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Jerry Ford, Mark Russel, Robert P. Welch, Travis Kell, J. Mathew Zundel, David K. Eaton, John D. Ford, Robert Aamodt, D. Scott BUnnell v.
American Express Financial Advisors, Inc. : Reply Brief

Utah Supreme Court

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IN THE SUPREME COURT OF THE STATE OF UTAH

JERRY FORD, MARK RUSSELL,
ROBERT P. WELCH, TRAVIS KELL,
J. MATHEW ZUNDEL, DAVID K.
EATON, JOHN D. FORD, ROBERT
AAMODT, D. SCOTT BUNNELL,
individuals, and others similarly
situated,

Plaintiffs and Appellees,

vs.

AMERICAN EXPRESS FINANCIAL
ADVISORS, INC., a Minnesota
Corporation,
Defendant and Appellant.

Supreme Court No. 20020550-SC
District Court No. 000905126
Priority No.

APPELLANT'S REPLY BRIEF

On Appeal as a Matter of Right from the Judgment and Incorporated Orders Entered by
The Honorable Stephen L. Henriod, Third District Court, Salt Lake County

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SUMMARY OF ARGUMENTS

Plaintiffs made a choice. By electing franchisee status and the compensation package that went with it, the named Plaintiffs increased their annual income by more than \$50,000 each. Nevertheless, Plaintiffs claim that they are entitled to have their welfare benefits subsidized by the company. This claim must be rejected because Plaintiffs did not actually earn those benefits before the FPA terminated, because the BFA expressly removed their claim to such benefits, and because they were told, explicitly and repeatedly, that they would no longer receive those subsidies if they chose the new franchise relationship. Plaintiffs' answering brief does not justify the result they seek.

First, Plaintiffs fail to identify the source of their contract claim in the FPA. While Plaintiffs contend that the FPA contained a "promise" of contributions for reaching Star Quest, they do not identify a single provision in the contract making such a "promise." The document on which they rely says only that, upon reaching a Star Level, the planners became "eligible" to earn benefits payments in the following year. This did not create a vested benefit. In fact, Section III of the FPA expressly stated that benefits not earned prior to its termination would not survive. Summary judgment should have been granted to AEFA for failure to identify an explicit, unconditional promise of benefits after termination.

Second, judgment should have been entered for AEFA as a matter of law because the unambiguous language of the BFA eliminated Plaintiffs' claim. The BFA plainly states that its compensation package is the "complete" amount due for Plaintiffs' "relationship with AEFA," and declares that the BFA supersedes "all prior and

contemporaneous agreements.” Plaintiffs seek to exploit an exception in the BFA for benefits plans that are amended to “specifically refer to Independent Advisors in their role as Independent Advisors.” However, Plaintiffs then ignore this very elaborate language and rely on Star Quest documents that do not use that phrase at all. The BFA is a substitute contract that restructured the parties’ relationship and provided a new compensation scheme in place of the old.

At the very least, AEFA’s very reasonable interpretation of the BFA should have prevented summary judgment *for Plaintiffs*. At the trial level, AEFA expressly opposed Plaintiffs’ motion for summary judgment, disputing their facts and offering conflicting evidence. For example, when Plaintiffs argued that their purpose was not to enter into a substitute contract, AEFA presented conflicting testimony from the named Plaintiffs themselves. But even more important, AEFA argued that it is the objectively manifested intent of the parties that controls. Here, AEFA had distributed multiple bulletins making clear that benefits contributions would not be available under the BFA. Plaintiffs do not dispute the adequacy of these notices. At a minimum, AEFA should have had an opportunity to present this extensive evidence to a jury.

Finally, Plaintiffs fail to justify the exclusion at trial of \$9 million in offsetting benefits. Plaintiffs claim that offsets are required “only” if the damaged party is relieved of performance, but they cite no legal authority to support this proposition. They do not attempt to address the cases offered by AEFA, which apply the larger principle that the defendant is entitled to an offset whenever he can prove that the plaintiff received a benefit proximately caused by the breach.

ARGUMENT

I. PLAINTIFFS HAVE NOT IDENTIFIED THE “PROMISE” ON WHICH THEIR CLAIM RESTS AND FAIL TO SATISFY FPA SECTION III

Plaintiffs’ argument rests on an unsupported assumption. Plaintiffs assume that they are “entitled” to benefits contributions because AEFA “promised” its planners that “they would receive an enumerated benefit contribution if they met specified production goals.” Pl. Br. 2, 7; *see also id.* at 10, 34. However, Plaintiffs’ brief fails to substantiate this “entitlement.” Plaintiffs never identify a single provision in the FPA that made a “promise” of this kind—an unconditional guarantee of benefits contributions to planners who met those goals. There is good reason why.

The FPA provided only that Planners who met Star Quest’s production levels would be *eligible for*, not entitled to, contributions from AEFA. In fact, in the sole passage where Plaintiffs describe the Star Quest program, they quote this sentence as the source of their claim:

To remain *eligible* for a company contribution to group benefits, advisors must meet the minimum weighted production requirement in any given year.

Pl. Br. 3 (quoting R. 1450, Dep. Ex. 8, at AX001623 n.** [AD 24] (emphasis added)).

On its face, this language did not supply a promise of benefits, but a statement of eligibility. The FPA’s benefits handbook likewise explained unequivocally that meeting Star Quest’s production levels made a planner “*eligible* to receive a Company contribution toward the cost of . . . insurance coverage.” R. 1450, Dep. Ex. 6, at AX001233 (emphasis added). Even though AEFA’s opening brief (AEFA Br. 21-26) pointed out that Plaintiffs could not assume they had “earned” benefits contributions

when the contract simply declared them “eligible” for payments in the following year, Plaintiffs never even address—let alone refute—this crucial distinction. The distinction between eligibility and entitlement is important because a planner who had become eligible for Star Quest still had to earn the contributions by continuing to work under the FPA in the second year, as well as elect the applicable benefits plan. *See* AEFA Br. 8-9, 24-25.¹ There was no promise that the planner became entitled simply by reaching a sales target.

Based on their unsubstantiated assumption of a promise, Plaintiffs then contend that AEFA unlawfully “revoke[d]” its offer under Star Quest “after the plaintiffs had undertaken to perform.” Pl. Br. 11. But AEFA did not revoke its offer under Star Quest. AEFA promised the same thing under Star Quest in 1999 as it did in 1997 and 1998: that planners who met the year’s specified minimum TWP would be “eligible” to receive benefits payments by meeting the FPA’s various requirements and conditions in the following year. R. 1450, Dep. Ex. 8, at AX001623 n.** [AD 24]; *see also* R. 1450, Dep. Ex. 6, at AX001233. The terms of that offer did not change. Instead, the entire contract terminated in accordance with its provisions. Those provisions specifically allowed the

¹ This requirement that planners earn their contributions through their work in the next year is borne out by the parties’ consistent practice under the FPA. Plaintiffs testified that the company never made benefits payments once a planner left the company. *See* AEFA Br. 8-9. In fact, Plaintiffs admitted on summary judgment that “all benefits contributions” under the FPA ceased once a planner’s “FPA contract was terminated.” *Compare* R. 306-07, *with* R. 1452, at 11.

