UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

MICHELLE MAZZOLA, individually and as mother of BABY DOE; GUY MAZZOLA, individually and 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.	Civil Action No. 3:25-cv-01433-OAW

DEFENDANTS' MOTION TO DISMISS AMENDED COMPLAINT

Defendant Anthem Health Plans, Inc., Carelon Behavioral Health, Inc., and Elevance Health, Inc., by and through their attorneys, respectfully submit this motion to dismiss the First Amended Class Action Complaint of Plaintiffs Michelle Mazzola; Guy Mazzola; Amec, LLC; and Lisa Kuller, (ECF No. 16-1), pursuant to the Federal Rules of Civil Procedure ("Fed. R. Civ. P.") Rule 12(b)(2) and (6). In support of this motion, Defendants rely upon the attached supporting memorandum of law, and Declaration of Debra Cheffer, which are incorporated herein by reference.

WHEREFORE, Defendants respectfully request that the Court dismiss the Complaint with prejudice.

[Signature follows on next page]

Dated: January 23, 2026

Respectfully Submitted,

By: /s/ *Stefanie Cerrone*

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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 23rd day of January, 2026.

/s/ Stefanie Cerrone
Stefanie Cerrone

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MICHELLE MAZZOLA, individually and as mother of BABY DOE; GUY MAZZOLA, individually and 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.	Civil Action No. 3:25-cv-01433-OAW

MEMORANDUM OF LAW IN SUPPORT OF
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Defendants Anthem Health Plans, Inc. ("Anthem"), Carelon Behavioral Health, Inc. ("Carelon"), and Elevance Health, Inc. ("Elevance") (collectively, "Defendants") through their undersigned counsel, submit this Memorandum of Law in Support of Defendants' Motion to Dismiss the First Amended Complaint (ECF No. 16-2) ("Complaint" or "Compl.") filed by Michelle Mazzola and Guy Mazzola in their individual capacities and as parents of their minor child "Baby Doe," (collectively, the "Mazzolas"), Amec, LLC ("Amec"), and Lisa Kuller ("Kuller") (collectively, "Plaintiffs") pursuant to Fed. R. Civ. P. 12(b)(2) and (6).

INTRODUCTION

Plaintiffs are three individual insureds under Anthem insurance plans and an employer (Amec) that sponsors the group health plan of which two of the plaintiffs, the Mazzolas, are members. Carelon provides mental health and related administrative services to Anthem and lacks privity with any of the Plaintiffs. Carelon and Anthem are both subsidiaries of Elevance, an Indiana Corporation with its principal place of business in Indiana, which likewise lacks privity with Plaintiffs and is not subject to this Court's personal jurisdiction.

Plaintiffs allege that Anthem's directory of participating, or "in-network," providers contains inaccurate information about the listed mental-health providers. Plaintiffs assert this resulted in damages due to delayed treatment and/or out-of-pocket costs incurred to see out-of-network providers. Plaintiffs also allege that Anthem failed to appropriately pay benefits due under their plans, imposed more stringent treatment limitations on certain behavioral health services, and improperly denied treatments.

Based on those allegations, Plaintiffs assert ten causes of action on behalf of themselves and a putative class, seven arising under state law and the remaining three arising under the Employee Retirement Income Security Act of 1974 ("ERISA"): (1) breach of contract as to certain individual members; (2) breach of contract as to certain employers; (3) breach of the covenant of

good faith and fair dealing; (4) violation of the Connecticut Unfair Trade Practices Act ("CUTPA"); (5) fraudulent misrepresentation; (6) negligent misrepresentation; (7) unjust enrichment; (8) improper denial of benefits under ERISA; (9) breach of fiduciary duty under ERISA; and (10) violation of the Mental Health Parity and Addiction Equity Act ("Parity Act").

Defendants dispute the allegations of the Complaint and deny that they, individually or collectively, publish a "deceptive" provider directory. But even if Plaintiffs' allegations were true, the Complaint is subject to dismissal because Plaintiffs' claims are legally deficient.

As a threshold matter, this Court lacks personal jurisdiction over Elevance because it is not "at home" in Connecticut such that it is subject to general jurisdiction, and Plaintiffs have not alleged contacts between Elevance and Connecticut that would subject it to specific jurisdiction related to the claims in this case. Because the Court lacks personal jurisdiction over Elevance, it must dismiss all claims as to Elevance. And even if Elevance was subject to personal jurisdiction, it did not administer any of the benefits at issue, as it is a publicly held holding company that is the ultimate parent of Anthem and Carelon. Plaintiffs thus have no viable claims against Elevance.

Next, Plaintiffs' first seven causes of action—those arising under state law—are preempted by ERISA to the extent they are asserted on behalf of the Mazzolas or Amec. Although Plaintiffs allege that the Anthem Silver Pathway CT PPO plan, upon which their claims in this litigation are based, was not subject to ERISA prior to 2025, Plaintiffs' allegations establish Amec offered the plan to *its employees*—including the Mazzolas—as an employer-sponsored health benefit plan to which ERISA applied (and continues to apply) as a matter of law. All state-law claims related to benefits under that employee benefit plan are therefore preempted, and Kuller is the only Plaintiff on whose behalf those claims could be pursued.

Turning to the individual causes of action, Plaintiffs' first claim for breach of contract must be dismissed as to Elevance and Carelon because Kuller lacks contractual privity with either Defendant. The only contract at issue is Kuller's Anthem Blue Cross Blue Shield Bronze PPO Pathway plan, which Plaintiffs allege is issued by Anthem. Plaintiffs do not allege a contract exists between Kuller and Elevance or Carelon, and they therefore cannot establish an existing contract—an essential element to assert a breach of contract claim against Elevance or Carelon. The Complaint also fails to state a claim for breach of contract more generally because the allegations identify no term of Kuller's insurance contract that Anthem's alleged conduct breached.

Plaintiffs' second claim for breach of contract on behalf of non-ERISA employers must be dismissed because no party to this action has standing to raise that claim. The only employer plaintiff in this litigation is Amec, which as noted above, provided an ERISA-governed plan to its employees at all relevant times. Thus, Amec cannot assert a breach of contract claim because any such claim would be preempted by ERISA.

Plaintiffs' third claim, for breach of the covenant of good faith and fair dealing, must likewise be dismissed as to Elevance and Carelon for lack of contractual privity, as such a claim requires the existence of an enforceable contract between the parties. That claim must also be dismissed more generally for failure to state a claim as to all defendants. Under Connecticut law, a claim for breach of the covenant of good faith and fair dealing must be tied to a breach of express contractual provisions. As Plaintiffs have failed to allege the breach of any specific terms of Kuller's insurance contract with Anthem—as noted above—Plaintiffs' assertions of bad faith are unmoored from any express contractual provision and thus fail to establish the requisite nexus to the contract's terms to support a claim for breach of the covenant of good faith and fair dealing.

Plaintiffs' fourth claim, for violation of CUTPA based on allegedly unfair insurance

practices, fails because Plaintiffs' allegations under CUTPA sound in fraud, and thus Plaintiffs were required—but failed—to plead with the specificity required by Rule 9(b). As Plaintiffs' allegations improperly lump Defendants together, fail to describe the context of purported false statements, and fail to explain why asserted misrepresentations are false, Plaintiffs' allegations fail to state a claim. Plaintiffs' statutory bases for CUTPA liability also fail, because none of the non-fraud bases for liability constitute "unfair" insurance practices.

Plaintiffs' fifth and sixth claims for fraudulent and negligent misrepresentation must be dismissed because Plaintiffs have failed to plead fraud with particularity. Plaintiffs' allegations of fraud fail to identify specific false statements, fail to allege the context around the making of those statements—the who, where, and when—and in some cases fail to even allege how the statement is false. Moreover, Plaintiffs again impermissibly lump all Defendants together as having made misrepresentations without identifying which Defendant made any particular misrepresentation and how that Defendant knew the representation was false. These allegations fail to meet Rule 9(b)'s specificity requirement for fraud claims. Moreover, Kuller fails to plead facts that establish that she saw or was aware of any specific misrepresentations at the time she chose to enroll in her Anthem plan, and thus the allegations fail to establish that Kuller actually relied on any such misrepresentations, let alone that such reliance would have been justifiable.

Plaintiffs' seventh claim for unjust enrichment must be dismissed as to Elevance and Carelon because Plaintiffs plead no facts demonstrating that Elevance or Carelon received any benefit as a result of Kuller's conduct, an essential element of such a claim. And that claim must be dismissed as to Anthem because Plaintiffs expressly incorporated into their unjust enrichment claim allegations that an express contract existed between Anthem and Kuller and that Anthem breached that contract. The availability of a breach of contract remedy precludes the availability

of unjust enrichment under Connecticut law.

Plaintiffs' remaining three claims arise under ERISA and are pleaded on behalf of the Mazzolas and Amec. As neither the Mazzolas nor Amec are in privity with Elevance or Carelon with respect to their ERISA plan, Plaintiffs cannot state a claim against Elevance or Carelon under ERISA. Each of those claims also fails as to Anthem on the merits.

Plaintiffs' eighth claim for benefits due under the Mazzolas' ERISA plan fails because Plaintiffs have not adequately alleged the exhaustion of administrative remedies for all but one of these claims as required under ERISA. And as to the only claim for which Plaintiffs adequately plead exhaustion—a single genetic-testing claim—Plaintiffs fail to state a claim because they have pleaded neither the terms of the ERISA plan that required Anthem to provide coverage for the services at issue nor facts showing that Anthem's denial of benefits was unreasonable, unsupported by evidence, or legally erroneous.

Plaintiffs' ninth claim for breach of fiduciary duty fails because Plaintiffs have failed to allege facts showing that the purported breaches of fiduciary duty were undertaken by Anthem in a fiduciary capacity, or in violation of a fiduciary duty imposed by ERISA.

Plaintiffs' tenth (and final) claim under the Parity Act fails to state such a claim because Plaintiffs' allegations focus on differences in outcomes—e.g., denial of benefits, number of providers available in certain specialties—rather than the processes used by Defendants to apply treatment limitations across benefit classifications. Plaintiffs fail to plead facts that could show a disparity in the processes used by Anthem as to any relevant treatment limitation, or any other violation of the Parity Act.

