

**UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION**

MARK COLEMAN,

Plaintiff,

v.

ALCATEL-LUCENT USA, INC., et al.,

Defendants.

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Case No.: 2:16-cv-00108-SGC

ORDER¹

On January 21, 2016, Mark Coleman (“Plaintiff”), filed this action individually and on behalf of his minor child, M.C., and a proposed class of similarly situated plaintiffs. (Doc. 1). Plaintiff seeks relief for alleged violations of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, *et seq.* (“ERISA”). He asserts a claim for breach of fiduciary duties under ERISA § 404(a)(1), 29 U.S.C. § 1104(a) (Count One); recovery of benefits and a declaration clarifying his right to present and future benefits under the plan pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (Count Two); and injunctive and equitable relief pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (Count Three).² (*Id.*).

This matter is now before the court on the motion to dismiss filed by Defendants, Alcatel-Lucent USA, Inc. (“Alcatel”), and United Healthcare Services, Inc. (“United”) (collectively, “Defendants”). (Doc. 16). For the reasons discussed below, the motion will be granted in part and denied in part.

¹ The parties have consented to the exercise of dispositive jurisdiction by a magistrate judge pursuant to 28 U.S.C. § 636(c). (Doc. 19).

² As discussed below, Plaintiff has since abandoned the claims asserted in Count One.

I. BACKGROUND AND RELEVANT FACTS

At all times relevant to this action, Plaintiff has been a beneficiary of the Alcatel-Lucent Medical Expense Plan for Retired Employees (the “Plan”). (Doc. 1 at 2). Plaintiff is a father whose minor child, M.C., has severe autism. (*Id.*). Alcatel is the plan administrator and a named fiduciary under ERISA. (*Id.*). United is the third-party claims administrator for the Plan and is also a fiduciary under ERISA. (*Id.*).

Autism can be treated but not cured, and the most common and recognized method for treating autism is Applied Behavioral Analysis therapy (“ABA therapy”). (*Id.*). Although ABA therapy has been recognized as an established necessary medical treatment by Medicaid, it is not an expressly covered treatment under the Plan. (*Id.*). However, the Plan does provide coverage for treatment of mental illness, and treatment for autism is covered under the Plan’s definition of mental illness. (*Id.*). In compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Plan was amended to require parity between mental and physical health benefits. (*Id.*).

In 2012, Plaintiff requested the Plan precertify ABA therapy for M.C. (*Id.* at 3). This request and a related appeal were denied, but in late 2014 the Plan did pay two (2) post-service claims in the total amount of \$243 for ABA therapy. (*Id.*).

A. Plaintiff’s Letter Of May 11, 2015

On May 11, 2015, Plaintiff again requested precertification of ABA therapy for M.C. (Doc. 22-1).³ In a May 11 letter, Plaintiff wrote to United and stated, “Please reference the

³ Plaintiff and Defendants rely on various documents which were submitted with their briefing on the motion to dismiss. Defendants contend, and Plaintiff does not dispute, that these documents are “incorporated by reference into the Complaint.” (Doc. 16 at 2 n.1). Because they are “central to the plaintiff’s claim” and the accuracy of their contents is not in dispute, the court agrees these documents may be considered without converting the motion to dismiss into a

attached documents, along with all previously submitted documents when considering this request for multiple services under this plan.” (*Id.* at 1). Two letters from M.C.’s physicians were attached: one from Gavin Brunsvold, M.D., dated April 20, 2015, and another from Kami Sester, M.D., of Greenvale Pediatrics in Alabaster, Alabama, dated April 7, 2015. (*Id.* at 3-4).

In the May 11 letter, Plaintiff explained M.C.’s physicians were increasingly concerned about the severity of her “self-injurious” behavior, including serious injuries sustained to her head. (*Id.* at 1). Plaintiff stated both doctors considered her status to be an “emergency mental health condition” in need of “urgent medical attention.” Plaintiff noted a neurologist’s evaluation had been recommended in connection with M.C.’s injuries and clarified that internal imaging would require sedation because even a simple ear examination requires M.C. to be restrained by multiple nurses. (*Id.*). Plaintiff pointed out that Dr. Brunsvold, whose letter was attached to the request, is “not a member of this plan and his services are not paid for under this plan,” but Plaintiff strongly urged United to contact Dr. Brunsvold.

Regarding the exact treatment he was requesting, Plaintiff stated, “Attached you will find letters from two physicians requesting multiple therapies and services as treatment for this dependant in a home based setting.” (*Id.*). Plaintiff clarified that “[o]ccupational therapies have been paid for by this plan before and are again requested in a home based setting.” (*Id.*). Plaintiff stated that in addition to occupational therapy, he was requesting speech therapy and was willing to restrict this request to the type of speech therapy that had been provided by United’s predecessor administrator. (*Id.* at 1-2). Plaintiff again referred to the doctors’ recommendations attached to the letter. (*Id.* at 1).

motion for summary judgment. *See, e.g., Tabb-Pope v. SAN, Inc.*, No. 7:12-2139-AKK, 2013 WL 5707327, at *1 n.2 (N.D. Ala. Oct. 21, 2013).

Plaintiff stated that although he had sought and been denied ABA therapy on several occasions, including on administrative appeal, two invoices for prepaid ABA therapy had been approved. (*Id.* at 2). Plaintiff explained it was difficult to determine what was and was not covered, and under what conditions, but Plaintiff's letter made clear he was seeking nothing less than the level of care that had been approved and paid on previous occasions. (*Id.*) ("This plan covers some type of behavioral services and I am requesting it."). The letter also made clear he did not believe the care which had been previously approved was sufficient, especially given M.C.'s deteriorating condition, and Plaintiff requested a level of care above and beyond what he had been occasionally able to obtain in the past. (*Id.*).

Finally, Plaintiff noted that as of October 17, 2014, United had been "ignor[ing]" his requests for a case manager. (*Id.*). Plaintiff reiterated he was "seeking treatment options for an urgent condition" and stated, "Since UHC refuses to address this issue, I am requesting UHC send a staff physician with the authority to evaluate the patient and approve treatment options to locally access the situation." (*Id.*).

In the attached letter from Dr. Brunsvold, he identified himself as M.C.'s physician who treated her in the school she attends. (*Id.* at 3). Dr. Brunsvold set out M.C.'s problems and stated, "Clinically, I feel [M.C.] needs intensive home based services including speech, occupational therapy, and Applied Behavioral Analysis for Autism." (*Id.*). This letter included Dr. Brunsvold's contact information. (*Id.*).