FPA to terminate “without cause with 15 days’ written notice.” R. 1450, Dep. Ex. 17, at AX001980 [AD 22].

In this respect, Plaintiffs’ claim resembles those of distance runners who are told that, with a good time in one event (*e.g.*, the Boston Marathon), they will be automatically eligible to compete in that event in the following year. If the event is not held the next year, the runner has no claim against the organizers. By the same token, the planners here, though eligible to earn Star Quest benefits under the FPA in the following year, had no claim when that contract terminated pursuant to its terms.

In fact, the contract here did not just provide for termination, it gave express warning that there would be no additional compensation after the contract ended. The FPA specifically voided all compensation that had not vested upon the contract’s termination. Section III of the FPA stated:

When this agreement terminates, you will not, except as provided by the Sales Compensation Plan, be entitled to . . . any further commissions, fees, overwriting or other compensation.

Id.; *see also* FPA § VI, *id.*, at AX001977 [A19]. By these terms, a planner’s claims to compensation not yet earned plainly expired when the FPA did. Because the benefits in dispute here had not been earned when the FPA ended on March 21, 2000, Plaintiffs have no claim to them.

The proviso of Section III, stating “except as provided in the Sales Compensation Plan,” does not help the planners. Plaintiffs have not been able to point to *any* language in the Sales Compensation Plan preserving their claim for Star Quest benefits after the

FPA's termination. The broad language of Section III expressly makes this their burden, and Plaintiffs' failure to carry that burden dooms their contract claim.²

Moreover, as explained in AEFA's opening brief (AEFA Br. 21-23), Minnesota law (like ERISA) requires a contract to contain "specific vesting language" for benefits to continue after its termination. *Hughes v. 3M Retiree Med. Plan*, 134 F. Supp. 2d 1062, 1071 (D. Minn. 2001), *aff'd*, 281 F.3d 786 (8th Cir. 2001); *see also, e.g., Chiles v. Ceridian Corp.*, 95 F.3d 1505, 1510 (10th Cir. 1996); AEFA Br. 21-23 & n.6. Plaintiffs now attempt to circumvent this line of cases with the cursory statement that "[n]one of the plaintiffs were terminated." Pl. Br. 15. This is immaterial. None of the cases cited by AEFA turned on whether the party seeking continued compensation remained affiliated with the company. They all focused on the contractual issue of whether the benefits being sought were supported by the written terms of their agreements. *Hughes*,

² Plaintiffs' position is made even more difficult by Section 9 of the Benefits Handbook, which stated that AEFA "makes no promise to continue these benefits in the future" and that "[r]ights to future benefits will never vest." R. 1450, Dep. Ex. 6, at AX001386 [AD 102] While Plaintiffs accuse (Pl. Br. 15) AEFA of "knowing misrepresentation" for relying on this language, it is Plaintiffs who fail to quote completely. The sentence on which they rely states: "*Except for the claims review procedure*, this section applies only to first year financial advisors, district managers within the State of New York, field vice presidents and group vice presidents" *Id* at AX001379 [AD 95] (emphasis added). Thus, Section 9, entitled "Claims review and ERISA information," has two principal substantive parts. (1) "*Plan administration*," which includes claims review procedures applicable to everyone; and (2) "*Your rights under ERISA*," which includes provisions applicable only to ERISA employees. The disclaimer AEFA cited appears in the first of these parts, along with other information for *all* participants. *See id.*; *cf.* R. 1453, at 9-10 (disputing Plaintiffs' interpretation). Nevertheless, at the very least, it warned even the most protected participants in the company's plans—those who could invoke the force of ERISA—that they had no vested right to future welfare benefits. Plaintiffs, who lacked such rights, could fare no better.

134 F. Supp. 2d at 1071 (“Vesting is determined by a review of the plan documents.”); *Knudsen v. Northwest Airlines, Inc.*, 450 N.W.2d 131, 133 (Minn. 1990) (contractual “terms and conditions” govern); *Sonneman v. Blue Cross & Blue Shield of Minnesota*, 403 N.W.2d 701, 706 (Minn. Ct. App. 1987) (construing contract according to its “clear[] and unambiguous[]” meaning).

In any event, it is the language of FPA Section III that controls here. Plaintiffs’ lengthy argument (Pl. Br. 12-14) that they remained associated with AEFA after the FPA’s expiration is beside the point. While the FPA’s benefits handbook did require planners to elect insurance coverage, pay their portion of the premium, and remain a member of an eligible class in order to receive benefits contributions, *see* AEFA Br. 8-9, 24, those conditions were independent of and in addition to Section III’s prerequisite that the FPA remain in effect.³ By conflating two distinct sets of conditions into one, the planners seek to erase Section III’s explicit disclaimer of “any further . . . compensation.” R. 1450, Dep. Ex. 17, at AX001977 [AD 19].

Thus, Plaintiffs’ claim of a broken promise fails under the terms of the FPA itself. Plaintiffs do not identify in the FPA any unqualified promise to pay them Star Quest benefits in the following year. They do not address the plain language of Section III,

³ These conditions were the stated requirements for obtaining benefits *coverage*, which was itself a prerequisite to receiving benefits *contributions*. Plaintiffs miss this point again in claiming that their “association” with AEFA was the “trigger” making them eligible for contributions. Pl. Br. 14. The language quoted by Plaintiffs does not say that benefits *contributions* resume upon a planner’s return, but that benefits “*elections*” will be reinstated R. 1450, Dep. Ex. 6, at AX001236 (emphasis added).

which limited their compensation to what had been actually earned prior to contract termination. And they do not satisfy the requirements of both that provision and Minnesota law that the Sales Compensation Plan must specifically provide for the payment of compensation after contract termination. Each of these defects was alone sufficient to compel rejection of Plaintiffs' contract claim as a matter of law. Together, they resoundingly confirm the conclusion that Plaintiffs had no continued right to benefits. The trial court should have granted AEFA summary judgment for this reason.

II. PLAINTIFFS' DECISION TO BECOME INDEPENDENT ADVISORS UNDER THE BFA EXTINGUISHED ANY CLAIM TO STAR QUEST CONTRIBUTIONS

Summary judgment also should have been granted to AEFA on a second theory—substituted contract. Plaintiffs concede on appeal that “each of the Advisors *chose* to continue their relationship with AEFA as Platform 2 Advisors.” Pl. Br. 5 (emphasis added). This was a choice made with full knowledge of the BFA's effect. Plaintiffs do not contest that AEFA consulted extensively with the planners over the BFA's terms, that AEFA made changes to the contract based on the concerns of a board of planners, or that hundreds of planners expressed a preference for increased commissions over benefits payments. *See* AEFA Br. 10-12. Plaintiffs likewise do not quarrel with AEFA's showing that they received special software to calculate the financial impact of their Platform choice, that they were given clear notice of each Platform's compensation provisions, and that those notices specifically stated no further benefits contributions would be made “under . . . Star Quest.” AEFA Br. 12-14, 34-35. Having chosen a course explicitly advertised as offering increased direct compensation in place of benefits

payments, Plaintiffs' demand for continued Star Quest contributions is inconsistent with the bargain they made.

