**Team 12**

**ORAL ARGUMENT SCHEDULED FOR MARCH 1, 2024**

**Civil Action No. 23-CV-499**

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**IN THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA**

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**J.D. and K.D.,**

**Appellant**

**Vs.**

**Universal Health Insurance Co.,**

**Appellee**

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**On Appeal from the**

**United States District Court for the District of Columbia**

**The Honorable Jacob K. Javits, Presiding**

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# BRIEF FOR APPELLEE

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**Counsel for Appellee**

**January 12, 2024**

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### UNITED STATES SUPREME COURT



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**FEDERAL DISTRICT COURT**



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## STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Under the Federal Rules of Civil Procedure, did Appellants sufficiently plead extraordinary circumstances to defeat the balancing test and permit proceeding under a pseudonym?

   Suggested Answer: No

2. Under ERISA, is the equitable relief sought under Section 502(a)(3) duplicative of the claim for benefits under 502(a)(1)(B)?

   Suggested Answer: Yes

3. Under ERISA, the Mental Health Parity and Addiction Equity Act of 2008, and the plausibility standard, should Count II be dismissed as a matter of law on an independent basis?

   Suggested Answer: Yes

## STATEMENT OF THE CASE

Procedurally, this action arises from Appellants, K.D. and J.D. ("Appellants"), participation in the CIA Consulting LLC Healthcare Plan (the "Plan"), insured and administered by Appellee, Universal Health Insurance Company ("Appellee"). (O. at 1.) The Plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA") and all amendments, including the Mental Health Parity and Addiction Equity Act of 2008 (the "Parity Act"). (C. at 1-2.) On August 2, 2023, Appellant anonymously filed suit in the United States District Court for the District of Columbia against Appellee. (C. at 7.)

Appellant brought two causes of action. Appellant sought relief under: (1) 29 U.S.C. §1132(a)(1)(b) alleging improper denial of plan benefits; and (2) 29 U.S.C. § 1132(a)(3) alleging violations of the Parity Act that give rise to equitable remedies. (C. at 5, 6.) Likewise, Appellant motioned to proceed anonymously, and proclaimed they would surrender their claim for benefits if their motion was denied. (O. at 1.) Universal filed a response to Appellant's motion. Additionally, Universal motioned to dismiss J.D. as Plaintiff and to dismiss Count II for the duplicative nature of the claim for benefits under Count I. (O. at 1.)

The Honorable Jacob F. Javits of the United States District Court for the District of Columbia denied Appellant's motion in full, granted Universal's motion

by the reasoning of duplicity, and did not rule on the motion to remove J.D. as a Plaintiff. (O. at 1.) Likewise, the Court determined that arguments on the "fail first" nature of the Policy were "inappropriate for resolution on a motion to dismiss. Appellant now appeals to this Court. (O. at 9.) Importantly, because Appellant's declared they would only continue the suit under pseudonyms and would not file an amended complaint with their legal names, the case was dismissed in entirety. (O. at 10-11.)

Factually, Appellants are covered by a health insurance plan, the mother via her employer and her nineteen-year-old daughter as a beneficiary. (C. at 1-2.) "The Plan provides coverage for *medically necessary* mental health and substance use disorder services, including residential treatment." (C. at 2.) (emphasis added). Likewise, the Plan has guidelines to aid the administration of claims against the Plan for benefits requested by covered individuals, namely regarding increasing levels of covered medical treatment. (C. at 2.)

Appellant has undergone medical care, partially covered by the Plan, for depression and anxiety. (C. at 2.) Three years before professional treatment, Appellant coped with her physical and psychological ailments by self-medicating with drugs and alcohol. (C. at 2.) Unfortunately, Appellant's symptoms intensified and required professional medical treatment. (C. at 2.)

In 2022, Appellee paid for the Plan's full coverage of Appellant's intensive outpatient treatment three days a week. (C. at 2.) The treatment was administered by a District of Columbia Facility, Road to Recovery. (C. at 3.) This intensive outpatient treatment proved to be insufficient, and Appellant's condition worsened. (C. at 3.) Later, Appellant was admitted into an emergency room and a psychiatric hospital because she attempted suicide, and she remained in the hospital for three weeks. (C. at 3.) The "*psychiatric hospital…recommended* [Appellant] receive treatment at a *partial hospitalization* level of care" through Road to Recovery. (C. at 3.) (emphasis added).

The recommended level of care required treatment five days a week, set to begin shortly after Appellant left the psychiatric hospital. (C. at 3.) Appellant was released and was on schedule to begin her partial hospitalization treatment. (C. at 3.) However, before the new treatment began, Appellant accidentally overdosed and was admitted to the emergency room. (R.5.) Again, Appellant was hospitalized for three weeks, and Appellee paid for her treatment in full. (C. at 3.)

During her stay, Appellant's doctor and treatment team at Road to Recovery recommended she receive *residential treatment* at a different facility, Lifeline Inc. ("Lifeline"). (C. at 3.) (emphasis added). Appellee approved full coverage for three weeks of residential treatment. (C. at 3.)

Lifeline treats both mental illness and substance use disorder and is located in Virginia. (C. at 3.) There, beginning on April 18, 2022, Appellant met with specialists that treat substance use disorders and related mental illnesses including a family nurse practitioner, a psychiatrist, and a physician. (C. at 3.) The Lifeline team diagnosed Appellant with generalized anxiety disorder, major depressive disorder, and substance use disorder. (C. at 3.) On May 9, 2022, after three weeks of paid treatment, Appellee reviewed the Plan in relation to Appellants request for continued residential treatment at Lifeline. (C. at 3.)

In a letter sent to Appellants, Appellee explained that a reviewing physician, Dr. James Matzer, determined the residential treatment at Lifeline was "*no longer medically necessary* and that [Appellant] *could be successfully treated at the lower level of care*", the partial hospitalization treatment she was scheduled to undertake before her unexpected emergency admittance to Lifeline (C. at 4.); *see* (Ex. B.) (emphasis added). Dr. Matzer further explained that because Appellant's health progressed to a level where she was no longer actively suicidal, she did not need to maintain the degree of supervision and structured care provided in residential treatment at Lifeline. *See* (Ex. B.)

In addition to Dr. Matzer's professional assessment of the Plan and Appellant's condition, the letter explained that Appellants could still make independent decisions about the continuation of their treatment, but if they decided

to maintain this extreme level of care, they would not be covered by the Plan. *See* (Ex. B.)

