UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

MICHELLE MAZZOLA, in her individual capacity and in her capacity as mother of BABY DOE, GUY MAZZOLA, in his individual capacity and in his capacity as father of BABY DOE, AMEC, LLC, and LISA KULLER, on behalf of themselves and all others similarly situated, Plaintiffs, v. ANTHEM HEALTH PLANS, INC., CARELON BEHAVIORAL HEALTH, INC., and ELEVANCE HEALTH, INC., Defendants.	Case No. 25 Civ. 1433 (OAW) (RAR) Oral Argument Requested

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

Date: March 2, 2026

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Plaintiffs Michelle Mazzola, Baby Doe, Guy Mazzola (together with Michelle Mazzola and Baby Doe, "the Mazzolas"), Amec, LLC, and Lisa Kuller respectfully submit this memorandum of law in opposition to Defendants Anthem Health Plans, Inc., Carelon Behavioral Health, Inc., and Elevance Health, Inc.'s motion ("Motion" or "Mot.") to dismiss the First Amended Complaint ("FAC").

PRELIMINARY STATEMENT

This case is about an insurance conglomerate lying about the size of its provider network in order to attract customers, boost profits, and avoid the costs of complying with network adequacy laws. This deceptive scheme was orchestrated by Elevance and executed through its wholly owned subsidiaries, Anthem and Carelon. It has denied vulnerable patients—including a two-year-old autistic child—the healthcare they paid for and desperately need.

Plaintiffs, like countless other Connecticut residents, enrolled in an Anthem health insurance plan that promised them access to a robust network of behavioral health providers—licensed professionals such as psychiatrists, psychologists, therapists, and social workers who diagnose, treat, and manage mental health conditions, behavioral issues, and substance use disorders. That promise—made in marketing materials, plan documents, and the Anthem provider directory—was a lie. Approximately 70% of the providers Defendants listed as in-network and available to treat new patients are phantom listings—they no longer practice, do not accept Anthem insurance, are not taking new patients, and/or do not provide the services listed. By grossly exaggerating their behavioral health provider network, Defendants lured customers (including Plaintiffs) under false pretenses, charged inflated premiums for illusory benefits, and avoided the costs of covering in-network care and maintaining a legally adequate network. Plaintiffs suffered in numerous ways, including having to forgo necessary care, incurring thousands of dollars in out-of-network expenses, and paying inflated premiums.

Plaintiffs brought this case to hold Defendants accountable for the dangerous and egregious violations of their contractual, statutory, and common law duties. Specifically, all Plaintiffs assert claims for (1) fraudulent misrepresentation; (2) negligent misrepresentation; (3) deceptive acts and practices in violation of the Connecticut Unfair Trade Practices Act ("CUTPA"); and (4) unjust enrichment. Additionally, Ms. Kuller asserts claims for (1) breach of contract and (2) breach of the covenant of good faith and fair dealing. The Mazzolas and Amec do not assert these two contract-based claims because they, unlike Ms. Kuller, purchased health insurance governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), which preempts such claims. The Mazzolas and Amec assert claims under ERISA for (1) denial of benefits in violation of 29 U.S.C. § 1132(a)(1)(B); (2) breach of fiduciary duty in violation of 29 U.S.C. §§ 1109(a), 1132(a)(2), and (a)(3); and (3) violation of the Mental Health Parity and Addiction Equity Act (the "Parity Act"), 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26.

Defendants seek to dismiss all of these claims, offering a slew of meritless arguments.

First, Defendants seek dismissal of all claims against Elevance for lack of personal jurisdiction. This argument fails because the FAC plausibly alleges that Elevance is Anthem's alter ego, operating as a single, integrated enterprise that purposefully directs its activities at Connecticut.

Second, Defendants argue that ERISA preempts all of the state law claims asserted by the Mazzolas and Amec. But these claims (fraudulent misrepresentation, negligent misrepresentation, violation of CUTPA, and unjust enrichment) are not preempted because they stem from generally applicable duties and do not require the Court to interpret the terms of an ERISA plan.

Third, Defendants contend that Ms. Kuller fails to state a claim for breach of contract or breach of the covenant of good faith and fair dealing because the FAC does not allege the

contractual terms breached and because she was not in privity with Elevance and Carelon. Both arguments are incorrect: the FAC spells out the contractual provisions that Defendants violated and sufficiently alleges that Elevance and Carelon are liable on a veil-piercing theory, as Anthem is Elevance's instrumentality and Anthem and Carelon share an identity.

Fourth, Defendants claim that Plaintiffs fail to plead their fraudulent misrepresentation, negligent misrepresentation, and CUTPA claims with particularity. However, this heightened pleading standard does not apply to Plaintiffs' negligent misrepresentation and CUTPA claims, as fraud is not a necessary element. Regardless, the FAC easily satisfies the heightened pleading standard for fraud. Indeed, it clearly identifies the fraudulent statements, the specific Defendants making the statements, when the statements were made, and why the statements are fraudulent. Moreover, contrary to Defendants' contention, the FAC clearly and repeatedly alleges that each Plaintiff relied on Defendants' misrepresentations when deciding to enroll in their Anthem health insurance plans.

Fifth, Defendants contend that the unjust enrichment claim fails because the FAC does not allege that Plaintiffs conferred a benefit on Elevance or Carelon and because Plaintiffs cannot simultaneously assert claims for unjust enrichment and breach of contract. But the FAC expressly alleges that Plaintiffs' enrollment in Anthem's plans increased Anthem's profits, which Anthem then passed on to Elevance and Carelon. And long-standing Second Circuit precedent allows Plaintiffs to plead unjust enrichment in the alternative to breach of contract.

Finally, Defendants seek dismissal of the Mazzolas' and Amec's ERISA claims for denial of benefits, breach of fiduciary duty, and violation of the Parity Act. Defendants' argument that Elevance and Carelon cannot be sued under ERISA fails because the FAC describes how Elevance and Carelon control plan administration and benefits determinations, making them proper ERISA

defendants. As to the denial of benefits claim, Defendants do not dispute that Baby Doe was entitled to and denied occupational, speech, and behavioral therapy treatments. Rather, they argue that the FAC fails to plead that the Mazzolas exhausted administrative remedies. However, Defendants misstate the pleading standard, and they ignore the six pages of allegations detailing the Mazzolas' exhausted appeals. As to the breach of fiduciary duty claim, Defendants argue that the FAC does not identify any fiduciary duty that was breached. That is incorrect. It is black-letter law that lying to plan beneficiaries violates the fiduciary duties of loyalty and good faith. Lastly, Defendants contend that the Parity Act claim fails because the FAC does not specify whether Defendants' *processes* are comparable between behavioral health and medical benefits. Defendants again ignore established precedent, as identifying disparate outcomes between behavioral and medical benefits is sufficient to state a claim. Indeed, it is the only way to allege a Parity Act violation before accessing Defendants' internal records through discovery.

In sum, Defendants' motion to dismiss should be denied in its entirety.

BACKGROUND

Plaintiffs are (1) Lisa Kuller, who suffers from a serious mental health condition known as dissociative disorder, (2) the Mazzola family (Michelle, Guy, and their two-year-old autistic child, Baby Doe), and (3) Amec, LLC, a small business owned by the Mazzolas. Ms. Kuller (through the state-run insurance marketplace) and the Mazzolas (through their small business) purchased Anthem health insurance plans, which provide behavioral health benefits through Carelon, Anthem's sister company. *See* FAC ¶¶ 19–26.[1] Plaintiffs chose to enroll in an Anthem plan based

[1] Ms. Kuller's plan is a non-ERISA plan. By contrast, the plan purchased by Amec for the Mazzolas is an ERISA plan, which means it is subject to ERISA's unique rules. Although Plaintiffs were previously informed that the Amec/Mazzola plan was a non-ERISA plan prior to 2025, *see* FAC ¶ 363, they have recently learned that it was always an ERISA plan.

on representations Anthem and Carelon made in plan documents and marketing materials regarding the breadth and quality of their behavioral health provider network. *See id*. ¶¶ 73–74, 95, 195–200, 319, 405.

Federal and Connecticut law require Anthem to maintain a sufficiently broad network of psychiatrists, psychologists, therapists, and other providers who are available to furnish behavioral health services to its members. *See id*. ¶¶ 54–57. These "network adequacy" laws are designed to ensure that health insurance companies offer convenient access to a sufficient number and array of available, in-network providers to meet the diverse needs of the insured population. *See id*. Federal and Connecticut law further require Anthem to publish an accurate, and regularly updated, directory of the providers who are in its network and available to see new patients. *See id*. ¶¶ 46–53.