A. The BFA's Plain Terms Created a Substituted Contract That Replaced the FPA

The planners agree that a substitute contract exists when “(1) the[re is] a previous valid contract; (2) the parties agreed to a new contract; (3) the parties formed a valid new contract; and (4) the parties intended to extinguish the old contract and substitute the new.” *Nat'l Am. Ins. Co. v. Hogan*, 173 F.3d 1097, 1105 (8th Cir. 1999). Nevertheless, Plaintiffs assert that the BFA is not a substituted contract because both parties must have a “‘clear and definite’” intent to enter into a substitute agreement, and “AEFA has never offered any evidence that *the plaintiffs* actually intended to release it from the obligation it incurred under . . . Star Quest.” Pl. Br. 17 (emphasis added).

At the threshold, AEFA disagrees that *Hogan* requires “clear and definite” evidence of intent for the same parties to form a substitute contract.⁴ But more important,

⁴ *Hogan* involved a novation, where the replacement contract also substituted a new *party* in place of one of the old ones. See 173 F.3d at 1105-06. Some courts, including *Hogan*, have required evidence of “clear and definite” intent for novations. However, no Minnesota case has ever adopted this elevated standard for substitute contracts. In fact, the Restatement, which draws a conspicuous distinction between the two doctrines, explains that a basic showing of intent is all that is necessary to create a substitute agreement: “If the parties intend the new contract to replace all of the provisions of the earlier contract, the contract is a substitute contract.” *Restatement (Second) of Contracts* § 279 cmt. a (1990). This difference makes sense, for a novation radically alters the underlying relationship by removing one party altogether, contrary to the baseline presumption that an obligor who assigns his duty to another party remains responsible to the obligee. See *id.* § 280 cmt. d; see also *Tony & Leo, Inc. v. United States Fid. & Guar. Co.*, 281 N.W.2d 862, 864 (Minn. 1979). In any event, the BFA's unambiguous language satisfies both standards.

Plaintiffs are not correct that it is their subjective intent that controls whether the BFA created a substitute contract. Substitute contracts are interpreted no differently than any other written agreement. If the language within the four corners of the contract is unambiguous, “the parties’ intentions are determined from the plain meaning of [that] language.” *Cent. Fla. Invs., Inc. v. Parkwest Assocs.*, 2002 UT 3, ¶ 12, 40 P.3d 599.

Whether the provisions of a subsequent contract are deemed to supersede the provisions of a prior contract turns on the parties’ intent which is ascertained from the contracts themselves when they are unambiguous.

Schneider v. Dumbarton Developers, Inc., 767 F.2d 1007, 1015 (D.C. Cir. 1985); *accord Hill v. Okay Constr. Co.*, 252 N.W.2d 107, 114 (Minn. 1977); *Bradshaw v. Birmingham*, 671 P.2d 196, 198 (Utah 1983); *In re Blackwood Assocs., L.P.*, 187 B.R. 856, 860 (E.D.N.Y. 1995). Indeed, at an earlier stage of this litigation, Plaintiffs themselves acknowledged that the BFA must be interpreted, not based on one party’s “alleged” purpose, but on the contract’s objective “language.” R. 193.

Here, the BFA’s unambiguous language establishes both parties’ intent to enter into a substitute contract that completely reshaped their relationship and introduced a fundamentally different compensation structure. The BFA’s Disclaimer of Benefits explicitly declares that its benefits package is the only remuneration to which Independent Advisors are entitled:

Independent Advisor acknowledges that the Manuals, including the Compensation Schedule contained therein, constitute the *complete* list of the compensation and benefits owed Independent Advisor resulting from this Agreement *or Independent Advisor’s relationship with AEFA*.

R. 1450, Dep. Ex. 28, at P000431 [AD 34] (emphasis added). The Disclaimer also states that every planner who chose Platform 2 agreed to relinquish any claims to payment from outside the BFA:

Independent Advisor has *no claim to any other compensation* or benefit plan, program or policy of or sponsored by AEFA unless such plan, policy or benefit plan specifically references Independent Advisors in their role as Independent Advisors as an eligible group under such plan, program, or policy

Id. This sweeping elimination of all prior compensation programs is unmistakable: If a compensation program does not “specifically” reference “Independent Advisors as an eligible group,” then the planners have “no claim” to such compensation, even if it derives from a separate aspect of their “relationship with AEFA.” *Id.*

The planners do not contend on appeal that any provision of Star Quest ever specifically referred to Plaintiffs as “Independent Advisors,” much less as “Independent Advisors in their role as Independent Advisors as an eligible group.” Instead, Plaintiffs retreat from this dispositive fact by asserting that AEFA’s obligations predating the BFA “survive,” because a planner who signed the BFA “may currently have claims against AEFA which he is not disclaiming.” Pl. Br. 18. This interpretation misapprehends the Disclaimer’s meaning.

The Disclaimer accomplishes two related objectives. It defines the BFA’s compensation structure as the “complete” amount of payment due for each Independent Advisor’s “relationship with AEFA,” and it renounces the planner’s right to any other AEFA-sponsored payment plan—“unless” the plan “specifically references Independent Advisors in their role as Independent Advisors.” R. 1450, Dep. Ex. 28, at P000431 [AD 34]. On its face, this proviso simply means that other compensation documents are

effective under the BFA only if they use the same language as the BFA to refer to the benefited group. Courts have struggled with the question of whether benefits plans for “employees” cover independent personnel such as franchisees, typically holding that independent contractors are not covered unless they are specifically referenced by the plan documents.⁵ The BFA follows that approach, generally excluding franchisees from coverage, but giving AEFA the flexibility to include Independent Advisors within a plan’s coverage by specifically naming them.

Thus, Plaintiffs are wrong that the “unless” clause preserved all existing benefits on the date the BFA was signed simply because it uses the present tense of “have.” If it did, it would completely upend the Disclaimer itself. The “unless” clause uses the present tense because it applied not only on the first day of the BFA, but on every day the agreement is in effect. It has an ongoing role. It expressly allows AEFA to amend other plans to apply to “Independent Advisors” by using that specific language.

Likewise, Plaintiffs’ convoluted effort to import Star Quest into the BFA by equating the phrase “Independent Advisor” with the term “independent contractor

⁵ In *Hensley v. Northwest Permanente P.C. Retirement Plan & Trust*, 258 F.3d 986, 1001-02 (9th Cir. 2001), for example, the court found the term “employees” to be ambiguous, but ultimately sustained a plan administrator’s conclusion that independent contractors were not covered by that term. The language used in the BFA’s Disclaimer avoids such potential ambiguity by explicitly declaring that coverage applies only if “Independent Advisors” are “specifically” referenced in the plan. See also *Montesano v. Xerox Corp. Ret. Income Guar. Plan*, 117 F. Supp. 2d 147, 161 (D. Conn. 2000) (upholding exclusion of “leased employees”), *aff’d in relevant part*, 256 F.3d 86 (2d Cir. 2001); *Admin. Comm. of Time Warner, Inc. v. Biscardi*, No. 99 Civ. 12270 DLC, 2000 U.S. Dist. LEXIS 16707, at *36-37 (S.D.N.Y. Nov. 17, 2000) (covered workers include “regular employees,” “full-time employees,” and “full-time regular employees”).

