04).

Under its new approach, SPX promised to (1) reimburse each year a maximum amount between $2000 and $5000 per member through the member's

[2] As of January 2015, there were 550 Medicare-eligible individuals receiving benefits under the L&N Settlement and 354 Medicare-eligible individuals receiving benefits under the Muskegon Settlement. (JA 472).

[3] Reimbursement from the HRA is not permitted for the costs of prescription drugs themselves until the retiree has expended several thousand dollars in a given year. (JA 702-04).

HRA; (2) permit reimbursement to each member for the amount of their Medicare Part B premiums; (3) provide "catastrophic drug coverage" through a separate HRA if a member incurred very significant prescription drug expenses; and (4) credit each Muskegon class member who had been enrolled in a dental plan an additional $500 per year. (JA 176-81, 198-203, 477-78, 702-04). The amount available for reimbursement through the primary HRA depends on the amount of the member's premium co-payment under the Settlement Agreements. (JA 178, 200). The annual amount made available through the HRA does not increase over time; it is fixed for the life of the class member. (JA 178, 200).

Each member is then required to select and purchase various insurance plans for himself and his spouse to replace the insurance coverage that SPX had been providing until 2015. (JA 177, 199, 704). Members have to choose from among several different categories of health insurance plans and numerous specific plans within each category. (JA 177, 199, 703-04).

To facilitate this process, SPX directed members to use "OneExchange." (JA 702-04). Members could purchase insurance plans from various insurers through OneExchange. (JA 702-04). Members were themselves required to pay premiums for the selected insurance plans and make other required payments, such as co-pays and co-insurance amounts, and then seek reimbursement for those costs

from their HRA through OneExchange by submitting the appropriate paperwork. (JA 179-80, 200-01, 219-20, 702-04). If the reimbursement is approved, SPX then funds the HRA to cover the approved reimbursement payment. (JA 219-20). If the combined costs of premiums and medical expenses exceeded the amount available through their HRA, members would either have to pay out-of-pocket or forego medical care. (JA 246).

SPX's new approach places significant new administrative burdens on the Medicare-eligible Settlement Class members, all of whom are elderly. It is very difficult to complete the insurance selection, purchase, and reimbursement process for members who have problems with their hearing or vision. (JA 252, 255). It is similarly difficult to complete these tasks for members with memory problems. (JA 247, 259). As a result, members are left very unsure about whether their insurance selection was a good choice. (JA 252, 255). They also worry that SPX's new approach will result in significantly higher out-of-pocket costs, which they may not be able to afford. (JA 255, 266, 269-70).

As of December 22, 2014, only 72% of Medicare-eligible Settlement Class members had signed up for insurance plans through OneExchange. (JA 481). Apparently, 28% of the Medicare-eligible members had failed to replace the insurance coverage that SPX ceased providing on December 31, 2014.

III. Plaintiffs Challenge SPX's Use of Health Reimbursement Accounts.

On November 25, 2014, the individual retiree plaintiffs, on behalf of themselves and others similarly situated, and UAW brought claims against SPX pursuant to LMRA Section 301 and ERISA Section 502(a)(1)(B), alleging that SPX's cancellation of insurance plans for the Settlement Class members and implementation of its new approach violated the Settlement Agreements. (JA 11-23). On December 15, 2014, plaintiffs filed a motion for preliminary injunction, seeking to bar SPX from cancelling the health insurance plans it had been providing to Settlement Class members and from implementing its new approach. (JA 239-42).

On September 29, 2015, the District Court denied plaintiffs' motion for preliminary injunction. (JA 822-29). The court first concluded that plaintiffs' motion was moot because, by the time of the court's decision, SPX had already cancelled the group insurance plans for members and implemented its new HRA-based approach. (JA 826-27). The court found that the "status quo" was the status as of March 2014, in which SPX provided health benefits to members through group insurance plans, and that the status quo had already changed by the time plaintiffs' motion was ripe. (JA 827).

The court also concluded that plaintiffs had not demonstrated a likelihood of success on the merits because determining whether SPX's use of HRA's provided "substantially equivalent" benefits was a fact-intensive inquiry requiring an evidentiary record that would not be available until discovery. (JA 827-828). The court mentioned that SPX had raised various threshold questions concerning jurisdiction, standing, and class certification, but it did not base its ruling on those issues. (JA 827). The court also concluded that plaintiffs had failed to demonstrate the type of irreparable injury necessary to justify a preliminary injunction. (JA 828). Finally, the court summarily concluded that plaintiffs had failed to show that the balance of equities tips in their favor or that an injunction would be in the public interest. (JA 828-29).