Appellants appealed the decision and Appellee undertook an expedited second review that was conducted by a second experienced healthcare professional, Dr. Jennifer Lawrence. (C. at 4.); *see* (Ex. C.) In accordance with the appeal process, Dr. Lawrence was not involved in the initial determination and did not work for or with Dr. Matzer. *See* (Ex. B.) Again, after reviewing and considering all the information shared, Appellant's request for continued residential treatment was *denied* and determined as *not medically necessary*. *See* (Ex. C.)

Appellant had exhausted all internal appeal remedies, but still could file an independent external appeal with the Department of Financial Services within four months. *See* (Ex. B.) However, Appellant forwent their external appeal and independently decided to continue residential treatment at Lifeline for a year while paying out of pocket. (C. at 4.) After finishing treatment, Appellant began pursing higher education and filed this suit by using their initials in an attempt to litigate anonymously. (C. at 4.); (O. at 3.)

## SUMMARY OF THE ARGUMENT

First, Appellants should not be permitted the ability to proceed under a pseudonym. The Public has a strong interest in knowing who is litigating in the court system and what the case is about, because caselaw forms the basis for future laws and precedent. Furthermore, public proceedings allow the public to know the court system is working for people like them and setting new standards on issues they face in their everyday life.

The district court properly concluded that Appellants could not proceed anonymously. The district court properly weighed several factors its brother and sister circuits laid out, to determine that Appellants' case did not rise to a level such that to overcome the presumption of openness laid out in Fed. R. Civ. P. 10(a). Here the Appellants' case was not of such a sensitive nature that anonymity was required. Appellants' were not minors over the course of the circumstances of litigation and Appellants had other options laid out by the district court that were not as drastic as proceeding anonymously. Therefore, this Court should uphold the district court's decision that Appellants' cannot proceed anonymously.

Second, the district court properly dismissed Appellants' Count II for equitable relief under ERISA Section 502(a)(3) because Count II is duplicative of Appellants' Count I claim for benefits under Section 502(a)(1)(B). Remedies under Sections 502(a)(1)(B) and 502(a)(3) do not overlap because it would result in

redundant avenues of recover for a beneficiary repackaging their denial-of-benefits claim as a claim for breach of fiduciary duty.

Here, Appellants attempt to stretch their alleged injury into duplicative recoveries when they claim a denial of benefits due and equitable relief regarding their future benefits. However, Section 502(a)(1)(B) governs all Appellants' claims because a civil action under Section 502(a)(1)(B) may be brought to *recover benefits due*, to enforce rights, or to *clarify rights to future benefits* under the terms of the plan. 29 U.S.C. § 1132(a)(1)(B). Section 502(a)(3), on the other hand, serves as a catchall provision for claims not covered elsewhere in Section 502 and is therefore not applicable to Appellants' claims since they are made whole under Section 502(a)(1)(B). This Court should affirm the district court's decision that Appellants are barred from bringing their Count II claim for equitable relief under Section 502(a)(3).

Furthermore, the Mental Health Parity and Addiction Equity Act of 2008 prevents plan administrators from imposing greater coverage restrictions on mental health illnesses than on medical or surgical conditions. 29 U.S.C. § 1185a. Here, even though the district court did not reach the issue, this Court should ultimately hold Appellee did not violate the Parity Act because (1) Appellants fail to provide evidence that receiving treatment at a level of partial hospitalization is a more restrictive limitation and (2) the Plan's medically-necessary standard is applied

equally to *all* types of residential treatment under the Plan, including treatment for mental health, substance use, physical illnesses, and surgical procedures.

Third, Count II should be dismissed for an independent basis because its allegations regarding the Parity Act fail under the plausibility standard as a matter of law. Courts should not blindly accept all sympathetic parties' claims and disregard pleading requirements detailed in the Federal Rules of Civil Procedure. Thus, Appellants' must allege facts, neither conclusions nor bare contentions, that can allow the court to reasonably infer the Appellee is liable for the alleged misconduct. Fed. R. Civ. P. 8; Fed. R. Civ. P. 10; *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

Here, a majority of Appellants' arguments rest on summaries and manufactured conclusions—statements that are not binding on the court and that are entirely disregarded in the plausibility standard's interpretation. Appellants' only surviving allegations are that Appellee applied a clinical criteria test via medical professionals to determine Appellants were no longer covered at the higher level of treatment. Therefore, after removing the conclusory statements and only viewing the remaining facts as sufficient, Appellants' claim should be dismissed as it fails as a matter of law because it does not lead this Court to any inference where Appellee violated the requirements of the Parity Act.

## ARGUMENT

### I. A TOTALITY OF THE CIRCUMSTANCES ANALYSIS OF THE SEVERAL FACTORS LAID OUT BY THE COURT RESULTS IN FAVOR OF THE APPELLEE BECAUSE APPELLANTS WERE NOT ABLE TO OVERCOME THE PRESUMPTION OF OPENNESS LAID OUT BY THE FEDERAL RULES OF CIVIL PROCEDURE 10(A).

Fed. R. Civ. P. 10(a) requires every pleading in federal court to name all the parties. Fed. R. Civ. P. 10(a). This rule is not absolute; however, proceeding under a pseudonym in federal court is, by all accounts, an unusual procedure. *Femedeer v. Haun*, 227 F.3d 1244, 1246 (10th Cir. 2000); *Plaintiff B v. Francis*, 631 F.3d 1310, 1316 (11th Cir. 2011). Importantly, "a party may [only] proceed anonymously in a civil suit in federal court by showing that he or she has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings". *Id.* Some courts have recognized that in exceptional circumstances, there may be a few compelling concerns relating to personal privacy or confidentiality that warrants some degree of anonymity in judicial proceedings, including use of a pseudonym. *See Co. Doe v. Pub. Citizen*, 749 F.3d 246, 273 (4th Cir. 2014). Nevertheless, proceeding by a pseudonym is a "*rare dispensation*" afforded by the courts. *Id*. (emphasis added). Albeit rare, in determining whether a party should be permitted to litigate pseudonymously, courts apply a list of non-exhaustive factors to make their decisions. *Id, see also James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 2993); *M.M. V.*

*Zavaras*, 139 F.3d 798, 803 (10th Cir. 1998); *Roe v. Aware Woman Ctr. For Choice Inc.*, 253 F.3d 678, 685 (11th Cir 2001).