advisors” carries no weight. Pl. Br. 24. The phrase “Independent Advisor” is a defined, capitalized term used throughout the BFA to refer to those planners who chose to elect Platform 2, “enter[] into” a franchisee relationship with AEFA, and operate an “Independent Financial Advisor Business.” R. 1450, Dep. Ex. 28, at P000426 [AD 29]. In contrast, the term “independent contractor advisor” (Pl. Br. 24) is not defined by the BFA and appears nowhere in the agreement. Even as Plaintiffs use this term (Pl. Br. 20), it encompasses all planners who had previously qualified for Star Quest—including those who chose to become employees and not sign the BFA. Plaintiffs’ textual gymnastics notwithstanding (*see* Pl. Br. 23-24), these two groups are not the same.⁶

In their attempt to extend the “unless” proviso, Plaintiffs also discard their own reminder that courts “must not interpret a contract so as to render its provisions meaningless.” Pl. Br. 20. The lengthy phrase “Independent Advisors in their role as Independent Advisors as an eligible group” is elaborate by design. R. 1450, Dep. Ex. 28, at P000431 [AD 34]. If it were not enough for the Disclaimer to restrict franchisees’

⁶ Plaintiffs make much of a deposition given by James Punch. Pl. Br. 20-24. However, because the Disclaimer is clear, this extrinsic evidence is irrelevant. *See Winegar v. Froerer Corp.*, 813 P.2d 104, 108 (Utah 1991). In addition, Plaintiffs omit repeated objections to their questions as ambiguous and improperly calling for legal conclusions from a nonlawyer. R. 1451, Punch Dep., at 59. Their quotation stops immediately before Mr. Punch explains: “As I reread that in totality, [that is] our statement of intent on the business side to no longer offer benefit programs in Platform II, and that the second part of that statement is focused [on] saying that unless in the future a Platform II advisor is specifically identified as eligible under a plan, that then they would be eligible but otherwise not.” *Id.* at 61. Mr. Punch also clarified later in the deposition that the term used to refer to planners before rollout was “independent contractors”—not “Independent Advisors.” *Id.* at 110-11. AEFA has no need to rely on the subsequent corrections to the Punch deposition because, in the end, he did not say anything decisive on these issues.

available compensation by referring to them with a capitalized term, the contract goes one step further and adds the requirement that any plan including Independent Advisors must also name them “in their role as Independent Advisors as an eligible group.” Despite the attention this phrase calls to itself, Plaintiffs attempt to equate the BFA’s class of Independent Advisors with a far broader group that “existed prior to . . . the franchise agreement.” Pl. Br. 20. Plaintiffs’ failure to identify a single provision of Star Quest referring to them in this manner is dispositive of their claim as a matter of law.

Plaintiffs reach almost as far to give the BFA’s Entire Agreement clause the limited meaning they place on it. That clause states:

This Agreement, the attachments hereto, and the documents referred to herein constitute the entire Agreement between AEFA and Independent Advisor concerning the subject matter hereof, and supersede all prior and contemporaneous agreements, negotiations and representations (written and oral), no other representations having induced Independent Advisor to execute this Agreement.

R. 1450, Dep. Ex. 28, at P000458 [AD 61]. Plaintiffs contend that this clause serves only to preclude extrinsic evidence because its statement that it “supersedes” all prior agreements “modifies the phrase ‘constitute the entire Agreement . . . concerning the subject matter hereof.’” Pl. Br. 24 (quoting R. 1450, Dep. Ex. 28, at P000458 [AD 61]). Plaintiffs’ interpretation does not withstand an “application of ‘elementary rules of punctuation and grammar.’” *State ex rel. Div. of Forestry, Fire & State Lands v. Tooele County*, 2002 UT 8, ¶ 13, 44 P.3d 680 (quoting *Newspaper Agency Corp. v. Auditing Div. of Utah State Tax Comm’n*, 938 P.2d 266, 271 (Utah 1997)). The Entire Agreement’s “supersede” language does not modify the “constitute” passage that precedes it. Both of those provisions are independent clauses that attach to the sentence’s subject (“This

Agreement . . .”), not to each other. Consequently, the BFA must be read to “constitute the entire Agreement” concerning its subject matter *and* to “supersede all prior and contemporaneous agreements” between AEFA and the Independent Advisors.

In any event, the Entire Agreement clause need not be construed to create a substitute contract by itself, but must be viewed in conjunction with the new agreement’s Disclaimer of Benefits and other provisions. This integrated analysis comports not only with the settled rule that a contract’s terms must be read together, *Chergosky v.*

Crosstown Bell, Inc., 463 N.W.2d 522, 525 (Minn. 1990); *Jones v. ERA Brokers Consol.*, 2000 UT 61, ¶ 12, 6 P.3d 1129, but with the approach numerous other courts have taken in finding the intent to form substituted contracts in integration clauses. In *In Re Worldwide Direct*, for instance, an employee had entered into a severance agreement that included both a release of liability provision disclaiming “all charges, complaints, claims, [and] liabilities” and an integration clause stating that the agreement “fully supersede[d] any and all prior agreements or understandings between the parties hereto pertaining to the subject matter hereof.” 268 B.R. 69, 72 (D. Del. 2001). The court held that it was the *integration* clause that “clearly and unequivocally” established the agreement as a substitute contract, while the *release of liability* provision emphasized by Plaintiffs gave “further” support to this interpretation. 268 B.R. 69, 72 (D. Del. 2001).⁷

⁷ See also, e.g., *Citigifts, Inc. v. Pechnik*, 492 N.Y.S.2d 752, 753 (N.Y. App. Div. 1985) (holding that language stating contract “supersedes any concurrent or previously signed documents” established substitute contract); *Eagle Indus., Inc. v. Thompson*, 900 P.2d 475, 479 (Or. 1995) (en banc) (finding that integration clause, “in the context of the entire written agreement,” extinguished prior agreement).

Of course, even without its Disclaimer of Benefits and Entire Agreement provisions, the BFA would be a substitute contract because it covers the same subject matter for which Plaintiffs seek to invoke the FPA: compensation from AEFA after March 21, 2000. Plaintiffs' theory is that the FPA provided for contributions in the year following its termination. This reading clashes with the BFA, which also determines compensation in that year and is therefore a substituted contract.

Plaintiffs attempt (Pl. Br. 26) to avoid that conclusion by relying on two cases, *Security Watch* and *Kentucky Fried Chicken*. But those cases involved “annual contracts” and “completed transactions” that had been fully discharged by the time their successor agreements became operative. *Sec. Watch, Inc. v. Sentinel Sys.*, 176 F.3d 369, 372 (6th Cir. 1999) (“[T]he term of the agreement is twelve months.”); *Kentucky Fried Chicken Corp. v. Collectramatic*, 547 A.2d 245, 248 (N.H. 1988) (restaurant equipment in question had been “bought and sold” more than a year-and-a-half before the second contract was formed). Here, Plaintiffs' argument depends on their assumption that the FPA somehow carried over into the very period in which the BFA governs.⁸

In the end, Plaintiffs' construction of the BFA cannot be reconciled with the agreement's written, objective terms. The only reasonable interpretation of the BFA as a

⁸ The other cases on which Plaintiffs rely (Pl. Br. 18-19) to rebut the BFA's effect as a substituted contract involve very different facts. In one, the parties conceded that there had not been a novation, *Resolution Trust Corp. v. Teem P'ship*, 835 F. Supp. 563, 569 (D. Colo. 1993). In the other, the new contract “specifically and unambiguously” provided that it did not extinguish existing obligations. *Lampley v. United States*, 17 F. Supp. 2d 609, 617 (N.D. Miss. 1998). Plaintiffs do not point to any language in the BFA “specifically and unambiguously” preserving obligations that existed prior to its effective date.

whole is that it “supersede[s] all prior” agreements between the parties by creating a new relationship in which “Independent Advisors” relinquish claim to “any other compensation,” and accept the BFA’s compensation as the “complete” amount due for their entire “relationship with AEFA.” R. 1450, Dep. Ex. 28, at P000426, P000431, P000458 [AD 29, 34, 61]. The trial court erred when it disregarded the BFA’s plain terms and ruled that the agreement “is not a substituted contract.” R. 906 [AD 6]. The court’s failure to enter judgment in favor of AEFA on this independent ground must be corrected on appeal.

