No. 25-CV-101

IN THE UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

Elinor Dashwood, Individually and on Behalf of the Estate of Marianne Dashwood and a Class of Others Similarly Situated,

Plaintiff-Appellant

v.

Willoughby Health Care Co.,

Willoughby RX, and

ABC Pharmacy, Inc.

Defendants-Appellants.

On Appeal from the United States District Court

For the Eastern District of Tennessee

BRIEF FOR PLAINTIFF-APPELLANT

Team 5

Counsel for Plaintiff-Appellant

January 23, 2026

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Due to the nature of the facts and law at issue, Appellant believes the Court would benefit from hearing oral argument

JURISDICTIONAL STATEMENT

This action arises under the Employment Retirement Income Security Act of 1974 ("ERISA"). The District Court for the Eastern District of Tennessee had proper subject matter jurisdiction pursuant to 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331. This Court has jurisdiction over the issues on appeal pursuant to 28 U.S.C. 1291. Plaintiff-Appellant filed a timely notice of appeal.

STATEMENT OF THE ISSUES

I. Whether the District Court erred in holding that ERISA preempts Appellant's state-law wrongful death claim.

II. Whether the District Court erred in granting Appellees' motion to dismiss and holding that Appellant failed to plausibly allege that Appellees' actions caused a loss that is remediable under ERISA Section 502(a)(3).

STATEMENT OF THE CASE

Marianne Dashwood, a former employee with Cottage Press was enrolled in an ERISA-governed welfare benefit plan, Cottage Press Healthcare Plan (the "Plan). Compl. ¶ 6. After her husband's death in 2023, she became the sole breadwinner for her infant son. Compl. ¶ 16. The Plan is fully insured by Defendant Willoughby Health Care ("Willoughby Health"), a multi-national

insurance company and healthcare conglomerate incorporated and headquartered in Hartford, Connecticut. Compl. ¶ 11, 13.

Under the summary plan description ("SPD"), the governing Plan document, the Plan promises to pay the cost of medically necessary prescription drug medications, subject to a $10 co-pay for all medications filled at ABC Pharmacies. Pursuant to the SPD, Willoughby Health also administers benefits under the Plan and is expressly granted full discretionary authority to decide claims for benefits. With respect to medications, Willoughby Health has delegated its authority to decide claims and administer such benefits to its subsidiary, Willoughby RX. Compl. ¶ 11. Defendant Willoughby RX is a pharmacy benefit manager ("PBM") within the meaning of Tennessee Code § 63-1-202. Compl. ¶ 14.

Defendant ABC Pharmacy is a nationwide pharmacy chain with retail outlets throughout the United States, including in Johnson City, where Ms. Dashwood lived and worked. In 2021, ABC Pharmacy was acquired by Willoughby RX, which is now a subsidiary of Willoughby Health. Compl. ¶ 14.

On December 1, 2024, Marianne cut her leg while hiking with her son. Compl. ¶ 9. Although she later cleaned and dressed the wound, she soon after developed a serious infection. Compl. ¶ 9. This led to her hospitalization at Johnson City Hospital Center in early December. Compl. ¶ 9. Her medical team at

the hospital determined that the infection was caused by a drug-resistant and life-threatening staph infection commonly referred to as MRSA. Compl. ¶ 9.

While at the hospital, Marianne had informed her medical team that she had a well-documented allergy to sulfa drugs and had suffered a severe allergic reaction to another sulfa drug that had been prescribed in 2022. Compl. ¶ 20. Understanding Marianne's allergy to sulfa drugs, the hospital prescribed vancomycin rather than Bactrim because Bactrim is in the sulfa drug class, whereas vancomycin is in a different class of antibiotics called fluoroquinolones. Compl. ¶ 20.

Upon Marianne's discharge from the hospital, her sister, Plaintiff Elinor Dashwood, immediately brought the prescription to an ABC Pharmacy in Johnson City, which did not have the vancomycin that had been prescribed, but instead had a five-day supply of Bactrim. Compl. ¶ 18. Noticing the discrepancy, Elinor asked the pharmacist about this, she was informed that Marianne's insurance company, Willoughby, had switched the prescription to Bactrim. Compl. ¶ 19. The pharmacist also told Elinor that Bactrim was simply the generic form of vancomycin. Compl. ¶ 19. Reassured, Elinor brought the prescription home and give it every day to her sister, for whom she was caring during Marianne's recover. Compl. ¶ 19.