FACTUAL ALLEGATIONS

Anthem offers health insurance plans to residents of Connecticut. Compl. ¶ 25. Carelon provides mental health and related administrative services to Anthem with respect to its insurance

plans. *Id*. ¶ 26. Elevance is the ultimate corporate parent of Carelon and Anthem and is incorporated and has its principal offices in Indiana. *Id*. ¶ 27.

Plaintiffs are members or purchasers of Anthem insurance plans. *Id*. ¶¶ 19–24. Amec is the sponsor of an ERISA-governed employee welfare benefit plan of which the Mazzolas are beneficiaries, which contracts with Anthem to provide the Anthem Silver Pathway CT PPO health insurance plan to Amec's employees. *Id*. ¶ 23. Kuller is a member of the Anthem Blue Cross Blue Shield Bronze PPO Pathway plan, a non-ERISA-governed individual plan purchased on the Connecticut health insurance marketplace. *Id*. ¶ 24; 192.

Plaintiffs allege Anthem's directory of in-network providers for the Anthem insurance plans at issue contains inaccurate information regarding mental health providers, including by listing providers that are not, in fact, in-network, and by listing inaccurate information for those who are in-network. *See, e.g.*, Compl. ¶¶ 4-5, 10, 272-81. Plaintiffs allege this renders Defendants' provider directory, marketing materials, and other representations "deceptive." *Id.* ¶¶ 10, 281, 236-41. Plaintiffs assert those alleged inaccuracies damaged them by causing them to delay treatment and/or incur the costs of using out-of-network providers. *See, e.g.*, *id.* ¶¶ 6, 14, 333, 368. Plaintiffs further contend Defendants improperly deny covered services, fail to credit expenditures to deductibles, and fail to appropriately reimburse members for costs incurred when they use out-of-network providers. *See, e.g., id.* ¶ 5, 90, 111.

LEGAL STANDARD

On a motion to dismiss for lack of personal jurisdiction under Rule 12(b)(2), the "plaintiff bears the burden of demonstrating personal jurisdiction over a person or entity against whom it seeks to bring suit." *Penguin Grp. (USA) Inc. v. Am. Buddha*, 609 F.3d 30, 34 (2d Cir. 2010). To survive such a motion, the plaintiff must make a "prima facie showing that jurisdiction exists," *i.e.*, the Complaint must include "legally sufficient allegations of jurisdiction, including an

averment of facts that, if credited[,] would suffice to establish jurisdiction over the defendant." *Id*. (internal quotation marks omitted).

Each of Plaintiffs' claims is also subject to dismissal under Rule 12(b)(6), as the allegations of the Complaint fail to state a claim for which Plaintiffs are entitled to relief. On a motion to dismiss for failure to state a claim, the Court assumes the truth of the factual allegations and draws all reasonable inferences in favor of the plaintiff. *See Smith v. Local 819 I.B.T. Pension Plan*, 291 F.3d 236, 240 (2d Cir. 2002). However, "a plaintiff's obligation to provide the grounds of his entitle[ment] to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do. Factual allegations must be enough to raise a right to relief above the speculative level." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (internal citations and quotations omitted). Thus, the Court is not required to assume the truth of "legal conclusions," or "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

Where the Complaint alleges fraud, the Court "must also view the complaint in light of Rule 9(b), which requires that 'the circumstances constituting fraud . . . be stated with particularity.'" *Shields v. Citytrust Bancorp, Inc.*, 25 F.3d 1124, 1127 (2d Cir. 1994) (quoting Fed. R. Civ. P. 9(b)). Rule 9(b) requires "specify[ing] the time, place, speaker, and content of the alleged misrepresentations" and "[w]here multiple defendants are asked to respond to allegations of fraud," the allegations must "inform each defendant of the nature of his alleged participation in the fraud." *DiVittorio v. Equidyne Extractive Indus., Inc.*, 822 F.2d 1242, 1247 (2d Cir. 1987).

ARGUMENT

I. THIS COURT LACKS PERSONAL JURISDICTION OVER ELEVANCE

Elevance must be dismissed as a party to this action because it is not subject to personal jurisdiction in Connecticut. If a court lacks personal jurisdiction over a party, it must dismiss the

case as to that party. Fed. R. Civ. P. 12(b)(2).

"As a general rule, the amenability of a foreign corporation to suit in a federal court in a diversity action is determined in accordance with the law of the state where the court sits, with federal law entering the picture only for the purpose of deciding whether a state's assertion of jurisdiction contravenes a constitutional guarantee." *Savage v. Scripto-Tokai Corp.*, 147 F. Supp. 2d 86, 90 (D. Conn. 2001) (internal quotation marks omitted). Connecticut's long-arm statute "stops short of authorizing jurisdiction to the extent permissible under the due process clause," and thus may preclude the exercise of jurisdiction even where constitutionally permissible. *Id*. However, a "finding that the due process clause of the Constitution prohibits this Court from asserting jurisdiction" necessarily precludes long-arm jurisdiction. *Id*. Here, exercise of personal jurisdiction over Elevance would satisfy neither due process nor Connecticut law.

A. The Due Process Clause Does Not Support the Exercise of Jurisdiction

"Personal jurisdiction can be general or specific." *Oklahoma Firefighters Pension & Ret. Sys. v. Banco Santander (Mexico) S.A. Institucion de Banca Multiple*, 92 F.4th 450, 456 (2d Cir. 2024). The Complaint establishes neither form of jurisdiction over Elevance.

As to general jurisdiction, except for "exceptional case[s]," "a corporation is at home (and thus subject to general jurisdiction, consistent with due process) only in a state that is the company's formal place of incorporation or its principal place of business." *Gucci Am., Inc. v. Weixing Li*, 768 F.3d 122, 135 (2d Cir. 2014). Elevance is incorporated in Indiana, and has its principal place of business in Indianapolis, Indiana. Declaration of Debra Cheffer ["Cheffer Decl."] ¶ 3; Compl. ¶ 25. Plaintiffs have pleaded no "exceptional" circumstances that would subject Elevance to general jurisdiction in Connecticut, and this Court thus lacks general personal jurisdiction over Elevance. *See Gucci Am.*, 768 F.3d at 135.

To establish specific jurisdiction, a plaintiff must show that the claims at issue "arise out

of or relate to the defendant's contacts with the forum state," that the defendant "'purposefully directed' its activities at residents of the forum state, and that the defendant could reasonably foresee being haled into court there." *Savage*, 147 F. Supp. 2d at 91. As to the second and third elements, "[i]t is essential in each case that there be some act by which the defendant purposefully avails itself of the privilege of conducting activities within the forum State, thus invoking the benefits and protections of its laws." *Id*. (quoting *Hanson v. Denckla*, 357 U.S. 235, 253 (1958)).

Here, the allegations of the Complaint fail to establish *any* element of specific jurisdiction, because the Complaint is devoid of allegations that *Elevance* took any act or engaged in any conduct in Connecticut at all. Rather, the Complaint attempts to assert jurisdiction over Elevance based on the activities of its subsidiaries Anthem and Carelon, alleging that Elevance "sets key policies, oversees and controls the operations" of Anthem and Carelon, Compl. ¶¶ 223–24, that it receives financial benefit from Anthem's business, *id*. ¶ 225, and that its relationship with its subsidiaries is thus "close and inextricably intertwined," *id*. ¶ 28. But these allegations do not demonstrate that Elevance *itself* "conduct[s] activities within the forum State" that are directed at Connecticut residents, and thus does not provide a basis for personal jurisdiction. *See Savage*, 147 F. Supp. 2d at 91. And Elevance does not sell insurance policies or provide claims administration services in Connecticut, is not licensed by the Connecticut Insurance Department, and does not have a contract with any of the Connecticut-based Plaintiffs. Cheffer Decl. ¶¶ 4–7.

Plaintiffs accordingly cannot establish that their claims arise from any activity Elevance both conducted in Connecticut and purposefully directed toward its residents and thus could expect to subject it to jurisdiction. *See Savage* , 147 F. Supp. 2d at 91.

B. Connecticut Law Does not Support the Exercise of Personal Jurisdiction.

Even Elevance's relationships with its subsidiaries supported personal jurisdiction as a matter of due process, they are inadequate to establish jurisdiction as a matter of Connecticut law.

Under Connecticut law, jurisdiction over a subsidiary does not establish jurisdiction over the parent. *See Leonard v. Gen. Motors L.L.C.*, 504 F. Supp. 3d 73, 86 (D. Conn. 2020). Rather, "to establish jurisdiction based on the presence of a subsidiary, the parent corporation must fully control the subsidiary corporation such that the corporate veil must be pierced." *Id*. Connecticut law is thus clear that a court may only exercise jurisdiction over a foreign parent entity under Connecticut's long-arm statute if "the corporate veil [is] pierced so that acts of the domestic subsidiary can be imputed to the absent parent." *Shanshan Shao v. Beta Pharma, Inc.*, No. 3:14-CV-1177 (CSH), 2019 WL 7882485, at *10 (D. Conn. Sept. 23, 2019) (quoting *Hersey v. Lonrho, Inc.*, 73 Conn. App. 78, 86, 807 A.2d 1009 (2002)). But "Connecticut courts generally pierce the corporate veil only under 'exceptional circumstances,' such as when 'the corporation is a mere shell, serving no legitimate purpose, and used primarily as an intermediary to perpetuate fraud or promote injustice.'" *Leonard*, 504 F.Supp. 3d at 86 (quoting *Naples v. Keystone Bldg. & Dev. Corp.*, 295 Conn. 214, 233, 990 A.2d 326 (2010)). And the "key" showing required to pierce the corporate veil is "improper use of the corporate form." *Id*.