The second attachment, from Dr. Sester, explained she had been M.C.'s pediatrician for eight years and described M.C.'s difficulties. (*Id.* at 4). Dr. Sester noted that M.C.'s father had been "attempting to obtain several services for her, to no avail." (*Id.*). Dr. Sester set out three specific problems and made three specific, corresponding requests for services. (*Id.*). First, Dr.

Sester explained that M.C. uses a special assistance device to help communicate basic needs, such as hunger, thirst, and pain, but even with the device, M.C. is unable to communicate well, and speech therapy would help the situation. (*Id.*) Second, Dr. Sester summarized M.C.'s "dangerous self-mutilating behaviors" and recommended "more intensive behavioral modification therapy, and occupational therapy." (*Id.*) Third, Dr. Sester stated that Plaintiff is unable to transport M.C. in his vehicle without her hurting herself, because he cannot drive and restrain her at the same time, but the harness device she prescribed was denied by United. (*Id.*) Dr. Sester ended by stating: "Please consider the above requests. If you have any further questions, feel free to contact me." (*Id.*) She also included her contact information. (*Id.*)

B. Subsequent Correspondence

On May 28, 2015, United sent its first response to Plaintiff's May 11 letter. (Doc. 22-2). The May 28 letter, which listed M.C. as the patient and Dr. Sester as the provider, stated:

We recently received correspondence on your behalf. Because it is unclear of your intent in sending this information, we will not treat this as an appeal of a coverage determination until we receive clear direction from you. We made this decision because you are allowed only one to two levels of appeal.

The appeals process presents an opportunity for meaningful dialogue between plan participants or their authorized representatives and the claims administrator. When you appeal a benefit determination, please submit all of the information available that you believe will help us understand your situation and possibly alter our original coverage determination.

(Doc. 22-2 at 1). The letter identified the date of service and claim amount as "PRE-SERVICE." (*Id.*) Though it suggested Plaintiff submit "all of the information that you believe will help us understand your situation" on appeal, this letter contained no information about the status of Plaintiff's claim, nor did it specify any additional information that would be needed to process it.

On June 8, 2015, Plaintiff's attorney wrote United explicitly requesting certain information in compliance with the ERISA regulations codified at 29 C.F.R. § 2560.503-

1(h)(2)(iii), including a request for M.C.'s claim file and any information relied upon in making the benefit determination. (Doc. 22-3 at 1-2). United then mailed nearly identical form letters to Plaintiff, dated June 10 and June 22, 2015, acknowledging receipt of "a letter sent on your behalf in the UnitedHealthcare [sic] Central Escalation Unit." (Docs. 22-4, 22-5). These letters began by stating, "You are not required to respond to this letter." (*See, e.g.*, Doc. 22-4 at 1). They also stated, "If your request qualifies for an appeal, grievance or complaint, we will complete our review and send you a letter about our decision within the required timeframe consistent with pertinent state or federal regulatory requirements." (*Id.*). The letters provided various addresses and stated, "If the request you have submitted does not qualify for an appeal, grievance or complaint, we will forward the issue to another unit for review." (*Id.* at 2). The only difference between the two is that the June 10 letter listed the subject as "RE: MARK COLEMAN," while the June 22 letter listed the subject as "RE: KAMI SESTER MD." (Docs. 22-4 at 1; 22-5 at 1).

On June 30, Plaintiff's counsel faxed a letter to United stating the law firm had been retained "regarding [Plaintiff's] appeal" of a health insurance matter. (Doc. 22-6). The letter pointed out Plaintiff had made several requests for the claim file and other relevant information. It asked where Plaintiff should direct future communications and referred to the "claims [Plaintiff] has made on his daughter's behalf." (*Id.* at 1). United sent a July 2, 2015 form letter identical to the June 10 and June 22 letters. (Doc. 22-7).

In a letter dated July 22, 2015, addressed to M.C. and referencing the date of service as June 8, 2015, United stated:

We have reviewed the concern submitted on your behalf requesting documents. We have determined that we need more information to respond to your request. Please send us the dates of service, the provider's name(s), and the amount of the claim that you are requesting information about so that we can send you the appropriate documents.

(Doc. 20-4). By its terms, this letter is a response to Plaintiff's attorney's June 8 request for documents and not a request for more information in order to make a decision regarding his claim. United's July 22 letter makes no reference to Plaintiff's May 11 letter.

On July 24, 2015, Plaintiff's counsel sent a letter enclosing Plaintiff's May 11 letter and its attachments to three addresses which United had directed Plaintiff to use. (Doc. 22-8). Plaintiff's counsel referred again to "the recent request for [M.C.] to be precertified for the treatment her doctors are recommending." (*Id.*). The July 24 letter referenced some of counsel's telephone calls with United representatives and third party vendors. For example, Plaintiff's counsel recounted having been referred back and forth between United and Optum, a third-party subrogation and recovery vendor, while trying to get information about the status of the claim. (*Id.* at 1-2). A United customer service representative advised counsel that United "had letters" indicating it was treating Plaintiff's claim as urgent. (*Id.* at 2). The representative also informed Plaintiff's counsel that "the claim was showing as an administrative appeal with a decision date of July 30, 2015." (*Id.*). Counsel noted that Plaintiff's description of his daughter's symptoms and medical situation met the Plan's definition of an urgent condition and pointed to a provision which states, "If the applicable Claims Administrator does not respond within the allotted time period, including any extensions, the Participant may consider the claim denied." (*Id.*).

Counsel's July 24 letter also noted United's procedures did not comply with the regulatory requirements for processing an urgent claim and asserted that further exhaustion of this claim was "clearly futile." (*Id.*). The letter stated, "[M.C.'s] condition continues to escalate while Mr. Coleman has been waiting (since approximately May 2015) for United Healthcare to respond to his urgent care claim." Counsel complained they were only getting "boilerplate" responses and cited the July 2 letter as an example. Counsel also complained that United was

refusing to let Plaintiff know why there had not been a decision regarding his claim and concluded by writing, “Failure to provide the information we’ve requested reveals a refusal to provide a full and fair review.” (*Id.*).

United sent more form letters dated July 27, July 30, August 3, and August 5, 2015. (Docs. 22-9, 22-10, 22-11, 22-12). Two were addressed to M.C., rather than Plaintiff, and one listed the subject as “RE: GREENVALE PEDIATRICS ALABASTER.” (Docs. 22-9, 22-10, 22-11).⁴ These letters are otherwise identical to United’s June 10, June 22, and July 2 letters.