Anthem's behavioral health provider network is woefully inadequate. Indeed, there are very few behavioral health providers in Connecticut who take Anthem's insurance and are available to see new patients. *See id*. ¶ 9. However, Anthem and Carelon—at the direction of their parent company, Elevance—lie about their deficient network in order to attract customers and create the appearance of network adequacy. *See id*. ¶¶ 4–5, 9–10, 27–28, 219–27, 311–18, 371, 396, 401–08. In plan documents disseminated to and relied on by Plaintiffs, Anthem represented that it complies with federal and state laws, including those regarding network adequacy and directory accuracy. *See id*. ¶¶ 251, 258, 261, 356, 364, 424. Anthem further promised Plaintiffs that by enrolling in its health insurance they would have access to the "large," "broad" network of behavioral health providers listed in its online directory. *Id*. ¶¶ 236–41, 273–77, 282; *see also id*. ¶¶ 250, 256 (quoting Anthem's contractual representation that "you can find out if a Provider or Facility is in the network for this Plan" and "also find out where they are located and details about

their license or training" by using "your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network"), 283–92 (detailing Carelon's statements about the supposedly broad network and accurate directory).

Anthem's directory shows a robust network of behavioral health providers located near Plaintiffs who are supposedly available to see new patients and qualified to treat Plaintiffs' specific conditions. *See id*. ¶¶ 150–51, 155–57, 160–62, 217–18. But that is a ruse. According to secret shopper surveys, approximately 70% of the listed providers no longer practice, do not take Anthem's insurance, are unavailable to see new patients, and/or do not provide the services listed. *See id*. ¶¶ 4, 152, 158, 163, 217–18, 275–81. Contrary to Defendants' marketing communications, contractual representations, and statutory obligations, their behavioral health provider network is virtually non-existent.

Defendants' deception worked. Plaintiffs enrolled in Anthem's health insurance, instead of better and less expensive options, because of Defendants' false promise of a robust, easily accessible provider network. *See id*. ¶¶ 73–74, 95, 195–200, 319, 405. This is not surprising: studies confirm that consumers choose their health insurance plan based largely on the breadth of the provider network. *See id*. ¶ 301.

Plaintiffs eventually discovered Defendants' scam when they sought treatment for their behavioral health issues. Using Anthem's directory, they contacted nearby providers listed as being in-network, available to see new patients, and qualified to treat their particular issues. *See id*. ¶¶ 75–80, 82–87, 202–09. However, the providers either closed down their practice, did not take Anthem's insurance, were unavailable to see new patients, or did not possess the qualifications listed in the directory. *See id*. After weeks of trying unsuccessfully to obtain in-

network care (during which time they did not receive the time-sensitive treatments they needed), Plaintiffs were forced to spend tens of thousands of dollars on out-of-network care. *See id*. ¶¶ 6, 77, 80, 83, 86, 90–93, 206, 209–10. Compounding problems, Anthem also refused to cover, or reimburse for, medically necessary treatments for Baby Doe, in violation of the terms of the Mazzolas' health insurance plan. *See id*. ¶¶ 99–112, 125–30, 165–89, 431–34.

LEGAL STANDARD

When evaluating a motion to dismiss under Federal Rule of Civil Procedure ("Rule") 12(b)(6), a court must "constru[e] the complaint liberally, accepting all factual allegations in the complaint as true, and drawing all reasonable inferences in the plaintiff's favor." *Chambers v. Time Warner, Inc.*, 282 F.3d 147, 152 (2d Cir. 2002). To survive a motion to dismiss, "detailed factual allegations" are not required. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). Rather, a complaint must simply contain sufficient factual matter, accepted as true, to "state a claim to relief that is plausible on its face." *Id.* at 570. A claim is facially plausible "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Rule 12(b)(6) "does not impose a probability requirement at the pleading stage; it simply calls for enough fact to raise a reasonable expectation that discovery will reveal evidence of [the truth of the allegations]." *Twombly*, 550 U.S. at 556.

ARGUMENT

Defendants move to dismiss the FAC on the following grounds: lack of personal jurisdiction over Elevance; ERISA preemption; lack of contractual privity between Ms. Kuller, on the one hand, and Elevance and Carelon, on the other; failure to plead fraud with particularity; failure to exhaust administrative remedies; and failure to allege the necessary elements of each claim. As explained below, these arguments are meritless.

I. ELEVANCE IS SUBJECT TO PERSONAL JURISDICTION IN CONNECTICUT

Defendants do not dispute personal jurisdiction over Anthem and Carelon, but argue the Court lacks personal jurisdiction over their parent company, Elevance. *See* Mot. at 7–12. Personal jurisdiction is proper when a defendant's conduct satisfies (1) Connecticut's long-arm statute and (2) the Due Process Clause's minimum contacts requirement. *See Ferra v. Munro*, 585 B.R. 269, 282 (D. Conn. 2018). Dismissal "is appropriate only if the submissions, when viewed in the light most favorable to the plaintiff, fail to make a prima facie showing of personal jurisdiction." *Gorbecki v. Mercedes Benz of Sarasota*, 2008 WL 2185914, at *3 (D. Conn. May 22, 2008) (citing *Distefano v. Carozzi N. Am., Inc.*, 286 F.3d 81, 84 (2d Cir. 2001)). The FAC's allegations as to Elevance, Anthem's alter ego, satisfy both requirements.

A. Connecticut's Long-Arm Statute Reaches Elevance Because It Is Anthem's Alter Ego

Connecticut's long-arm statute, Conn. Gen. Stat. § 33-929(f), subjects a foreign corporation to suit arising from tortious conduct or repeated solicitation of business in the state. When a complaint alleges that a foreign corporation is the alter ego of a domestic defendant, the corporate veil may be pierced "so that acts of the domestic subsidiary can be imputed to the absent parent." *Shanshan Shao v. Beta Pharma, Inc.*, 2019 WL 7882485, at *10 (D. Conn. Sept. 23, 2019) (quoting *Hersey v. Lonrho, Inc.*, 807 A.2d 1009, 1015 (Conn. App. Ct. 2002)); *see also Procaccino-Hague v. Boll Filter Corp.*, 2004 WL 78155, at *3 (D. Conn. Jan. 13, 2004) (holding long-arm statute satisfied by "interrelated operations" and "common management and financial control" of Connecticut subsidiary by foreign parent).

The FAC pleads sufficient facts to establish jurisdiction over Elevance based on its repeated solicitation of its health insurance plans and related tortious activity in Connecticut. *See* FAC ¶¶ 399–418. The allegations in the FAC—including that Elevance is Anthem's sole owner,

see id. ¶ 219, does business under the Anthem name, *see id.* ¶ 226, "actively directs and controls Anthem's … activities," *id.* ¶¶ 27–28, uses Anthem to interface with customers and administer its health insurance plans, *see id.* ¶ 221, sets Anthem's policies and oversees and controls its operations, *see id.* ¶ 223, "actively manages" and "handl[es Anthem's] finances, information and technology systems, and claims processing," *id.* ¶ 27, and pockets Anthem's profits, *see id.* ¶ 225—support piercing the corporate veil to establish jurisdiction over Elevance. *See Duff v. Centene Corp.*, 565 F. Supp. 3d 1004, 1018 (S.D. Ohio 2021) (holding that parent insurance company could be held liable for subsidiary's lies about its provider network on alter ego and veil-piercing grounds based on similar allegations).

Unlike an alter ego theory of liability, the establishment of an alter ego relationship for jurisdictional purposes does not require a showing that the relationship was used to commit fraud. *See Star Child II, LLC v. Lanmar Aviation, Inc.*, 2013 WL 1103915, at *9 (D. Conn. Mar. 16, 2013). Even so, the FAC alleges Elevance's involvement in the fraud perpetrated through Anthem, specifically that "Elevance … oversaw and directed Anthem to maintain and publish th[e] materially false directory of providers," FAC ¶¶ 308, 313, 371, used Anthem "to deceive Plaintiffs about the extent of Anthem's provider network and terms of coverage," *id.* ¶ 315, and engaged in this deception to attract customers and boost Elevance's profits, *see id.* ¶¶ 225, 325, 396, 420. These allegations further support personal jurisdiction.

B. This Court's Exercise of Personal Jurisdiction Over Elevance Comports with Due Process

The exercise of personal jurisdiction over Elevance is proper because Elevance "purposefully avail[ed] itself of the privilege of conducting activities within" Connecticut. *Hanson v. Denckla*, 357 U.S. 235, 253 (1958). The FAC alleges Elevance has had continuous and systematic contacts with Connecticut by functioning as Anthem's alter ego to conduct business in

the state. *See* FAC ¶¶ 27–28, 219–35. By operating as a single, integrated enterprise with Anthem, Elevance's Connecticut activities are more than sufficient to establish the necessary contacts for personal jurisdiction. *See Procaccino-Hague*, 2004 WL 78155, at *3.