The change in medication occurred by Willoughby Health Care, Willoughby RX, and ABC Pharmacy. Compl. ¶ 21. In doing so, no one consulted her doctor about whether Bactrim was a safe and appropriate treatment for Marianne. Compl. ¶ 21. Rather, Willoughby RX, acting through ABC Pharmacy, switched her medication to what it considers similar preferred drugs. Compl. ¶ 22. Consistent with this policy, Willoughby RX and ABC Pharmacy switched Marianne's medication merely because Bactrim is less expensive than vancomycin, and because its manufacturer provides Willoughby RX financial incentives to do so. Compl. ¶ 22.

This change in prescription had severe consequences for Marianne and her son. Compl. ¶ 23. After taking Bactrim for just over a day, Marianne suffered a severe allergic reaction and died, leaving her son an orphan. Compl. ¶ 24. Plaintiff Elinor Dashwood has been appointed executor of her estate and the guardian and caretaker of Marianne's young son. Compl. ¶ 12.

On May 14, 2025, Plaintiff Elinor Dashwood individually and on behalf of estate, filed a complaint against Defendants Willoughby RX and ABC Pharmacy only with respect to Count I. Compl. ¶¶ 34—38. In addition, Plaintiff Elinor Dashwood, on behalf of the estate of Marianne Dashwood, and on behalf of a class, filed a complaint against Willoughby RX and Willoughby Health Care Company (the "Willoughby Defendants") only with respect to Count II. Compl. ¶¶

24—33. The Eastern District of Tennessee granted Defendant' motion to dismiss, finding that Plaintiff failed to state a claim. *Dashwood et al*., No. 25-CV-101 (E.D. Tenn. L.R.). Plaintiff appealed to this Court.

SUMMARY OF THE ARGUMENT

Section 514(a) of ERISA preempts state laws that relate to an employee benefit plan. The Tennessee statute does not explicitly mention employee benefit plans, nor does its operation depend on their existence. Accordingly, the statute makes no reference to an employee benefit plan. It also does not govern core aspects of plan administration or interfere with ERISA's goal of nationally uniform plan administration. It does not affect benefit determinations, reporting, disclosure, or plan structure. Instead, the statute manages health and safety through broad requirements that govern prescription drug substitution. Since the statute does not encroach upon ERISA's core functions or undermine national uniformity, ERISA does not preempt the Tennessee statute.

Plaintiff has plausibly alleged that Defendants' actions caused a harm or loss that is remediable under ERISA Section 502(a)(3). Plaintiff has provided the court with relevant case law, finding equitable surcharge as appropriate equitable relief under section 502(a)(3). Because an equitable surcharge is permissible under ERISA, Plaintiff pointed to a finding of actual harm caused by Defendants, which

is a necessary finding to obtain relief under the surcharge theory. While the Sixth Circuit does not recognize equitable surcharge as appropriate equitable relief under section 502(a)(3), Appellant is still entitled to relief under a theory of unjust enrichment. Additionally, Appellant has provided the court with relevant case law, finding funds specifically identified when Plaintiff does not provide an exact monetized amount. Thus, Appellant specifically identified the funds that are permissible for a disgorgement remedy under section 502(a)(3). Taking the facts presented as true and in favor of the nonmoving party, and given that Appellant has met their burdens, the lower court's granting of the motion to dismiss was improper.

ARGUMENT

I. STANDARD OF REVIEW

This Court reviews *de novo* the district court's grant of a Rule 12(b)(6) motion to dismiss. *Peterson v. Johnson*, 87 F. 4th 833, 836 (6th Cir. 2023). To survive a motion to dismiss, plaintiffs must plausibly state a claim for which relief can be granted. Fed. R. Civ. P. 12(b)(6); *Johnson v. Parker-Hannifin Corp.*, 87 F. 4th 205, 212 (6th Cir. 2024) (*citing Ashcroft v. Iqbal*, 556 U.S. 662 (2009)) ("A complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face."); *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 556 (2007).

II. THE LOWER COURT ERRED IN HOLDING THAT SECTION 514 OF ERISA PREEMPTS THE TENNESSEE STATE LAW BECAUSE THE LAW DOES NOT "RELATE TO" AN EMPLOYEE BENEFIT PLAN.

Section 514 of the Employee Retirement Income Security Act ("ERISA") states that the provision "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). "A state law relates to an ERISA plan if it has a connection with or reference to such a plan." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 80 (2020) (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001)).