In a letter dated August 6, 2015, listing the provider’s name as Gavin Brunsvold, MD, United stated, “We took a look at your letter. We found we have an earlier request we are reviewing. When we complete our review we will send you the coverage decision and explanation by mail.” (Doc. 22-13). Although United’s August 6 letter does not specify which letter it is a response to, it is addressed to Plaintiff’s attorney, Ariel Blocker, and may refer to Ms. Blocker’s July 24 letter written on Plaintiff’s behalf. United’s August 6 letter is signed, “Resolving Analyst, Central Escalation Unit.” (*Id.*).

In another letter dated August 13, 2015, addressed to M.C. and listing Dr. Sester as the provider, United stated:

Dear [M.C.]:

The UnitedHealthcare Central Escalation Appeals Unit received your letter dated July 24, 2015. A letter was sent by our Central Escalation Appeals Unit, acknowledging receipt of your request, on August 3, 2015.

Upon further review of your request, we determined the questions and concerns expressed in your correspondence do not qualify as an appeal. As a result, your letter and any attached documents have been forwarded to the appropriate UnitedHealthcare department for review. You will receive a response to your issues shortly.

⁴ As noted above, this is Dr. Sester’s practice group.

(Doc. 22-14 at 1). This letter is signed, “Sarah W., Central Escalations Unit.” (*Id.* at 2).

Yet another letter from United, dated August 18, 2015, stated:

Dear [M.C.]:

We reviewed your concern and found that no corrective steps are needed at this time. We made this decision because the received correspondence from you consisting of nothing other than appeal letter with incomplete information [*sic*]. We are unsure of your intent in sending this information to us. We hesitate to treat this as an appeal of a coverage determination because participants in group health plans governed by the Employee Retirement Income Security Act (ERISA) are allowed only one to two levels of appeal.

(Doc. 22-15 at 1). The letter warned Plaintiff of the consequences of an appeal and did not specify which “concern” or correspondence it was intended to address. (*Id.*). It is signed, “Avik K., Appeals Coordinator.” (*Id.* at 2). In a letter dated August 20, 2015, a representative from the Central Escalation Unit advised Plaintiff, “We took a look at your letter and found that we have already reviewed this request and sent you a letter explaining the decision.” (Doc. 22-16). United’s August 20 letter listed Plaintiff’s date of service as July 24, 2015. (*Id.*).

In a letter dated September 1, 2015, an Appeals Coordinator named Aaren P. wrote and requested Plaintiff provide the patient name, medical ID card number, dates of service, claim number, and “any documentation or other written information to support your request.” (Doc. 22-17). This list tracks the requirements for precertification of a claim under the Plan’s Traditional Option as outlined in the Summary Plan Description (“SPD”). (*See* Doc. 16-21 at 77-78).⁵

Finally, in a letter dated December 7, 2015, Plaintiff’s current counsel requested a “FINAL determination” within fourteen days and specifically referenced Plaintiff’s claims for

⁵ As discussed below, Defendants point to the SPD in their briefing as a document which defines the requirements for a request to constitute a perfected claim. (Doc. 16 at 7-9). The SPD has been submitted in its entirety. (Doc. 16-21).

“home-based speech and occupational therapy,” as well as ABA therapy. (Doc. 22-18). Counsel stated that United had been declining to review Plaintiff’s claim and instead was persistently sending the claim back to the precertification stage. (Doc. 22-18). The December 7 letter included Plaintiff’s May 11 letter and its attachments. (*Id.*). No response to this letter appears in the record. Plaintiff filed the instant lawsuit on January 21, 2016. (Doc. 1).

II. STANDARD OF REVIEW

In ruling on a motion to dismiss brought pursuant to Rule 12(b)(6), the court must accept the factual allegations set forth in the complaint as true. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Swierkiewicz v. Sorema N.A.*, 534 U.S. 506, 508 n.1, (2002); *see also Lotierzo v. Woman's World Med. Ctr., Inc.*, 278 F.3d 1180, 1182 (11th Cir. 2002). In addition, all reasonable inferences should be drawn in favor of the plaintiff. *See Omar ex. rel. Cannon v. Lindsey*, 334 F.3d 1246, 1247 (11th Cir. 2003) (per curiam). Nonetheless, the plaintiff must still meet some minimal pleading requirements. *Jackson v. Bellsouth Telecomm.*, 372 F.3d 1250, 1262–63 (11th Cir. 2004) (citations omitted). While “[s]pecific facts are not necessary[,]” the complaint should ““give the defendant fair notice of what the . . . claim is and the grounds upon which it rests.”” *Erickson v. Pardus*, 551 U.S. 89, 93 (2007) (per curiam) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). Further, the plaintiff must allege “enough facts to state a claim to relief that is plausible on its face.” *Twombly*, 550 U.S. at 570. “A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.” *Iqbal*, 556 U.S. at 678 (citing *Twombly*, 550 U.S. at 556).

A “plaintiff’s obligation to provide the grounds of his entitlement to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will

not do.” *Twombly*, 550 U.S. at 555 (internal quotations omitted); *see also Jackson*, 372 F.3d at 1262 (explaining that “[c]onclusory allegations, unwarranted deductions of facts or legal conclusions masquerading as facts will not prevent dismissal”) (internal citation and quotations omitted). Indeed, “the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions,” which simply are “not entitled to [an] assumption of truth.” *Iqbal*, 556 U.S. at 678, 680. Thus, in ruling on a motion to dismiss, the Court must determine whether the complaint contains “sufficient factual matter, accepted as true, to ‘state a claim to relief that is plausible on its face.’” *Id.* at 678 (quoting *Twombly*, 550 U.S. at 570).

III. DISCUSSION

A. Count One – Breach Of Fiduciary Duty

In Count One of the complaint, Plaintiff asserts a claim for breach of fiduciary duty in violation of 29 U.S.C. § 1104(a). (Doc. 1 at ¶¶ 35-39). Plaintiff concedes this claim should be dismissed for failure to state a claim upon which relief can be granted. (Doc. 22 at 12). Accordingly, the claim asserted in Count One is due to be dismissed.

B. Administrative Exhaustion Of A Perfected “Claim”

Defendants contend all of Plaintiff’s claims should be dismissed because he does not have a right to sue. (Doc. 16 at 6-14). This argument is comprised of two parts: first, that Plaintiff did not submit a claim for the precertification of ABA therapy; and second, that he did not exhaust his administrative remedies before filing suit. Before turning to the substance of Defendants’ argument, it is helpful to review the legal context in which Plaintiff’s claims arise.