The exercise of personal jurisdiction over Elevance also "comport[s] with fair play and substantial justice." *U.S. Bank Nat'l Ass'n v. Bank of Am. N.A.*, 916 F.3d 143, 150 (2d Cir. 2019) (cleaned up). Plaintiffs are Connecticut domiciliaries, *see* FAC ¶¶ 19–24, and Elevance made fraudulent misrepresentations to Plaintiffs with respect to Connecticut-specific plans, *see id*. ¶¶ 9–10, 78–87, 97, 200, 202–05, 207–08, 311–18, 371, 401–08, giving Elevance "fair warning" that its misrepresentations could "subject [it] to the jurisdiction of a foreign sovereign," *Burger King Corp. v. Rudzewicz*, 471 U.S. 462, 472 (1985) (cleaned up); *see also Procaccino-Hague*, 2004 WL 78155, at *3 (foreign parent "cannot argue that it was unaware that it could be subjected to suit in Connecticut for … tortious conduct where [subsidiary] had established a branch office"). Moreover, Connecticut has "a manifest interest in providing its residents with a convenient forum for redressing injuries inflicted by out-of-state actors," *Burger King Corp.*, 471 U.S. at 473 (cleaned up), particularly when these injuries involve matters of significant state policy, *see* FAC ¶¶ 383–98.

Because the FAC's allegations are more than sufficient to make a prima facie showing of personal jurisdiction over Elevance, Defendants' effort to dismiss all claims against Elevance on jurisdictional grounds should be denied.

II. THE MAZZOLAS' AND AMEC'S STATE LAW CLAIMS ARE NOT PREEMPTED BY ERISA

Unlike Ms. Kuller, the Mazzolas are enrolled (through Amec) in a health insurance plan governed by ERISA. The Mazzolas and Amec are not asserting claims for breach of contract or breach of the covenant of good faith and fair dealing because, as the FAC acknowledges, ERISA

preempts such claims.[2] However, they are asserting four other state law claims, specifically: (1) violation of CUTPA (Count Four); (2) fraudulent misrepresentation (Count Five); (3) negligent misrepresentation (Count Six); and (4) unjust enrichment (Count Seven). Plaintiffs allege that Defendants lied about the scope and sufficiency of their behavioral health provider network to attract customers and boost profits. *See* FAC ¶¶ 10, 396, 410, 422–24. This alleged misconduct violates basic legal duties generally applicable to all businesses operating in Connecticut, and falls outside of ERISA's exclusive purview. Therefore, contrary to Defendants' contention, *see* Mot. at 14–16, ERISA does not preempt the Mazzolas' and Amec's four state law claims.

Section 514 of ERISA provides that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Supreme Court has held that ERISA preempts a state law claim when: (1) the plaintiff "could have brought his claim under ERISA"; and (2) "there is no other independent legal duty that is implicated by a defendant's actions." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). The Second Circuit has held that ERISA preemption does not apply where the applicable state law claims are "neutral toward ERISA plans." *Stevenson v. Bank of New York Co., Inc.*, 609 F.3d 56, 62 (2d Cir. 2010); *see also Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989) (noting that "laws that have been ruled preempted … provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee"). The Mazzolas' and Amec's

[2] *See* Counts One and Three (stating claims on behalf of those "enrolled in a non-ERISA plan"). Since the filing of the FAC, Plaintiffs have learned that the Amec plan has always been covered by ERISA (they were previously informed that it was a non-ERISA plan prior to 2025). Accordingly, Plaintiffs are no longer pursuing Count Two (breach of contract on behalf of Amec) because it is preempted by ERISA.

state law claims have nothing to do with ERISA—they stem from generally applicable prohibitions on commercial deception.

Each of the Mazzolas' and Amec's state law claims addresses legal protections distinct from their rights under their ERISA plan. The CUTPA claim alleges that Defendants engaged in deception by "misrepresenting the breadth of the Anthem provider network in informational and marketing materials and in their online directory" in order to "attract members." FAC ¶¶ 383, 396. The fraudulent misrepresentation and negligent misrepresentation claims allege that Defendants "misled [prospective customers] regarding the breadth and adequacy of the network and the availability of behavioral health providers" and "negligently misrepresented [Defendants'] provider network and the availability of behavioral health providers." *Id.* ¶¶ 401, 413. The claim for unjust enrichment alleges that Defendants' "lies artificially inflated the price of, and induced Plaintiffs to enroll in, Anthem's plan, which increased the premiums paid to Anthem and, by extension, the money Anthem paid to Carelon and Elevance." *Id.* ¶ 420. The Court does not need to interpret any plan term to adjudicate these claims, and thus, there is no preemption. *See Geller v. Cnty. Line Auto Sales, Inc.*, 86 F.3d 18, 23 (2d Cir. 1996); *Connecticut Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP*, 128 F. Supp. 3d 501, 517 (D. Conn. 2015) (no ERISA preemption when the "crux of the state fraud claim is the surgical centers' alleged misconduct … not the terms of the ERISA-governed plans"). Stated another way, "laws of general application … whose effect on ERISA plans is incidental" are not preempted. *Aetna Life Ins.*, 869 F.2d at 146. *See Guardian Flight LLC v. Aetna Life Ins. Co.*, 789 F. Supp. 3d 214, 238 (D. Conn. 2025) (holding that ERISA did not preempt plaintiffs' CUTPA claim); *NEMS PLLC v. Harvard Pilgrim Health Care of Connecticut Inc.*, 615 F. Supp. 3d 125, 142 (D. Conn. 2022) (same); *Geller*, 86 F.3d at 23 (holding that ERISA did not preempt plaintiffs' fraudulent misrepresentation claim); *Connecticut Gen. Life*

Ins., 128 F. Supp. 3d at 517 (same); *Cigna Health & Life Ins. Co. v. BioHealth Lab'ys, Inc.*, 2025 WL 1450727, at *13–14 (D. Conn. May 20, 2025) (holding that ERISA did not preempt plaintiff's unjust enrichment claim); *Emergency Physician Servs. of New York v. UnitedHealth Grp., Inc.*, 749 F. Supp. 3d 456, 470 (S.D.N.Y. 2024) (same).

Defendants incorrectly argue that these state law claims require interpretation of the ERISA plan's terms. *See* Mot. at 15–16. The terms of the plan, however, address the services covered, the cost of coverage, and the process for filing, adjudicating, and appealing claims for benefits. Evaluating Defendants' liability for deceptively marketing their health insurance requires no interpretation of the rules for making coverage and benefit determinations.

Moreover, the Mazzolas' and Amec's state law claims, and their corresponding requested relief, are separate and distinct from their ERISA claims.[3] That is further reason why preemption does not apply. *See, e.g.*, *Gerosa v. Savasta & Co.*, 329 F.3d 317, 329 (2d Cir. 2003) (holding that ERISA did not preempt state law claims seeking money damages because "the 'appropriate equitable relief' authorized by [29 U.S.C.] § 1132(a)(3) will rarely have any meaningful deterrent effect … since such relief cannot compare to a common-law action for damages"); *Skaggs v. Subway Real Estate Corp.*, 2006 WL 1042337, at *5 (D. Conn. Apr. 19, 2006) (holding ERISA did not preempt state law claim that sought "damages other than the loss of benefits under the health plan").

[3] Whereas the state law claims seek monetary damages, including damages beyond just the loss of benefits under the plan, the ERISA claims also seek equitable relief for breach of fiduciary duty and violation of the Parity Act. *See* FAC ¶¶ 435–45, 447.

III. MS. KULLER STATES A CLAIM FOR BREACH OF CONTRACT AND BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING

The FAC asserts claims for breach of contract (Count One) and breach of the covenant of good faith and fair dealing (Count Three) on behalf of Ms. Kuller, the sole Plaintiff enrolled in a non-ERISA plan. *See* FAC ¶¶ 353–60, 369–74.

Ms. Kuller's health insurance contract requires Anthem to supply a provider network that matches its provider directory and complies with network adequacy laws. *See id.* ¶¶ 256–58. Ms. Kuller alleges breach of contract and breach of the covenant of good faith and fair dealing based on the violation of these contractual obligations.

To state a claim for breach of contract in Connecticut, a plaintiff must plead "1) formation of an agreement, 2) performance by one party, 3) breach by the other party, and 4) damages." *Wnorowski v. Univ. of New Haven*, 552 F. Supp. 3d 308, 315 (D. Conn. 2021). Breach of the covenant of good faith and fair dealing requires the defendant to have acted in bad faith to impair the plaintiff's right to receive the benefits of the contract. *See De La Concha of Hartford, Inc. v. Aetna Life Ins. Co.*, 849 A.2d 382, 388 (Conn. 2004). It must be tied to an alleged breach of a contractual obligation.