A. The State Law Is Not Expressly Preempted Because It Does Not "Refer To" an Employee Benefit Plan.

i. The Statute Does Not Act Immediately and Exclusively on ERISA Plans.

A state law is preempted when it refers to a plan if it acts immediately and exclusively with respect to ERISA plans. *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319-20 (2016) ("a State[] law [that] acts immediately and exclusively upon ERISA plans . . . will result in preemption"); *see Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 825 (1988) (holding that the anti-garnishment statute was preempted because it expressly referred and solely applied to ERISA employee benefit plans). Such laws single out ERISA plans for special treatment while applying to no other entity. *Mackey*, 586 U.S. at 830. In some circumstances, the statute's text expressly refers to plans. *Id. at 825.* In *Mackey*, the Georgia anti-

garnishment provision was preempted because it expressly exempted ERISA plans from garnishment. *Id.* at 841. Here, unlike in *Mackey*, there is no express reference to an ERISA plan. The Tennessee statute is intended to regulate pharmacy benefit managers and makes no explicit reference to employee benefit plans.

ii. The Statute Does Not Depend on the Existence of an ERISA Plan.

A state law is also preempted where the existence of an ERISA plan is essential to the law's operation. *Rutledge*, 592 U.S. at 81 (a state law is not preempted where the "existence of ERISA plans is not essential to the law's operation"). If an ERISA plan is a critical element of a state-law claim and liability cannot arise in the absence of an ERISA plan, then the law is preempted. *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 133 (1990). The Court in *Ingersoll-Rand* found that the state-law cause of action was expressly premised upon the existence of a pension plan.

Here, however, the statute's operation is not contingent upon the existence of an ERISA plan; rather, the statute applies regardless of whether ERISA plans are present. In this case, the Tennessee statute refers only to the conduct of pharmacy benefit managers. Because the Tennessee statute neither singles out ERISA nor depends on it for its existence, it does not refer to an employee benefit plan. Therefore, the Court must determine whether the statute has an impermissible connection with ERISA plans.

B. The State Law Does Not Have An Impermissible "Connection With" ERISA Plans.

To determine whether a state law has an impermissible connection with an ERISA plan, the court considers ERISA's objectives as a guide to the scope of the state law that Congress intended to survive. *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995). Additionally, the court evaluates whether the state law encroaches on core plan administration or interferes with nationally uniform plan administration. *Gobeille*, 577 U.S. at 323 (holding that ERISA preempted the Vermont statute because it interfered with a central matter of plan administration).

i. Section 514 of ERISA preempts a State Law that infringes upon core Plan administration.

A state law that has an impermissible "connection with" an ERISA plan if it "governs a central matter of plan administration." *Rutledge*, 592 U.S. at 80 ("to determine whether an impermissible connection exists, the court must ask whether the state law 'governs a central matter of plan administration.'"). Central matters of plan administration include plan structure, benefit determinations, and reporting and disclosure. *Id.* at 86-87 ("ERISA is therefore primarily concerned with preempting laws that require providers to structure benefit plans in particular ways."); *Egelhoff v. Egelhoff*, 532 U.S. 141, 152 (2001) (holding that the Washington statute was preempted because it governed the payment of benefit's

which is a central matter of plan administration); *see Gobeille,* 577 U.S. at 336 ("the reporting of information about plan benefits . . . qualifies as a core ERISA function."). However, indirect economic or administrative effects, as well as regulations of third-party service providers, are not preempted. *Travelers,* 514 U.S. at 23 (finding that laws which have "an indirect and solely economic impact upon plans do not have a sufficient connection with ERISA plans to be preempted"); *see also Rutledge*, 592 U.S at 25 (holding that the state law was not preempted because it did not regulate the structure or management of the plan but rather it regulated how third-party administrators interact with fourth parties that provide goods that a plan has already chosen to cover).

a) The Tennessee Statute Does Not Govern Benefit Determinations or Plan Structure

A state law that "binds ERISA plan administration to a particular choice of rules for determining beneficiary status or payment of benefits" is preempted because such laws govern a central matter of plan administration. *Egelhoff*, 532 U.S. at 152 (holding that Washington state was preempted because it dictated how benefits would be paid, which directly conflicted with ERISA's requirements); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (finding that ERISA preempted a wrongful death claim based on a refusal to authorize certain benefits). ERISA is likewise "concerned with preempting state laws that require providers to

structure benefit plans in particular ways." *Rutledge*, 592 U.S at 86 (*citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 (1983)).