B. Evidence of a Substituted Contract Precluded a Grant of Summary Judgment for Plaintiffs

Even if the BFA did not unambiguously create a substituted contract, the court erred by granting summary judgment to Plaintiffs on this issue. Summary judgment for Plaintiffs was inappropriate because the BFA’s terms in no way sustained *their* reading of the contract, and because extensive parol evidence supported AEFA’s interpretation that it was a substitute agreement. AEFA’s contrary, reasonable interpretation of the BFA created a factual dispute that should have prevented summary judgment in favor of the planners. *SME*, 2001 UT 54 at ¶ 9.

Plaintiffs contend that AEFA waived this argument because AEFA “never raised” any “factual disputes” before the trial court concerning the BFA’s meaning. Pl. Br. 28. This is false. AEFA preserved numerous factual issues of the parties’ intent in forming the BFA, including whether the BFA’s terms created a substituted contract. In the proceedings below, AEFA moved for summary judgment *and opposed* Plaintiffs’ summary judgment motion. AEFA’s combined pleading specifically made the argument

that the BFA “constitutes a substituted contract, extinguishing . . . Star Quest.” R. 341. AEFA supported this argument with an analysis of the BFA’s terms, R. 337-40, applicable caselaw, R. 337-44, and relevant, numbered facts.⁹ AEFA argued that Plaintiffs had signed the BFA knowing AEFA “viewed the BFA as a replacement” for the FPA, and that Plaintiffs understood AEFA planned to apply Star Quest funds to the higher, 85% commission payouts. R. 343, 344 & n.17; *see also* R. 1453, at 5-6, 36-47. Finally, AEFA specifically disputed Plaintiffs’ claim that planners were called “Independent Advisors” prior to the BFA’s effective date. R. 299. Thus, if the court had any doubt about whether the BFA’s terms created a substitute agreement, it was plainly on notice that a jury trial would be necessary to determine the parties’ intent.

Utah procedure requires that if a court finds a contract ambiguous based on conflicting, reasonable interpretations of its terms, the ambiguity must be resolved “by determining the parties’ intent from parol evidence.” *Plateau Mining Co. v. Utah Div. of State Lands & Forestry*, 802 P.2d 720, 725 (Utah 1990). In *SME Industries, Inc. v. Thompson, Ventulett, Stainback & Associates*, for instance, each party had sought summary judgment based on differing contractual readings. 2001 UT 54, ¶¶ 12-13, 28 P.3d 669. On appeal, this Court found both parties’ textual interpretations “tenable,” and

⁹ For example, one portion of AEFA’s facts section, entitled “Facts Regarding Substituted Contract,” explained that “[s]ome Advisors subjectively understood that the BFA replaced the FPA.” R. 315. AEFA also quoted the statement in the Platform Resource Kit notice that Independent Advisors would “pay the full cost” of insurance after rollout, as well as a September 1999 reminder that planners who chose Platform 2 would not receive “a Company contribution” toward benefits. R. 309.

thus, remanded the case for a determination of the contract's meaning from parol evidence. *Id.* ¶ 15. Similarly, in *Dixon v. Pro Image Inc.*, this Court held that consideration of extrinsic evidence was necessary to determine the meaning of the term "sale" in the employment agreement at issue, even though both parties argued for conflicting interpretations of that term from the contract's "unambiguous[]" and "plain" language. 1999 UT 89, ¶¶ 10, 18, 22, 987 P.2d 48.¹⁰

In this case, AEFA's interpretation of the BFA as a substitute agreement that entirely replaced the FPA was not only "tenable, reasonable, and supportable" by the contract's terms, it was confirmed by the evidence that AEFA submitted on summary judgment. *WebBank v. Am. Gen. Annuity Serv. Corp.*, 2002 UT 88, ¶ 27, 54 P.3d 1139. As AEFA's initial brief demonstrated (AEFA Br. 34-36), Plaintiffs received repeated notices that they would not collect any additional Star Quest payments if they decided to become Independent Advisors under the BFA. One bulletin, distributed nearly six months before rollout, could not have been more clear:

Platform 1 advisors will receive company contributions to health and welfare benefits as part of the Platform 1 design. In Platform 2, funding previously allocated for Star Quest benefit awards has been incorporated into the 85% [BFA commissions] payout rate. Therefore, there will be *no additional reimbursements to advisors for benefits that would have been earned under the Star Quest program.*

¹⁰ *Accord St. Paul Fire & Marine Ins. Co. v. Nat'l Computer Sys.*, 490 N.W.2d 626, 630 (Minn. 1992) ("If issues of fact exist, the fact that the parties have brought cross motions for summary judgment will not obviate the need for trial . . ."); *Donnay v. Boulware*, 144 N.W.2d 711, 716 (Minn. 1966) (remanding for consideration of parol evidence after parties offered conflicting, reasonable interpretations of the contracts plain language).

R. 1450, Dep. Ex. 21, at AX001769 (emphasis added); *see also, e.g.*, R. 1450, Dep. Ex. 11, at AX001158 & n.* [AD 84] (no company benefits contribution in Platform 2); AEFA Br. 34-36. This evidence objectively manifests the parties' intent to form a substitute contract in which the BFA's compensation package would replace benefits payments under Star Quest.

Indeed, even under the subjective intent test that Plaintiffs espouse, summary judgment for Plaintiffs was precluded. Two of the named Plaintiffs actually admitted that the BFA extinguished the FPA. As Plaintiff John Ford granted: "Q. You understood your prior contracts were being terminated and [the BFA] was being substituted, correct? A. Correct." R. 1451, John Ford Dep., at 192; *see also* R. 1451, Aamodt Dep., at 136. In these circumstances, the trial court could not hold as a matter of law that the parties had not intended to enter into a substitute agreement.