A. Anthem

Anthem does not dispute the first (formation of an agreement), second (performance by one party), or fourth (damages) elements of breach of contract. Its only argument—with respect to both breach of contract and breach of the covenant of good faith and fair dealing—is that the FAC "does not plausibly allege conduct … that breached a term of Kuller's agreement." Mot. at 18; *see also id*. at 20. That is false.

The FAC clearly spells out the contractual provisions that were breached. Ms. Kuller's health insurance contract states that she will be able to "find out if a Provider or Facility is in the

Network for this Plan," as well as "where they are located and details about their license or training," by using the "directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in the Plan's Network." FAC ¶ 256. It also states that "on Anthem's website," "You may … obtain … A listing/directory of In-Network Providers." *Id*. The contract explicitly "require[s]" Anthem "to confirm the list of In-Network Providers in its Provider Directory every 90 days." *Id*. ¶ 257. In addition, the contract explicitly "requires Anthem to comply with all applicable federal and state laws," which would include laws mandating directory accuracy and network adequacy. *Id*. ¶ 258.

The FAC clearly alleges that Anthem breached these contractual provisions by maintaining: (1) a grossly inaccurate provider directory, in which approximately 70% of the listed providers no longer practice, do not take Anthem's insurance, are unavailable to see new patients, and/or do not provide the services listed; and (2) a woefully inadequate behavioral health provider network, in which there are virtually no available in-network providers. *See id*. ¶¶ 4, 9, 152, 158, 163, 217–18, 275–81, 356–57. *See generally Wilson v. Centene Mgmt. Co., L.L.C.*, --- F.4th ---, 2026 WL 473217, at *2, 6–7 (5th Cir. Feb. 19, 2026) (vacating denial of class certification in breach of contract case involving similar facts).

Thus, contrary to Anthem's contention, the FAC plausibly alleges conduct that breached Ms. Kuller's contract.

B. Elevance and Carelon

Elevance and Carelon seek dismissal of the breach of contract and breach of the covenant of good faith and fair dealing claims because they were not parties to Ms. Kuller's contract. *See* Mot. at 16–17, 19–20. However, the claims against Elevance and Carelon cannot be dismissed at this stage because the FAC plausibly alleges liability on a veil-piercing theory. *See Avant Cap. Partners, LLC v. Strathmore Dev. Co. Michigan, LLC*, 2015 WL 136391, at *5 (D. Conn. Jan. 9,

2015) (explaining that non-contracting parties may be held liable for breach of contract and breach of covenant of good faith and fair dealing under a veil-piercing theory).

Under Connecticut law, "courts disregard the fiction of a separate legal entity to pierce the shield of immunity afforded by the corporate structure in a situation in which the corporate entity has been so controlled and dominated that justice requires liability to be imposed on the real actor." *Tucker v. Am. Int'l Grp., Inc.*, 745 F. Supp. 2d 53, 70 (D. Conn. 2010) (cleaned up). There are two separate tests for piercing the corporate veil: (1) the "instrumentality" test; and (2) the "identity" test. *Id*. Elevance satisfies the instrumentality test, and Carelon satisfies the identity test.

The instrumentality test requires "(1) control by the parent of the finances, policies and business practices relating to the transaction at issue to such an extent that the subsidiary had at the time no separate mind, will or existence of its own; (2) that the parent exercised that control over the subsidiary in order to commit a fraudulent, wrongful, or otherwise unlawful act; and (3) the control and breach of duty must have proximately caused the plaintiff's injury." *Id*. (cleaned up). The FAC alleges each of these elements.

First, the FAC alleges that Elevance, Anthem's sole owner, "controls the operations of Anthem," "actively directs and controls Anthem's … activities," and "sets" its "policies."[4] FAC ¶¶ 27, 219, 223. Moreover, Elevance "actively manages" and "handl[es Anthem's] finances, information and technology systems, and claims processing." *Id*. ¶ 27.

Second, the FAC alleges that Elevance exercised its control over Anthem to deny Ms. Kuller the provider network she was promised. Indeed, the FAC alleges that "Elevance … oversaw and directed Anthem to maintain and publish th[e] materially false directory

[4] Notably, Elevance was previously called Anthem, and it recently disclosed in SEC filings that it continues to do business under the Anthem name. *See* FAC ¶ 226.

of providers" and used Anthem "to deceive Plaintiffs about the extent of Anthem's provider network and terms of coverage." *Id*. ¶¶ 313, 315. Moreover, Anthem and Carelon (Elevance's other wholly owned subsidiary) acted "under the direction of parent company Elevance to create, maintain, and promulgate an intentionally inaccurate provider directory." *Id*. ¶ 371. Elevance orchestrated this deception in order to enrich itself, as the deception attracted customers to Anthem, thereby generating profits that were siphoned off to Elevance. *See id*. ¶¶ 225, 325, 396, 420.

Third, the FAC alleges that Elevance's deceptive conduct harmed Ms. Kuller by denying her access to the behavioral health network she was entitled to and by forcing her to spend thousands of dollars on out-of-network care. *See id*. ¶¶ 202–10, 338–41, 360.

Because Elevance satisfies the instrumentality test, the breach claims against it cannot be dismissed for lack of privity. *See Duff*, 565 F. Supp. 3d at 1018–19 (denying motion to dismiss breach of contract claim against insurer's parent company based on similar facts and allegations).

Carelon satisfies the "identity" test. Under that test, a court will pierce the corporate veil if "there was such a unity of interest and ownership that the independence of the corporations had in effect ceased or had never begun," such that "an adherence to the fiction of separate identity would serve only to defeat justice and equity by permitting the economic entity to escape liability arising out of an operation conducted by one corporation for the benefit of the whole enterprise." *Tucker*, 745 F. Supp. 2d at 70 (cleaned up).

As the FAC explains, Anthem and Carelon, which are both owned and controlled by Elevance, are "inextricably intertwined." FAC ¶ 28; *see id.* ¶¶ 27, 371. They work together as one—under Elevance's command—to create the false appearance of a behavioral health provider network in order to enrich themselves and Elevance. *See id*. ¶¶ 225, 283, 290–91, 314–16, 318, 371, 420. Carelon oversees the behavioral health component of Anthem's health insurance and

communicates with Anthem members on behalf of Anthem. *See id*. ¶¶ 26, 228–35, 283, 291. In short, "Carelon is virtually indistinguishable from Anthem in its interactions with members." *Id*. ¶ 283.

Because Anthem and Carelon have a "unity of interest and ownership" and operate as a single enterprise, it would "defeat justice and equity" to allow Carelon to evade liability for denying Ms. Kuller her contractual benefits. *Tucker*, 745 F. Supp. 2d at 70 (cleaned up).

IV. PLAINTIFFS STATE CLAIMS FOR FRAUDULENT AND NEGLIGENT MISREPRESENTATION

Plaintiffs have adequately stated claims for fraudulent and negligent misrepresentation. Defendants contend that the fraudulent misrepresentation claim fails to comply with Rule 9(b) and that both the fraudulent and negligent misrepresentation claims should be dismissed for failure to plead reliance on Defendants' misstatements. *See* Mot. at 23–26.[5] Both arguments fail.

First, Plaintiffs have complied with Rule 9(b) by alleging that particular Defendants made specific false statements to Plaintiffs. *See Loreley Fin. (Jersey) No. 3 Ltd. v. Wells Fargo Secs., LLC*, 797 F.3d 160, 171 (2d Cir. 2015) (explaining that Rule 9(b) requires plaintiff to (1) detail the fraudulent statements or omissions, (2) identify the speaker, (3) state where and when the statements or omissions were made, and (4) explain why the statements or omissions are fraudulent). Plaintiffs allege that in marketing materials and plan documents, Anthem (under Elevance's direction and with Carelon's assistance) grossly exaggerated the breadth and adequacy

[5] Defendants do not appear to argue that Plaintiffs' negligent misrepresentation claim is subject to Rule 9(b). *See* Mot. at 24–25 (arguing that Plaintiffs' fraudulent misrepresentation claim is subject to Rule 9(b)); *see also Miceli v. Wearable Health Sols., Inc.*, 2024 WL 4433463, at *4 (D. Conn. Oct. 7, 2024) ("This court has previously explained that Rule 9(b) does not apply to claims of negligent misrepresentation under Connecticut law. And other courts in this district have arrived at the same conclusion." (cleaned up)). In any event, Plaintiffs' negligent misrepresentation claim satisfies Rule 9(b) for the same reasons given below.

of its behavioral health provider network, including by publishing a provider directory in which roughly 70% of the providers were improperly listed. *See* FAC ¶¶ 4, 236–41, 250, 256, 273–81, 287–91, 294–95, 313–16, 383–85. Plaintiffs further allege that "all of these misrepresentations, misstatements, and omissions are not only currently being made, they were also made before and throughout Plaintiffs' enrollment in Anthem's health insurance." *Id.* ¶ 15. And Plaintiffs allege that Defendants: (1) must have known that Anthem's representations regarding its provider network were inaccurate given prior notice of the inaccuracies, the extent of the inaccuracies, and their obligation to regularly identify and eliminate inaccuracies, *see id*. ¶¶ 47, 49, 303–04, 306, 310; and (2) intentionally lied in order to attract customers, boost profits, and reduce costs, *see id*. ¶¶ 10, 396, 410, 422–24.