Here, "the complaint does not articulate any factual allegations that suggest that piercing the corporate veil for jurisdictional purposes is warranted." *See id*. While Elevance is the ultimate corporate parent of Anthem and Carelon, "[m]ere ownership by a parent corporation of a subsidiary corporation present in the forum state generally will not subject the parent to personal jurisdiction in that forum." *Id*. (quoting *Tekdoc Servs., LLC v. 3i-Infotech, Inc.*, 2009 WL 5064456, at *5 (D. Conn. Dec. 15, 2009)). Nor does Plaintiffs' conclusory allegation that Elevance is "inexplicably intertwined" with Anthem and Carelon because it "oversees and controls" their operations suffice. *Id*. Rather, to establish that "the corporate form should be disregarded," Plaintiffs would need to allege facts establishing either: (1) that Elevance exercised over its

subsidiaries "complete domination," which was used to commit the wrong at issue (the "instrumentality rule"); or (2) that Elevance and its subsidiaries are "controlled as one enterprise," both due to "common owners, officers, directors or shareholders" and the "lack of observance of corporate formalities between the two entities" (the "identity rule"). *See Am. Wholesalers Underwriting, Ltd. v. Am. Wholesale Ins. Grp., Inc.*, 312 F. Supp. 2d 247, 257 (D. Conn. 2004) (citing quoting *Zaist v. Olson*, 154 Conn. 563, 575, 227 A.2d 552 (1967); *Angelo Tomasso, Inc. v. Armor Const. & Paving, Inc.*, 187 Conn. 544, 560, 447 A.2d 406 (1982)). And even if such a showing is made, "[t]he party seeking to pierce the corporate veil must *also* show that the corporate form was a mere shell . . . used primarily as an intermediary to perpetrate fraud or [to] promote injustice." *Deutsche Bank AG v. Sebastian Holdings, Inc.*, 346 Conn. 564, 593, 294 A.3d 1, 19 (2023) (internal quotations marks omitted, omission and second alteration in original).

Plaintiffs allege no facts supporting a failure by Elevance to observe corporate formalities or the sharing of personnel among its subsidiaries and therefore cannot support application of the identity rule. *See Am. Wholesalers*, 312 F. Supp. 2d at 257. As to the instrumentality rule, it requires a showing that the parent exercised "not mere majority or complete stock control, but complete domination, not only of finances but of policy and business practice in respect to the transaction attacked so that the corporate entity as to this transaction had at the *time no separate mind, will or existence of its own*." *Id.* (emphasis added). This rule is ordinarily applied to "impose[] individual liability for corporat[ion] actions upon a shareholder, director, or officer" where the "corporate form is used to perpetrate some kind of wrongful act for the benefit of one who controls the corporation." *Id*. Plaintiffs' allegations that Elevance sets "key" policies, and "oversees and controls the operations" of Anthem and Carelon, fail to establish the "complete domination" required to pierce the corporate veil. Rather, as Plaintiffs allege, Elevance relies on

Anthem to "administer Elevance's health insurance products and interface with healthcare consumers and providers," and on Carelon to "administer Elevance's behavioral health services." Compl. ¶¶ 221–22. Plaintiffs' allegations that Elevance controls or directs some part of Anthem's and Carelon's business practices, while those entities administer portions of Elevance's business on its behalf, fail to demonstrate that Anthem or Carelon lack a separate "will or existence of [their] own" such that corporate veil may be pierced. *See Am. Wholesalers*, 312 F. Supp. 2d at 257.

Even if Plaintiffs had alleged such facts, however, Plaintiffs make no effort to establish that Carelon and Anthem are "mere shell[s]" used by Elevance "primarily as an intermediary to perpetrate fraud or [to] promote injustice." *Deutsche Bank*, 346 Conn. 564 at 593. Absent such a showing, the Court cannot pierce the corporate veil as to Elevance, *id*., and accordingly cannot exercise personal jurisdiction over Elevance under Connecticut's long-arm statute, *Hersey*, 73 Conn. App. at 86. Elevance must be dismissed from this litigation.[1]

II. PLAINTIFFS' STATE LAW CLAIMS SHOULD BE DISMISSED

Plaintiffs' first through seventh claims all arise under Connecticut state law. To the extent these causes of action are asserted by and on behalf of the Mazzolas and Amec, they are preempted by ERISA and must be dismissed. As to Kuller, whose claims are not ERISA preempted, each alleged claim also fails for the reasons discussed below.

A. The Mazzolas' and Amec's Plans are Governed by ERISA.

The health care plan upon which the Mazzolas and Amec based their claims is governed by ERISA. Although Plaintiffs allege that the Anthem Silver Pathway CT PPO plan that Amec provided to its employees—including the Mazzolas—was a non-ERISA plan prior to 2025, that

[1] In the event the Court were to exercise personal jurisdiction over Elevance, all arguments herein for dismissal of claims against Carelon apply with equal or greater force to Elevance, and Elevance incorporates and adopts those arguments as alternative grounds for dismissal of claims against it.

allegation is a legal conclusion which is erroneous as a matter of law.

ERISA, by its plain terms, governs "any employee benefit plan, other than listed exceptions." *Browe v. CTC Corp.*, 15 F.4th 175, 194 (2d Cir. 2021). This includes health benefit plans. *See* 29 U.S.C. § 1002(3) ("employee benefit plan" includes an "employee welfare benefit plan"); *id*. § 1002(1) ("employee welfare benefit plan" includes any "plan, fund, or program" established or maintained by an employer to provide "medical, surgical, or hospital care or benefits"). Although ERISA has exceptions for certain plans, such as governmental or church plans, it generally applies to all plans offered by private employers. *See* 29 U.S. Code § 1003(a), (b). Whether ERISA applies to a given benefit plan "is cognizable on a Rule 12(b)(6) motion" and "a Court may decide the applicability of ERISA as a matter of law." *Pasciutti v. LiquidPiston, Inc.*, No. 3:20-CV-01243 (RNC), 2021 WL 4502950, at *2 (D. Conn. Sept. 30, 2021)

Amec is "a small company that provides health insurance to its employees," and "[t]he plan Amec chose for its employees and their families was the Silver Pathway CT PPO plan." Compl. ¶¶ 96, 97. The employees to whom Amec offered benefits under this plan include the Plaintiffs. *Id*. ¶ 23. And Amec concedes that the same plan is currently an ERISA plan. *Id*. ¶ 10.

Plaintiffs' allegations establish Amec's provision of the Silver Pathway CT PPO plan to its employees is—and always has been—governed by ERISA. Amec contracted with Anthem to provide health benefits to its employees, establishing an employee welfare benefit plan. 29 U.S.C. § 1002(1). All such employee benefit plans provided by private employers are governed by ERISA, unless an exception applies. *See Browe*, 15 F.4th at 194; *see* 29 U.S. Code § 1003(a), (b). Plaintiffs allege no facts from which the Court could infer or conclude that any exception applies. *See* 29 U.S. Code § 1003(b). The health plan Amec offers to its employees is thus governed by ERISA. *See Pasciutti*, 2021 WL 4502950, at *2.

B. The Mazzolas' and Amec's State-law Claims are Preempted.

The Mazzolas' and Amec's state-law claims are thus preempted by ERISA's "expansive pre-emption provisions" under Section 514, *Aetna Health Inc. v. Davila,* 542 U.S. 200, 208 (2004), which expressly "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA, *Murphy Med. Assocs., LLC v. Yale Univ.*, 120 F.4th 1107, 1114 (2d Cir. 2024) (quoting 29 U.S.C. § 1144(a)).

The Supreme Court has consistently held that ERISA's "carefully integrated civil enforcement provisions," *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985), "were intended to be exclusive," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health*, 542 U.S. at 208. ERISA's preemption provisions operate to "eliminate the threat of conflicting and inconsistent State and local regulation." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) (quoting 120 Cong. Rec. 29197 (1974)). ERISA therefore preempts state law claims "that seek 'to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and do not attempt to remedy any violation of a legal duty independent of ERISA.'" *Paneccasio v. Unisource Worldwide, Inc.*, 532 F.3d 101, 114 (2d Cir. 2008) (citation omitted).

ERISA's express preemption provision preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" covered under the statute. 29 U.S.C. § 1144(a). State laws "relate to" an ERISA plan for purposes of preemption if the law either has a "reference to" or has a "connection with" the plan at issue. *See Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 504 (2d Cir. 2014) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983)). The "related to" language in that provision is "deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.'" *Pilot Life Ins. Co.*, 481 U.S. at 46 (cleaned up).

A state law claim makes "reference to" an ERISA plan when: (1) "the existence of a[n ERISA] plan is a critical factor in establishing liability," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139–40 (1990); or (2) the court's examination will "require interpreting the plan's terms." *Menkes v. Prudential Ins. Co. of Am.*, 762 F.3d 285, 294 (3d Cir. 2014). And a state law claim has a "connection with" an insurance benefits plan when the claim "provide[s] 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." *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989).

As discussed above, the plan under which the Mazzolas seek benefits—and which Amec acquired on their behalf—is an ERISA governed plan. And the ERISA plan is a "critical factor" in establishing liability because each of these claims is premised on Defendants' failing to provide the benefits available under that insurance plan:

- Plaintiffs' claims for breach of contract and breach of the covenant of good faith and fair dealing are expressly based on a purported violation of the Plaintiffs' ERISA-governed insurance contract. Compl.,¶¶ 354–58; 362–65; 370.
- Plaintiffs' claim for violation of CUTPA is premised on allegations Defendants "misrepresenting the health care benefits available to members," the number of providers from whom services could be obtained, and the cost of obtaining care, and limiting benefits available. *Id*. ¶¶ 383–85, 390, 392, 394.
- Plaintiffs' fraud claims are based on allegations that Defendants misrepresented the availability of mental health providers and the cost to obtain care. *Id*. ¶¶ 403–04, 414–15.
- And Plaintiffs' unjust enrichment claim relies on allegations that Plaintiffs conferred a benefit on Defendants by "enrolling in Anthem's health insurance" but did not "receive the full value of what they were owed" and "unjustly incurred" out-of-pocket costs. *Id*. ¶¶ 421, 423, 425.

For each of those claims, the insurance plan in which the Mazzolas were enrolled is a "critical factor" in the claim, and each claim will require the Court to examine and interpret the plan's terms to determine what promises and representations Defendants actually made to the Plaintiffs.

Plaintiffs' claims make "reference to" an ERISA plan and, accordingly, "relate to" the ERISA plan such that the claims fall within ERISA's preemption provision. Plaintiffs' state-law claims are thus preempted by ERISA as to the Mazzolas and Amec, and "must be dismissed." *Murphy Med. Assocs.*, 120 F.4th at 1114.