1. ERISA Framework

Underlying Plaintiff’s claims is his entitlement to a “full and fair review” of his application for benefits under the ERISA statute and its regulatory framework. (Doc. 1 at ¶¶ 15-

20). ERISA provides, in pertinent part, that “every employee benefit plan shall ... afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.” 29 U.S.C. § 1133(2).

The ERISA regulations provide more detail about what must occur before and during a “full and fair review.” A plan administrator must provide the participant with written or electronic notice of an adverse decision within seventy-two (72) hours of receiving a claim for urgent care. 29 C.F.R. § 2560.503-1(f)(2)(i). In the event a claim for urgent care does not contain sufficient information for the plan administrator to make a determination, the claimant must be notified of the specific information necessary to complete the claim as soon as possible, and in no event later than twenty-four (24) hours from the plan’s initial receipt of the claim. *Id.* The claimant then has forty-eight (48) hours to provide the necessary information. *Id.* If a claim is denied, the notification must set forth:

- (i) The specific reason or reasons for the adverse determination;
- (ii) Reference to the specific plan provisions on which the determination is based;
- (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; [and]
- (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review....

29 C.F.R. § 2560.503–1(g)(1)(i)–(iv). Further:

Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

29 C.F.R. § 2560.503–1(h)(1). To constitute a “full and fair review,” the appeal procedures must:

- (i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
- (ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- (iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section; [and]
- (iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

29 C.F.R. § 2560.503–1(h)(2)(i)–(v). Pursuant to subsection (m)(8), a “document, record, or other information” shall be considered “relevant” to a claimant's claim if it:

- (i) Was relied upon in making the benefit determination;
- (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- (iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or
- (iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

29 C.F.R. § 2560.503–1(m)(8). The plan administrator must provide the claimant with a written or electronic decision on his request for review within fifteen (15) days of receiving the request.

29 C.F.R. § 2560.503–1(i)(2). If the decision is adverse to the claimant, the notice must set forth:

- (1) The specific reason or reasons for the adverse determination;
- (2) Reference to the specific plan provisions on which the benefit determination is based;
- (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other

information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section; [and]

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act....

29 C.F.R. § 2560.503–1(j)(1)–(4). If a plan fails to “establish or follow claims procedures consistent with” these regulations, the claimant:

shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the grounds that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

29 C.F.R. § 2560.503–1(l).

2. Claim for Precertification of ABA Therapy

Under the Plan, a participant is not entitled to benefits until he or she submits a claim according to the Plan’s claim procedures. Defendants contend Plaintiff never submitted a claim for the benefits he sought for M.C. (Doc. 16 at 6). Defendants assert that in order to constitute a claim, a claimant’s request must be “perfected” in that it must contain “sufficient information to decide the claim.” (*Id.* at 7) (citing *Tarr v. State Mut. Life Assur. Co. of Am.*, 913 F. Supp. 40, 45 (D. Mass. 1996)). Defendants contend Plaintiff did not perfect his claim because he failed to provide sufficient information and, thus, is not entitled to sue.

a. Requirements of Article 17

Defendants point to Articles 17.3 and 17.4 of the Plan to support their argument that Plaintiff’s May 11 letter did not contain sufficient information to constitute a claim. (Doc. 16 at 7-8). Article 17 does not appear to set out formal requirements for a claim. (Doc. 16-3 at 139-40) (Articles 17.1 through 17.3, setting forth the scope of the procedures which apply to claims

and claim denials and specifying procedures upon submission of a claim). However, Article 17.3 does provide that the claims administrator may “request additional information relevant to the claim” if it does not have sufficient information to process the claim or appeal. (*Id.* at 140).

Also in keeping with the enabling regulations, Article 17.3 provides that when a claim for Plan benefits is denied, either in whole or in part, the Plan will send the claimant “[a] description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary,” and “[a]ppropriate information” will be provided if the claimant desires to submit the claim for review. Article 17.3 also states, “If a claim for benefits is denied or if a Participant believes that benefits under the Plan to which he or she is entitled have not been provided, the Participant or his or her representative may appeal this denial.” This language appears to track the requirements of the enabling regulations which provide for the claims administrator to make a determination, notify the claimant, and seek any additional information that is needed within a specific timeframe depending on the urgency and nature of the claim. *See* 29 C.F.R. § 2560.503–1.

b. Contents of the SPD

In addition to Article 17, Defendants point to the SPD as further defining the information required for a precertification request to constitute a claim. (Doc. 16 at 7-9). The SPD has a section titled “How to Precertify.” (Doc. 16-21 at 77-78). This section provides instructions on how to precertify a claim under both the Traditional Indemnity Option (“Traditional Option”) and the Mental Health and Chemical Dependency Program.⁶

⁶ It appears from the correspondence between the parties, as well as Defendants’ briefing, that Defendants reviewed Plaintiff’s requests in light of the requirements for precertification under the Traditional Option. It is unclear why this was so, given the parties’ apparent agreement that the services Plaintiff is suing over were part of the Plan’s mental health coverage, which has a shorter and less specific set of requirements. (*Id.* at 78-79).

To precertify under the Traditional Option, the Plan requires a claimant to “call the telephone number printed on [his] medical ID card within the following timeframes.” (*Id.* at 77). The SPD provides a chart of deadlines that vary depending on the provider’s network and area; urgent care can be precertified any time before treatment or admission, but for emergency care, notification after admission is allowed. (*Id.*). When calling to arrange precertification under the Traditional Option, the claimant is instructed to “have the following information ready:”

- The patient’s name, address, telephone number, age, identification number and relationship to you;
- All the information on your medical ID card;
- The type of care for which you’re requesting precertification;
- The Physician’s name, address and telephone number; and
- If admitted to a Hospital, the name, address and telephone number of the Hospital.

The SPD explains that the claimant and physician will be advised whether or not the requested care is precertified and, “if applicable, the specific duration of time for which it’s certified (applies for an admission to a Hospital or Extended Care Facility, home healthcare services or Private Duty Nursing).” (*Id.*). In any event, the SPD contemplates a claimant calling via telephone to precertify services, and it only requires that a claimant “have the information ready.”

c. Plaintiff’s compliance with the Plan documents

It appears Plaintiff provided the information necessary to process his claim. To the extent he failed to do so, it was United’s obligation to advise him of this fact in a timely and precise fashion, which United failed to do. As an initial matter, many of the SPD’s instructions on precertification do not undermine Plaintiff’s contention that he submitted a valid claim because they require information which was already known to Defendants. For example, M.C.’s

name and contact information were already known to Defendants, a point which no party disputes. The same is true for the information contained on Plaintiff's medical ID card.