Courts apply a combination of ten factors to determine whether to grant a party the ability to proceed under a pseudonym. *Sealed Plaintiff v. Sealed Defendant #1*, 537 F.3d 185, 190 (2nd Cir. 2008). Courts apply the following factors on a case by case basis depending on which are present in each case. See *Id*. The first factor is whether the litigation involves matters that are highly sensitive and of a personal nature. *Id*.; *Doe v. Frank*, 951 F.2d 320, 323 (11th Cir. 1992). The second factor is whether the identification poses a risk of retaliatory physical or mental harm to the party wishing to remain anonymous or to innocent non-parties. *Sealed Defendant #1*, 537 F.3d at 190; *Zavaras*, 139 F.3d at 803. The third factor is whether identification presents other harms and the likely severity of those harms. *Sealed Defendant #1*, 537 F.3d at 190; *Does I thru XXII v. Advanced Textile Corp.*, 214 F.3d 1058, 1068 (9th Cir. 2000); *Doe v. Town of Libson*, 78 F.4th 38, 46 (1st Cir. 2023). The fourth factor is whether the plaintiff is particularly vulnerable to the possible harms of disclosure. *Sealed Defendant #1*, 537 F.3d at 190; *Town of Libson*, 78 F. 4th at 46. The fifth factor is whether the suit is challenging the actions of the government or that of a private party. *See Jacobson*, 6 F.3d at 238.

The sixth factor is whether the defendant is prejudiced by allowing the plaintiff to press his claims anonymously, whether the nature of that prejudice (if any) differs at any particular stage of litigation, and whether any prejudice can be mitigated by the district court. *Sealed Defendant #1*, 537 F.3d at 190; *Advanced Textile Corp.*, 214 F.3d at 1068. The seventh factor is whether the plaintiff's identity has thus far been kept confidential. *Id.* The eighth factor is whether the public's interest in the litigation is furthered by requiring the plaintiff to disclose his or her identity. *Id.* The ninth factor is whether because of the purely legal nature of the issues presented or otherwise, there is an atypical weak public interest in knowing the litigants' identities. *Sealed Defendant #1*, 537 F.3d at 190. Lastly the tenth factor is whether there are any alternative mechanisms for protecting the confidentiality of the plaintiff. *Sealed Defendant #1*, 537 F.3d at 190.

Medical records do not fall into the category of information that is highly sensitive and of a personal nature, such that a party is warranted to use a pseudonym during litigation. *See Doe v. Blue Cross & Blue Shiel United*, 112 F.3d 869, 872 (11th Cir. 1997). In *Blue Cross*, a plaintiff underwent psychiatric treatment and sued her insurer for benefits governed by ERISA. *Id*. Plaintiff proceeded under a pseudonym due to the fear that her psychiatric records would be disclosed, which would bring her immense embarrassment. *Id*. The court opined that fictious names or pseudonyms may seldom be permitted in a case regarding a

particularly vulnerable party, but ultimately ruled that a case involving medical issues was not a sufficient reason for using a pseudonym. *Id*.; *see also Doe v. Univ. of Pittsburg*, 2019 U.S. App LEXIS 17423 at *6 (holding that the issues of plaintiff's medical records did not warrant the use of a pseudonym but instead could be filed under seal); *Roe v. Skillz, Inc.*, 858 Fed. Appx 240, 241 (9th Cir. 2021) (holding that a past gambling addiction with accompanying mental health problems is not so out of the norm as to constitute sensitive and highly personal in nature).

Here, Appellant's medical records and medical history are not the kinds of information that courts tend to consider highly sensitive material, and thus, Appellant's claim should not rise to the occasion of allowing their usage of a pseudonym. Appellant lives with a depressive disorder, substance abuse issues, and general anxiety, and although these issues may be sever, they are not the kinds of issues courts find highly sensitive. (D.at 1.) Similar to *Blue Cross*, where the patient suffered from mental illness, Appellant endures mental issues, but the court in *Blue Cross* opined that this alone was not enough to weigh in favor of the use of a pseudonym. 112 F.3d at 872; (D. at 1.) Additionally, Appellant also has an addiction problem like the plaintiff in *Skillz, Inc.*, where the court explained that an addiction issue is also not one of a highly sensitive nature because it is not so out of the norm for people in today's society. 858 Fed. Appx. at 241; (D. at 1.)

Although serious, Appellant's substance abuse issue is a very common problem in today's society. The National Center for Drug Abuse Statistics reported that over 11.89 million people aged 18-25 use drugs at least once a month, and almost five-thousand Americans aged 15-24 die from an overdose every year. *Drug Use Among Youth: Facts and Statistics*, NATIONAL CENTER FOR DRUG ABUSE STATISTICS, Jan. 7, 2024, https://drugabusestatistics.org/teen-drug-use/. Similarly, the National Institute for Mental Health reported that as least 5 million people ranging from ages 12-19 have suffered at least one major depressive episode in their life. *Major Depression,* NATIONAL INSTITUTE OF MENTAL HEALTH, Jan. 7, 2024, https://www.nimh.nih.gov/health/statistics/major-depression. Importantly, as unfortunate as the statistics are, these issues are not viewed as a rare occurrence, and therefore bolster the opinion of courts like *Skillz, Inc.* that concluded that because these issues are not out of the norm, they can't be considered highly sensitive. 858 Fed. Appx. at 24. Therefore, after applying the caselaw and considerations behind the judicial opinions, this factor grants considerable weight against the use of pseudonyms.

If an alternative measure to using a pseudonym is available for a plaintiff, then that option weighs in favor of the presumption that proceeding under a pseudonym is an unusual procedure. *See Sealed Defendant #1*, 537 F.3d at 190. In *Medco Health Solutions, Inc.*, the court considered a plaintiff's request to use a

pseudonym due to the sensitivity of the plaintiff's medical record. *Anonymous v. Medco Health Solutions, Inc.*, 588 Fed. Appx. 34, 35 (2nd Cir. 2014). The court considered the fact that instead of proceeding under a different name, the plaintiff could have certain documents redacted or sealed as the litigation commenced. *Id*. The court ruled that this option cut against the plaintiff's motion to proceed under a pseudonym because there were other, less drastic alternative options available for the plaintiff. *See Id*.; (*citing Sealed Defendant #1*, 537 F.3d at 190).

Here, Appellants' private information could be shielded in less drastic ways than proceeding through litigation anonymously. The District Court noted that Appellant could redact certain private information or could even seal that information to a certain extent. (C. at 33.) Moreover, the District Court said it would allow them to refile their complaint under seal. (C. at 33.) Like *Medco Health Solutions, Inc.*, where the court noted that there were other, less drastic option available to the plaintiff, that is the same case here. 588 Fed. Appx. at 35. The District Court even noted that it was the Appellants' fault that they proceeded the way they did instead of trying to redact information at the start. (C. at 33.) The District Court is giving the Appellants another chance to refile their case under seal, and because of that possibility this factor overwhelmingly weighs in favor of the Appellees. (C. at 33).