C. Plaintiffs' State Law Claims Must Be Dismissed for Failure to State a Claim

Because Plaintiffs' state-law claims are preempted as to the Mazzolas and Amec, those claims may be asserted only on behalf of the remaining Plaintiff, Kuller. However, each of Plaintiffs' claims must be dismissed for failure to state a claim as they relate to Kuller.

1. Kuller Fails to State a Claim for Breach of Contract

To plead a plausible claim for breach of contract under Connecticut law, Plaintiffs must allege "(1) the formation of an agreement; (2) performance by one party; (3) breach of the agreement by the opposing party; (4) direct and proximate cause; and (5) damages." *See Henderson v. Wells Fargo Bank, N.A.*, No. 3:13CV378 (JBA), 2017 WL 731780, at *6 (D. Conn. Feb. 21, 2017) (quoting *McMann Real Equities Series XXII, LLC v. David McDermott Chevrolet, Inc.*, 93 Conn. App. 486, 503–04 (2006)).

As an initial matter, the claim must be dismissed as it relates to Carelon and Elevance because Plaintiffs do not allege a contract between those entities and Kuller. "[I]t is axiomatic that an action 'for breach of contract may not be maintained against a person who is not a party to the contract.'" *Szynkowicz v. Bonauito-O'Hara*, 170 Conn. App. 213, 224, 154 A.3d 61, 69 (2017). The only contract Plaintiffs have identified to which Kuller is a party is her insurance contract with Anthem: the Anthem Blue Cross Blue Shield Bronze PPO Pathway plan. Compl. ¶¶ 24, 190. Plaintiffs do not allege either Carelon or Elevance is a party to that insurance contract. Accordingly, Plaintiffs have not alleged the "formation of an agreement" between Kuller and Carelon or Elevance, *Henderson*, 2017 WL 731780, at *6, and Kuller therefore cannot maintain a

breach of contract claim against either party, *Szynkowicz*, 170 Conn. App. at 224.

Moreover, Plaintiffs' breach of contract claim fails on the merits because the Complaint does not plausibly allege conduct by Defendants that breached a term of Kuller's agreement with Anthem. "In asserting a breach of contract claim, the complaint must allege the provisions of the contract upon which the claim is based." *Timmons v. City of Hartford*, 283 F. Supp. 2d 712, 718 (D. Conn. 2003); *see also McKeon V. Connecticut Water Co.*, No. KNL-CV-24-6071229-S, 2025 WL 2218705, at *4 (Conn. Super. Ct. July 31, 2025) ("To adequately plead a breach of that contract, however, Superior Court judges have consistently held that the plaintiff must identify a specific provision of the contract that has been violated"). This is because to "determin[e] whether a breach has been alleged, the court must look to the language of the contract." *Id*.

Here, the Complaint alleges that Kuller's subscriber agreement includes various descriptions of Anthem's provider network and how members can access it, along with other purported terms of the Plan. Compl. ¶¶ 256–60. But Plaintiffs identify no term that imposes a specific contractual obligation on Anthem to ensure Kuller could identify an in-network provider within a certain distance from her home, or requires Anthem to pay a different or greater reimbursement for out-of-network services than Kuller alleged she received.[2] Thus, Plaintiffs' allegations that Kuller was unable to identify a provider within a certain distance from her home, Compl. ¶¶ 202, 207, or that Anthem only pays a certain amount for out-of-network services, Compl. ¶¶ 206, 210, cannot establish a breach absent allegations that Anthem was contractually obligated to make a provider available within that distance or to calculate a greater allowed amount

[2] Although the Complaint includes references to Kuller's Subscriber Agreement, it is not attached as an Exhibit.

for out-of-network services.[3] Because Plaintiffs have not alleged specific provisions of Kuller's insurance contract that were breached by Anthem's alleged conduct, their claim for breach of contract necessarily fails . *See Timmons*, 283 F. Supp. 2d at 718.

2. Plaintiffs' Second Claim for Breach of Contract Must be Dismissed for Lack of Standing

Plaintiffs' second claim for breach of contract must be dismissed because Plaintiffs lack standing to bring suit on behalf of non-parties to the case. "A party generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004). Thus, a plaintiff lacks standing to assert claims to vindicate the rights of others unless the plaintiff can show a "close" relationship with the person who possesses the right, or the person is hindered in protecting his own interests. *Id*.

Plaintiffs' second claim is alleged on behalf of "all employer Plaintiffs and Class members which provided *non-ERISA* plans." Compl. at 64 (emphasis added). However, the only "employer Plaintiff" that is a party to this action is Amec. *See* Compl. ¶ 362. But the Plan Amec provided to its employees is an ERISA plan, *see supra* Part II(a), and it therefore is not within the class of persons or entities on whose behalf the second claim is asserted. Because there is no employer Plaintiff offering a non-ERISA plan that is a party to the case, and Plaintiffs have not alleged the existence of such an entity that meets the exceptions to the bar on third-party standing, Plaintiffs lack standing to assert their second claim on behalf of unidentified non-parties, and that claim must be dismissed.

[3] Plaintiffs' allegation that the subscriber agreement "requires Anthem to comply with all applicable federal and state laws," Compl. ¶ 258, does not salvage this claim, as the Complaint likewise does not allege the terms of any federal or state law that requires Anthem to make a provider available within 15 miles from Kuller's home or reimburse greater amounts than Anthem paid for these services.

3. Kuller Fails to State a Claim for Breach of The Covenant of Good Faith and Fair Dealing

To plead a breach of the covenant of good faith and fair dealing, a plaintiff must allege "acts by which a defendant allegedly impeded the plaintiff's right to receive reasonably expected contract benefits," and that those acts "were taken in bad faith." *Landry v. Spitz*, 102 Conn. App. 34, 47, 925 A.2d 334, 344 (2007). "The covenant of good faith and fair dealing presupposes that the terms and purpose of the contract are agreed upon by the parties and that what is in dispute is a party's discretionary application or interpretation of a contract term." *Hoskins v. Titan Value Equities Grp., Inc.*, 252 Conn. 789, 793, 749 A.2d 1144, 1146 (2000).

Thus, under Connecticut law, "the claim [that the covenant has been breached] must be tied to an alleged breach of a specific contract term, often one that allows for discretion on the part of the party alleged to have violated the duty." *Landry*, 102 Conn. App. at 47; *Geysen v. Securitas Sec. Servs. USA, Inc.*, 322 Conn. 385, 399, 142 A.3d 227, 237 (2016) (citing *Landry* favorably); *see also Nwachukwu v. Liberty Bank*, 257 F. Supp. 3d 280, 296 (D. Conn. 2017) ("Connecticut courts have adopted the view that a claim for breach of the implied covenant of good faith and fair dealing must be tied to an alleged breach of an express contract term."). "[T]he covenant 'is not implicated by conduct that does not impair contractual rights.'" *Ultimate Nutrition, Inc. v. Leprino Foods Co.*, 779 F. Supp. 3d 203, 224 (D. Conn. 2025), *appeal docketed*, No. 25-1284 (2d Cir. May 20, 2025) (quoting *Capstone Bldg. Corp. v. Am. Motorists Ins. Co.*, 308 Conn. 760, 794-795, 67 A.3d 961 (2013)).

As with Plaintiffs' breach of contract claim, the absence of contractual privity is fatal to Plaintiffs' claim against Carelon or Elevance for breach of the covenant of good faith and fair dealing. "[T]he existence of a contract between the parties is a necessary antecedent to any claim of breach of the duty of good faith and fair dealing." *Hoskins*, 252 Conn. at 793. Because Plaintiffs

allege no contract between Kuller and Carelon or Elevance, they cannot maintain a claim against those parties for breach of the covenant of good faith and fair dealing, and that claim must be dismissed as to Carelon and Elevance.

Furthermore, as discussed with respect to Plaintiffs' first claim, Plaintiffs have not alleged the specific terms or provisions of Kuller's contract with Anthem that Defendants' conduct purportedly breached. Because Plaintiffs "ha[ve] not stated a claim for breach of the contract's express terms," they cannot maintain a claim for breach of the covenant of good faith and fair dealing. *See Nwachukwu*, 257 F. Supp. 3d at 280.

4. Kuller Fails to State a Claim for Violation of CUTPA

"To state a claim under CUTPA, a plaintiff must plead that she (1) suffered an ascertainable loss of money or property, (2) that was caused by, (3) an unfair method of competition or an unfair or deceptive act in the conduct of any trade or commerce." *Smith v. Wells Fargo Bank, N.A.*, 158 F. Supp. 3d 91, 100 (D. Conn. 2016), *aff'd*, 666 F. App'x 84 (2d Cir. 2016). "[A] violation of CUTPA may be established by showing either an actual deceptive practice or a practice amounting to a violation of public policy." *Caires v. JP Morgan Chase Bank, N.A.*, 880 F. Supp. 2d 288, 299 (D. Conn. 2012). "When a plaintiff in federal court bases a CUTPA claim on fraud allegations, the plaintiff must satisfy the particularity requirement of Federal Rule of Civil Procedure 9(b)." *Aviamax Aviation Ltd. v. Bombardier Aerospace Corp.*, No. 3:08-CV-1958(CFD), 2010 WL 1882316, at *9 (D. Conn. May 10, 2010).

a. Fraud-based CUTPA Claims

Here, Kuller's allegations of putative violations of CUTPA all sound in fraud. *See* Compl. ¶¶ 307–09, 317, 319–22. Accordingly, Plaintiffs were required to satisfy Rule 9(b)'s particularity requirement with respect to these claims but failed to do so. To comply with Rule 9(b), "the complaint must: (1) specify the statements that the plaintiff contends were fraudulent, (2) identify

the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent." *Mills v. Polar Molecular Corp.*, 12 F.3d 1170, 1175 (2d Cir. 1993); *see also Waldman v. New Chapter, Inc.*, 714 F. Supp. 2d 398, 402 (E.D.N.Y. 2010) (citing *Mills* for the proposition that a plaintiff must "state where, when and to whom the statements were made"). "Rule 9(b) is not satisfied where the complaint vaguely attributes the alleged fraudulent statements to 'defendants.'" *Mills*, 12 F.3d at 1175

Plaintiffs fail to meet Rule 9(b)'s pleading requirements with respect to their CUTPA claim because they do not allege with specificity the false representations that they contend violate CUTPA. Many of Plaintiffs' CUTPA allegations and general factual allegations attribute allegedly false statements generally to "Defendants," without specifying which defendant purportedly made any given statement or representation. *See* Compl. ¶¶ 383–85, 319–22; *see also, e.g.*, *id.* ¶¶ 5, 14, 15, 97, 154, 159, 164, 281. Even where the purported speaker is identified, however, Plaintiffs fail to specify the actual false statements, *see, e.g., id.* ¶¶ 15, 282, to identify the circumstances of the purported statement, including when, how, and to whom it was made, *see, e.g., id.* ¶¶ 284, 287–289, or to explain how the statements were false, *see, e.g., id.* ¶¶ 236–41, 273.[4] These allegations fail to satisfy Rule 9(b)'s particularity requirements, and thus fail to provide adequately pleaded support for a fraud-based CUTPA claim.