Thus, the FAC specifies the precise misstatements made to Plaintiffs, when and where they were made, and who bore responsibility for them. That more than satisfies Rule 9(b). *See Loreley Fin.*, 797 F.3d at 173 ("Even under the heightened pleading standard of Rule 9(b), Plaintiffs are not obliged to disaggregate these affiliates to pursue their fraud claim."); *id.* at 174 (under Rule 9(b), courts must still consider allegations "in the light most favorable to Plaintiffs"). As the Second Circuit has emphasized, Rule 9(b) is satisfied when the complaint "clearly and repeatedly alleges that [defendant] falsely" represented that its product had certain qualities that the product in fact lacked. *MacNaughton v. Young Living Essential Oils, LC*, 67 F.4th 89, 100 (2d Cir. 2023). That is precisely what occurred here when Defendants falsely represented—in their advertising, on their website, and in their official insurance documents—that members would have access to the robust network of behavioral health providers listed in the provider directory.

Second, Plaintiffs have adequately alleged reliance on Defendants' misstatements. *Contra* Mot. at 25–26. Defendants suggest that Plaintiffs fail to allege reliance on their misstatements

when enrolling in Anthem's health insurance plans, but that is flatly contradicted by Plaintiffs' allegations. *See, e.g.*, FAC ¶ 74 ("When deciding to enroll in coverage through Anthem, the Mazzolas relied on implicit and explicit representations by Anthem that the provider directory was robust and accurate, especially with respect to behavioral health providers."); *id.* ¶¶ 196–200 (alleging that Ms. Kuller relied on Defendants' false statements regarding the breadth of the behavioral health provider network when deciding to enroll in Anthem's insurance plan); *id.* ¶ 405 ("Plaintiffs … chose to enroll in their Anthem plan (instead of better, cheaper options) based on the lies Defendants told about the [provider network]"); *id.* ¶¶ 95, 302, 416, 420 (similarly alleging Plaintiffs' reliance). These allegations are more than sufficient to allege reliance. *See O&G Indus., Inc. v. Aon Risk Servs. Ne., Inc.*, 922 F. Supp. 2d 257, 270–71 (D. Conn. 2013) (plaintiff adequately alleged reliance sufficient to state misrepresentation claim based on statements in insurer's manual); *accord Conn. Gen. Life Ins.*, 128 F. Supp. 3d at 514–15 (holding that plaintiff adequately alleged reliance on misstatements by stating it always relies on statements made by its counterparty). Because Plaintiffs allege that Defendants made specific false statements that Plaintiffs relied upon, Plaintiffs have stated claims for fraudulent and negligent misrepresentation.

V. PLAINTIFFS STATE A CLAIM UNDER CUTPA

"A plaintiff bringing a CUTPA claim must show that (1) the defendant engaged in unfair or deceptive acts or practices in the conduct of any trade or commerce; and (2) it has suffered an ascertainable loss of money or property as a result of the defendant's acts or practices." *Guardian Flight*, 789 F. Supp. 3d at 234 (cleaned up). "The CUTPA plaintiff need not prove reliance or that the [deceptive] representation became part of the basis of the bargain." *Hinchliffe v. Am. Motors Corp.*, 440 A.2d 810, 815–16 (Conn. 1981).

Individuals may bring a CUTPA claim based on violations of Connecticut's Unfair Insurance Practices Act ("CUIPA"), Conn. Gen. Stat. § 38a-816. *See Dorfman v. Smith*, 271 A.3d

53, 76 (Conn. 2022). Plaintiffs' CUTPA claim is based on Defendants' violations of Conn. Gen. Stat. § 38a-816(1) and (2). *See* FAC ¶¶ 381–85. These provisions prohibit, respectively, (1) "[m]aking" or "causing to be made" any "statement" or "omission" which "[m]isrepresents the benefits, advantages, conditions or terms of any insurance policy" and (2) "[m]aking" or "causing … to be made … an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance" which is "untrue, deceptive or misleading."

Plaintiffs state a claim under both provisions. They allege that in marketing materials, plan documents, and the online provider directory, Anthem (under the direction of Elevance and with the assistance of Carelon) grossly exaggerated the breadth and adequacy of its behavioral health provider network. *See* FAC ¶¶ 236–41, 250, 256, 273–81, 287–91, 294–95, 312–15, 383–85. Plaintiffs further allege that Defendants knew, or at least should have known, that Anthem's representations regarding its provider network were inaccurate given prior notice of the inaccuracies, the extent of the inaccuracies (roughly 70%), and their obligation to regularly identify and eliminate inaccuracies. *See id*. ¶¶ 47, 49, 303–04, 306, 310. Moreover, Plaintiffs allege that they detrimentally relied on Anthem's misrepresentations, both when choosing to enroll in Anthem's insurance and when looking for in-network care, and they incurred monetary damages in the form of out-of-network costs and inflated premiums. *See id*. ¶¶ 74, 77, 196–209, 302, 335–41, 398, 405, 416. *See Pagan v. Travelers Home & Marine Ins. Co.*, 2013 WL 1943833, at *6 (Conn. Super. Ct. Apr. 17, 2013) (holding that plaintiffs "state[d] a legally sufficient [CUTPA] claim" under § 38a–816(2) because they "allege[d] that the defendant made an untrue statement concerning the services it performs in its business of insurance, and did so to the public"); *Associated Constr. / AP Constr., LLC v. Hanover Ins. Co.*, 2017 WL 1190363, at *7 (D. Conn.

Mar. 30, 2017) (denying motion to dismiss CUTPA claim predicated on § 38a-816(1) because complaint "allege[d] a [negligent] misrepresentation of fact" regarding insurance policy).

Defendants seek dismissal of the CUTPA claim based on its purported failure to plead fraud with the particularity required by Rule 9(b). *See* Mot. at 20–21. However, "[i]t is well-established that CUTPA claims in federal court need not meet the heightened pleading standards of Rule 9(b)." *Davis v. Angelcare USA, LLC*, 727 F. Supp. 3d 99, 134 (D. Conn. 2024). That is because "fraud is not a necessary element of a state CUTPA claim." *Bruce v. Home Depot, U.S.A., Inc.*, 308 F. Supp. 2d 72, 77 (D. Conn. 2004).[6] Plaintiffs have alleged that Defendants' misrepresentations were at least negligent, *see* FAC ¶ 413, which is more than sufficient under CUTPA. *See Web Press Services Corp. v. New London Motors, Inc.*, 525 A.2d 57, 67–68 (Conn. 1987).

Regardless, as explained in Section IV, *supra*, Plaintiffs' allegations regarding Defendants' fraudulent conduct easily satisfy Rule 9(b)'s heightened pleading standard.

VI. PLAINTIFFS STATE A CLAIM FOR UNJUST ENRICHMENT

Defendants seek dismissal of Plaintiffs' unjust enrichment claim on the grounds that (1) Plaintiffs fail to allege that they conferred a benefit on Carelon or Elevance and (2) Connecticut state courts do not permit such claims to be pleaded when a plaintiff alleges that the parties had a contract. *See* Mot. at 26–28. These arguments are foreclosed by Second Circuit precedent.

First, Plaintiffs quite clearly allege that Carelon and Elevance received monetary benefits from Plaintiffs' decision to enroll in Anthem's health insurance plans. *Contra* Mot. at 27.

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[6] *See also Milo v. Galante*, 2011 WL 1214769, at *8 (D. Conn. Mar. 28, 2011) ("Only where allegations of fraudulent conduct form a necessary foundation for a claim must a plaintiff abide by the heightened standard of Rule 9(b)."); *Lentini v. Fid. Nat. Title Ins. Co. of New York*, 479 F. Supp. 2d 292, 299 (D. Conn. 2007) (dismissing fraudulent omission claim for failure to plead with particularity, but refusing to dismiss CUTPA claim premised on same allegations).