As to Defendants' suggestion that it was not possible to determine the "type of care" Plaintiff was requesting, the May 11 letter requests several things. Specifically, it explains Plaintiff is requesting (1) speech therapy to supplement M.C.'s communication abilities beyond the assistance her device provides; (2) occupational and behavioral therapy to mitigate her extreme and frequent self-harm; and (3) a harness for M.C. so Plaintiff could transport her in his private vehicle without risk of crashing. Defendants correctly note Plaintiff's Count Two of Plaintiff's complaint addresses only the denial of ABA therapy benefits. However, there is nothing in the SPD's instructions on precertification to suggest a claim can only be submitted for one type of care at a time. Therefore, the May 11 letter's description of several requested services would not have precluded it from constituting a claim for ABA therapy.

Defendants contend Plaintiff did not request ABA therapy in his May 11 letter, but the document itself plainly contradicts this assertion. (*See* Doc. 22-1). For example, Plaintiff stated, "Both physicians recommend some home based behavioral treatment. On numerous occasions we have sought ABA therapy and have been denied." (*Id.* at 2). Plaintiff further stated, "This plan either offers some behavioral type ABA therapy or has shown fiduciary irresponsibility." (*Id.*). Next, Plaintiff wrote, "Regardless of this plan[']s coverage of ABA therapy two physicians have recommended some type behavioral therapy in a home based setting." Finally, he concluded, "This plan covers some type of behavioral services and I am requesting it." (*Id.*).

Defendants characterize the wording of Plaintiff's May 11 letter as ambiguous, but they do not deny that ABA therapy is a "type of behavioral service." Additionally, they do not suggest the correspondence from M.C.'s physicians should not have been considered. Therefore,

the court finds the May 11 letter supports Plaintiff's allegation that his claim was for ABA therapy. Further, the ERISA guidelines make plain that in the event United regarded Plaintiff's claim as ambiguous, it was United's responsibility to investigate in a timely fashion. As Plaintiff asserts, the correspondence suggests United failed to discharge its duties in that regard.

Further, the Plan language Defendants point to raises ambiguities. Regarding physician information, the SPD is unclear whether the required "name, address, and telephone number" references the physician who recommends the requested care or the physician who will provide that care. (*Id.*). This part of the instructions is especially unclear because not all care that is subject to precertification necessarily takes the form of physician care. For example, Dr. Sester's letter requested a physical harness for Plaintiff's vehicle. The physician information needed for that request could only refer to the prescribing physician (Dr. Sester), and her information was included. For the behavioral therapy request, it may have been that Dr. Sester was both the prescribing physician and the doctor who was intended to provide therapy. It is also possible Dr. Sester contemplated another provider stepping in to provide those services. Nothing in United's correspondence sought to resolve this ambiguity resulting from the SPD's language.

The SPD's instructions are also ambiguous in that they appear to apply to pre-service claims and post-service claims alike. While certain information would clearly be established by the time a post-service claim is made, the same may not be true for a pre-service claim. For example, is not clear from the pleadings or supporting documents whether ABA therapy can only be provided by a physician. Thus, in the context of a pre-service claim for ABA therapy, the SPD's requirement of a physician's contact information may merely be intended to ensure United would have the contact information of the physician guiding the request. In this case, that would be Dr. Sester, whose information was provided. In addition, later correspondence from

United indicates United regarded Dr. Sester as the provider whose services were being requested. (See, e.g., Doc. 22-2 (May 28 letter listing Kami Sester, M.D., as the provider relating to Plaintiff's claim); Doc. 22-5 (listing Dr. Sester as provider and acknowledging receipt of previous correspondence); Doc. 22-11 (listing Greenvale Pediatrics Alabaster, Dr. Sester's practice group, as the provider relating to Plaintiff's claim)).

Finally, Counsel's July 24 letter further supports Plaintiff's position that United regarded the requests in his May 11 letter as a claim. In the July 24 letter, Plaintiff's counsel recounted a conversation with a customer service representative, who explained that "letters listed Mr. Coleman's claim as urgent." (Doc. 22-8 at 2). The representative further noted the claim "was showing as an administrative appeal with a decision date of July 30, 2015." (*Id.*). This correspondence tends to show United's own records reflected Plaintiff had an open claim during the period in question.⁷ "[W]hen exhibits contradict the general and conclusory allegations of the pleading, the exhibits govern." *Griffin* 496 F.3d at 1206. A review of the documents and authorities provides no basis for concluding Plaintiff failed to comply with the requirement that he submit a claim for benefits.

⁷ Defendants' motion to dismiss points to non-binding authority which states the filing of a claim is a prerequisite to a lawsuit challenging the claim's denial. (Doc. 16 at 7-9). The cited cases address circumstances in which a plaintiff filed suit without having made any attempt to submit a claim within the plan's review process. In *Leit v. Revlon, Inc.*, the court granted a motion to dismiss where the plaintiff had not made any attempt at all to submit a claim for review by the plan administrator. 85 F. Supp. 2d 1293, 1296 (S.D. Fla. Apr. 13, 1999). In *Dunlap v. Ormet Corp.*, the plaintiff never submitted anything purporting to be a claim; rather, she sued in state court under conventional tort theories, and the case was removed. 2009 WL 763382 (N.D. W. Va. Mar. 19, 2009). Here, Plaintiff clearly attempted to avail himself of the administrative process, and thus, the cited cases are distinguished.

To the extent Defendants are correct that the SPD establishes the formal requirements for a claim, it appears Plaintiff met those requirements.⁸ To the extent Plaintiff's request failed to provide adequate information or made an ambiguous request, the regulations placed the burden on United to investigate the claim and request anything it needed in a timely fashion. 29 C.F.R. §§ 2560.503-1(f)(2)(i) and (g)(1)(i)-(iv) (urgent care claimant is entitled to determination within seventy-two (72) hours; claimant must be notified of the specific information necessary to complete the claim; and notification must set forth specific reasons for the adverse determination, including specific plan provisions relied upon and a description of any additional information necessary for the claimant to perfect the claim, as well as an explanation of why the information is necessary). The parties' correspondence makes clear United failed to comply with these requirements. Accordingly, Defendants' motion to dismiss is due to be denied as to their contention that Plaintiff failed to submit a claim.