Another factor courts weigh is the age of the plaintiff into their decision, especially if the child is a minor. *See Doe v. Stegall*, 635 F.2d 180, 186 (4th Cir. 1981). The Federal rules of procedure only require that minor children's identities are protected. *See* Fed. R. Civ. P. 5.2(a)(3). In *Doe*, the court examined a case of a college student attempting to use a pseudonym in a sexual harassment case. *Doe v. Doe*, 85 F.4th 206, 209 (4th Cir. 2023). Although the age of the student was not known, the court described the boy as a college student who was not a minor and they explained that "all parties [were] adults". *See Id*. at 215-215. There, the court did not weigh this factor in favor of the student desiring to use a pseudonym because he was not a minor. *Id*. The court factored the age of the party into their totality of the circumstances decision and ruled that the student was not permitted to use a pseudonym in this case. *Id*. at 217; *Cf*. M.V.V. v. Barr, No. 19-cv-2773, 2019 U.S. Dist. LEXIS 234068, at *9 (D.D.C. September 26, 2019) (holding that a minor plaintiff and their parent may use a pseudonym); *James v. Jacobson*, 6 F.3d 233, 238-243 (4th Cir. 2993) (remanding the case to the district court for consideration on the factor that the plaintiffs involved a minor and the minors parents who are suing a fertility doctor for unethical practices).

When weighing the factor of the parties age into the totality of the circumstances approach, courts look specifically to whether the party is a minor or not. Here, Appellant is not a minor, and at the time she was admitted to inpatient

care at Lifeline, Inc., she was 18 years old. (O. at 32.) Moreover, when this litigation first commenced, Appellant was 19 years old. (O. at 4.) Like *Doe*, where the court denied the college student anonymity because they were not a minor, the court should hold similarly here. 85 F.4th at 209. Additionally, courts have held that parties who are minors and their parents can litigate using pseudonyms, *Jacobson*, 6 F.3d 233 at 243, but here, Appellant was an adult throughout the entire process and 19 when litigation commenced. (R.4.) Furthermore, Appellant's mother is also trying to proceed anonymously, but there is no foundation for her assertion. The court noted in *Stegall* that the age of the party does factor into the decision, but that is when the party in a minor and since that is not the case here the factor of age should weigh in favor of not allowing the Appellants to proceed anonymously. 635 F.2d at 186, (C. at 4.)

When analyzing whether identification will present other harms and the severity of those harms, courts tend to give deference to any physical harms the plaintiff may incur by others and not mental harms or the impressions of others. *See Xingfei Lou v. Wang*, 71 F.4th 1289, 1301 (10th Cir. 2023); *Anonymous v. Medco Health Solutions, Inc.*, 588 Fed. Appx. 34, 35 (2nd Cir. 2014). In *Wang*, the plaintiff filed her complaint under a pseudonym because she had been the victim of sexual assault and did not want any kind of stigma attached to her name or to be re-victimized. *Wang*, 71 F.4th at 1291. The court noted that revealing the identity of a

person would not likely lead to future physical harms. *See Id*. at 1300. Furthermore, the court specifically noted that because the plaintiff would have to testify, they would be subject to re-victimization and similar issues regardless of their usage of a pseudonym. *Id*. at 1301; *see also Medco Health Solutions, Inc.*, 588 Fed Appx. at 35 (holding plaintiff's concerns that his name being used in litigation would only exacerbate the harm already done was a non-factor for the court when considering the other harms and likely severity of them if the plaintiff proceeded under his real name).

Here, revealing Appellants' identity will not likely lead to the types of harms courts worry about when considering whether to allow someone to proceed under a pseudonym. Appellants' rely solely on the Doctor Smith's Declaration to substantiate their claim for proceeding anonymously, but the issue is that the doctor's statement is merely conclusory—they cannot point to anything concrete that will absolutely happen if the Appellants are not allowed to proceed anonymously. (D. at 1-2.) For example, the doctor said, "I believe it is possible" to conclude that Appellant could suffer an adverse reaction from proceeding under her real name. (D. at 2.) Like in *Wang*, where the plaintiff was worried about a stigma being attached to her name if she was not allowed to proceed anonymously, here, Doctor Smith talked about how K.D. is worried about possibly being shunned if information comes out about her treatment. *Wang*, 71 F.4th at 1300; (D. at 2)

The court ruled that the plaintiff's concern in *Wang* was not enough of a reason to overcome the presumption of litigating under her real name. *Wang*, 71 F.4th at 1300. Here, Doctor Smith's presumption that Appellant could suffer is not enough to overcome that presumption either. Furthermore, Appellant will likely have to tell her side of the story during litigation, regardless of whether she is allowed to proceed under a pseudonym like the Plaintiff in Wang. *Id*. Therefore, this factor is one that should be weighed in favor of the Appellee.

Courts also weigh the prejudice to the party opposing anonymity and how that compares if any for the party trying to proceed anonymously and the public in general. *United States v. Hubbard*, 650 F.2d 293, 320-322 (D.C. Cir. 1980); *see also AFGE v. In re United States OPM Data Sec. Breach Litig.*, 928 F.3d 42, 82 (D.C. Cir. 2019). In *Doe v. Doe*, the court explained that plaintiffs proceeding under solely their initials could problematic, specifically noting "this pervasive anonymity could lead to difficulty and confusion for [Appellee] during discovery." 85 F.4th 206, 216 (4th Cir. 2023). Furthermore, in *Doe v. Megless*, the court illustrated that considerations into whether a party would forgo a suit because they were denied the ability to proceed pseudonymously weighed heavily in their calculation of the totality of the circumstances. 654 F.3d 404, 410-411 (3rd Cir. 2011). However, the court in *Megless* said, "a plaintiff's stubborn refusal to litigate openly by itself cannot outweigh the public's interest in open trials." *Id*. Lastly, the

*Megless* court looked at the public interests in the case going forward without the use of pseudonyms. *Id*. at 410. The court specifically noted that there was no evidence to show that disclosing the party's names in the case would not dissuade other people facing similar circumstances to purse a case, and therefore ruled that the presumption of openness in court was not outweighed by the litigants need for anonymity. *See Id*. at 411.