Summary of Argument

The District Court abused its discretion in several respects in denying plaintiff's motion for a preliminary injunction. First, it erred as a matter of law in finding the motion moot because a preliminary injunction could properly have restored the status quo after January 1, 2015. Second, the court erred as a matter of law in evaluating the merits of plaintiffs' claims. As a simple matter of contract interpretation, SPX breached the Settlement Agreements because its HRA-based new approach does not provide insurance "coverage" as required by the

agreements. No additional evidentiary record is necessary to demonstrate SPX's breach. And the various threshold issues alluded to by the court do not undermine plaintiffs' success on the merits.

Third, in evaluating the injuries due to SPX's breach, the court abused its discretion by failing to consider the 28% of the Settlement Class who apparently did not replace the insurance that SPX had provided until 2015. Finally, in light of the harm to class members who did not replace the insurance from SPX, the court abused its discretion in failing to find that the balance of equities tips in plaintiffs' favor and that an injunction would be in the public interest.

Argument

Standard of Review

To obtain a preliminary injunction, plaintiffs must "demonstrate that (1) they are likely to succeed on the merits, (2) they are likely to suffer irreparable harm, (3) the balance of hardships tips in their favor, and (4) the injunction is in the public interest." *Pashby v. Delia*, 709 F.3d 307, 320 (4th Cir. 2013).

This Court reviews for abuse of discretion a district court's denial of a preliminary injunction. *Aggarao v. MOL Ship Mgmt. Co.*, 675 F.3d 355, 366 (4th Cir. 2012). In doing so, this Court reviews the district court's factual findings for clear error and reviews its legal conclusions *de novo*. *Pashby*, 709 at 319. "A

district court has abused its discretion if its decision is guided by erroneous legal principles or rests upon a clearly erroneous factual finding." *Morris v. Wachovia Sec., Inc.*, 448 F.3d 268, 277 (4th Cir. 2006) (citation and quotations omitted).

I. Plaintiffs' Preliminary Injunction Motion Was Not Mooted When SPX Implemented Its New Approach on January 1, 2015.

The District Court erred in concluding that plaintiffs' motion for preliminary injunction was moot. The court properly identified the status quo as the point in 2014 at which SPX was providing group health insurance plans to Settlement Class members. The court, however, failed to recognize that a preliminary injunction can act to restore the status quo even after defendants have disturbed it. Because a preliminary injunction can restore the status quo, plaintiffs' motion was not mooted by SPX's implementation of its new approach on January 1, 2015.

This Court has recognized that a preliminary injunction can restore, rather than merely preserve, the status quo. In *Aggarao v. MOL Ship Management Co.*, 675 F.3d 355 (4th Cir. 2012), a cargo ship employee was seriously injured, and after providing him medical care for a period, the employer-defendants ceased providing care. *Id.* at 362-63. As part of the employee's suit, he sought a preliminary injunction to order the defendants to resume providing him medical care. *Id.* at 364. Defendants argued that the injunction sought was improper

because it did not preserve the status quo. *Id.* at 378. This Court disagreed, holding that "'it is sometimes necessary to require a party who has recently disturbed the status quo to reverse its actions …, [but] such an injunction restores, rather than disturbs, the status quo ante.'" *Id.* at 378 (emphasis added) (quoting *O Centro Espirita Beneficiente Uniao Do Vegetal v. Ashcroft*, 389 F.3d 973, 1013 (10th Cir. 2004)). Therefore, the Court remanded the case so that the trial court could consider the request for a preliminary injunction. *Id.* at 378-79.

Similarly, in *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013), at issue was North Carolina's implementation of a new Medicaid policy for at-home care. *Id.* at 313. A change in policy that tightened eligibility requirements for at-home care was set to go into effect on June 1, 2011. *Id.* at 314. Plaintiffs filed suit and moved for a preliminary injunction on May 31, 2011, seeking to prohibit implementation of the stricter requirements. *Id.* at 315. The district court granted the injunction on December 8, 2011, halting application of the new policy at that point. *Id.*

This Court agreed that a preliminary injunction was appropriate. *Id.* at 319-31. In doing so, the Court held that because the plaintiffs had filed their preliminary injunction motion before the policy change took effect, the status quo was the status before the change. *Id.* at 320. The preliminary injunction, which

halted application of the policy change, thus preserved the status quo. *Id*. The Court rejected the defendant's argument to the contrary, which it characterized as contending "that the delays inherent in the judicial system somehow altered the status quo to the [plaintiffs'] detriment." *Id*.