3. Exhaustion

An ERISA plaintiff must exhaust his administrative remedies before suing in federal court. *Counts v. Amer. Gen. Life & Accident Ins. Co.*, 111 F.3d 105, 108 (11th Cir. 1997). However, the district court has the sound discretion to "to excuse the exhaustion requirement when resort to administrative remedies would be futile or the remedy inadequate." *Id.* The district court may also excuse the exhaustion requirement "where a claimant is denied 'meaningful access' to the administrative review scheme in place." *Perrino v. Southern Bell Tel.*

⁸ The court notes Defendants have not addressed the fact that the SPD contemplates the information being provided by telephone and only requires that the claimant have the requested information ready when calling, not that the information be submitted in an unambiguous and final form. In other words, the court cannot conclude the language of the SPD amounts to a standard for judging the sufficiency of a claim, or if it did, that such a standard would undermine Plaintiff's allegation that he submitted a claim for benefits. *Griffin Indus., Inc. v. Irvin*, 496 F.3d 1189, 1206 (11th Cir. 2007).

& Tel. Co., 209 F.3d 1309, 1315 (11th Cir. 2000) (quoting *Curry v. Contract Fabricators, Inc. Profit Sharing Plan*, 891 F.2d 842, 846-47 (11th Cir. 1990)).

a. “Bare allegations” of futility

“The futility exception [to ERISA’s exhaustion requirement] protects participants who are denied meaningful access to administrative procedures.” *Lanfear v. Home Depot, Inc.*, 536 F.3d 1217, 1224 (citing *Curry*, 891 F.2d at 844, 846-47). However, “[b]are allegations of futility are no substitute for the ‘clear and positive’ showing of futility required before suspending the exhaustion requirement.” *Bickley v. Caremark RX, Inc.*, 461 F.3d 1325, 1330 (11th Cir. 2006) (citing *Springer v. Wal-Mart Assocs. Group Health Plan*, 908 F.2d 897, 901 (11th Cir. 2000)). Defendants contend Plaintiff’s allegations are the sort of “bare allegations” that should not support a futility excuse from ERISA’s exhaustion requirements. (Doc. 16 at 10). They point to Plaintiff’s “single sentence” allegation that “[f]urther exhaustion of administrative remedies would be futile.” (*Id.*) (citing Doc. 1 at ¶ 19).

In the cases cited by Defendants, the plaintiffs alleged futility in a general way but, unlike Plaintiff here, made no attempt whatsoever to seek a remedy through the administrative process. For example, in *Bickley*, the plaintiff sued over an alleged breach of fiduciary duty without making any attempt to pursue an administrative remedy. He argued such a pursuit would have been futile because only claims for benefits, as opposed to equitable relief for fiduciary breaches, were contemplated by the plan’s administrative procedures. The Eleventh Circuit agreed with the district court and held that by providing an avenue to “resolve all interpretive, equitable and other questions,” the plan provided an administrative remedy that the plaintiff was obliged to use. *Bickley*, 461 F.3d at 1329. In *Harrison v. United Mine Workers of Am. 1974 Ben. Plan & Trust*, the plaintiffs “never submitted applications for benefits to the Plan” and “failed to take the

most rudimentary administrative steps to obtain their benefits.” 941 F.2d 1190, 1193 (11th Cir. 1990). These cases make clear that a plaintiff cannot simply plead futility without actually attempting to have his claim considered by the plan.

Defendants also point to *Tarr v. State Mut. Life Assur. Co. of America*, 913 F. Supp. 40 (D. Mass. Jan. 30, 1996), in which a plaintiff submitted several purported claims but was nevertheless found to have inadequately pled futility of exhaustion when filing suit. (Doc. 16 at 11). In *Tarr*, the plaintiff provider claimed reimbursement for services rendered, and the claims administrator responded with requests for additional information. (*Id.*). The provider sued, pleading exhaustion was futile because administrative review was unavailable without a denial. (*Id.*). The district court sided with the defendants, who pointed to the provider’s own refusal to comply with their requests for records relating to the claims he submitted. 913 F. Supp. at 45. More specifically, when the plan asked for records relating to the reimbursement claims, the provider responded that the plan would have to get permission from each patient before he would provide the records required to make a determination. *Id.* The court reasoned that the provider thwarted the administrative process by refusing to respond to a request for information and then pleaded futility when resorting to litigation. *Id.* On policy grounds, such an approach is to be discouraged. *Id.*; see also *Springer*, 908 F.2d at 899 (listing policy considerations underlying the exhaustion doctrine).

Here, Plaintiff has provided detailed allegations and supporting documents regarding his attempts to present and exhaust his claim. It is clear that United, not Plaintiff, was responsible for the failures of the administrative process in this case. Even viewing the requirements for a claim as Defendants would have it—that is, by reference to the information described in the SPD—Plaintiff’s May 11 letter contained everything United needed to process his claim.

Therefore, the court finds Plaintiff has provided sufficient information to overcome Defendants' assertion that he has not adequately pleaded futility.

b. Meaningful review

Plaintiff asserts he was entitled to a response within a timeframe that United did not meet and, therefore, his claim should be deemed exhausted. Plaintiff's May 11 letter makes clear it is a claim "involving urgent care." (Doc. 22-1 at 1) ("Both physicians have recently established this patient[']s status as an emergency mental health condition and as an urgent medical condition."). Accordingly, Plaintiff was entitled to a determination (adverse or otherwise) within seventy-two (72) hours. 29 C.F.R. § 2560.503-1(f)(2)(i). If, as Defendants assert, United determined Plaintiff's claim did not contain sufficient information to be completed, they were obliged to notify Plaintiff of this fact and request the missing information within forty-eight (48) hours. *Id.*⁹

United's first response to Plaintiff's May 11 letter was its letter of May 28 (Doc. 22-2), addressed to M.C. and listing the provider as "Kami Sester, MD" and the date of service and claim amount as "Pre-Service." (*Id.* at 1). That letter states, "Because it is unclear of your intent in sending this information, we will not treat this as an appeal of a coverage determination until we receive clear direction from you." (*Id.*). The May 28 letter invites Plaintiff to submit "all the information available that you believe will help us understand your situation and possibly alter our original coverage determination." (Doc. 22-2 at 1). However, Plaintiff had not been advised of a coverage determination, let alone any reason underlying it. Plaintiff's June 8 letter clearly

⁹ To the extent Defendants contend Plaintiff's May 11 letter constituted an appeal, as United appears to have asserted in its June 10 letter (Doc. 22-4), United was still obliged to notify Plaintiff of its determination within seventy-two (72) hours. § 2560.503-1(i)(2)(i). Further, Plaintiff's June 8 letter explicitly invoked his right to any information relied upon in making an adverse benefits determination as part of his entitlement to a "full and fair review." (Doc. 22-3).

intended to establish whether a coverage determination had been made and, if so, on what basis. It was United's responsibility to provide that information in the first instance. Therefore, the invitation to provide "all the information available that you believe will help us" had already been complied with and, given its context, was nonsensical. United next requested information in its July 22 letter, but this was directed at Plaintiff's June 8 request for documentation, as opposed to a request for information about his claim. (Doc. 20-4).