Moreover, the Complaint fails to allege any specific false statement that was made *to* Kuller, that she was aware of the statements, or that she acted in reliance on them. *Cf. Patane v. Nestle Waters N. Am., Inc.*, 761 F. Supp. 3d 424, 446 (D. Conn. 2024) (common law fraud requires

[4] Plaintiffs' allegations are more specific with respect to purported false statements to the Mazzolas, however, ERISA pre-empts any CUTPA claim by the Mazzolas, as discussed above, and Kuller lacks standing to assert a CUTPA claim based on any misrepresentation to the Mazzolas, as she cannot trace any concrete injury to misrepresentations allegedly made to others. *See Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016).

a showing "the plaintiff has received, believed, and acted upon the defendant's misrepresentation"). Instead, the Complaint vaguely alleges that Kuller relied on unspecified "implicit and explicit representations by Anthem that the provider directory was robust and accurate" and "representations she saw on the Anthem website about the size of Anthem's network." Compl. ¶¶ 197, 200. Such allegations fail to meet Rule 9(b)'s particularity requirement and do not demonstrate Kuller was aware of or relied on any particular alleged misrepresentation. Plaintiffs' allegations thus fail to establish a fraud-based CUTPA claim.

b. CUTPA Claims Based on Purported Statutory Violations

Many of Plaintiffs' CUTPA allegations also invoke purported violations of Connecticut state statutes. The majority of these allegations relate to either (1) Anthem's decisions regarding coverage of autism treatment, which Kuller never sought from Anthem, or (2) Anthem's denial of coverage on various bases that Kuller does not allege applied to her own requests for benefits. Compl. ¶¶ 386–89, 390. Kuller accordingly lacks standing to assert a CUTPA claim on these bases, as she has no injury traceable to the alleged conduct. *See Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016).

These claims also fail because the statutes on which Plaintiffs rely cannot provide the basis for a CUTPA claim under Connecticut law. As the Connecticut Supreme Court has made clear, the Connecticut Unfair Insurance Practices Act ("CUIPA") is the "comprehensive and exclusive means of identifying unfair insurance practices" for purposes of CUTPA. *See NEMS, PLLC v. Harvard Pilgrim Health Care of Connecticut, Inc.*, 350 Conn. 525, 534, 325 A.3d 196, 202 (2024) (citing *State v. Acordia, Inc.*, 310 Conn. 1, 73 A.3d 711 (2013)). Accordingly, "unless an insurance related practice violates CUIPA . . . it cannot be found to violate CUTPA." *Id*. at 537, 539. And an insurance-related practice is an unfair practice in violation of CUIPA only if it is: (1)

enumerated in General Statutes § 38a-816 or (2) the Insurance Commissioner has made a specific determination that the practice violates CUIPA. *See id*. at 535 (citing Conn. Gen. Stat. § 38a-815). Here, Plaintiffs contend Defendants' alleged conduct violates Conn. Gen. Stat. §§ 38a-488b and 38a-477h.[5] But neither a violation of Conn. Gen. Stat. § 38a-488b nor § 38a-477h is enumerated as an unfair practice under § 38a-816, nor has there been any showing the Insurance Commissioner has made a determination that a violation of those statutes is an unfair practice. Accordingly, Plaintiffs' CUTPA claim based on the alleged violation of General Statutes §§ 38a-488b and 38a-477h fails. *See NEMS, PLLC*, 350 Conn. at 537.

5. Kuller Fails to State a Claim for Fraudulent or Negligent Misrepresentation.

Plaintiffs' fifth and sixth claims for fraudulent and negligent misrepresentation must be dismissed both because Plaintiffs fail to plead fraud with particularity as required under Rule 9(b) and because Plaintiffs do not plead facts showing actual reliance by Kuller on any specific false statement by any Defendant.

"The four essential elements of fraud are (1) that a false representation of fact was made; (2) that the party making the representation knew it to be false; (3) that the representation was made to induce action by the other party; and (4) that the other party did so act to her detriment." *Pospisil v. Pospisil*, 59 Conn. App. 446, 450, 757 A.2d 655, 658 (2000). "[T]he party to whom the false representation was made [must claim] to have relied on that representation and to have suffered harm as a result of the reliance." *Simms v. Seaman*, 308 Conn. 523, 548, 69 A.3d 880, 894 (2013) (alterations in original). "The elements of a claim for negligent misrepresentation are: (1) that a misrepresentation of fact was made; (2) that the party making it knew or should have

[5] Plaintiffs' fraud allegations, which they allege demonstrate a violation of Conn. Gen. Stat. § 38a-477, are discussed above.

known that it was untrue; (3) that the other party reasonably relied upon it; and (4) that the latter suffered pecuniary harm as a result thereof." *Drena v. Bank of Am., N.A.*, No. 3:15-CV-176 (VAB), 2017 WL 6614094, at *14 (D. Conn. Dec. 27, 2017) (internal quotation marks omitted).

As discussed above, when fraud is alleged, the Court "must also view the complaint in light of Rule 9(b), which requires that 'the circumstances constituting fraud . . . be stated with particularity.'" *Shields v. Citytrust Bancorp, Inc.*, 25 F.3d 1124, 1127 (2d Cir. 1994) (quoting Fed. R. Civ. P. 9(b)). Rule 9(b) requires the plaintiff to identify: (1) the specific statements the plaintiff contends where fraudulent; (2) the speaker of each statement; (3) the circumstances under which the statement was made, including where, when, and to whom; and (4) how and why the statements are fraudulent. *See Mills*, 12 F.3d at 1175; *Waldman*, 714 F. Supp. 2d at 402. Where a complaint names multiple defendants, Rule 9(b) does not permit allegations attributing fraudulent statements generally to all defendants. *See Mills*, 12 F.3d at 1175; *Apace Commc'ns, Ltd. v. Burke*, 522 F. Supp. 2d 509, 517 (W.D.N.Y. 2007) ("Rule 9(b) does not allow a complaint to merely lump multiple defendants together but 'require[s] plaintiffs to differentiate their allegations when suing more than one defendant . . . and inform each defendant separately of the allegations surrounding his alleged participation in the fraud.'").

Plaintiffs fail to meet Rule 9(b)'s pleading requirements with respect to their fraud claim because they do not allege with specificity false representations of fact made to Kuller by a specific defendant, the surrounding circumstances of those representations, and Kuller's reliance on the particular representation. Many of the allegations specific to Plaintiffs' fraud claims, as well as their general factual allegations, attribute allegedly false statements generally to "Defendants," without specifying which defendant purportedly made any given statement or representation. *See* Compl. ¶¶ 383–85, 319–22; *see also, e.g.*, *id.* ¶¶ 5, 14, 15, 97, 154, 159, 164, 281. Even where the

purported speaker is identified, however, Plaintiffs fail to specify the actual false statements, *see, e.g., id.* ¶¶ 15, 282, to identify the circumstances of the purported statement, including when, how, and to whom it was made, *see, e.g., id*. ¶¶ 284, 287–289, or to explain how the statements were false, *see, e.g., id.* ¶¶ 236–41, 273. Those allegations fail to satisfy Rule 9(b)'s particularity requirements and thus fail to state a claim for fraudulent or negligent misrepresentation.

Plaintiffs also fail to plead facts establishing Kuller's reasonable reliance on any purported misrepresentation in taking any action. The Complaint alleged Kuller "relied on Anthem's statements about the breadth of its network," "implicit and explicit representations by Anthem that that the provider directory was robust and accurate," and "representations she saw on the Anthem website about the size of Anthem's network" in choosing to enroll in an Anthem plan. Compl. ¶¶ 196, 197, 200. But conspicuously absent from these allegations is the identification of any specific statement by Anthem that Kuller relied on that was false.

Because the only "reliance" Plaintiffs allege was induced by Defendants' purported misrepresentations was Plaintiffs' enrollment in their Anthem plan, the failure to plead Kuller's reliance on any specific representation by Anthem with the requisite particularity is fatal to Defendants' fraud claims.[6] Nor do their generalized allegations that "Plaintiffs and class members justifiably relied on Defendants' representations and omissions, as Defendants had unique knowledge of the facts underlying their representations" alter the analysis. Compl. ¶ 406; *see also id.* ¶¶ 302, 341. Such allegations "are conclusory," because they "they do not explain how or why the plaintiffs relied on the allegedly false [statements]" where there is no allegation Kuller had saw

[6] Plaintiffs attempt to bolster their fraud claims by alleging they "detrimentally relied on the inaccurate directory when searching for in-network providers." Compl. ¶ 416; *see also id.* ¶ 405. But Plaintiffs allege no "pecuniary harm" stemming from such reliance and accordingly cannot establish fraud on the basis of such reliance. *See Drena*, 2017 WL 6614094, at *14.

any particular claimed misrepresentation. *See Stuart v. Freiberg*, 316 Conn. 809, 828, 116 A.3d 1195, 1207 (2015). Rather, "[w]ithout *actual* reliance, reasonable reliance cannot possibly exist." *Id*. (emphasis in original). And absent from Plaintiffs' Complaint are any allegations that Kuller actually saw or was aware of any specific allegedly false statements at the time she made her enrollment decision.