Other courts have likewise concluded that preliminary injunctions can properly restore the status quo after it has been disturbed. *See Savoie v. Merchants Bank*, 84 F.3d 52, 58-59 (2d Cir. 1996) (upholding preliminary injunction that restored the status quo by ordering bank to escrow $500,000, and noting that logistical hurdles to restoring the status quo were "properly laid at the doorstep of the Bank, which acted precipitously, not the plaintiffs, who appropriately pursued their legal remedies"); *United Steelworkers of Am., AFL-CIO v. Textron, Inc.*, 836 F.2d 6, 10 (1st Cir. 1987) (upholding preliminary injunction that required defendant to resume paying insurance premium payments, in part because during the "last uncontested status," defendant had paid premiums) (Breyer, J.).

In this case, plaintiffs filed suit and filed their motion for preliminary injunction in 2014, before SPX had cancelled the group health insurance plans for Settlement Class members and implemented its new approach. SPX's implementation of its new approach on January 1, 2015, did not moot plaintiffs' motion. Rather, even after that date, the District Court could have entered a

preliminary injunction ordering SPX to restore the status quo, which was when SPX was providing group health insurance plans. *See Aggarao*, 675 F.3d at 378; *Pashby*, 709 F.3d at 320; *Savoie*, 84 F.3d at 59; *Textron, Inc.*, 836 F.2d at 10.

In its decision, the District Court cited *Railway Labor Executives Association v. Chesapeake West Railway*, 915 F.2d 116 (4th Cir. 1990), but its reliance on this case was misplaced. In that case, several unions sued a railway company that was selling its railroad lines to other companies without bargaining beforehand. *Id.* at 118. The unions sought a preliminary injunction to prohibit a particular sale to a third party, which the trial court denied. *Id.* By the time the appeal reached this Court, the sale had already occurred. *Id.* Because the particular act to be enjoined had already occurred, the court held that the appeal was moot. *Id.*

In this case, by contrast, plaintiffs do not seek to enjoin one particular act that cannot be undone. Plaintiff seek to enjoin SPX's ongoing failure to provide the group health insurances plans that had been provided to Settlement Class members until 2015. As in *Aggarao* and *Pashby*, a preliminary injunction could order SPX to restore the status quo and resume providing that insurance coverage. Such a restoration was not possible in *Chesapeake West Railway* because the Court could not have ordered the third-party buyer of the railroad line to return the asset

to the defendant. *See Seafarers Int'l Union v. National Marine Services, Inc.*, 820 F.2d 148 (5th Cir. 1987) (finding similar injunction of corporate sale moot because "no order of this court could affect the parties' rights with respect to the injunction we are called upon to review").[4]

Accordingly, because a preliminary injunction could have ordered SPX to restore the status quo, the District Court erred in concluding that plaintiffs' motion for preliminary injunction was mooted by SPX's implementation of its new approach on January 1, 2015.

II. Plaintiffs Are Likely to Succeed on the Merits Because SPX Breached the Plain Terms of the Settlement Agreements.

A. SPX's Use of HRA's Does Not Provide Insurance "Coverage" as Required by the Settlement Agreements.

The District Court erred as a matter of law in evaluating the merits of plaintiffs' claims. SPX breached the plain language of the Settlement Agreements because its HRA-based new approach does not provide insurance "coverage" as required by the agreements. No additional evidentiary record is necessary to demonstrate SPX's breach. Plaintiffs are thus likely to prevail on their claims.

[4] The District Court also relied on *Winston v. Federal Bureau of Prisons*, No. 5:10-HC-2192-FL, 2011 WL 3664416 (E.D.N.C. Aug. 18, 2011) (unpublished). This decision, involving a prisoner plaintiff acting *pro se*, cited *Chesapeake West Railway* without substantive discussion. *Id.* at *2. Its reliance on *Chesapeake West Railway* was misplaced for the same reason as in this case.

Plaintiffs' claims are based on ERISA Section 502(a)(1)(B) and LMRA Section 301. Under ERISA Section 502(a)(1)(B), a participant or beneficiary may sue to recover benefits due under the terms of a plan and to enforce his rights under the terms of the plan. 29 U.S.C. §1132(a)(1)(B); *see Pender v. Bank of Am. Corp.*, 788 F.3d 354, 361 (4th Cir. 2015). Section 502(a)(1)(B) is applicable here because the Settlement Agreements constitute "employee welfare benefit plans" under ERISA. *See* 29 U.S.C. § 1002(1); *Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410, 417 (4th Cir. 1993) (noting that ERISA "explicitly states that the establishment of a plan may be accomplished through the purchase of insurance").