In *Egelhoff*, the Supreme Court held that ERISA preempted the Washington statute because it required plan administrators to disregard plan documents and follow state law when determining beneficiary status. *Egelhoff*, 532 U.S. at 152. Since the Tennessee statute regulates the prescription substitution process rather than determining coverage, eligibility, or benefit terms of the plan, it operates outside of the internal administration of ERISA plans. Additionally, in *Tolton,* the Sixth Circuit ruled that the plaintiff's wrongful death claim under state law was preempted because the issue centered on benefit determination, specifically a utilization review decision that required interpreting the plan's terms. *Tolton v. Am. Biodyne, Inc.*, 48 F.3d at 942. Unlike *Tolton*, the current claim does not center on coverage or eligibility under an ERISA plan but focuses on the quality and safety of medical care outside of the plan. Therefore, the Tennessee statute governs PBM conduct in the prescription process, a form of healthcare regulation that operates independently of plan benefit determinations.

This conclusion is consistent with *Rutledge*, where the Court held that ERISA did not preempt the Arkansas statute regulating PBM reimbursement rates because the law did not require plans to adopt a particular plan structure or administrative scheme. *Rutledge*, 592 U.S at 86-87. Similar to the statute upheld in

Rutledge, the Tennessee statute does not mandate plans to follow a specific structure or a particular set of administrative procedures. Instead, it governs third-party PBM conduct to protect beneficiaries from improper medication substitutions.

b) The Statute Imposes No Reporting or Disclosure Requirements.

State laws that require ERISA plans to report claims or beneficiary information are preempted because reporting and disclosure are core ERISA functions. *Gobeille*, 577 U.S. at 336. The Court in *Gobeille* upheld the preemption of a Vermont statute because it compelled plans to report detailed information about claims and plan members. Here, the Tennessee statute imposes no reporting or disclosure requirements because it does not compel plans to submit data or alter administrative reporting practices. Therefore, there is no ERISA interference.

c) The Statute governs third-party conduct and has only indirect economic effects.

ERISA does not preempt state laws that regulate third-party service providers or only have an indirect economic impact on ERISA plans. *See generally Rutledge*, 592 U.S. at 80 ; *Travelers*, 514 U.S. at 23 (holding that New York state regulation of healthcare providers that only indirectly affects ERISA plans is not sufficient to trigger preemption). In *Rutledge*, the Court found that ERISA did not preempt the Arkansas statute regulating pharmacy benefit managers because the

law governed PBMs rather than plan administration. *Rutledge*, 592 U.S. at 80. Although the statute could increase plan costs, the Court in *Travelers* explained that such indirect economic impacts are insufficient to establish an impermissible connection with ERISA.

The Tennessee statute operates in the same manner as *Rutledge*, regulating third-party service providers. *See Rutledge*, 592 U.S at 81. It exclusively regulates PBM conduct by requiring procedural safeguards before medication substitution, which falls outside the scope of core plan administration. Since PBMs are third-party service providers, regulation of their conduct does not equate to regulation of plan administration. Any resulting costs arising from third-party regulation are indirect and speculative, placing the statute squarely within the category of laws the Supreme Court upheld in *Rutledge* and *Travelers*.

ii. A State Law Is Preempted When The Law Interferes With Nationally Uniform Plan Administration

Upon passing § 514(a), Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law" with the goal of minimizing administrative and financial burdens from complying with conflicting directives among states or between a state and the federal government. *Travelers*, 514 U.S. at 656 (citing *Ingersoll-Rand*, 498 U.S. 133, 142 (1990)); *FMC Corp v. Holiday*, 498 U.S. 52, 60 (1990).

The state law in *FMC Corp* required plan providers to calculate benefit levels in Pennsylvania, which frustrated plan administrators' continuing obligation to maintain uniform benefit levels nationwide. *FMC Corp*, 498 U.S at 60. Here, the statute requires pharmacy benefit managers to obtain proper authorization before substituting medication. In contrast to *FMC Corp,* the plan administrator here is not required to make any decisions to alter the plan to conform with this law. This statute applies only to PBM conduct outside the plan's core functions. Although PBM practices vary by state, ERISA does not guarantee uniformity in medical or pharmacy regulation. The body of law is intended to protect uniformity in plan administration. Therefore, Tennessee's regulation of PBM conduct does not undermine ERISA's goal of nationwide uniform plan administration, as it imposes no obligations on plan administrators to choose between uniform nationwide administration and state-specific compliance.