Any possible prejudice the Appellants face is not enough to outweigh the presumption of openness in litigation. First, Appellants claim that they will forgo litigation if they are not allowed to proceed anonymous, but the court in *Megless* specifically addressed this issue and said that this factor does not outweigh the public's interest in open trials. 654 F.3d at 411; (D. at 6.) Simply, because the Appellants do not want to move forward with their names being presented is not enough when weighed into the totality of the circumstances to tip the scales in favor of proceeding anonymously. Second, as the District Court noted, the public has an interest in open litigation, and Appellants failed to show that the public would be dissuaded from litigating in matters like theirs if they are not allowed to proceed anonymously. (D. at 6.) Lastly in *Doe*, the court noted that there could be discovery issues down the line due to allowing the plaintiff in the case to proceed with their initials and that is the analogous to the case here. 85 F.4$^{th}$ at 216. These

last factors that Appellants may look to for support are not enough to tip the scales in their favor and overcome the presumption of openness in courts.

## II. THE DISTRICT COURT PROPERLY DISMISSED APPELLANTS' COUNT II FOR EQUITABLE RELIEF UNDER SECTION 502(a)(3) BECAUSE COUNT II IS DUPLICATIVE OF APPELLANTS' COUNT I CLAIM FOR BENEFITS UNDER SECTION 502(a)(1)(B) AND APPELLEE DID NOT VIOLATE THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008.

ERISA is a "comprehensive and reticulated statute, the product of a decade of congressional study of the Nation's private employer benefit system." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002). ERISA's failure to include certain remedies was not an oversight by Congress, but rather, the statute's "carefully crafted and detailed enforcement scheme provides strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly," emphasizing courts' reluctance "to tamper with [ERISA's] enforcement scheme." *Id*. (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)).

Under ERISA Section 502(a), a civil action may be brought by a participant or beneficiary to *recover benefits due*, to *enforce rights*, or to *clarify rights to future benefits* under the terms of the plan. 29 U.S.C. § 1132(a)(1)(B) (emphasis added). Furthermore, a civil action may also be brought by a participant, beneficiary, or fiduciary to: (1) enjoin any act or practice which violates any

provision of the subchapter or the terms of the plan; (2) obtain other appropriate equitable relief to redress such violations; or (3) enforce any provisions of the subchapter or the terms of the plan. 29 U.S.C. § 1132(a)(3). In other words, Section 502(a)(3) functions as a "safety net," offering appropriate equitable relief for injuries caused by violations that Section 502 does not adequately remedy elsewhere in the act. *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 371 (6th Cir. 2015). Notably, besides a few exceptions and rare factual circumstances, a plaintiff is not permitted to recover from claims under both Sections 502(a)(1)(B) and 502(a)(3).

The Parity Act is an amendment to ERISA. *See* 29 U.S.C. § 1185a. Congress enacted the Parity Act "to end discrimination in the provision of insurance coverage for mental health and substance use disorders as compared to coverage for medical and surgical conditions in employer-sponsored group health plans." *Am. Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 356 (2d Cir. 2016). This provision maintains a requirement that plans providing for "both medical and surgical benefits and mental health or substance use disorder benefits" must not impose more coverage restrictions on mental health problems than it imposes on medical or surgical problems. *See* 29 U.S.C. § 1185a(a)(3)(A); *Stone v. UnitedHealthcare Ins. Co.*, 979 F.3d 770, 774 (9th Cir. 2020). This prohibits providers from applying separate treatment limitations only to mental health

benefits that are more restrictive than "the predominant treatment limitations applied to substantially all medical and surgical benefits." 29 U.S.C. § 1185a(a)(3)(A)(ii). Concisely, plan administrators are obligated to treat mental health and substance use disorder coverage on par with other medical coverage.

a. Appellants are barred from recovering under both Sections 502(a)(1)(B) and 502(a)(3) because Appellants' claims are duplicative of each other and do not fall into any exception that would change that determination.

Remedies under Sections 502(a)(1)(B) and 502(a)(3) do not often overlap. *See e.g.*, *Pilger v. Sweeney*, 725 F.3d 922, 927 (8th Cir. 2013) ("Plaintiffs' ability to seek this relief in their § 1132(a)(1)(B) claim forecloses them from also pursing it in this § 1132(a)(3)(B) claim"). Instead, the Supreme Court regularly limits such an expansion of ERISA coverage by acknowledging "where Congress elsewhere provided *adequate* relief for a beneficiary's injury, there will likely be *no need for further equitable relief*, in which case such relief normally *would not be appropriate*." *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (emphasis added).

As the seminal case discussing the interplay between Sections 502(a)(1)(B) and 502(a)(3), the *Varity* court highlighted the notion that ERISA remedies are concerned with the *adequacy* of relief to rectify the claimant's injury, rather than the nature of the defendant's wrongdoing. *See id.* Equitable relief under Section 502(a)(3) is not appropriate when a more specific section of ERISA provides a remedy similar to what the plaintiff seeks under the equitable catchall provision.

*Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 726 (8th Cir. 2014). Accordingly, the Supreme Court cautions against permitting a plaintiff beneficiary to simply "repackage" their denial-of-benefits claim under Section 502(a)(1)(B) as a claim for breach of fiduciary duty under Section 502(a)(3). *See Varity*, 516 U.S. at 513.

As an exception to *Varity's* stance on the duplicative nature between Sections 502(a)(1)(B) and 502(a)(3), individual relief for wrongfully denied benefits under Section 502(a)(1)(B) and plan-wide injunctive relief under Section 502(a)(3) may be considered two discrete injuries if the injunctive relief claim is based upon the defendant's breach of its fiduciary duty. *See Hill v. Blue Cross & Blue Shield of Mich.*, 409 F.3d 710, 717–18 (6th Cir. 2005); *Peters v. Aetna Inc.*, 2 F.4th 199, 238 (4th Cir. 2021). *Compare Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 615–16 (6th Cir. 1998) (holding, because Section 502(a)(1)(B) provides a remedy for the plaintiff's alleged injury from a denial of benefits to which the plaintiff believes she is entitled, she does not have a right to a cause of action for breach of fiduciary duty pursuant to Section 502(a)(3)), *with Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 891–92 (7th Cir. 2013) (citing *CIGNA Corp. v. Amara*, 563 U.S. 421, 444–45 (2011)) (holding equitable relief is available under Section 502(a)(3) in appropriate circumstances, such as monetary compensation for a breach of fiduciary duty).