Plaintiffs do not challenge the explicitness, clarity, or comprehensiveness of AEFA's notices that planners who became Independent Advisors would not receive additional Star Quest payments.¹¹ Hence, whatever Plaintiffs now claim their subjective motive was, the circumstances surrounding the BFA's formation make obvious their

¹¹ Without any analysis or explanation, Plaintiffs quote a March 1999 e-mail sent by Craig Wallenta. Pl. Br. 5-6. This email was written by a nonlawyer early in the rollout process, before AEFA modified the draft BFA in response to the Advanced Advisory Board's concerns. Plaintiffs do not include the response, which stated: "We have no legal obligation to give [planners] a Company contribution for something that they will no longer be eligible for. [I]f they are in Platform II, Benefit eligibility goes away the minute they choose Platform II." R. 1452, Ex. I, at AX005070. In any event, this internal exchange was never communicated to the planners and thus cannot establish the parties' intent.

objective intent: By signing the BFA, Plaintiffs were accepting a more profitable commission structure in place of further Star Quest payments. Because the facts regarding notice are undisputed, this evidence—along with the BFA’s explicit language—could have formed the basis for granting summary judgment to AEFA.¹² But at the very least, this evidence should have prevented the trial court from awarding summary judgment to Plaintiffs. In the event of any ambiguity, the court was required to submit the “parol . . . evidence as to the parties’ intentions” for jury consideration.

WebBank, 2002 UT 88 at ¶ 28; *Cent. Fla. Invs.*, 2002 UT 3 at ¶ 12; *Dixon*, 1999 UT 89 at ¶ 22; *accord Trondson v. Janikula*, 458 N.W.2d 679, 681 (Minn. 1990).

III. AEFA WAS ENTITLED TO INTRODUCE EVIDENCE OF THE FINANCIAL BENEFITS PLAINTIFFS OBTAINED UNDER THE BFA

The trial court also erred by prohibiting AEFA from introducing any evidence of offsetting benefits in the trial on damages. AEFA was prepared to demonstrate to the jury that funding previously allocated to Star Quest had been used to increase the commission rate for Independent Advisors from 83% to 85%, and that this had resulted in offsetting benefits to the class of \$9,282,226.71. *See* AEFA Br. 38-39.

Plaintiffs first assert that this Court must review the trial court’s decision to exclude offsetting benefits evidence “for abuse of discretion.” Pl. Br. 1. While Plaintiffs

¹² Indeed, Plaintiffs acknowledge, “[AEFA] could have made this restructure contingent upon the agreement of the Advisors to expressly waive their Star Quest benefits.” Pl. Br. 34. What Plaintiffs fail to recognize, however, is that the sweeping disclaimers of the BFA, combined with the explicit notices that Star Quest benefits would not be paid, achieved precisely this result.

correctly note that a trial court's decision to exclude particular factual evidence demands deference, *e.g.*, *Whitehead v. American Motors Sales Corp.*, 801 P.2d 920, 923 (Utah 1990), the trial court here disallowed evidence of offsetting benefits across the board. It made a legal determination that offsets apply "only" if the planners were saved from "the cost of performance on the breached contract." R. 1056 [AD 8]. The issue of "how the law of damages should treat" a plaintiff's claim is a legal conclusion to which this Court accords "no particular deference but review[s] for correctness." *Anesthesiologists Assocs. v. St. Benedict's Hosp.*, 884 P.2d 1236, 1237-38 (Utah 1994).¹³

The trial court's legal conclusion was incorrect. Although the offset principle allows for reduced damages where the plaintiff is relieved from performance, nothing in the doctrine restricts its application to that lone situation. The rule is that where a defendant's breach causes harm "but also operates directly to confer some benefit upon the Plaintiff, the Plaintiff's claim for damages may be diminished by the amount of the benefit." Dan B. Dobbs, *Handbook of the Law of Remedies—Damages, Equity and Restitution* § 3.6, at 181 (1973). The offset rule therefore applies whenever "the benefits accruing to the plaintiff are sufficiently proximate to the contract to warrant reducing the plaintiff's damages and the failure to do so would permit the plaintiff to obtain

¹³ See also, *e.g.*, *Lysenko v. Sawaya*, 2000 UT 58, ¶ 23, 7 P.3d 783 (measure of damages legal question where there is a general "'rule[] or principle[]'" that governs (quoting *State v. Pena*, 869 P.2d 932, 935 (Utah 1994)); *Corbett v. Seamons*, 904 P.2d 229, 232 (Utah Ct. App. 1995) (applying correctness standard of review trial court's admission of evidence on lost earning capacity). See generally *State v. Thurman*, 846 P.2d 1256, 1270 n.11 (Utah 1993) (admissibility decisions are "sum of several rulings, each of which may be reviewed under a separate standard").

unreasonable damages.” *Louisiana Sulphur Carriers, Inc. v. Gulf Res. & Chem. Corp.*, 53 F.R.D. 458, 462 (D. Del. 1971); cf. *Soules v. ISD No. 518*, 258 N.W.2d 103, 106 (Minn. 1977) (breach cannot place the plaintiff in a “better position than he would have been in had the contract been fully performed”); *Anesthesiologists Assoc.*, 884 P.2d at 1238 (same).

Consequently, the court in *Buono Sales, Inc. v. Chrysler Motors Corp.* looked not just to the fact that the plaintiff had been relieved from selling DeSotos, as the planners stress (Pl. Br. 32), but also to the fact that the plaintiff directly “benefited from th[e] wide choice of Plymouths” made possible by discontinuation of the DeSoto line. 449 F.2d 715, 720 (3d Cir. 1971). Similarly, in *Macon-Bibb County Water & Sewerage Authority v. Tuttle/White Constructors, Inc.*, the court in part allowed an offset because “the means necessary for the plaintiff to have obtained the profit . . . would have been unavailable” absent the breach. 530 F. Supp. 1048, 1055 (M.D. Ga. 1981); see also *King Grain Co. v. Caldwell Mfg. Co.*, 820 F. Supp. 569, 573-74 (D. Kan. 1993) (defendant entitled to offset insurance proceeds causally connected to contractual breach).

On appeal, Plaintiffs do not challenge this reasoning or the causal relationship between the reallocation of Star Quest funds and their higher commissions. See AEFA Br. 37-38. Plaintiffs simply adopt the trial court’s conclusory holding that the offset rule applies “only” where the plaintiffs are “spared . . . part of their performance.” Pl. Br. 30-31. But Plaintiffs do not provide a single case, or any other legal authority, that limits the offset doctrine “only” to cases where the breach relieves the complainant of performance.

Plaintiffs likewise do not dispute the enormous benefits they received by signing the BFA. AEFA has pointed out—without contradiction—that the nine named Plaintiffs

earned an average of \$52,985 more in 2000 as a result of their transition from Star Quest to the BFA, despite the fact that their aggregate sales production did not rise at all.

AEFA Br. 16, 42. AEFA's estimate of \$9 million in offsetting benefits to the plaintiff class is also not contested on appeal. Thus, despite the assertions in their brief that "Advisors were in no way benefited by AEFA's breach of contract," Pl. Br. 9, there is persuasive evidence in the record that these planners were substantially benefited.

By depriving the jury of the chance to consider this and similar evidence, the trial court erred. The trial court got this issue right the first time, when in denying summary judgment it found that there were unresolved factual issues. R. 862 [AD 01]. Even assuming a breach of the FPA, AEFA was entitled to submit to a jury the question of whether any damages from this breach should have been reduced by the benefits Plaintiffs received as a result of Star Quest's termination.