"'ERISA plans are contractual documents which, while regulated, are governed by established principles of contract and trust law.'" *Johnson v. Am. United Life Ins. Co.*, 716 F.3d 813, 819 (4th Cir. 2013) (quoting *Haley v. Paul Revere Life Ins. Co.*, 77 F.3d 84, 88 (4th Cir. 1996)). In interpreting the terms of a plan, the "primary effort should be to ascertain the intent of the parties ... by giving language its ordinary meaning...." *Glocker v. W.R. Grace & Co.*, 974 F.2d 540, 544 (4th Cir. 1992). Moreover, "[c]ourts must look at the ERISA plan as a whole and determine the provision's meaning in the context of the entire agreement." *Johnson*, 716 F.3d at 819. Under LMRA Section 301, agreements are likewise interpreted "according to ordinary principles of contract law, at least when those

principles are not inconsistent with federal labor policy." *M & G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 933, 190 L. Ed. 2d 809 (2015).

In this case, the L&N and Muskegon Settlement Agreements require SPX to "provide" Settlement Class members with "coverage under" a specific group health insurance plan "or its substantial equivalent." (JA 33-35, 114-16). SPX is required to provide such coverage to the class members "for the remainder of their lives." (JA 33, 114). The Settlement Agreements defined providing coverage under a "substantial equivalent" as follows:

> Notwithstanding any other provision hereof, any obligation on the part of SPX to provide coverage under a specified plan or its substantial equivalent shall be deemed to require only that SPX provide coverage which is substantially equivalent in benefits and it shall not be deemed to obligate SPX to provide such coverage through an HMO, to maintain or replicate coverage in a particular network, to provide benefits through a structure under which the patient designates a primary care physician or otherwise to regulate or affect the manner in which SPX makes such substantially equivalent benefits available.

(JA 38, 117) (emphasis added). As the Settlement Agreements explicitly obligate SPX to "provide coverage which is substantially equivalent in benefits," they necessarily require SPX to provide "coverage." Under its new approach, SPX makes available a sum of money through an HRA for each member, which the member can use for reimbursement of certain expenses. This is not providing "coverage" as required by the Settlement Agreements.

In *Aid Association for Lutherans v. U.S. Postal Service*, 321 F.3d 1166 (D.C. Cir. 2003), the D.C. Circuit Court of Appeals analyzed the term "coverage" as a matter of statutory interpretation. *Id.* at 1176. The court relied on several dictionary definitions of "coverage," such as "protection by [an] insurance policy: inclusion within the scope of a protective or beneficial plan" (Webster's Third New International Dictionary of the English Language Unabridged 525 (1993)); "the extent of protection afforded by an insurance policy" (American Heritage Dictionary 334 (2d Coll. ed.1982)); and "inclusion of a risk under an insurance policy; the risks within the scope of an insurance policy" (Black's Law Dictionary 372 (7th ed. 1999)). *Id.* The court concluded that, "[o]rdinarily, in the context of insurance policies, the word 'coverage' . . . usually refers to the inclusion or exclusion of specific risks under an insurance policy." *Id.*; *see also Schleuter v. N. Plains Ins. Co.*, 772 N.W.2d 879, 886-87 (N.D. 2009) (collecting cases supporting this definition of "coverage").

As this analysis makes clear, "coverage" means the inclusion of certain risks under an insurance plan. Therefore, by requiring SPX to provide "coverage," the Settlement Agreements require SPX to provide an insurance plan covering certain medical expenses.

This plain language interpretation is also supported by the other provisions of the agreements. While requiring SPX to provide coverage under a specified plan or its substantial equivalent, the Agreements specified that SPX retained the right to (a) "amend or modify the provisions of any plan;" (b) "change the plan administrator, carrier, [or] trustee;" (c) "merge the plan with any other plan or split up or spin off any portion of any plan;" and (d) "make any change to any plan" required by law or for tax purposes. (JA 38-39, 117) (emphasis added). All of these reservations are phrased in terms of a "plan," making clear that SPX is obligated to provide an insurance plan to class members.