Moreover, ERISA plaintiffs may not pursue "a duplicative or redundant remedy … to redress the same injury." *Rochow*, 780 F.3d at 373. In *Rochow*, the plaintiff recovered all benefits that he had been wrongfully denied under Section 502(a)(1)(B), which was an adequate remedy for the plaintiff's only injury suffered—the denial of his benefits. *See id.* at 374. The Sixth Circuit held "[t]he remedy Congress chose to make available under § 502(a)(1)(B) having thus not been shown to be inadequate, it follows that permitting [the plaintiff] to obtain further equitable relief for the same injury under § 502(a)(3) would contravene the scheme established by Congress as well as the Supreme Court's teaching in *Varity*." *Id.* at 374–75; *see also Varity*, 516 U.S. at 515 (indicating equitable relief is not appropriate where Congress has elsewhere provided adequate means of redress for a claimant's injury).

Here, Appellants are simply not permitted to recover twice. Appellants pursued a cause of action for Appellee's denial of benefits under Section 502(a)(1)(B). Thus, as seen in *Rochow*, Section 502(a)(1)(B) governs Appellants' claims and would be the proper remedy to make Appellants whole, *but only if they can prove their injury*. Nonetheless, Appellants do not stop there.

In addition to seeking relief under Section 502(a)(1)(B)—requiring Appellee to pay the cost of Appellant's treatment at Lifeline—Appellants also seek an injunction under Section 502(a)(3), demanding Appellee pay the cost of treatment

in the future if Appellant relapses and needs residential care again. (C. at 7.) However, Appellants' additional claim for an injunction under Section 502(a)(3) fails because Congress already considered this type of assertion when constructing ERISA.

Contrary to Appellants' contention, their equitable relief claim for an injunction is enclosed within Section 502(a)(1)(B), since that provision permits *not only* a suit "to recover benefits due," *but also* permits a claim "to clarify [a claimant's] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). On its face, that is precisely what Appellants are attempting to accomplish in Count II—clarify their rights to future benefits should Appellant relapse and require care in the future. (C. at 5–7.) Similar to *Rochow*, if proven, Appellants suffered *one injury*—their alleged denial of benefits—and Section 502(a)(1)(B) is more specific to, and governs that claim entirely. *See Silva*, 762 F.3d at 726 (holding catchall equitable relief under Section 502(a)(3) is not permitted when a more specific section of ERISA, such as Section 502(a)(1)(B), provides a remedy for the plaintiff's injury). Therefore, Appellants' relief under Section 502(a)(3) is not permissible because it would be duplicative of Appellants' remedies under Section 502(a)(1)(B).

Further, in specific factual circumstances, injunctive relief under Section 502(a)(3) could make an ERISA plaintiff whole—who also alleges wrongful denial

of benefits under 502(a)(1)(B)—by requiring the insurer to alter the manner in which it administers *all* the program's claims for particular coverages, such as emergency-medical-treatment expenses. *See Hill*, 409 F.3d at 718. In *Hill*, the plaintiffs sought plan-wide injunctive relief under Section 502(a)(3), alleging the administrator for the plaintiffs' employer-sponsored health insurance program violated its fiduciary duties to program members by "utilizing an automated claims-processing system that makes claim determinations based on a physician's *final diagnosis* rather than the claimant's signs and symptoms at the time of treatment" when determining what constitutes a "medical emergency." *Id.* at 714–16 (emphasis added). To the plaintiffs' advantage, and in opposition to the administrator's automated system, the program's definition of "medical emergency" stated the plaintiffs' "signs and symptoms […], and *not the final diagnosis*, must confirm the existence of a threat" to the plaintiff. *Id.* at 714. The district court dismissed the plaintiffs' Section 502(a)(3) claim for injunctive relief, finding the plaintiffs' alleged fiduciary-duty claims "were merely repackaged claims for individual benefits and did not constitute actual fiduciary-duty claims." *Id.* at 717. The Sixth Circuit reversed, distinguished *Varity*, and held the plaintiffs' relief under the catchall provision arose out of a defect in *plan-wide* claim handling procedures that were contrary to the program's set definitions and resulted in a breach of the administrator's fiduciary duty. *See id.* at 718. Therefore, this plan-

wide claim mishandling was a *separate injury* to the plaintiffs and constituted a valid claim under Section 502(a)(3). *Id.*

Here, Appellants' injunctive relief claim under Section 502(a)(3) does not fall within *Hill's* exception to *Varity* because Appellants failed to show Appellee breached any plan-wide fiduciary duty under ERISA. Instead, Appellants allege they "have been damaged in the amount of all of the out-of-pocket medical bills incurred for their desired treatment," and further seek to "clarify [Appellant's] rights to future benefits under the terms of [her] plan" through an injunction. (C. at 5–7.) Contrary to the administrators plan-wide mishandling of claims in *Hill*, here Appellants' contention that Appellee violated the Parity Act fails because Appellee evaluates *all* residential treatment matters—not just mental health illnesses—under the same "medically necessary" standard. (Ex. A.) The only reasonable interpretation of the Plan's unambiguous language is that the Plan only covers residential treatment for "medically necessary" care, no matter the illness or condition being treated. (Ex. B.)

Residential treatment—for both mental and physical illnesses—is considered medically necessary for those who meet all the following: they (1) cannot cooperate with treatment unless they have round-the clock structured care; (2) are a danger to themselves or others; and (3) cannot be safely treated at a lower level of care. (Ex. B.) Appellee's "medically necessary" standard for residential treatment

is applied equally to mental health and substance use illnesses as it is to physical and surgical conditions. Accordingly, if proven, Appellants would have one singular injury for their denial of benefits, and their invalid claim under Section 502(a)(3) would therefore be duplicative of Appellants' Section 503(a)(1)(B) claim because the Plan complies with the Parity Act.