Plaintiffs allege that Defendants' false representations caused them to enroll in Anthem's health insurance plans, pay premiums to Anthem, and increase Anthem's profits. *See* FAC ¶ 225, 420–24. Plaintiffs further allege that "Anthem passes on a portion of its profits to Elevance and Carelon; thus, the more Anthem profits, the more Elevance and Carelon profit." *Id.* ¶ 225. "Accordingly, Anthem, Elevance, and Carelon all benefit financially when consumers, including Plaintiffs, enroll in Anthem's health insurance, pay premiums and other costs for that health insurance, and do not use or receive the full health insurance benefits they are owed." *Id.* That concrete monetary benefit conferred on Elevance and Carelon suffices to show that those Defendants obtained a benefit from Plaintiffs—the only element of an unjust enrichment claim that those Defendants dispute. *See* Mot. at 26; *Myun-Uk Choi v. Tower Rsch. Cap. LLC*, 890 F.3d 60, 69 (2d Cir. 2018) (holding that plaintiff could pursue unjust enrichment claim even when it had only an "indirect" relationship with the defendant, so long as plaintiff had conferred a monetary benefit); *accord Clinger v. Edgewell Personal Care Brands, LLC*, 2023 WL 2477499, at *16 (D. Conn. Mar. 13, 2023) (holding that plaintiffs stated an unjust enrichment claim where defendants indirectly benefited from plaintiffs' purchase).

Second, Defendants argue that the unjust enrichment claim against Anthem fails because Plaintiffs allege the existence of an express contract with Anthem. *See* Mot. at 28. Anthem relies on two Connecticut state court cases holding that, as a matter of state procedural law, a plaintiff cannot incorporate allegations pertinent to a breach of contract when alleging a claim for unjust enrichment. *See Piccolo v. Am. Auto Sales, LLC*, 225 A.3d 961, 971 (Conn. App. Ct. 2020); *Whitby Sch., Inc. v. Grenaille*, 2003 WL 23191957, at *2 (Conn. Super. Ct. Dec. 29, 2003). But state procedural rules do not apply in federal court. *See Gasperini v. Ctr. for Humanities, Inc.*, 518 U.S. 415, 427 (1996) (summarizing *Erie* doctrine); Fed. R. Civ. P. 8(a), (d)(3) (requiring only

"a short and plain statement" of claims and allowing a party to "state as many separate claims or defenses as it has, regardless of consistency"). And the Second Circuit has repeatedly held that unjust enrichment claims may be pleaded alongside claims for breach of contract, particularly where, as here, a defendant denies liability under the contract. *See, e.g.*, *Rynasko v. N.Y. Univ.*, 63 F.4th 186, 202 (2d Cir. 2023); *accord Intermed, Inc. v. Alphamedica, Inc.*, 2009 WL 5184195, at *6–7 (D. Conn. Dec. 21, 2009) ("a plaintiff may simultaneously plead a claim for recovery under a contract and a claim for recovery under a theory of unjust enrichment"). That is true even where, as here, Plaintiffs have pleaded the existence of an enforceable contract and have incorporated by reference all of the complaint's allegations in the unjust enrichment count. *See Rynasko*, 63 F.4th at 201–02 (holding that plaintiff plausibly alleged unjust enrichment in count that began by "incorporat[ing] by reference the allegations contained in all preceding paragraphs of this complaint,"[7] including breach of contract allegations). In any event, even if this Court concluded that Plaintiffs' unjust enrichment claim improperly incorporated the breach of contract allegations—which it should not—that would be a non-substantive defect that could be easily cured through repleading.

VII. THE MAZZOLAS AND AMEC STATE CLAIMS UNDER ERISA

The Mazzolas and Amec (the "ERISA Plaintiffs") bring Counts Eight through Ten pursuant to ERISA. *See* FAC ¶¶ 428–53. Defendants argue that Carelon and Elevance are improper ERISA defendants and that, regardless, the FAC fails to state any ERISA claim. *See* Mot. at 29–36. Each of Defendants' arguments fails.

[7] Proposed Second Amended Complaint, ECF No. 50 ¶ 147, *Rynasko v. N.Y. Univ.*, 20-CV-03250 (S.D.N.Y.).

A. Elevance and Carelon Are Proper ERISA Defendants

Defendants argue that the ERISA Plaintiffs cannot state ERISA claims against Elevance or Carelon because neither is party to the Anthem Silver Pathway CT PPO Plan (the "Silver Plan"). *See* Mot. at 29. Defendants misstate the law. The proper inquiry is whether Carelon and Elevance "exercised [] control" over the Plan. *Est. of Kenyon v. L + M Healthcare Health Reimbursement Acct.*, 404 F. Supp. 3d 627, 631 (D. Conn. 2019). The ERISA Plaintiffs' allegations pass that test.

Entities that control discretionary plan decisions and administration are proper ERISA defendants. In an ERISA benefits claim pursuant to 29 U.S.C. § 1132(a)(1)(B), a defendant can be sued as a plan administrator when it "controls the distribution of funds and decides whether or not to grant benefits." *Puri v. Hartford Life & Accident Ins. Co.*, 2010 WL 4514278, at *2 (D. Conn. Nov. 2, 2010). Further, an ERISA fiduciary is someone with "*any* discretionary authority or discretionary responsibility in [plan] administration." 29 U.S.C. § 1002(21)(A) (emphasis added). ERISA fiduciaries are proper defendants for breach of fiduciary duty claims pursuant to 29 U.S.C. § 1132(a)(2) and (a)(3). *See* 29 U.S.C. §§ 1132(a)(2), 1109 (creating cause of action when a "fiduciary … breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries"); *Harris Tr. & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 246 (2000) (29 U.S.C. § 1132(a)(3) places "no limit … on the universe of possible defendants"). Accordingly, the "burden to bring [breach of fiduciary duty] claims is more lenient than for benefits claims." *Popovchak v. UnitedHealth Grp. Inc.*, 692 F. Supp. 3d 392, 418 (S.D.N.Y. 2023). Parity Act claims may be asserted under both 29 U.S.C. § 1132(a)(1)(B) and (a)(3). *See Gallagher v. Empire HealthChoice Assurance, Inc.*, 339 F. Supp. 3d 248, 250 (S.D.N.Y. 2018); *see also* FAC ¶ 447.

Elevance and Carelon are proper defendants under 29 U.S.C. § 1132(a)(1)(B), (a)(2), and (a)(3) because the FAC makes "detailed allegations of control" as to them. *Est. of Kenyon*, 404 F. Supp. 3d at 634.

Regarding the 29 U.S.C. § 1132(a)(1)(B) claims (Counts Eight and Ten), Plaintiffs allege that Elevance directs and controls Anthem's activities and operations; sets Anthem's coverage, reimbursement, and benefits-related policies; processes Anthem's claims; and handles Anthem's finances. *See* FAC ¶¶ 27–28, 81, 210, 223, 226; *see also Atzin v. Anthem, Inc*, 2018 WL 501543, at *3 (C.D. Cal. Jan. 19, 2018) (holding plaintiff adequately alleged defendant controlled benefits determination by "wield[ing] control over the policy making process"). Plaintiffs allege that Carelon makes care and coverage decisions, as evidenced by approval and denial letters stating they were "[r]eviewed for your plan by Carelon." FAC ¶¶ 102, 125–26; *see id.* ¶¶ 26, 28, 95, 102, 125–126, 165, 228–35. *See Hogan v. Metromail*, 107 F. Supp. 2d 459 (S.D.N.Y. 2000) (holding plaintiffs pleaded that defendant was ERISA plan administrator when "denial of benefits was written on [defendant's] letterhead by [defendant's] authorities"). At minimum, before the ERISA Plaintiffs have conducted discovery, "[i]t is premature to determine, as a matter of law, that [Defendants] do[] not act as the plan administrator." *Haag v. MVP Health Care*, 866 F. Supp. 2d 137, 142–43 (N.D.N.Y. 2012) (denying dismissal of benefits claim when defendant allegedly determined when to pay providers, medical necessity, and prior authorization).

Regarding the 29 U.S.C. § 1132(a)(2) and (3) claims (Counts Nine and Ten), the FAC asserts that Defendants breached their fiduciary duty by lying about the adequacy of the Anthem behavioral health provider network, which also violates the Parity Act, 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26. *See* FAC ¶¶ 440, 453; *see also Gallagher*, 339 F. Supp. at 259 (holding that violation of Parity Act breaches ERISA fiduciary duty). The FAC establishes that Elevance and Carelon acted as fiduciaries because they had discretionary authority over representations of the provider directory. *See* 29 U.S.C. § 1002(21)(A). Specifically, Carelon assisted and Elevance oversaw and directed Anthem to maintain and publish a false provider directory. *See* FAC ¶¶ 10,

273, 283–84, 287–89, 313–14, 371. And Elevance and Carelon have a financial incentive to misstate the adequacy of Anthem's provider network because Elevance and Carelon profit when Anthem members, including the Mazzolas, do not receive their full benefits or have access to in-network behavioral health providers. *See id.* ¶¶ 225, 420.