The L&N Settlement Agreement defined the amount of the "premium co-payment" in terms of the "cost of the benefits provided." (JA 36-37). In doing so, the Agreement contemplated only two possible scenarios: SPX provided benefits "under a plan which is not self-funded by SPX" or it did so "under a plan which is self-funded by SPX." (JA 36-37.) Similarly, the Muskegon Settlement Agreement contemplated only two possible scenarios in defining the "cost of the benefits provided": SPX provided benefits "under a plan which is not self-funded by SPX" or it did so "under a plan which is self-funded by SPX." (JA 115, 117-18.) Thus, the agreements specifically contemplated that SPX would provide class members with an insurance plan, either self-funded or not by SPX.

Before 2014, SPX acted in accord with this plain understanding of the Settlement Agreements. Although it changed the insurance coverage provided to class members three times from 2007 to 2011, it always provided group health insurance plans that were either self-funded or not by SPX. Each time it made a change, SPX emphasized to class members that the new plan would provide "substantially equivalent coverage" or a "substantially equivalent medical plan." (JA 301, 303, 317). Thus, the parties' history of implementing the Settlement Agreements also demonstrates that the agreements require SPX to provide coverage through an insurance plan to class members.

Under its new approach effective January 1, 2015, SPX ceased providing health insurance plans to the Settlement Class members. Instead, it merely makes available a certain amount of money through an HRA for each member, leaving it to the member to select and purchase some other insurance plan or pay for medical expenses, and then seek reimbursement. If the amount of money proves insufficient, the member has to pay out-of-pocket or forego medical care. In other words, the ultimate risk of loss is borne by the member instead of by SPX or SPX's insurance plan. Because it is no longer providing insurance to cover that ultimate risk, SPX is no longer providing "coverage" as required by the Settlement Agreements. *See Aid Association*, 321 F.3d at 1176.

In another case where a company replaced retiree health insurance plans with HRA's, the Sixth Circuit Court of Appeals reached the same conclusion: "HRAs are not company-provided group insurance; they are health care vouchers—essentially cash." [5] *United Steelworkers of Am., AFL-CIO ("USW") v. Kelsey-Hayes Co.*, 750 F.3d 546, 555 (6th Cir. 2014), *reh'g granted, opinion vacated on other grounds, and remanding*, 795 F.3d 525 (6th Cir. 2015); *see also USW v. Kelsey-Hayes Co.*, No. 4:11-cv-15497, 2016 WL 337467, at *7 (E.D. Mich. Jan. 28, 2016) (reaffirming on remand the granting of summary judgment to plaintiffs on basis that HRA's did not meet contractual obligation to provide retirees health insurance).[6] As is the case here, the court noted, "HRAs shift significant risks, including the potential costs of medical care, from the company to plaintiffs." *Id.* The court thus concluded that the use of HRA's breached the company's contractual obligation to provide specific "healthcare coverages" to its retirees. *Id.* at 554-55.

[5] HRA's are in fact not as useful as cash because they can only be used for certain expenses and require members to go through a burdensome reimbursement process. (JA 179-80, 200-01, 214-38).

[6] The district court in *Kelsey-Hayes* had previously concluded that the "HRA funding structure—substituting reimbursement for insurance, replacing comprehensive coverages with capped HRA credit and imposing administration on the retirees in lieu of company administration of the Insurance Program—constitutes a CBA breach." *USW v. Kelsey-Hayes Co.*, 943 F. Supp. 2d 747, 757 (E.D. Mich. 2013), *aff'd*, 750 F.3d 546 (6th Cir. 2014).

An analogous situation was addressed in *Bontrager v. Indiana Family & Soc. Servs. Admin.*, 829 F. Supp. 2d 688 (N.D. Ind. 2011) *aff'd*, 697 F.3d 604 (7th Cir. 2012), where Indiana provided $1000 as the maximum payment for dental services under the state's Medicaid plan. *Id.* at 698. At issue was whether this constituted "coverage" of required dental services. *Id.* The state contended that it would "'cover' medically necessary dental services by paying the first $1,000 dollars of them and then leaving all remaining costs to the Medicaid recipient." *Id.* at 699. As the court explained, the "State's $1,000 cap on dental services takes this commonsense definition of insurance coverage and turns it on its head." *Id.* "This is a bizarro-world notion of insurance coverage: once the insurance provider (the State) meets the initial deductible ($1,000), the insured is left covering all the remaining costs." *Id.* The court concluded: "Under any commonsense notion, this is not insurance 'coverage.'" *Id.*

In this case, SPX is similarly making available to Settlement Class members a sum of money for reimbursement and then leaving them with the risk of covering all remaining costs. Under the ordinary meaning of the term, and in light of the surrounding provisions in the Settlement Agreements and the past practices of the parties, SPX's new approach does not provide insurance "coverage." *See Aid Association*, 321 F.3d at 1176; *Kelsey-Hayes Co.*, 750 F.3d at 554-55. SPX's new

approach thus breaches its obligations under the Settlement Agreements. Therefore, plaintiffs will succeed on their claims under ERISA Section 502(a)(1)(B) and LMRA Section 301.