Absent such allegations establishing actual reliance on specific false statements—pleaded with the particularity required by Rule 9(b)—the Complaint cannot establish reasonable reliance and thus fails to state a claim for either fraudulent or negligent misrepresentation. *See id.; see also Sec. Inv. Prot. Corp. v. BDO Seidman, LLP*, 222 F.3d 63, 72 (2d Cir. 2000) (reliance cannot be established where plaintiffs did not receive misrepresentation); *Hunte v. Abbott Lab'ys, Inc.*, 556 F. Supp. 3d 70, 88 (D. Conn. 2021) (dismissing negligent misrepresentation claim for lack of reliance where plaintiff "does not allege that she ever saw or read" the claimed misrepresentations).

Because Plaintiffs have neither pleaded their fraud claims with the required particularity, nor pleaded facts to show Kuller's reasonable reliance on any specific misrepresentation, Plaintiffs' fifth and sixth claims must be dismissed.

6. Kuller Fails to State a Claim for Unjust Enrichment

Plaintiffs' final state-law claim, for unjust enrichment, must be dismissed as to Carelon and Elevance because Plaintiffs have not alleged nonconclusory facts establishing that either received a benefit from Kuller, and must be dismissed as to Anthem because the claim improperly incorporates allegations of breach of contract that preclude an equitable remedy. "Plaintiffs seeking recovery for unjust enrichment must prove (1) that the defendants were benefited, (2) that the defendants unjustly did not pay the plaintiffs for the benefits, and (3) that the failure of payment was to the plaintiffs' detriment." *Vertex, Inc. v. City of Waterbury*, 278 Conn. 557, 573, 898 A.2d 178, 190 (2006).

As to Carelon and Elevance, the Complaint contains no non-conclusory allegation that Carelon or Elevance received any benefit from Kuller. The threshold showing of an unjust enrichment claim is that the defendant "benefited from the transaction or has received something of value" that it would be unjust for the defendant to retain. *See Garwood & Sons Const. Co. v. Centos Assocs. Ltd. P'ship*, 8 Conn. App. 185, 187, 511 A.2d 377, 379 (1986). As discussed above, Carelon and Elevance are not in privity with Kuller, as her insurance contract is with Anthem, and Plaintiffs do not allege either Carelon or Elevance is a party to that contract. *See* Compl. ¶¶ 24, 190, 198. Kuller pays her insurance premiums to Anthem, and Plaintiffs expressly allege that *Anthem*—not Carelon or Elevance—is "enriched" by receipt of those premiums. *Id*. ¶ 326.

Plaintiffs instead allege that Kuller "conferred a benefit on Defendants by enrolling in Anthem's health insurance and thereby directing [her] medical premiums to Defendants." *Id*. ¶ 346. Plaintiffs' allegation that Kuller "directed" her premium payments to Defendants, however, does not establish that Carelon or Elevance itself *received* any portion of those premiums or any other benefit from Kuller. Recognizing this analytical gap, Plaintiffs allege Kuller's enrollment in the Anthem plan "increased the premiums paid to Anthem and, by extension, the money Anthem paid to Carelon and Elevance." *Id.* ¶ 420. But Plaintiffs' own allegations assert that any payment Anthem makes to Carelon and Elevance is based not on enrollment or premiums received, but on Anthem's profits. *Id*. ¶ 225. Plaintiffs nowhere allege that Kuller's enrollment in an Anthem plan resulted in an increase in Anthem's *profits*, and they accordingly fail to establish that Elevance or Carelon were paid anything by Anthem as a result of her enrollment under Plaintiffs' own theory. *Id*. The Complaint thus fails to allege non-conclusory facts establishing Carelon or Elevance "benefited from the transaction" of Kuller's enrollment with Anthem, *Garwood*, 8 Conn. App. at 187, and Plaintiffs' unjust enrichment claim fails as it relates to Carelon and Elevance.

As to Anthem, Plaintiffs' unjust enrichment claim fails because, under Connecticut law, an unjust enrichment claim that incorporates allegations that an express contract exists, and was breached by the defendant, cannot survive a pleading challenge. As a general rule, Connecticut courts permit parties to "plead alternative counts alleging breach of contract and unjust enrichment." *Stein v. Horton*, 99 Conn. App. 477, 485, 914 A.2d 606, 613 (2007). However, the "lack of a remedy under a contract is a precondition to recovery based on unjust enrichment." *Piccolo v. Am. Auto Sales, LLC*, 195 Conn. App. 486, 499, 225 A.3d 961, 970 (2020). Thus, alternative pleading of breach of contract and unjust enrichment claims is permitted only where the plaintiff does not "allege an express contract in his unjust enrichment counts," and does not "incorporate the breach of contract allegations . . . in the unjust enrichment counts." *Id*. at 501–02. "Asserting both an express contract and claiming unjust enrichment [within the same count] is legally insufficient." *Whitby Sch., Inc. v. Grenaille*, No. CV030195602, 2003 WL 23191957, at *2 (Conn. Super. Ct. Dec. 29, 2003) (alteration in original). "Where a plaintiff incorporates allegations of an express contract in a count alleging unjust enrichment, the claim for unjust enrichment cannot lie." *Id*.

Here, Plaintiffs allege the existence of an express contract—and its breach—in paragraphs 354–58 of the Complaint. As part of their seventh claim for unjust enrichment, Plaintiffs "incorporate by reference *all allegations* in this Complaint and restate them as if fully set forth herein." Compl. ¶ 419 (emphasis added). Plaintiffs have thus incorporated allegations of an express contract between Kuller and Anthem and the breach of that contract in their claim for unjust enrichment, rendering it "legally insufficient" under Connecticut law as to Anthem. *See Piccolo*, 195 Conn. App. at 499; *Whitby Sch.*, 2003 WL 23191957 at *2. Plaintiffs' seventh claim for unjust enrichment accordingly fails to state a claim and must be dismissed.

III. PLAINTIFFS' CLAIMS UNDER ERISA MUST BE DISMISSED FOR FAILURE TO STATE A CLAIM.

Plaintiffs' last three claims all arise under ERISA and are asserted on behalf of the Mazzolas and Amec as the beneficiaries and purchaser, respectively, of an ERISA-governed insurance plan, the Anthem Silver CT Pathway PPO plan. *See Supra* Part II(a). Plaintiffs' attempt to assert these claims against Carelon and Elevance must fail because they are not parties to any agreement with the Mazzolas and Amec enforceable under ERISA. Moreover, Plaintiffs' causes of action under ERISA each fail to state a claim and must be dismissed.

A. Plaintiffs Cannot Maintain ERISA Claims Against Carelon and Elevance

First, Plaintiffs cannot pursue ERISA claims against Carelon and Elevance because the ERISA plan their claims arise under is insured by Anthem, and neither Carelon nor Elevance is party to that agreement. "ERISA plans are contracts, and courts use 'familiar rules of contract interpretation' when addressing an ERISA plan." *Est. of Kenyon v. L + M Healthcare Health Reimbursement Acct.*, 404 F. Supp. 3d 627, 632 (D. Conn. 2019) (quoting *Lifson v. INA Life Ins. Co. of N.Y.*, 333 F.3d 349, 353 (2d Cir. 2003)). "[A] parent corporation and its subsidiar[ies] are regarded as legally distinct entities and a contract under the corporate name of one is not treated as that of both*." Carte Blanche (Singapore) Pte., Ltd. v. Diners Club Intern., Inc.*, 2 F.3d 24, 26 (2d Cir. 1993). Thus, where a parent or subsidiary corporation is not party to an ERISA plan, a plaintiff cannot pursue ERISA claims against such an entity absent a "factual basis" for those claims "other than their status as the parent" of a party to the plan. *Lines v. Hartford Fin. Serves. Group, Inc.*, No. 3:21-CV-00029 (KAD), 2022 WL 408820, at *4 (D. Conn. Feb. 10, 2022).

The only ERISA-governed plan Plaintiffs have identified is the Anthem Silver Pathway CT PPO plan, which Plaintiffs allege Amec "contracted with Anthem to purchase and provide" to the Mazzolas. Compl. ¶¶ 19, 21, 13. Plaintiffs do not allege Carelon or Elevance is a party to that

insurance contract (which they are not). Accordingly, Plaintiffs lack privity with Carelon or Elevance under the insurance plan on which their ERISA claims are based, Plaintiffs thus cannot pursue claims against Carelon or Elevance under ERISA, and Plaintiffs' eighth through tenth causes of action must be dismissed as to Carelon and Elevance for this reason. *See Lines*, 2022 WL 408820, at *4.

B. Plaintiffs' Claim for Benefits Under ERISA Fails

Plaintiffs' eighth claim for denial of benefits under 29 U.S.C. § 1132(a)(1)(B) must be dismissed for failure to adequately plead exhaustion of administrative remedies. To the extent exhaustion is adequately pleaded for any claims, Plaintiffs fail to plead facts establishing that Anthem's benefits determination was incorrect. Plaintiffs' ERISA benefits claim accordingly must be dismissed.

1. Plaintiffs Have Failed to Plead Exhaustion of Administrative Remedies

Although ERISA does not contain an exhaustion requirement, the Second Circuit "has recognized the firmly established federal policy favoring exhaustion of administrative remedies in ERISA cases" and requires exhaustion of administrative appeals before a claimant may sue to recover benefits. *See Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993); *see also Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. 99, 105 (2013) ("The courts of appeals have uniformly required that participants exhaust internal review before bringing a claim for judicial review under § 502(a)(1)(B)."). "The failure to exhaust administrative remedies before filing an action in federal court requires [an] ERISA cause of action to be dismissed." *Cooper v. Int'l Bus. Machines Corp.*, No. 3:24-CV-656 (VAB), 2024 WL 5010488, at *7 (D. Conn. Dec. 6, 2024) (quoting *Neurological Surgery, P.C. v. Aetna Health, Inc.*, 511 F. Supp. 3d 267, 293 (E.D.N.Y. Jan. 4, 2021) (alteration in original). And while failure to exhaust is an affirmative defense rather than a jurisdictional defect, "Courts within the Second Circuit 'routinely dismiss

ERISA claims . . . on a 12(b)(6) motion to dismiss where the plaintiff fails to plausibly allege exhaustion of remedies.'" *Neurological Surgery*, 511 F. Supp. 3d at 296.