Additionally, an ERISA plaintiff may plead claims under Sections 502(a)(1)(B) and 502(a)(3) alternatively, but not redundantly. *See Silva*, 762 F.3d at 726; *see also* Fed. R. Civ. P. 8(d)(2) ("A party may set out 2 or more statements of a claim or defense alternatively or hypothetically, either in a single count or defense or in separate ones"). In *Silva*, the plaintiff presented two alternative theories of liability—as opposed to duplicative theories. *See* 762 F.3d at 726. The Eighth Circuit held the plaintiff may plead both theories because the plaintiff's claims were based on *alternative* legal bases for relief. *Id.* at 728. Conversely, if on remand, the district court found defendants liable under the plaintiff's Section 502(a)(1)(B) claim, then the court need not reach the plaintiff's equitable catchall claim under Section 502(a)(3), "as the former subsection has already provided the plaintiff with adequate relief." *Id.*

Here, not only are Appellants not permitted to *recover* twice under ERISA, but Appellants are also not permitted to *plead* duplicative theories of liability as they did in their complaint. Appellants "made it clear in their briefs and argument

before [the district court] that they will not file an amended complaint." (O. at 10.) *Varity, Rochow,* and *Hill* make clear that Appellants' injunctive relief claim under Section 502(a)(3) is duplicative of their Section 502(a)(1)(B) claim for benefits because Appellants allege only one injury. Since Appellants' complaint does not allege their injunctive relief claim in the alternative, and they will not amend, Appellants are not permitted to plead duplicative theories of liability against Appellee.

Having established Appellants' duplicative claims are not saved by the exception in *Hill*, both claims should be evaluated under the standard set by the Supreme Court in *Varity* and exemplified in circuit cases like *Rochow*. This Court should affirm the district court's dismissal of Count II for equitable relief because Appellants' claim for an injunction under Section 502(a)(3) is duplicative of their 502(a)(1)(B) claim for benefits in Count I, and their *single* alleged injury, if proven, is adequately remedied through their 502(a)(1)(B) claim.

b. Even if Appellants' Count I and II claims are not duplicative, Appellants' equitable relief claim in Count II still fails because Appellee's medically-necessary standard for residential treatment is applied equally to both mental and physical illnesses and therefore, Appellee did not violate the Mental Health Parity and Addiction Equity Act of 2008.

As an amendment to ERISA, the Parity Act requires plans providing for "both medical and surgical benefits and mental health or substance use disorder

benefits" must not impose more restrictive coverage on mental health illnesses than it imposes on medical or surgical conditions. *See* 29 U.S.C. § 1185(a)(3)(A); *Stone v. UnitedHealthcare Ins. Co.*, 979 F.3d 770, 774 (9th Cir. 2020). This prohibits providers from applying separate treatment limitations only to mental health benefits that are more restrictive than "the predominant treatment limitations applied to substantially all medical and surgical benefits." 29 U.S.C. § 1185a(a)(3)(A)(ii). The term "treatment limitation" is defined by the Parity Act to refer to "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." 29 U.S.C. § 1185a(a)(3)(B)(iii). This means plan administrators are obligated to treat mental health and substance use disorder coverage on par with other medical and surgical coverage.

When a health care plan's term or condition, regarding the treatment of mental health and substance use problems, is "applied equally to all benefits" under the plan, that term or condition does not violate the Parity Act. *See Stone*, 979 F.3d at 776. In *Stone*, the plaintiff's employer-provided health care plan excluded coverage for *any* out-of-state treatment, whether for mental or physical health issues. *See id.* at 771. The plaintiff understood her plan did not cover any out-of-state treatment, yet still enrolled her daughter into a residential treatment center in a different state. *Id.* at 772. After the plaintiff was denied benefits for her

daughter's out-of-state treatment, she filed an ERISA complaint alleging a denial of benefits under Section 502(a)(1)(B) and a breach of fiduciary duty under the Parity Act. *Id.* at 773. The district court concluded the Parity Act did not apply because there was *no disparity* in the plaintiff's plan between the coverage for mental and physical illnesses. *Id.* The Ninth Circuit affirmed, holding there was no dispute that the plan's limitation for out-of-state treatment applies to *any* type of treatment and that the plaintiff did not present any evidence that the plan's coverage of mental illnesses is "less generous than its coverage of physical illnesses, or that the exclusion for out-of-state treatment limits coverage of mental health conditions, but not physical health conditions." *Id.* at 777.

Here, even though the district court did not reach the issue, this Court should ultimately hold the Plan does not violate the Parity Act because Appellants fail to provide evidence that receiving treatment at a level of "partial hospitalization" is a more restrictive limitation on mental health treatment than the Plan's limitations on treatment for medical and surgical illnesses. Similar to the plaintiff's health care plan in *Stone* that excluded coverage for *any* out-of-state treatment, here the Plan only covered medically necessary care for *all* types of residential treatment, including treatment for mental health, substance use, physical illnesses, and surgical procedures. *See* 979 F.3d at 771–72; (Ex. B.)

Importantly, Appellant's psychiatrist disagreeing with Appellee's determination that Appellant's residential treatment was no longer medically necessary does not change the fact that Dr. James Matzer conducted a good-faith review that "included more than clinical guidelines and scientific data alone," but also considered Appellant's personal health and the Plan as well. (Ex. B.) Accordingly, Appellants' self-conceived "fail first" assertion is unsupported because the Plan provided Appellant with three weeks of residential treatment before Appellee's medical professionals concluded Appellant was no longer actively suicidal. (Ex. B.) Thus, Appellant was not required to "fail first" under the Plan.

Furthermore, another reviewing physician, Dr. Jennifer Lawrence, relied on Appellee's Standard of Care Guidelines to determine residential treatment was no longer medically necessary because Appellant could safely receive the care she needed at a partial hospitalization level. (Ex. C.) *See also* (Ex. B) (stating residential treatment is considered medically necessary *only* for those who (1) cannot cooperate with treatment without round-the clock structured care; (2) are a danger to themselves or others; *and* (3) *cannot be safely treated at a lower level of care*). In *Stone*, the Ninth Circuit held the Parity Act did not apply because the plaintiff did not present any evidence that her plan's exclusion of out-of-state treatment limited coverage of mental health conditions, but not physical health

conditions. *See* 979 F.3d at 777. Likewise, here the record is absent of any factual evidence showing Appellee's residential treatment guidelines are applied more restrictively or separately to mental health and substance use illnesses than to physical or surgical conditions, and therefore, Appellee did not violate the Parity Act.

Even if Appellants' Count I and II claims are not considered duplicative by this Court, Appellants' equitable relief claim in Count II still fails because Appellee's medically-necessary standard is applied *equally* to *all* types of residential treatment under the Plan, including treatment for mental health, substance use, physical illnesses, and surgical procedures. Therefore, Appellee did not violate the Parity Act and the district court properly dismissed Appellants' Count II claim for equitable relief.

## III. EVEN IF THE COURT DOES NOT FIND FOR APPELLEE ON THE FIRST TWO GROUNDS, AND EVEN THOUGH THE DISTRICT COURT DID NOT RULE ON THIS ISSUE BEFORE, COUNT II SHOULD BE DISMISSED AS A MATTER OF LAW FOR FAILING TO PLEAD A SPECIFIC PLAUSIBLE CLAIM.