Thus, the FAC pleads that Elevance and Carelon are proper defendants under 29 U.S.C. § 1132(a)(1)(B), (a)(2), and (a)(3).

B. The Mazzolas and Amec State a Claim for Denial of Benefits

To state a claim for denial of benefits pursuant to 29 U.S.C. § 1132(a)(1)(B), a plaintiff must plead (1) the plan is covered by ERISA, (2) the plaintiff is a participant or beneficiary of the plan, and (3) the defendant failed to provide the required benefits. *See Giordano v. Thomson*, 564 F.3d 163, 168 (2d Cir. 2009). Defendants do not dispute that Plaintiffs' plan is covered by ERISA or that they are participants in the plan. Nor do Defendants dispute that Plaintiffs sufficiently plead the terms of the Silver Plan that entitled Baby Doe to speech, behavioral, and occupational therapy or that Defendants' denials of those treatments were erroneous. Defendants argue that the FAC fails to adequately plead exhaustion of the speech and occupational therapy denials. *See* Mot. at 30–32. However, Defendants misstate the ERISA Plaintiffs' burden and their allegations.

The Second Circuit has held that failure to exhaust administrative remedies is an implied affirmative defense under ERISA, which need not be pleaded in a complaint. *See Paese v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 446 (2d Cir. 2006); *accord Cunningham v. Cornell Univ.*, 604 U.S. 693, 702 (2025). In their Motion, Defendants do not identify ***any*** requirement in the Plan documents that Plaintiffs failed to exhaust prior to filing suit. *See Masten v. Metro. Life Ins. Co.*, 543 F. Supp. 3d 25, 38 (S.D.N.Y. 2021) (rejecting defendants' argument that plaintiffs failed to exhaust because defendants "point[ed] to no provision of the [p]lan with which [p]laintiffs failed to comply"). Instead, Defendants argue that Plaintiffs pleaded exhaustion

"on a blanket basis." Mot. at 31. Not so. The FAC contains six detailed pages about Defendants' contractual requirements, Defendants' denial of the Mazzolas' benefits, and the Mazzolas' appeals. *See* FAC ¶¶ 101–12, 132–42, 165–89. This includes dates and details about when the Mazzolas' claims were denied and when they were appealed. As discussed elsewhere in the FAC, Baby Doe sees providers for the treatment of autism multiple times a week. Anthem and Carelon, per Elevance's policy, denied each claim for coverage of Baby Doe's speech therapy from January 13 to July 10, 2025. *See id.* ¶ 185. Ms. Mazzola appealed the denials in February and March 2025, Anthem determined that the denials were appropriate on appeal, and Ms. Mazzola sought external review of the adverse coverage determination. *See id.* ¶ 186. Further, although Anthem reversed its denial of an out-of-network exception for Baby Doe's occupational therapy, it has not paid most of the Mazzolas' occupational therapy claims. *See id.* ¶ 187. These allegations more than suffice to show exhaustion. Meanwhile, "Defendants have failed to provide any guidance to the Court as to what administrative procedures Plaintiffs should complete in order [] for their claims to become ripe for judicial review," so their argument that Plaintiffs' claims should be dismissed for failure to exhaust fails. *Masten* 543 F. Supp. 3d at 39.

Separately, Defendants argue that the ERISA Plaintiffs fail to plead exhaustion of speech therapy claims denied between April 2025 and July 2025 (a limited subset of the alleged claim denials). *See* Mot. at 31–32. Even if this argument were correct (it is not), exhaustion of those claims would have been futile given the history of the speech therapy denials. The ERISA Plaintiffs allege that "[t]he Mazzolas have directly appealed Defendants' denials of the Mazzolas' contested claims," FAC ¶ 179, and made clear that Ms. Mazzola submitted internal electronic appeals of these denials for several months. *See id.* ¶ 185. She then sought external review of Anthem's adverse coverage determination, which concluded that speech therapy was appropriate

but at a lesser frequency, *see id.* ¶ 186, after which "Anthem persisted in its denial of the Mazzolas' claims for coverage of speech therapy for Baby Doe" up until "July 2025." *Id.* ¶ 187. Even if these detailed allegations were somehow insufficient to show exhaustion, any attempt at exhaustion would have been futile given that Ms. Mazzola had been unsuccessfully availing herself of Defendants' claims procedures for the same coverage determination for months. *See Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993) ("Where claimants make a 'clear and positive showing' that pursuing available administrative remedies would be futile, … a court will release the claimant from the [exhaustion] requirement.").

Lastly, it is undisputed that the FAC pleads the terms of the Plan that entitled Baby Doe to coverage for out-of-network speech, occupational, and behavioral therapy and Defendants' failure to provide the coverage.[8] *See Neufeld v. Cigna Health & Life Ins. Co.*, 2018 WL 4158377, at *7 (D. Conn. Aug. 30, 2018) (pleading plan terms and breach suffices to state benefits claim). As for the plan terms, the Silver Plan covered medically necessary services and provided that Anthem "may approve an Out-of-Network Provider" if "there is no In-Network Provider who is qualified to perform the treatment You require." FAC ¶¶ 88, 167. The Certificate of Coverage stated that limits for physical, occupational, and speech therapy did not apply for autism treatment. *See id.* ¶¶ 170–72. The Mazzolas' obligation was a 50% co-insurance for out-of-network providers and 20% if there were no available, qualified in-network alternatives. *See id.* ¶ 91. Finally, Anthem and Carelon, per Elevance's policies, approved Baby Doe's autism treatment plan, which found that occupational, speech, and behavioral therapies were medically necessary, and that Baby Doe required "40 hours per week" of such therapies. *Id.* ¶ 103; *see id.* ¶¶ 99–102.

[8] Defendants argue only that the ERISA Plaintiffs failed to plead a denial of benefits claim as to Baby Doe's genetic testing. They do not address whatsoever the merits of the claim as to Baby Doe's denied speech, occupational, and behavioral therapy. *See* Mot. at 32–34.

Despite the foregoing, Defendants denied coverage for Baby Doe's out-of-network occupational and speech therapy on the grounds that they were medically unnecessary and that there were available in-network providers. *See id.* ¶¶ 104–10; 185–87. In reality, there were no appropriate, available in-network providers because Defendants' provider network was woefully inadequate.[9] *See id.* ¶ 182; Section IV*, supra*. Because Defendants would not approve Baby Doe's speech therapist, Defendants likewise refused to apply the more than $1,000 cost of an Augmentative Communications Device to the Mazzolas' deductible, even though Baby Doe's speech therapist instructed the Mazzolas to purchase the device for him. *See id.* ¶ 135. Likewise, Anthem and Carelon, per Elevance's policy, denied coverage for a previously approved out-of-network behavioral therapist because Anthem identified a purportedly available in-network provider who was not actually available. *See id.* ¶¶ 27, 125–29. Also, Anthem has not paid most of the Mazzolas' behavioral, speech, and occupational therapy claims or applied the Mazzolas' payments towards their deductible. *See id.* ¶¶ 90–93, 132–41, 187.

Consequently, the FAC asserts a denial of benefits claim pursuant to 29 U.S.C. § 1132(a)(1)(B).

C. The Mazzolas and Amec State a Claim for Breach of Fiduciary Duty

To plead breach of fiduciary duty pursuant to 29 U.S.C. § 1132(a)(2) or (a)(3), a plaintiff must allege that (1) the defendant is a plan fiduciary, (2) the defendant acted in its fiduciary capacity, and (3) the defendant breached its fiduciary duty. *See Popovchak*, 692 F. Supp. 3d at

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[9] Anthem insisted that Baby Doe could visit in-network speech therapists within 100 miles of the Mazzolas' home, which would have required the Mazzolas to drive up to five hours roundtrip five days per week. Due to Baby Doe's autism, it is medically unsafe to keep him restrained in a car seat for more than 20 minutes. *See* FAC ¶¶ 82–84. And Defendants knew the frequency of treatment that Baby Doe required, since they approved his autism treatment plan. *See id.* ¶ 103. Moreover, the Mazzolas' Certificate of Coverage requires that the services be "clinically appropriate, in terms of … *site*." *Id.* ¶ 168 (emphasis added).

410. Here, the claim is based on Defendants' fraud. *See* FAC ¶ 440. Defendants contend that the claim fails because the FAC does not (1) establish that Anthem acted as a fiduciary when it lied about the adequacy of its provider directory or (2) identify which fiduciary duty was breached. *See* Mot. at 35–37. Each of Defendants' arguments falls short.