Importantly, a bald assertion of exhaustion is insufficient to withstand a motion to dismiss. *See Murphy Med. Assocs., LLC v. Cigna Health & Life Ins. Co.*, No. 3:20CV1675(JBA), 2022 WL 743088, at *8 (D. Conn. Mar. 11, 2022), *reconsideration granted on other grounds*, 2022 WL 10560321 (D. Conn. Oct. 18, 2022) (citing *Kesselman v. The Rawlings Co.*, 668 F. Supp. 2d 604, 608-09 (S.D.N.Y. 2009)). Nor can exhaustion be alleged in gross. *See Neurological Surgery*, 511 F. Supp. 3d at 294 (rejecting sufficiency of allegation that plaintiff "appealed each of the 200 claims at issue"). Rather, for each benefit denial sought to be challenged, the plaintiff must allege facts from which the Court can infer "what each ERISA plan's appeals procedure required, whether Plaintiff followed that procedure, when the appeal was taken, and when the appeal was decided," from which the Court can determine "that an appeal was timely taken," *id*., and a final administrative decision reached.

Based on that standard, Plaintiffs fail to adequately plead administrative exhaustion. As an initial matter, Plaintiffs cannot establish exhaustion on a blanket basis: Plaintiffs' general allegations that they "filed timely appeals" as to "repeated claims," Compl. ¶ 165, "directly appealed Defendants' denials," *id*. ¶ 179, and "repeatedly submit[ed] electronic appeals," *id*. ¶ 179, are inadequate. It is "well established" that "bald assertions that administrative remedies have been exhausted do not withstand a 12(b)(6) motion." *Neurological Surgery*, 511 F. Supp. 3d at 294. Accordingly, Plaintiffs' blanket assertion of exhaustion must be rejected.

Plaintiffs' attempt to demonstrate exhaustion as to particular claims, however, fares no better. Plaintiffs allege that Anthem denied an unspecified number of claims for speech therapy between January 13, 2025 and July 10, 2025. Compl. ¶ 185. Plaintiffs allege the Mazzolas

"appealed these denials by repeatedly submitting electronic appeals to Anthem throughout February and March 2025" and Anthem upheld the decisions on appeal. *Id*. But these allegations are inadequate for at least two reasons: First, Plaintiffs fail to identify which claims were actually appealed or even *how many* claims were appealed during this period. Plaintiffs' allegations thus fail to demonstrate exhaustion with respect to any particular claim or claims, or to provide sufficient information for Defendants or the Court to even understand which or how many claims may be at issue. Second, Plaintiffs' allegations fail to demonstrate that the Mazzolas exhausted any speech therapy claims denied between April 2025 and July 2025. They do not allege they submitted any appeals after March 2025, and thus all claims denied between April 2025 and July 2025 would be subject to dismissal.

Because Plaintiffs have failed to allege facts sufficient to demonstrate which of the challenged speech-therapy claims denied between January 13, 2025 and July 10, 2025 were actually appealed and upheld by Anthem, Plaintiffs cannot establish exhaustion for any of these claims. *See Neurological Surgery*, 511 F. Supp. 3d at 294.

2. Plaintiffs' ERISA Benefits Claim Fails on the Merits

The only claim for which Plaintiffs adequately plead exhaustion is their allegation that Baby Doe was seen for genetic testing in September 2025, that Anthem denied the claim for lack of medical necessity, that Plaintiffs appealed the denial in October 2025, and Anthem denied the appeal and upheld its decision. Compl. ¶ 189. However, Plaintiffs' claim must be denied because they fail to establish an entitlement to benefits for this claim under their plan's terms.

A claim for benefits under 29 U.S.C. § 1132(a)(1)(B), "in essence, is the assertion of a contractual right." *Feifer v. Prudential Ins. Co. of Am.*, 306 F.3d 1202, 1210 (2d Cir. 2002). To proceed on a claim under this section, a plaintiff must establish "benefits due [them] under the terms of [the] plan." *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (quoting 29 U.S.C.

§ 1132(a)(1)(B)). Thus, as with a breach of contract claim, for which the plaintiff must "allege the provisions of the contract upon which the claim is based," *Timmons*, 283 F. Supp. 2d at 718, an ERISA plaintiff "must allege . . . the provisions of the plan that entitle it to benefits." *Forest Ambulatory Surgical Assocs., L.P. v. United HealthCare Ins. Co.*, No. 10-CV-04911-EJD, 2011 WL 2748724, at *5 (N.D. Cal. July 13, 2011). Where, as here, the health plan gives Anthem "discretionary authority with respect to the administration of the plans and the payment of plan benefits," Compl. ¶ 25, the plaintiff must allege facts that, if true, show that benefit decision was: (1) without reason; (2) unsupported by substantial evidence; or (3) erroneous as a matter of law. *See O'Shea v. First Manhattan Co. Thrift Plan & Trust*, 55 F.3d 109, 112 (2d Cir. 1995).

As noted, the only claim for which Plaintiffs adequately plead exhaustion relates to genetic testing services for Baby Doe in September 2025. Thus, to plausibly plead a claim for benefits, Plaintiffs needed to identify the specific terms of their insurance plan that required coverage of genetic testing and plead facts demonstrating that Anthem's determination the testing was not medically necessary was without reason, unsupported by evidence, or legally incorrect. *See O'Shea*, 55 F.3d at 112. Plaintiffs have failed to do so.

First, Plaintiffs do not plead any terms of the plan establishing that genetic testing is a covered service, or the requirements for such services to be covered. Plaintiffs thus cannot establish an entitlement to benefits for these services, because they have not pleaded the provisions of their health insurance plan under which benefits are due. *See Timmons*, 283 F. Supp. 2d at 718. That alone is fatal to Plaintiffs' ERISA benefits claim. Second, Plaintiffs do not even allege that Anthem's denial was unreasonable, unsupported by evidence, or legally erroneous, let alone facts that would demonstrate that Anthem's determination was unsound. Plaintiffs allege only that benefits were denied, that they appealed, and that Anthem upheld its denial. Compl. ¶ 189. But

these facts, without allegations setting forth how Anthem's decision was inconsistent with the Plan's terms—or even that it was—are insufficient for the Court to conclude that benefits are due under the plan. *See Timmons*, 283 F. Supp. 2d at 718.

In short, even for the one testing claim for which Plaintiffs plausibly alleged exhaustion of administrative remedies, Plaintiffs have failed to allege facts that would establish that Anthem's denial of benefits for those claims was unreasonable or incorrect. Plaintiffs accordingly have failed to allege "benefits due [them] under the terms of [the] plan," *Varity Corp.*, 516 U.S. at 515, and their eighth claim for benefits under ERISA must be dismissed.

C. Plaintiffs' Claim for Breach of Fiduciary Duty Under ERISA Must be Dismissed

Plaintiffs' claim for breach of fiduciary duty must be dismissed for failure to state a claim because the alleged misconduct does not establish the breach of any fiduciary duty Anthem owed to Defendants.

"[T]o prevail on a claim for breach of fiduciary duty, the plaintiffs must demonstrate that (1) the defendant was a fiduciary who (2) was acting in a fiduciary capacity, and (3) breached his fiduciary duty." *Haddock v. Nationwide Fin. Servs., Inc.*, 293 F.R.D. 272, 282 (D. Conn. 2013) (internal quotation marks omitted). "Generally, the threshold question for a breach of fiduciary duty claim under ERISA is whether the alleged misrepresentations were in fact made by an ERISA fiduciary." *Pugliese v. United Techs. Corp.*, 552 F. Supp. 2d 266, 269 (D. Conn. 2008). But "a person may be an ERISA fiduciary with respect to certain matters but not others, for he has that status only 'to the extent' that he has or exercises the described authority or responsibility." *F.H. Krear & Co. v. Nineteen Named Trustees*, 810 F.2d 1250, 1259 (2d Cir. 1987). Thus, "ERISA's rules and prohibitions 'apply only to decisions by an [entity] acting in its fiduciary capacity.'" *Haddock*, 293 F.R.D. at 283 (quoting *Flanigan v. General Elec. Co.*, 242 F.3d 78, 87 (2d Cir.2001)

(alteration in original). A plaintiff thus must "demonstrate not only that the defendant qualifies for fiduciary status, but that the actions or transactions complained of were undertaken in the defendant's capacity as a fiduciary to the plan." *Id*.

Here, Plaintiffs allege Anthem breached its fiduciary duties in two ways: by "grossly inflating the size of their provider network and exaggerating plan benefits in order to increase enrollment and profits," Compl. ¶ 440, and by "failing to pay the appropriate amounts to providers who Defendants classified as Authorized Service Providers." Compl. ¶ 441. Neither allegation establishes a breach of a fiduciary duty.

As to Plaintiffs' first theory, their allegations fail to establish that Anthem's representations about the size of its provider network were made in a fiduciary capacity, or that they breached any fiduciary duty under ERISA. To establish Anthem was acting in a fiduciary capacity with respect to a particular decision or conduct, it is not enough to allege Anthem is an "ERISA fiduciary," Compl. ¶ 437, Plaintiffs must also allege that the complained of actions fall within some "discretionary authority or discretionary control respecting management of [the] plan" that Anthem holds or is exercising. *See Haddock*, 293 F.R.D. at 282. Plaintiffs allege generally that Anthem exercises "discretionary authority with respect to the administration of the plans and the payment of plan benefits." Compl. ¶ 437. But Plaintiffs identify no manner in which Anthem's marketing and promotion of its provider network to "increase enrollment" in its plans—communications by definition directed toward non-participants—implicate any discretionary authority or control Anthem may hold with respect to "management of [the Amec] plan." *See Haddock*, 293 F.R.D. at 282.[7] Plaintiffs accordingly cannot demonstrate any such representations

[7] Plaintiffs do not allege that Anthem's underlying provider-contracting or other network-management decisions that dictate the availability of providers to plan participants violate any fiduciary duty.

were made in a "fiduciary capacity" with respect to the Amec plan. *Id*.