B. No Threshold Issues Undermine Plaintiffs' Likelihood of Success on the Merits.

Before the District Court, SPX raised several issues related to jurisdiction, standing, and class certification. The District Court alluded to these issues, but did not base its decision on them. (JA 827). These issues have no effect on plaintiffs' likelihood of success on the merits.

First, SPX questioned whether plaintiffs' claims can be brought under Section 301 of the LMRA. This question is beside the point at this stage. Plaintiffs' claims under ERISA are equivalent to those under the LMRA as they are both essentially breach of contract claims. As discussed above, SPX's breach of the Settlement Agreements violates ERISA Section 502(a)(1)(B), which alone justifies a preliminary injunction. *See* Section II.A, *supra*.

Second, SPX questioned whether UAW is required to have the consent of the Settlement Class members to bring LMRA Section 301 claims in a representative capacity. This question is irrelevant for two reasons. Plaintiffs have valid claims under ERISA regardless of LMRA Section 301, and the individual

plaintiffs can bring claims for breach of the Settlement Agreements regardless of UAW's capacity to do so.

Third, SPX questioned whether UAW has standing to bring claims under ERISA. This question is also irrelevant because, regardless of UAW's standing, the individual plaintiffs plainly have standing. *See* 29 U.S.C. §1132(a)(1)(B) (providing that "participants" and "beneficiaries" may bring claims).

Fourth, SPX questioned whether plaintiffs have a claim for equitable relief under ERISA Section 501(a)(3). This question is irrelevant because plaintiffs have meritorious claims under ERISA Section 502(a)(1)(B), which alone justifies a preliminary injunction. *See* Section II.A, *supra*; *see also Mattive v. Healthsource of Savannah, Inc.*, 893 F. Supp. 1559, 1573 (S.D. Ga. 1995) (granting preliminary injunction for claim brought under Section 502(a)(1)(B)); *Leonhardt v. Holden Bus. Forms Co.*, 828 F. Supp. 657, 672 (D. Minn. 1993) (same).

Finally, SPX questioned whether the class certification requirements of commonality and typicality would be met because it contended that the issue of "substantial equivalence" depends on each class member's particular circumstances. This question reflects SPX's mistaken view of the Settlement Agreements in this case.

As discussed above, SPX ceased providing "coverage which is substantially equivalent" to all class members because it replaced group health insurance plans with HRA's for all class members. *See* Section II.A, *supra*. SPX thus breached the Settlement Agreements for every class member, regardless of the member's particular circumstances. Given that plaintiffs' claims are based on this single, common question of interpretation of the class settlement agreements, class certification is plainly appropriate. *See Lienhart v. Dryvit Sys., Inc.*, 255 F.3d 138, 146 (4th Cir. 2001) (holding that commonality requires that there are dispositive questions of law or fact common to the class and that typicality requires that named class representatives possess the same interest and suffer the same injury as the class members).

III. The District Court Abused Its Discretion in Failing to Consider the Irreparable Harm to a Significant Portion of the Settlement Class.

In evaluating the injury due to SPX's breach of the Settlement Agreements, the District Court abused its discretion by failing to consider the 28% of the Settlement Class who apparently failed to replace the insurance that SPX had been providing until 2015. The loss of insurance for these retirees results in irreparable harm due to their inability to afford medical care, delay in obtaining medical care,

or need to forego other necessities to afford medical care, as well as their uncertainty and stress caused by the lack of insurance.

"Numerous courts have found that reductions in retiree insurance coverage constitute irreparable harm, meriting a preliminary injunction." *Golden v. Kelsey-Hayes Co.*, 845 F. Supp. 410, 415 (E.D. Mich. 1994), *aff'd*, 73 F.3d 648 (6th Cir. 1996) (citing *United Steelworkers of Am., AFL-CIO v. Textron, Inc.*, 836 F.2d 6, 8 (1st Cir. 1987); *Schalk v. Teledyne, Inc.*, 751 F. Supp. 1261, 1267-68 (W.D. Mich. 1990), *aff'd*, 948 F.2d 1290 (6th Cir. 1991); *Mamula v. Satralloy Inc.*, 578 F. Supp. 563, 577 (S.D. Ohio 1983)). In *Golden*, the court found irreparable harm because retirees "may be forced to forego needed medical care because they would have to absorb part of the cost of the care under defendant's modified benefits plan." *Golden*, 845 F. Supp. at 415.