First, the FAC establishes that each Defendant was a Plan fiduciary and acted in its fiduciary capacity when it committed fraud.[10] A defendant acts as an ERISA fiduciary when it "offer[s] beneficiaries detailed plan information" because such affirmative statements are "an act of plan administration." *Varity Corp. v. Howe*, 516 U.S. 489, 503, 505 (1996). Accordingly, because each Defendant had "discretionary authority or discretionary responsibility" over the misstatements regarding the scope and adequacy of the Anthem behavioral health provider network, each Defendant acted as a fiduciary when it lied. 29 U.S.C. § 1002(21)(A); *see* Section VIII.A *supra* (describing Elevance's and Carelon's authority over the misstatements); Section IV *supra* (describing Anthem's authority over the misstatements); FAC ¶¶ 236–41, 250, 256, 273–81, 287–91, 294–95, 313–14, 383–85. Defendants' argument that they did not act as fiduciaries because their misstatements were communications "directed toward non-participants" in the Plan falls flat, *see* Mot. at 35, as the ERISA Plaintiffs allege that Defendants continued to deceive them while they were enrolled in the Plan. *See id.* ¶¶ 72–95; *Broga v. Ne. Utils.*, 315 F. Supp. 2d 212, 243–44 (D. Conn. 2004) (holding misstatements made to plan participants state a claim for breach

[10] The ERISA Plaintiffs' breach of fiduciary duty claim does not preempt the state law claims based on misrepresentations (Counts Four, Five, and Six). First, the state law claims encompass misstatements made to prospective and actual enrollees, whereas the breach of fiduciary duty claim applies only to fraudulent statements made to ERISA beneficiaries. Second, Plaintiffs seek monetary damages under the state law claims, and equitable relief under the ERISA breach-of-fiduciary duty claim. *See Gerosa*, 329 F.3d 317 at 329 (holding that ERISA did not preempt state law claims seeking money damages when plaintiffs sought equitable relief under 29 U.S.C. § 1132(a)(3)).

of fiduciary duty under ERISA); *Mullins v. Pfizer, Inc.*, 899 F. Supp. 69, 77 (D. Conn. 1995) (holding ERISA plan owes duty to members to provide accurate information relevant to enrollment decisions).

Second, it is black-letter law that "fiduciaries breach their duty of loyalty if they knowingly or intentionally mislead plan beneficiaries." *In re DeRogatis*, 904 F.3d 174, 194 (2d Cir. 2018) (cleaned up); *see also Varity Corp.*, 516 U.S. at 506 ("Lying is inconsistent with the duty of loyalty owed by all fiduciaries …."); *Broga*, 315 F. Supp. 2d at 242–46 (holding defendant breached its ERISA fiduciary duty by making misstatements regarding retirement policies). Fraud also breaches the fiduciary duty of care because lying is "both imprudent and disloyal." *Popovchak*, 692 F. Supp. 3d at 415 (holding the same conduct can breach duties of loyalty and care because "the duties are interrelated and overlapping" (internal quotation marks omitted)).

Thus, the FAC sufficiently pleads that each Defendant breached its fiduciary duties of loyalty and care when it lied to Plaintiffs for financial gain. *See* 29 U.S.C. § 1104(a)(1) (ERISA fiduciaries must discharge their duties "solely in the interest of the participants and beneficiaries").

D. <u>The Mazzolas and Amec State a Claim for Violation of the Parity Act</u>

To state a Parity Act claim, Plaintiffs must show that (1) the Act applies to the plan; (2) the plan provides medical and mental health benefits; (3) "the plan has a treatment limitation—either quantitative or nonquantitative—for one of those benefits that is more restrictive for mental-health treatment than it is for medical treatment; and (4) the mental-health treatment is in the same classification as the medical treatment to which it is being compared" (both are classified in-network, for instance). *Gallagher*, 339 F. Supp. 3d at 256 (cleaned up); *accord, e.g.*, *Gary K. v. Anthem Blue Cross & Blue Shield*, 2025 WL 2782409, at *6 (S.D.N.Y. Sept. 30, 2025).

There can be no dispute that the Mazzolas' and Amec's claim easily satisfies the first, second, and fourth requirements: the Parity Act applies to ERISA plans, *see* 29 U.S.C. § 1185a

(incorporated into ERISA); the Silver Plan offers physical and mental health benefits, *see* FAC ¶ 448; and the allegations compare in-network mental health treatment to in-network medical treatment, *see id.* ¶ 450.

The ERISA Plaintiffs' allegations also satisfy the third requirement, since they allege that the Mazzolas had a vastly easier time finding in-network medical care than in-network mental health care. *See id.* ¶¶ 113–23. The FAC also pleads that "Defendants' processes for ensuring network adequacy for mental health disorder providers were less rigorous and less effective than the process applied to medical/surgical providers," *id.* ¶ 452, in addition to other nonquantitative treatment limitations on the Mazzolas' access to mental health treatment that were more restrictive than that for medical treatment. *See id.* ¶¶ 78–87, 113–23; 446–53; *see also* 29 C.F.R. § 2590.712(c)(4)(ii) ("Nonquantitative treatment limitations include … [s]tandards related to network composition, including but not limited to … procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage.").

Defendants complain that Plaintiffs' Parity Act allegations lack detail or are too outcome-focused. *See* Mot. at 37–40. Defendants fundamentally misunderstand the standards applicable at the motion to dismiss stage.[11] Identifying disparate outcomes as evidence of disparate process is the only manner of alleging a Parity Act violation without access to Defendants' internal records. *See* FAC ¶¶ 78–87, 113–23; 446–53; *see also Bushell v. Unitedhealth Grp., Inc.*, 2018 WL 1578167, at *6 (S.D.N.Y. Mar. 27, 2018) ("The nature of [nonquantitative treatment limitation] Parity Act claims counsels against a rigid pleading standard."). Recognizing this asymmetry,

[11] Tellingly, Defendants only cite decisions at the summary-judgment stage and motion-for-judgment stage for support. *See* Mot. at 38–39.

courts have applied a more relaxed pleading standard, reasoning that "[w]hile a plaintiff may be able to find out what process her insurer used to deny *her* claim, it is much more difficult to find out the process her insurer uses to evaluate analogous medical claims." *Bushell*, 2018 WL 1578167 (emphasis in original); *accord M.R. v. United Healthcare Ins. Co.*, 2024 WL 863704, at *3 (S.D.N.Y. Feb. 29, 2024) (same).

As a result, courts have readily inferred that "disparate results" evidence "disparate process." *Bushell*, 2018 WL 1578167, at *5–6 (holding that plaintiff adequately alleged Parity Act violation where insurer covered nutritional counseling for diabetes but not anorexia); *see also Gallagher*, 339 F. Supp. 3d at 258 (holding that, at motion to dismiss stage, it was sufficient that the insurer provided *any* services for inpatient medical services but refused to cover the *specific* service that plaintiff sought for inpatient mental health treatment); *M.R. v. United Healthcare Ins. Co.*, 2023 WL 8178646, at *12–16 (S.D.N.Y. Nov. 20, 2023) (holding that categorical exclusion of "wilderness therapy" for mental health treatment stated a Parity Act claim, even though same therapy was not covered for other medical conditions), *report & recommendation adopted*, 2024 WL 863704; *Gary K.*, 2025 WL 2782409, at *7 (holding that plaintiff stated Parity Act claim where he alleged that Anthem required "acute" symptoms before authorizing treatment at a mental health residential facility, but did not impose that requirement for other medical conditions).

The Parity Act regulations confirm that discrepancies in outcomes provide strong evidence of a violation. *See* 29 C.F.R. § 2590.712(c)(4)(iii)(B) (if data on outcomes reveals "material differences in access to mental health and substance abuse use disorders as compared to

medical/surgical benefits in a classification, such differences will be considered a ***strong indicator*** that the plan or issuer violates this paragraph (c)(4)") (emphasis added).[12]

Plaintiffs have, accordingly, satisfied their burden for alleging a Parity Act violation.

CONCLUSION

For the foregoing reasons, Defendants' motion to dismiss should be denied in its entirety. If the Court dismisses any of Plaintiffs' claims in whole or in part, Plaintiffs respectfully request leave to amend. *See Loreley Fin.*, 797 F.3d at 190–91 (explaining that plaintiffs should ordinarily be granted leave to amend if Court grants motion to dismiss).

[12] While the document-gathering obligations of 29 C.F.R. § 2590.712(c)(4)(iii) did not begin to apply to Defendants until January 1, 2026, the above-quoted portion of the regulation supports the conclusion of many courts that "disparate results" evidence "disparate process" under the Parity Act. *See, e.g.*, *Bushell*, 2018 WL 1578167, at *5–6. Moreover, Defendants' compliance with their document-gathering obligations is relevant to any damages Plaintiffs and class members have incurred since January 1, 2026.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been furnished by CM/ECF to all counsel of record on this 2nd day of March 2026.

/s/ Jacob Gardener