Count II should be dismissed for an independent basis because Appellants' allegations regarding the "fail first" application of the Parity Act are non-specific and insufficient under the plausibility standard as a matter of law.

A motion to dismiss as a matter of law permits the court to determine that even if all the alleged facts are assumed to be true, the Plaintiff's claim will fail.

*See* Fed. R. Civ. P. 12; *Savage v. Scales*, 310 F. Supp. 2d 122, 136 (D.D.C. 2004). Although allegations of fact must be accepted as true, legal conclusions are not binding on the court. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). By definition, a fact is, "an actual or alleged event or circumstance, as distinguished from its legal effect or consequence, or interpretation." *Black's Law Dictionary* 709 (10th ed. 2014). Conversely, a conclusion of law is, "an inference on a question of law, made as a result of a factual showing, [with] no further evidence being required." *Id*. at 351. Ergo, courts must precisely distinguish if each allegation is a fact or a conclusion of law when assigning its proper weight in a dismissal interpretation.

After removing conclusions of law from the allegations, pleadings must still specifically allege "more than an unadorned, the-defendant-unlawfully-harmed-me accusation." *See* Fed. R. Civ. P 8(a)(2); *Ashcroft*, 566 U.S. at 677. Moreover, pleadings may be outright dismissed if they merely declare "'naked assertions' devoid of 'further factual enhancement'" that are not specific or plausible. *Id*; *Bell Atlantic Corp. v. Twombly*, 550 U.S. 554, 556 (2007). Thus, upon combining the sentiments of Federal Rules of Civil Procedure 8 and 12, the plausibility standard considers whether the complaint: (1) pleads sufficient, specific, and nonconclusory factual matters; and (2) allows the court to reasonably infer the defendant is liable for the misconduct alleged. *Id*.

"Only a complaint that states a plausible claim for relief survives a motion to dismiss," and issues in a complaint may be dismissed solely for violating this standard. *See Id*. at 556. For example, in *Hughes*, the Supreme Court remanded the matter solely for reasons of considering the pleading standard in relation to whether the claim was plausibly alleged. *See Hughes v. Northwestern Univ*., 142 S. Ct. 737, 742 (2022). Importantly, on this ground, the Court placed emphasis on reevaluating the allegations from the newly specific, fact driven, and nonconclusory complaint to ensure the court could make reasonable inferences towards the defendant's alleged violations. *See Id*.

Similarly, here, Appellants' argument fails against the plausibility standard. Appellants' argument rests on their summary of the Plan—their own conclusions of law which are not binding on the court—rather than specific facts. Importantly, paragraphs twenty-seven and twenty-eight of the complaint begin with "upon information and belief," rather than stating specific facts. (C. at 6.) Here, Appellants blatantly avoid stating facts in favor of expressing pure conjecture and a characterization that they provide no proof for within the complaint.

Moreover, like *Hughes*, *Ashcroft*, and *Twombly*, where the Court required more than fancified speculations and postulations to satisfy the plausibility standard, Appellants' allegations are inadequate because their arguments are unreasonable and non-specific after removing the conclusions of law. *See Hughes*,

142 S. Ct. at 742, *Ashcroft*, 556 U.S at 677; *Twombly*, 550 U.S. at 556. Here, Appellants merely state "[Appellee] violated this requirement by applying a 'fail first' policy…[for] her mental health and substance use disorder…[but do] not apply such a 'fail first' policy with respect to long-term inpatient medical and surgical treatment,'" without citing to a specific provision in the Plan. (C. at 6.) Appellants plainly concluded that Appellee's non-coverage of the treatment was because of a "fail first" requirement—a conclusion not grounded in any factual proof and solely reliant on a term conjured by Appellants that is not found anywhere in the Plan itself.

Further, after removing the legal conclusions from Count II, Appellants' facts that may be assumed to be true are exceptionally limited. Ultimately, Appellants allege that the daughter had an illness that was covered by the Plan on an emergency basis, but her coverage ended when Appellee's doctors determined that her residential treatment was no longer medically necessary. (C. at 3-4.) Additionally, Appellants paid out-of-pocket for continuous treatment at the residential level, with full knowledge that the Plan did not cover the costs. (C. at 3-4.) Lastly, Appellants allege that Appellee utilized clinical criteria to determine the amount of coverage she was entitled to. (C. at 3-4.)

In accepting these allegations as true, the court can agree to a simple story. Appellee used doctors to assess the situation, and Appellants did not accept the

outcome the doctors arrived at after they applied clinical criteria to the facts—facts that do not promote the court to reasonably infer Appellee is liable for the alleged misconduct.

Plainly, using clinical criteria to decide Appellant is no longer covered at a high level of treatment is not a breach of the Plan. Every illness, circumstance, and individual needs their own patient-specific criteria in determining what is medically necessary, a reasonable and appropriate approach to individualized healthcare plans. While the results may vary, the restrictions placed on making these decisions remain constant throughout the process—an established coverage review by medical professionals. Thus, it may be unfortunate that Appellants feels shorted by their coverage, however, in accepting the limited specific factual allegations as true, Appellee did not violate the requirements of the Parity Act.

Lastly, in a broader view, courts are not bound by bare legal conclusions for reasons exemplified by this matter. If courts were to blindly accept all conclusive allegations as factually sufficient and specific, any plaintiff under any plan could bring an action and undoubtably win—*endlessly*. Here, it is clear through Appellants' reliance on a term found nowhere within the Plan, and their continuous use of insufficient conclusory statements dressed up as factual allegations in disguise, Appellants' claim fails as a matter of law against the plausibility standard.

Therefore, because Appellants' "fail first" legal conclusions are not binding on the court, and their remaining factual allegations regarding the Parity Act lack specificity and lead their claim to failure under the plausibility standard, this Court should find an independent basis for dismissal of Count II as a matter of law.

## CONCLUSION

For the forgoing reasons, this Court should: (1) affirm the district court's ruling that there are no extraordinary circumstances to support Appellants to proceed in this matter under their initials; (2) affirm the district court's decision that Appellants are barred from bringing their Count II claim for equitable relief under Section 502(a)(3) because it is duplicative of their claim for benefits under Section 502(a)(1)(B); and (3) dismiss Count II's fail first argument as a matter of law because it fails to plead a specific claim under the plausibility standard.

Respectfully Submitted,

*/s/ Team 12*
Team 12
ATTORNEYS FOR APPELLEE