CONCLUSION

The judgment in this case is not sound. Neither the language of the contracts nor the surrounding circumstances received an adequate examination. Pertinent evidence on damages was excluded. Magnified by a nationwide class action, these errors resulted in a \$14 million verdict that is contrary to law. This Court should reverse and order entry of judgment for the Defendant based on the plain language of the contracts. Alternatively, it should order a trial at which the surrounding circumstances and any benefits to the Plaintiffs can be considered by a jury.

DATED this 1st day of February, 2003.

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CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of February, 2003, I caused to be hand
delivered a true and correct copy of the foregoing APPELLANT'S REPLY BRIEF to:

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ADDENDUM

Section 9 Claims review and ERISA information
(See also Section 1 of this Handbook)

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Section 9: Claims review and ERISA information
(See also Section 1 of this Handbook)

Introduction

Administrative details about your benefit plans are included in this section of your benefits handbook. General descriptions of each plan are in other sections of this Handbook. Except for the claims review procedure, this section applies only to first year financial advisors, district managers within the State of New York, field vice presidents and group vice presidents.

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Section 9: Claims review and ERISA information
(See also Section 1 of this Handbook)

Plan sponsor

Except for the Business Travel Accident Plan, the sponsor of these plans is American Express Financial Corporation. The sponsor's address is:

American Express Financial Corporation
IDS Tower 10
Minneapolis, MN 55440

The employer identification number (EIN) assigned to American Express Financial Corporation for benefit reporting purposes is:

13-3180631

The sponsor for the Business Travel Accident Plan is:

American Express Company
World Financial Center
New York, NY 10285-4780

The employer identification number (EIN) assigned to American Express Company for benefit reporting purposes is:

13-4922250

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Section 9 Claims review and ERISA information
(See also Section 1 of this Handbook)

Plan facts

The following chart shows the names and administrative numbers of the benefit plans described in this Handbook. The chart also lists the type of plan, type of administration and current insurance carrier.

Official plan name	Common plan name	Plan #	Type of plan	Type of administration	Insurer/ Claims Administrator
American Express Financial Corporation Health Care Coverage Plan	Medical Plan	501	Welfare benefit plan providing medical benefits through a major medical plan health maintenance organizations and point of service plans	By American Express Financial Corporation for the Traditional Medical Option and Choice Plus with processing and payment of claims by Aetna/US Healthcare for the Traditional Medical Option and by HealthPartners for Choice Plus By insurance carrier — All HMOs	Self funded — Traditional Medical Option Choice Plus Names and addresses of HMOs are available upon request by calling HRICS at 800 483 3944
American Express Financial Corporation Dental Plan	Dental Plan	505	Welfare benefit plan providing dental coverage through closed panel and point of service plans	Administrative Service Agreement (Traditional Option) Insurer (Prepaid Option)	Delta Dental 7807 Creekridge Circle PO Box 330 Minneapolis MN 55440 Aetna/ US Healthcare 151 Farmington Avenue Hartford CT 06156 3007
American Express Financial Corporation Short Term Disability Plan for members of the field organization	Short term Disability Income Plan for members of the field organization	510	Welfare benefit plan providing short term disability income benefits	Insurer	Metropolitan Life Insurance Company PO Box 1057 Glastonbury CT 06033 6057
American Express Financial Corporation Long Term Disability Plan for members of the field organization	Long term Disability Income Plan	506	Welfare benefit plan providing long term disability income benefits	Insurer	Metropolitan Life Insurance Company PO Box 1057 Glastonbury CT 06033 6057

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Plan facts *continued*

Official plan name	Common plan name	Plan #	Type of plan	Type of administration	Insurer/ Claims Administrator
American Express Financial Corporation Group Life Insurance Plan for members of the field organization	Group Life Insurance Plan	502	Welfare benefit plan providing group life insurance benefits	Insurer	Metropolitan Life Insurance Company PO Box 1057 Glastonbury CT 06033 6057
American Express Financial Corporation Accidental Death and Dismemberment Insurance Plan for members of the field organization	Accidental Death and Dismemberment Insurance	504	Welfare benefit plan providing accidental death and dismemberment benefits	Insurer	Metropolitan Life Insurance Company PO Box 1057 Glastonbury CT 06033-6057
American Express Business Travel Accident Plan	Business Travel Accident Plan	504	Welfare benefit plan providing accidental death and dismemberment benefits	insurer	Hartford Life Insurance Company Washington Health Claims Office 4900 Seminary Road #300 Alexandria VA 22311
American Express Financial Corporation Vision Care Plan	Vision Care Plan	520	Welfare benefit plan providing vision care benefits	Administrative Service Agreement	Vision Service Plan One Gatehall Dr Parsippany NJ 07054
American Express Financial Corporation Legal Assistance Plan	Legal Assistance Plan	511	Welfare benefit plan providing legal assistance benefits	Contract Administration	Hyatt Legal Services 1215 Superior Avenue Cleveland OH 44114 3292 Signature Legal Services 200 North Martingale Rd Schaumburg, IL 60173

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Section 9: Claims review and ERISA information
(See also Section 1 of this Handbook)

Plan facts *continued*

Additional providers:

The following companies also provide administrative services to various plans

Express Pharmacy
620 Epsilon Drive
Pittsburgh PA 15238

Provides mail-order prescription drug services to persons covered under the Traditional Medical Option

ValueOptions
433 River Street
Troy NY 12180

Provides network and administrative services for mental health/chemical dependency treatment for persons covered under the Traditional Medical Option

Express Scripts/Value Rx
P.O. Box 41366
Plymouth, MN 55441-0366

Provides prescription drug services for persons covered under the Traditional Medical Option

Plans Not Insured — Information on Aetna Life Insurance Company and HealthPartners/GHI Administration Inc. (Traditional Medical Plan and Choice Plus Options)

Neither Aetna Life Insurance Company nor HealthPartners/GHI Administration Inc. guarantees or insures benefits under the Traditional or Choice Plus medical options. Aetna and HealthPartners provide plan administration for these options including such services as claims payment, utilization review, case management, quality assurance and grievance and appeals procedures, among others.

Address of Claims Administrators — Aetna Life Insurance Company, P.O. Box 2907, Loop Station, Minneapolis, MN 55402; HealthPartners/GHI Administration Inc., P.O. Box 1309, Minneapolis, MN 55440-1309

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Section 9: Claims review and ERISA information
(See also Section 1 of this Handbook)

Plan administration

Who is the plan administrator?

The plan administrator for all of the welfare benefit plans listed on pages 9-4 and 9-5 of this Handbook is:

For first-year financial advisors, district managers in New York, field vice presidents and group vice presidents:

Employee Benefits Administration Committee
c/o Vice President, Retirement Plans
IDS Tower 10 — FB11/360
Minneapolis, MN 55440-0010
(612) 671-1924

For all other financial advisors who are independent contractors:

Vice President, U.S. Benefits
American Express Company
World Financial Center
200 Vesey Street
New York, NY 10285
(212) 640-2000

HRICS, which administers the welfare plans on a day-to-day basis, can be reached at:

Human Resources Information and Client Services
American Express Financial Corporation
IDS Tower 10 — FB11/115
Minneapolis, MN 55440-0010
(612) 671-3051
(800) 483-3944

The Plan Administrator has the sole discretion and authority to:

- Make and enforce rules and regulations for the efficient administration of the plans and the transaction of business pertaining to the plans;
- Interpret the plans and decide any and all matters arising thereunder, including factual issues relating to any benefit claims;
- Remedy possible ambiguities, inconsistencies, or omissions concerning the plans;
- Determine eligibility to participate in and receive benefits under the plans;
- Authorize payment of benefits;
- Appoint a claims review committee to resolve appeals relating to claims under the plans.