Claims cannot be appealed until they are made and acted upon in the first place. (See Article 17.4, Doc. 16-3 at 140). Plaintiff attempted over the course of approximately two months to exercise his right to information which should have been provided automatically – *i.e.*, the basis for United's *de facto* denial of his claim. When Plaintiff ultimately tried to get United to treat his request as an appeal of a denied claim, it refused to do that as well, even though United internally categorized Plaintiff's request as a claim that was pending appeal. (Docs. 22-8 at 2 (revealing United regarded Plaintiff's claim as pending appeal); 22-9 (form letter acknowledging receipt of correspondence and instructing, "You are not required to respond to this letter," and "If your request qualifies for an appeal, grievance, or complaint, we will complete our review and send you a letter about our decision within the required timeframe consistent with pertinent state and federal regulatory requirements."); 22-10 (same); 22-11 (same); 22-12 (form letter acknowledging Plaintiff's communication via phone call with Optum); 22-13 ("When we complete our review we will send you the coverage determination and explanation by mail."); 22-14 ("We determined the questions and concerns expressed in your correspondence do not qualify as an appeal.")). Contradicting itself, United then sent a letter on August 18, 2015, which stated:

Dear [M.C.]:

We reviewed your concern and found that no corrective steps are needed at this time. We made this decision because the received correspondence from you consisting of nothing other than appeal letter [*sic*] with incomplete information. We are unsure of your intent in sending this information to us. We hesitate to treat this as an appeal of a coverage determination because participants ... are only allowed one to two levels of appeal.

(Doc. 22-15 at 1). This letter offered no details as to why the information was supposedly incomplete, or why it was being treated as an appeal rather than a claim, or which “concern” was being reviewed and responded to. (*Id.*). However, the August 18 letter did state:

We do not want you to exhaust one level of your appeal rights without a clear expression from you that you wish to appeal a specific determination. When you appeal a benefit determination, it is to your benefit to provide us with all of the information available to you that you believe will help us understand your situation and possibly alter our original coverage determination. Please provide details of the claim, provider, services and date of service so that the claim could be considered.

(*Id.*).

Though United’s letters of July 27, July 30, August 3, and August 5 do not specify which communication they are responding to, their timing suggests they were directed at Counsel’s July 24 letter. (Docs. 22-9, 22-10, 22-11, 22-12). The same appears to be true of United’s August 6 letter because it is addressed to Ariel Blocker, who wrote the July 24 letter on Plaintiff’s behalf. (Doc. 22-13). United’s August 13 letter is explicitly directed at the July 24 letter. As noted above, United’s August 18 letter refers only to a “concern” and does not specify which communication it was intended to address.

Counsel’s July 24 letter stated in its opening paragraph:

Since our firm has been representing the Colemans, we have sent correspondence three (3) different times in June just trying to get a copy of the plan documents related to this matter. Mr. Coleman has a right under 29 C.F.R. § 2560.503-1 to know the documents that are being utilized to review the claim. Failure to provide this information reveals a refusal to provide a full and fair review.

(Doc. 22-8 at 1). This letter describes the services sought as urgent pursuant to the definition set forth in 29 C.F.R. § 2560-503-1 and refers to the May 11 letter's request "for [M.C.] to be pre-certified for the treatment her doctors are recommending. See the enclosed letters as exhibit 1." (*Id.*). The letter goes on to recount Plaintiff and his counsel's calls and correspondence, as well as United's rights and obligations under ERISA's statutory and regulatory framework. (*Id.* at 1-5).

To the extent United lacked information it needed to process Plaintiff's claim, its letters were insufficient to explain what that information was or why Plaintiff's several attempts to clarify the situation were inadequate. As an example, the August 18 letter did not explain what United reviewed except by referring to Plaintiff's "concern," what determination it reached except that "no corrective steps are necessary at this time," or why the information Plaintiff had already provided, on several occasions and in various ways, was insufficient. Instead, these were clearly form letters which made no attempt to address the substance of the ongoing communications between Plaintiff and United.

United's failure to respond to Plaintiff's communications in a meaningful way is an adequate basis for excusing the exhaustion requirements. *Lanfear*, 536 F.3d at 1224 (citing *Curry*, 891 F.2d at 844, 846-47) ("In *Curry*, for example, we found that exhaustion was futile because plan administrators had denied a participant meaningful access to administrative proceedings by repeatedly ignoring requests for documents supporting the denial of benefits."). In sum, the documents make clear it was United's responses, or lack thereof, to Plaintiff's correspondence which amounted to the denial of "meaningful access to administrative proceedings" as those proceedings are defined in the relevant legal authorities.

For these reasons, the court finds Plaintiff has adequately alleged that he did pursue his administrative remedies and, to the extent he failed to comply with any procedural requirements set forth in the Plan, his failures were due to United’s refusal to provide “meaningful access to administrative proceedings.” Accordingly, the court finds Plaintiff is excused from the requirement of administrative exhaustion, and the motion to dismiss for failure to state a claim on the basis of Plaintiff’s alleged failure to adequately plead exhaustion is due to be denied.

C. Count Three – Injunctive and Equitable Relief

In Count Three, Plaintiff asserts a claim for injunctive and equitable relief pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). (Doc. 1 at ¶¶ 43-45). Specifically, Plaintiff seeks, individually and on behalf of the proposed class, to enjoin Defendants from applying a “blanket denial of coverage for medically necessary ABA therapy” and “any and all equitable remedies” to the extent full relief is not available under the other stated claim. (*Id.* at ¶¶ 44-45).

Defendants argue this claim is due to be dismissed because it asserts a claim for relief which Plaintiff is prohibited from asserting in combination with his claim in Count Two. Defendants contend that under Eleventh Circuit law, “[a]n ERISA plaintiff with an adequate remedy under § 1132(a)(1)(B) cannot alternatively plead and proceed under § 1132(a)(3).” (Doc. 16 at 15) (quoting *Ogden v. Blue Bell Creameries U.S.A., Inc.*, 348 F.3d 1284, 1287 (11th Cir. 2003)); *see also Varity Corp. v. Howe*, 516 U.S. 489, 514-15 (1996) (where a claim is brought pursuant to § 1132(a)(1)(B) for remedy of a plan’s wrongful refusal to provide benefits, including a declaration that the plan is required to provide such benefits and an injunction enforcing the declaration, plaintiff’s claim for the same relief under § 1132(a)(3) is precluded).