In *Textron*, an opinion written by Justice Breyer while still on the First Circuit, the court found irreparable harm from the elimination of health insurance to retirees because it presumed that "some retired workers may find it difficult to obtain medical insurance on their own while others can pay for it only out of money that they need for other necessities of life." *Textron*, 836 F.2d at 8 (citing *United Steelworkers of Am., AFL-CIO v. Fort Pitt Steel Casting*, 598 F.2d 1273, 1280 (3d Cir. 1979) ("surely the possibility that a worker would be denied

adequate medical care as a result of having no insurance would constitute 'substantial and irreparable injury'")). The court concluded that "retired workers would likely suffer emotional distress, concern about potential financial disaster, and possibly deprivation of life's necessities (in order to keep up in insurance payments)," which constitutes irreparable harm. *Id.*; *see also Cole v. ArvinMeritor, Inc.*, 516 F. Supp. 2d 850, 876 (E.D. Mich. 2005) ("Alteration and elimination of retiree health benefits causes retirees and dependents health risk, uncertainty, anxiety, financial hardship, and other irreparable harm.").

In *Schalk*, the court found irreparable harm from the reduction in health insurance to Medicare-eligible retirees due to "the distinct possibility that retirees living on such limited means might choose to forego necessary medical treatment if they are required to pay co-pays and deductibles which are obviously well outside their means;" and, independently, from "the uncertainty posed by the lack of knowing just how much money will be needed to cover medical expenses under the current [plan]." *Schalk*, 751 F. Supp. at 1268.

In *Mamula*, the court, in similarly finding irreparable harm, held that the "ultimate effects of delay in obtaining medical attention or of not receiving any medical attention, or of purchasing inadequate coverage are all incapable of being easily measured," and thus "cannot be adequately compensated by some judgment

for damages awarded" in the future. *Mamula*, 578 F. Supp. at 577; *see also Welch v. Brown*, 551 F. App'x 804, 813 (6th Cir. 2014) (unpublished) ("While money damages would provide Plaintiffs with the resources to afford the increased deductibles and co-pays after the fact, this remedy fails to make Plaintiffs whole for the interim inability to access care.").

And in *LaForest v. Former Clean Air Holding Co.*, 376 F.3d 48 (2d Cir. 2004), the Second Circuit Court of Appeals affirmed a similar finding of irreparable harm even though plaintiffs merely suffered a reduction in benefits (or increased costs of maintaining benefit levels), ninety percent of the putative class was eligible to secure alternative coverage through Medicare, and every member of the class was given the opportunity to participate in an alternative prescription drug program. *Id.* at 56.

In this case, as of December 22, 2014, only 72% of Medicare-eligible Settlement Class members had signed up for insurance plans through SPX's OneExchange. (JA 481). Apparently, 28% of the Medicare-eligible members had failed to replace the insurance coverage that SPX ceased providing on December 31, 2014. Because SPX's HRA-based approach places all of the administrative burden on elderly class members instead of simply providing them insurance, it is

unsurprising that so many members failed to replace the SPX group health insurance plans that had been covering them.

As the foregoing cases demonstrate, these members are likely to forego needed medical care or prescription drugs due to cost, delay obtaining needed medical care, or forego other necessities in order to afford medical care. *See LaForest*, 376 F.3d at 56; *Textron*, 836 F.2d at 8; *Golden*, 845 F. Supp. at 415; *Schalk*, 751 F. Supp. at 1268; *Mamula*, 578 F. Supp. at 577. In addition, these members will have great uncertainty and distress caused by the lack of insurance, as also shown by plaintiffs' affidavits. *See Textron*, 836 F.2d at 8; *Schalk*, 751 F. Supp. at 1268; *Cole*, 516 F. Supp. 2d at 876; (JA 252, 255).