C. The Statute Regulates a Traditional Area of State Authority

Where federal law is said to bar state action in fields of traditional state regulation, the Court has operated from the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655 (citing *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). Therefore, the Court "must respect the separate sphere of state authority." *Fort Halifax Packing Co. v.*

Coyne, 482 U.S. 1, 19 (1987) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)) (internal quotation marks omitted); *see generally California Div. of Lab. Standards Enf't v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 317 (1997). A field that has traditionally been occupied by the State is the regulation of health and safety matters. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 807 (1997) (citing *Hillsborough Cnty. v. Automated Med. Laboratories, Inc.*, 471 U.S. 707, 715 (1985)). In *De Buono*, the Court held that ERISA did not preempt the state tax pursuant to the State's traditional police powers, even when the tax increased the cost of operating an ERISA plan. *Id.* at 806. Similarly, the Court in *Dillingham* upheld a state apprenticeship law because it recognized that it fell within the traditional realm of state regulation. *Dillingham,* 519 U.S. at 317.

Similar to the statute in *De Buono*, the Tennessee statute is a health and safety regulation. In this case, the statute serves patient safety interests by requiring authorization before substituting prescription medication, which aligns with the state's traditional role in regulating health and safety. Likewise, this case is similar to *Dillingham* because the statute functions as a generally applicable regulation in a traditional area of state concern, rather than as a law governing plan administration. Accordingly, in alignment with both *De Buono* and *Dillingham*,

this Court should find that the statute falls within the traditional area of state authority and assume a presumption against preemption.

III. THE DISTRICT COURT ERRED IN GRANTING DEFENDANTS' MOTION TO DISMISS BECAUSE APPELLANT PLAUSIBLY ALLEGED THAT DEFENDANTS' ACTIONS CAUSED A HARM OR LOSS THAT IS REMEDIABLE UNDER ERISA SECTION 502(A)(3).

A. Surcharge is an available remedy under Section 502(a)(3).

i. The Supreme Court Held Equitable Surcharge as Appropriate Equitable Relief Under Section 502(a)(3).

In *Amara*, the Supreme Court held surcharge as appropriate equitable relief under section 502(a)(3) because equity courts historically had the power to provide monetary "compensation" for a trustee's breach of duty or to prevent the trustee's unjust enrichment. *Cigna Corp. v. Amara*, 563 U.S. 421, 441–42 (2011) (explaining "prior to the merger of law and equity this kind of monetary remedy against a trustee, sometimes called a 'surcharge,' was 'exclusively equitable.'") (quoting *Princess Lida of Thurn & Taxis v. Thompson,* 305 U.S. 456, 464 (1939)). The surcharge remedy extended to a breach of trust committed by a fiduciary, including any violation of duty imposed on that individual fiduciary. *Amara* 563 U.S. at 442. Surcharge damages are designed to make plaintiffs "whole from an actual loss that resulted from a fiduciary's breach of duty." *Erban v. Tufts Med. Ctr. Physicians Org.*, 795 F. Supp. 3d 176, 192 (D. Mass. Aug. 12, 2025). Where the fiduciary is analogous to a trustee an award of make-whole relief is available,

falling within the scope of "appropriate equitable relief" in section 502(a)(3). *Id.* at 193 (quoting *Amara*, 563 U.S. at 442) ("Defendants' role as fiduciaries here is 'critical' because fiduciary-defendants are 'analogous to… trustee[s]' and surcharge damages were historically an equitable remedy available against trustees"). "Just as a court of equity would not surcharge a trustee for a nonexistent harm, a fiduciary can be surcharged under section 502(a)(3) only upon a showing of actual harm – proved (under the default rule for civil cases) by a preponderance of evidence. That actual harm may consist of detrimental reliance, but it might also come from the loss of a right protected by ERISA or its trust-law antecedents." *Amara*, 563 U.S. at 444.