In Count Two, Plaintiff asserts a claim under § 1132(a)(1)(B). This section provides that a civil action may be brought “by a participant or beneficiary” who seeks “to recover benefits

due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B). Plaintiff seeks through Count Two to obtain ABA benefits and “a declaration of present and future rights to Plan coverage for ABA therapy to treat autism.” (Doc. 1 at ¶ 42). Plaintiff seeks these remedies on his own behalf, as well as on behalf of the class. (*Id.*).

In Count Three, Plaintiff proceeds under § 1132(a)(3). This section provides that a civil action may be brought by a participant, beneficiary, or fiduciary:

(A) To enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

U.S.C. § 1132(a)(3). According to Plaintiff, this is a “catchall” provision which allows for relief not contemplated in § 1132(a)(1)(B). (Doc. 22 at 12). Because he seeks equitable remedies in Count Three on the basis of Defendants’ breach of fiduciary duties, Plaintiff contends he has stated a claim for equitable relief that is not provided by § 1132(a)(1)(B).

Plaintiff’s complaint clearly alleges that United’s denial of claims for ABA therapy amounts to a breach of Defendants’ fiduciary duties and he seeks equitable relief on that basis. (Doc. 1 at ¶¶ 7, 8, 23, 42, 45). Count Three is explicitly framed as a request for equitable relief “to the extent full relief is not available under 29 U.S.C. § 1132(a)(1)(B) [as asserted in Count Two] or 29 U.S.C. § 1132(a)(2) [as asserted in Count One].” (*Id.* at ¶ 45). Defendants characterize Plaintiff’s claim in Count Three as seeking “equitable relief preventing Defendants from denying coverage for ABA therapy.” (Doc. 16 at 15). However, a review of the complaint shows Plaintiff contemplates obtaining other, equitable relief under Count Three in the form of, for example, “unjust enrichment, restitution, and disgorgement, arising out of defendants[’] failure to properly administer the Plan.” (Doc. 1 at ¶ 45).

a. Injunctive relief

Relief is precluded under § 1132(a)(3) where substantially the same relief is also provided for and sought under § 1132(a)(1)(B). See *Wallace v. Blue Cross and Blue Shield of Alabama*, 2014 WL 5335823 (S.D. Ala. Oct. 20, 2013) (citing *Ogden*, 348 F.3d at 1288, and *Varity*, 516 U.S. at 515). In *Wallace*, which is cited by Defendants, the plaintiff sought exactly the same relief under both § 1132(a)(1)(B) and § 1132(a)(3). *Id.* at *8 (“Plaintiffs assert a claim under [§](a)(1)(B) in Count II . . . and their [§](a)(3) claim is essentially a recasting of that claim as both claims are based on the same allegations and seek the same relief.”). In both counts at issue in *Wallace*, the plaintiffs sought the same medical benefit and declaration of rights to present and future benefits. *Id.* Here, Plaintiff clearly limits his claim in Count Three to cover only the injunctive and equitable relief that cannot be obtained in Count Two. Further, Plaintiff’s briefing clarifies that he seeks this relief only for Defendants’ breach of fiduciary duties. (Doc. 22 at 12). Thus, it does not appear Plaintiff seeks exactly the same relief in both counts.

However, it is clearly prohibited for Plaintiff to seek the same declaration of present and future rights via Count Three as he seeks via Count Two. *Varity*, 516 U.S. at 515. To the extent Plaintiff seeks injunctive relief via Count Three, he seeks the same relief via Count Two because, in Count Two, he seeks a declaration of the present and future rights of Plan participants to ABA therapy. Accordingly, the court finds Plaintiff’s claim for injunctive relief in Count Three is barred by the prohibition against seeking identical relief simultaneously under §§ 1132(a)(1)(B) and (a)(3).

b. Equitable relief

In *Varity*, the Supreme Court recognized that equitable relief was available under § 1132(a)(3) where the plaintiff otherwise would have “no relief at all.” 516 U.S. at 515. However, the *Varity* opinion did not limit § 1132(a)(3)’s application to such a circumstance. Instead, the Supreme Court observed that § 1132(a)(3)’s allowance of equitable relief is limited to *appropriate* equitable relief. *Id.* As the Supreme Court stated:

[T]he statute authorizes “*appropriate*” relief. We should expect that courts, in fashioning “appropriate” equitable relief, will keep in mind the special nature and purpose of employee benefit plans, and will respect the policy choices reflected in the inclusion of certain remedies and the exclusion of others.

516 U.S. at 515 (emphasis original; internal quotations and citations omitted).

Neither party addresses whether the equitable relief Plaintiff seeks would be “appropriate,” as that term is used in *Varity* and other ERISA cases, under the circumstances of this case. However, the court finds at least two of the specific remedies listed by Plaintiff are likely not in the nature of what § 1132(a)(3)’s equitable relief clause, as a catchall provision, is intended to protect and provide. *See Space Gateway Support v. Prieth*, 371 F. Supp. 2d 1364 (M.D. Fla. 2005) (unjust enrichment not available in spite of properly stated claim for breach of fiduciary duty); *Eldridge v. Wachovia Corp. Long-Term Disab. Plan*, 383 F. Supp. 2d 1367 (N.D. Ga. 2005) (restitution claim not a claim for equitable relief under ERISA because it is likely contained within the available contract rights). Nevertheless, the court recognizes that “individualized relief for a fiduciary’s breach of its duties is available under § [1132](a)(3)” even though it is not available under § 1132(a)(2). *Heffner v. Blue Cross and Blue Shield of Ala.*, 443 F.3d 1330, 1339 (11th Cir. 2006). Accordingly, Plaintiff’s claim for equitable relief as to Defendants’ breach of their fiduciary duty will be permitted to proceed insofar as it seeks available equitable relief.

IV. CONCLUSION

For the foregoing reasons, the Defendants' motion to dismiss (Doc. 16) is **GRANTED IN PART** and **DENIED IN PART**. The motion is **GRANTED** as to Count One and Count Three to the extent Plaintiff seeks injunctive relief pursuant to 29 U.S.C. § 1132(a)(3). The motion is **DENIED** as to Count Two and Count Three to the extent Plaintiff seeks permissible equitable relief for Defendants' breach of fiduciary duty. The parties **SHALL** meet and confer pursuant to Fed. R. Civ. P. 16 and submit a report of the planning meeting within twenty-one (21) days of the entry of this order.

DONE this 1st day of September, 2017.

A handwritten signature in black ink, reading "Staci G. Cornelius", written over a horizontal line.

STACI G. CORNELIUS
U.S. MAGISTRATE JUDGE