Even though the members may still be covered by Medicare, they face the risk of very significant medical expenses because of the gaps in Medicare. For example, without supplemental insurance to Medicare, individuals are required to pay 20% of the costs under Medicare Part B, which includes all surgeries, physician visits, and diagnostic tests. (JA 428-31); *see Rehab. Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444, 1446 (4th Cir. 1994) ("The service provider can charge the beneficiary for the remaining 20% of the reasonable charge."). Inevitably, some members will not be able to afford all of the medical care or prescription drugs they need because they lack the insurance SPX had been

providing. *See Textron*, 836 F.2d at 8; *Golden*, 845 F. Supp. at 415. Many members will experience significant distress and uncertainty due the possibility of unpayable medical costs. *See Textron*, 836 F.2d at 8; *Schalk*, 751 F. Supp. at 1268. This harm is irreparable; it cannot be remedied later by money damages. *See Schalk*, 751 F. Supp. at 1268; *Mamula*, 578 F. Supp. at 577.

The District Court concluded that plaintiffs had not demonstrated any irreparable harm, but the court never mentioned or discussed the class members who did not replace the SPX group health insurance plans in 2015. (JA 828). By failing to consider the evidence of irreparable harm to the 28% of the class without new insurance to replace SPX's insurance coverage, the District Court abused its discretion. *See G.G. v. Gloucester Cty. Sch. Bd.*, __ F.3d __, 2016 WL 1567467, at *10 (4th Cir. Apr. 19, 2016) (reversing denial of preliminary injunction where district court failed to consider proffered evidence regarding irreparable harm).

In light of the harm to class members who did not replace the insurance from SPX, the court also abused its discretion in failing to find that the balance of equities tips in plaintiffs' favor and that an injunction would be in the public interest. The equity in favor of a preliminary injunction is ensuring that all class members receive all necessary medical care. On the other side of the scale, all SPX can point to is the administrative inconvenience of reinstating the group

health insurance plans it had been providing. Clearly, the equities favor an injunction. *See Golden*, 845 F. Supp. at 416 (holding that the harm suffered by retirees outweighed the harm to the company in reinstating its insurance plans where there was no showing that reinstatement would cause severe financial hardship); *Savoie v. Merchants Bank*, 84 F.3d 52, 58-59 (2d Cir. 1996) (noting that logistical hurdles to restoring the status quo were "properly laid at the doorstep of the Bank, which acted precipitously, not the plaintiffs, who appropriately pursued their legal remedies").

In denying plaintiffs' motion, the District Court also relied on the supposed administrative burden to class members from reinstating the group health plans. (JA 828). The court, however, failed to consider that any such burden could be minimized by ordering the insurance transition to occur at the end of the calendar year. Under SPX's HRA-based approach, class members are required to purchase insurance policies on a year-to-year basis. (JA 176, 198, 702). There would be little, if any, burden on the class members to have their SPX health insurance plans reinstated at the start of the next calendar year.

Finally, because a preliminary injunction would ensure that all class members receive all necessary medical care, such an injunction is plainly in the public interest. *See Schalk*, 751 F. Supp. at 1268 (holding that the "public interest

lies in protecting the legitimate expectations of retirees that their health insurance will be provided for the rest of their lives," and that when an act is prohibited by ERISA, "the public interest is best served by preventing the prohibited act"); *Golden*, 845 F. Supp. at 416 (holding similarly).

Accordingly, because the District Court erred as a matter of law regarding mootness and the merits of plaintiffs' claims, and failed to fully consider the evidence of irreparable harm, the court abused its discretion in denying plaintiffs' motion for preliminary injunction. This Court should vacate the order denying plaintiffs' motion for preliminary injunction and remand for reconsideration in light of the correct legal principles.

Conclusion

For the foregoing reasons, Plaintiffs respectfully request that the Court vacate the District Court's order denying Plaintiff's Motion for Preliminary Injunction and remand for reconsideration.

Request for Oral Argument

Plaintiffs hereby request oral argument in this case. Oral argument is necessary because the issues here have not been authoritatively decided and oral argument will aid significantly in the decisional process.

Respectfully submitted, this the 9th day of May, 2016.

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Certificate of Compliance

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 7,610 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in fourteen-point Times New Roman font.

This the 9th day of May, 2016.

/s/ Narendra K. Ghosh
Narendra K. Ghosh

Certificate of Filing and Service

The undersigned hereby certifies that a copy of the foregoing Opening Brief of Appellants was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to David C. Wright, III, Cary B. Davis, and Amanda R. Pickens, Attorneys for Defendant-Appellant.

The undersigned further certifies that the required number of bound copies of the foregoing Opening Brief of Appellants was served via UPS Ground Transportation to the Clerk of this Court.

This the 9th day of May, 2016.

/s/ Narendra K. Ghosh
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