Nor have Plaintiffs established that such representations, even if false, violated a fiduciary duty imposed by ERISA. Plaintiffs assert that ERISA imposes on fiduciaries an obligation "to ensure that no false statements or representations are made in connection with the marketing or sale of a plan." Compl. ¶ 62. But Plaintiffs' allegation is premised on the terms of 29 U.S.C. § 1149, *see id.* ¶ 62 & n.39, which prohibits the making of false statements in the marketing or sale of a "multiple employer welfare arrangement" as that term is defined in 29 U.S.C. § 1002(40). And a plan qualifies under that section only if it is "established or maintained for the purpose of offering or providing [employee welfare benefits] to the *employees of two or more employers*," with some exceptions not relevant here. 29 U.S.C. § 1002(40)(A) (emphasis added). Nothing in Plaintiffs' Complaint establishes that the Amec-sponsored plan of which the Mazzolas are beneficiaries offers or provides benefits to the employees of some employer other than Amec. Plaintiffs accordingly cannot establish that 29 U.S.C. § 1149 applies with respect to the plan at issue, and therefore that statute does not impose any duty with respect to the marketing of the plan, fiduciary or otherwise. Plaintiffs have thus failed to identify any fiduciary duty Anthem's marketing purportedly violated.

Plaintiffs' second contention, that Anthem violated a fiduciary duty by "failing to pay the appropriate amounts to providers who Defendants classified as Authorized Service Providers," Compl. ¶ 441, fails because Plaintiffs do not allege that Defendants ever "classified" any provider as an "Authorized Service Provider." Rather, Plaintiffs contend throughout the Complaint that Defendants *refused* to recognize out-of-network providers as Authorized Service Providers. *Id*. ¶¶ 88, 111, 123. But Plaintiffs do not contend that refusal constitutes a breach of fiduciary duty and, absent Anthem's classification of an Authorized Service Provider, Anthem could not have "fail[ed]

to pay the appropriate amounts" to such a provider where none exists. The Complaint thus fails to allege facts to state a claim for breach of fiduciary duty on this basis.

D. Plaintiffs' Claim for Violation of the Parity Act Must be Dismissed.

Plaintiffs' last claim contends that Defendants violated the Parity Act by failing to "provide a network of mental health providers commensurate with their network of medical/surgical providers" and thus "denying claims for coverage of mental health services as not medically necessary when the true reason for the denial of coverage was lack of available in-network providers of mental health services." Compl. ¶ 450. And Plaintiffs allege a disparity exists because Defendants do not do the same for medical surgical benefits, "because in-network providers for medical and surgical treatments were more widely available under Defendants' health insurance." *Id*. Plaintiffs' allegations fail to allege a plausible claim under the Parity Act.

The Parity Act requires that if a group health plan provides both medical and surgical benefits as well as mental health or substance abuse disorder benefits, it must not apply any "treatment limitation to mental health or substance use disorder benefits . . . that is more restrictive than the predominant . . . treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification." 29 C.F.R. § 2590.712(c)(2)(i). Non-quantitative treatment limitations—those that limit the scope or duration of benefits rather than numerical limits—are permissible if the "processes, strategies, evidentiary standards, or other factors" used to apply the limitations "are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors" used to apply the limitation to medical/surgical benefits in the same treatment classification. 29 C.F.R. § 2590.712(c)(4)(i) (2014).[8] That is, the Parity Act requires parity in *process*, not *outcome*—"[d]isparate results alone

[8] Defendants cite to the Parity Act regulations that were in effect during the dates of service at issue in this case. While the regulations have since been amended, the Department of Labor, Department

do not mean that" a non-quantitative treatment limitation fails to "comply with [parity] requirements." Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,254 (Nov. 13, 2013); *K.K. v. Premera Blue Cross*, No. C21-1611-JCC, 2023 WL 3948236, at *5 (W.D. Wash. June 12, 2023) ("All that the Parity Act requires is that the process in determining how best to treat behavioral versus medical disorders be based on a similar level of evidence and support." (citing 29 C.F.R. § 2590.712(c)(4)(iii) Ex. 4)), *aff'd* No. 23-35480, 2025 WL 415721 (9th Cir. Feb. 6, 2025).

Accordingly, the mere denial of benefits for mental health or substance use disorder treatment does not give rise to a claim under MHPAEA; instead, a plaintiff must allege:

> (1) the insurance plan is of the type covered by the Parity Act; (2) the insurance plan provides both medical benefits 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.

Gallagher v. Empire HealthChoice Assurance, Inc., 339 F. Supp. 3d 248, 256 (S.D.N.Y. 2018). Accordingly, a plaintiff must allege the "treatment limitations" the plan imposes on mental health/substance treatment and those on medical/surgical analogues and allege facts showing that the mental-health limitation is more restrictive. *See id.; Michael M. v. Nexsen Pruet Grp. Med. & Dental Plan*, No. 3:18-cv-00873, 2021 WL 1026383 (D.S.C. Mar. 17, 2021) (comparing plan's requirements for analogous facility types). And in comparing the treatment limitation across

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of Health and Human Services, and the Department of Treasury have issued a notice of non-enforcement of those revised regulations, which have never come into effect as a result. *See* Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury regarding enforcement of the final rule on requirements related to the Mental Health Parity and Addiction Equity Act, U.S. Department of Labor, Employee Benefits Security Administration (May 15, 2025), available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/statement-regarding-enforcement-of-the-final-rule-on-requirements-related-to-mhpaea.

benefits, a plaintiff must allege a plausible disparity in the process by which the limitation is applied to mental health benefits. *See Michael M.*, 2021 WL 1026383, at *12.

Plaintiffs' allegations underpinning their Parity Act claim improperly focus on the outcome—Anthem's alleged denial of benefits, or the number of providers offering specific treatment modalities—rather than whether the processes are comparable between mental health and medical surgical benefits. Plaintiffs' allegation that the Mazzolas or others more readily found in-network medical/surgical providers within a "reasonable distance" than providers for a specific mental health condition does not demonstrate any disparity in the "manner" or process by which Defendants apply any nonquantitative treatment limitation, but only a difference in outcome. That is insufficient to establish a violation of MHPAEA. *See K.K*, 2023 WL 3948236, at *5 (granting summary judgment to defendants where plaintiffs identified no evidence that defendants "employed differing processes, strategies, or evidentiary standards to develop" nonquantitative treatment limitations for mental health treatment as compared to skilled nursing).

Plaintiffs plead a single allegation addressing this standard, asserting that "Defendants processes for ensuring network adequacy for mental health disorder providers were less rigorous and less effective than the processes applied to medical/surgical providers." Compl. ¶ 452. But this is a quintessential conclusory allegation, devoid of any facts alleging *what* Defendants' processes were for ensuring the adequacy of its provider networks or *how* those applied to mental health providers were less "rigorous" and "effective." *Id*. Moreover, even if credited, this allegation fails to even address the appropriate inquiry under the Parity Act, which asks whether the processes for applying treatment limitations are applied more restrictively to mental health benefits, not whether they are more "effective" at producing certain outcomes. 78 Fed. Reg. 68,254; *Michael M.*, 2021 WL 1026383, at *12.

Plaintiffs attempt to bolster their argument by asserting that the Parity Act's implementing regulations impose certain requirements relating to network composition and require insurers to collect data about outcomes related to mental health access and take reasonable action to address material differences. Compl. ¶ 449. And Plaintiffs allege Defendants failed to collect such data or take reasonable action in response. *Id*. ¶ 451. Plaintiffs' allegations fail to demonstrate a violation of the Parity Act, however, because each of the cited requirements are drawn from the 2024 amendments to the Parity Act's regulations, which the promulgating agencies have given official notice of nonenforcement in the face of litigation over whether those rules were unlawfully adopted. *See* Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 FR 77,586, 77,608, 77,609, 77,617.[9] Those regulations thus impose no obligations upon Anthem, and the purported failure to comply with those regulations cannot establish a violation of the Parity Act.

Accordingly, Plaintiffs' tenth claim for violation of the Parity Act fails to state a claim and must be dismissed.

CONCLUSION

For the foregoing reasons, Plaintiffs' Complaint should be dismissed. Because Plaintiffs have already been afforded an opportunity to amend their complaint to cure these defects, dismissal should be with prejudice and without leave to amend.

[9] *See Supra* note 8.

Dated: January 23, 2026

Respectfully Submitted,

By: /s/ *Stefanie Cerrone*

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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 23rd day of January 2026.

/s/ Stefanie Cerrone
Stefanie Cerrone

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

MICHELLE MAZZOLA, individually and as mother of BABY DOE; GUY MAZZOLA, individually and 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.	Civil Action No. 3:25-cv-01433-OAW

DECLARATION OF DEBRA CHEFFER IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

Pursuant to 28 U.S.C. § 1746, Debra Cheffer, under the penalty of perjury under the laws of the United States of America, declares the following to be true and correct:

1. I am a Senior Legal Specialist for Elevance Health, Inc. ("Elevance"). I submit this Declaration in support of Defendants' Motion to Dismiss and Memorandum in Support of that Motion. I have personal knowledge of Elevance's business operations by virtue of my duties and responsibilities in this role.

2. The contents of this declaration are based on my personal knowledge and experience, which I have obtained through my position as a Senior Legal Specialist and through my review of documents in Elevance's possession that relate to Elevance's business operations. The matters set forth in this declaration are true and correct to the best of my knowledge.

3. Elevance is a corporation organized under the laws of the state of Indiana. Elevance maintains its principal place of business at 220 Virginia Avenue, Indianapolis, Indiana 46204.

4. Elevance does not sell insurance policies or provide claims administration services for self-funded benefit plans. Instead, it has subsidiaries and affiliates who sell insurance policies and provide claims administration services for self-funded benefit plans in various states.

5. Elevance does not have a contract with any of the Plaintiffs.

6. Elevance is not licensed by the Connecticut Insurance Department.

7. Elevance does not sell insurance policies in Connecticut or provide claims administration services for any Connecticut-based employers.

I hereby certify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 7th day of November, 2025.

Debra Cheffer

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 23rd day of January, 2026.

/s/ Stefanie Cerrone
Stefanie Cerrone