Section 9: Claims review and ERISA information
(See also Section 1 of this Handbook)

Plan administration *continued*

All interpretations, determinations, and decisions of the Plan Administrator or the Plan Administrator's designee, including decisions concerning disputed facts and or possible ambiguities, inconsistencies, and omissions, are final, conclusive and binding upon the plan sponsor, participants, beneficiaries, and all other persons having any interest under the plans to the full extent permitted by ERISA.

Who is the agent for the service of legal process?

The Vice President of Field Compensation and Administration is also the agent for the service of legal process related to the welfare benefit plans, excluding the Business Travel Accident Plan, and may be contacted as the agent for service of legal process at the address above. The General Counsel of the American Express Company is the agent for the service of legal process for the Business Travel Accident Plan.

How is a plan year defined?

The financial records for all plans described in this Handbook are kept on the basis of a calendar year beginning on Jan. 1 and ending on Dec. 31.

What is the claims review procedure if my claim is denied?

Claims review procedure

The plan administrator makes all determinations that relate to the right of any person to a benefit under the plan, unless the plan administrator has delegated that responsibility to an insurer or provider. If you believe you are eligible for benefits under a plan, you may file a claim for benefits. All claims for benefits under a plan must be submitted in writing following the procedures provided in the plan.

Claim denial and appeal procedure.

Ordinarily, within 90 days after receiving a written claim for benefits, the plan administrator, the provider or the insurer will notify the claimant in writing if the claim has been denied. This written notice of denial will include the specific reasons for the denial, specific references to the plan provisions on which the denial is based, a description of any additional material or information that is needed to perfect or process the claim and an explanation of why it is necessary, and an explanation of the claimant's right to appeal the decision to deny the claim.

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If, because of special circumstances, an extension of time is required, the plan administrator, the provider or the insurer may take another 90 days to process the claim. Written notice of the extension will be given to the claimant before the end of the 90 day period. This notice will indicate the special circumstances requiring the extension of time and the date by which a decision is expected to be made.

If the claimant is not notified in writing within 90 days (or within 180 days in special circumstances) that the claim has been denied, the claim is considered denied and the claimant may proceed to the review stage described in the next paragraph.

Section 9 Claims review and ERISA information

(See also Section 1 of this Handbook)

Plan administration *continued*

A claimant (or his or her duly authorized representative) who wants to appeal the plan administrator's, provider's or insurer's decision to deny a claim must submit a written request for review to the plan administrator, provider or insurer within 60 days after receipt of the notice of denial. The claimant's (or duly authorized representative's) request for review must include specific reasons why the claimant believes the claim should be approved. In preparing a request for review and in presenting the case to the plan administrator, provider or insurer, the claimant (or his or her duly authorized representative) shall be entitled to review pertinent plan documents that relate to the claim made.

Ordinarily, within 60 days after receiving a request for review, the plan administrator, provider or insurer will review the claim and its decision to deny and will give written notice of its final decision to the claimant. However, if special circumstances require additional time, an extension of up to 60 days will be allowed for making this decision. If such an extension of time is required, written notice of the extension will be given to the claimant before the end of the initial 60-day period. The notice of final decision will include specific reasons for the decision and references to the plan provision on which the decision is based. If the plan administrator's, provider's or insurer's final decision is not provided within the 60-day period (or 120 days period in special circumstances), the claim is deemed to be denied on review.

First-year financial advisors, district managers in New York, field vice presidents and group vice presidents have additional rights if a claim is denied. The following page details those rights.

What are my rights to these plans?

American Express and American Express Financial Corporation make no promise to continue these benefits in the future and have the right to amend or terminate any coverage for active plan participants or retired covered individuals at any time. Rights to future benefits will never vest. Retirement does not give any retiree any vested rights to continue plan benefits.

Information Applicable to this Handbook

This Handbook describes only certain highlights of some of American Express Company's employee benefits plans. It does not supersede the actual provisions of the applicable plan documents, which in all cases are the final authority. The Plan Administrator has the sole discretion and authority to determine eligibility for benefits and to interpret ambiguous provisions of the respective plans.

If you have questions about your benefits after reading this material, please contact HRICS East at (800) 483-3944.

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The plans described here may be amended (or even terminated) by the Company at any time without prior notice to or consent by employees.

Section 9 Claims review and ERISA information
(See also Section 1 of this Handbook)

Plan administration *continued*

This Handbook does not create a contract of employment between the Company and any employee.

Future of the Plans

Because of the need for confidentiality, decisions regarding changes to the Company's benefits plans, programs, practices or policies are generally not discussed or evaluated below the highest levels of management. Managers and their representatives below these levels do not know whether the Company will or will not change or adopt any particular benefit plan. Nor are they in a position to advise any employee on, or speculate about, future plans. Participants should make no assumptions about future changes or the impact changes may have on their personal situation until a change is formally announced by the Company.

The plans described here may be amended or terminated by the Company through its Board of Directors, at any time without prior notice to or consent by employees. The Company's Board of Directors may delegate amendment authority to the Company's Chief Executive Officer, President or any Executive Vice President, as the Board, in its sole discretion, deems appropriate. These SPDs do not create a contract of employment between the Company and its subsidiaries and any employee.

Your benefits at or after retirement, if any, may be different from those described here due to changes made to the plans or the termination of any of the plans.

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Section 9: Claims review and ERISA information
(See also Section 1 of this Handbook)

Your rights under ERISA

What rights and protection am I entitled to under ERISA?

As a participant in the plans described in this Handbook, first-year financial advisors, district managers in New York state, field vice presidents and group vice presidents are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents, including insurance contracts and copies of all documents filed by the plans with the US Department of Labor, such as annual reports and plan descriptions
- Obtain copies of all plan documents (if different from this Handbook) and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies
- Receive a summary of the plan's annual financial reports. The plan administrator is required by law to furnish each participant with copies of these summary annual reports

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plans

The people who operate your plans, called 'fiduciaries' of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the administrator

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Section 9: Claims review and ERISA information
(See also Section 1 of this Handbook)

Claims review and ERISA information

What additional rights do I have under ERISA?

If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, PWBA, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC, 20210, phone (202) 219-4377.

Information Applicable to First-Year Financial Advisors, District Managers in New York State, Field Vice Presidents and Group Vice Presidents

This information in this Benefits Handbook forms the Summary Plan Descriptions (SPDs) for the benefit plans described. Each SPD consists of the plan's separate section in the Handbook, plus applicable portions of Section 1 and Section 8, as cited in every chapter.

These SPDs contain only certain highlights of the plans. They do not supersede the actual plan documents, which in all cases are the final authority. Due to the ever-increasing complexity of employee benefit plans, plan participants should rely only on the written SPDs or formal plan documents. The Plan Administrator retains exclusive authority and discretion to interpret the terms of the benefit plans described here.

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