Relying on the Supreme Court's decision in *Amara,* the Second, Fifth, Seventh, Eighth, Ninth, and Eleventh Circuits all permit surcharge as appropriate equitable relief available under section 502(a)(3). *See, e.g.*, *Trs. of N.Y. State Nurses Ass'n Pension Plan v. White Oak Glob. Advisors, LLC,* 102 F. 4th 572, 603–604 (2d Cir. 2024); *Gearlds v. Entergy Servs.,* Inc., 709 F. 3d 448, 452 (5th Cir. 2013); *Kenseth v. Dean Health Plan, Inc.,* 722 F.3d 869, 882–83 (7th Cir. 2013); *Silva v. Metro. Life Ins. Co.,* 762 F. 3d 711, 722 (8th Cir. 2014); *Guenther v. Lockheed Martin Corp.,* 972 F. 3d 1043, 1050 (9th Cir. 2020); *Gimeno v. NCHMD, Inc.,* 38 F. 4th 910, 914–15 (11th Cir. 2022). *See also e.g., Erban*, F. Supp. 3d 176, 191–93 (D. Mass. Aug. 12, 2025) (recognizing equitable remedy

under section 502(a)); *Est. of Smith v. Raytheon Co.,* 573 F. Supp. *487*, 509 (D. Mass. 2021) (same); *Turner v. Liberty Mut. Ret. Benefit Plan,* 2023 WL 5179194, at *6 (same).

When drafting ERISA, understanding the high degree of responsibility owed by fiduciaries, Congress intended to "provide the courts with broad remedies for redressing the interests of participants and beneficiaries when they have been adversely affected by breaches of fiduciary duty." *Eaves V. Penn*, 587 F. 2d 453, 462 (10th Cir. 1978) (citing S. Rep. No. 93-127, 93d Cong., 1st Sess., Reprinted (1974) U.S. Cong. & Admin. News pp. 4838, 4871) ("the enforcement provisions have been designed specifically to provide both the Secretary and participants and beneficiaries with broad remedies for redressing or preventing violations of the Retirement Income Security for Employees Act… The intent of the committee is to provide the full range of legal and equitable remedies available in both state and federal courts…"). This Circuit, alongside the Fourth Circuit, take a stark stance contradicting the legislature's intent in providing broad remedies for redressing the interests of participants and beneficiaries. *See generally Aldridge v. Regions Bank*, 144 F. 4th 828 (2025) (finding equitable surcharge impermissible under section 502(a)(3); *Rose v. PSA Airlines*, Inc., 80 F. 4th 488, 497 (4th Cit. 2023) (same). *But cf. Amara*, 563 U.S. at 441—42 (finding equitable surcharge permissible under section 502(a)(3)).

The lower court failed to grant monetary relief under section 502(a)(3) because of its perceived limitations on the nature of relief that could be offered while still being considered equitable. *See Dashwood et al*., No. 25-CV-101 at *14 (E.D. Tenn. L.R.) ("As recently pointed out by the Sixth Circuit, the Supreme Court 'had explained that the phrase [appropriate equitable relief] includes only those remedies that were typically available in equity', not all remedies that equity courts could provide in say trust cases.") (citing *Aldridge*, 144 F. 4th at 846) (citing *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 256 (1993)).

The lower court is correct in determining that a request for compensatory damages, that is, a request for monetary relief for the plaintiff's losses, falls on the legal side of the divide and is therefore considered non-actionable. As in *Mertens*, the Supreme Court held a claim that seeks compensatory damages against a non-fiduciary, is traditionally legal, and therefore falls on the nonactionable side of the divide. *Mertens*, 508 U.S. at 526. Likewise, in *Knudson*, the Supreme Court considering a claim brought by a plan fiduciary seeking reimbursement of money that a plan beneficiary received from a tort defendant, noted that the money in question was not the money paid by the tort defendant, making the claim legal rather than equitable. *See Great-West Life & Annuity Ins. Co. v.* Knudson, 534 U.S. 204, 207—216 (2002). Thus, this claim could not be brought under section 502(a)(3). *Id.*

Amara is distinguishable from *Knudson* and *Mertens* because the parties in the suit were brought by a beneficiary against a plan fiduciary. Amara, 563 U.S. at 440. Under ERISA, a plan fiduciary is treated a trustee. *Id.* In the days of the divided bench, a breach of trust case committed by a fiduciary warranting equitable surcharge as a remedy was a power possessed by the equity courts. *Kenseth*, 722 F. 3d at 879 ("Indeed, prior to the merger of law and equity this kind of monetary remedy against a trustee, sometimes called a 'surcharge,' was 'exclusively equitable.'") Thus, an equitable surcharge is a permissible remedy where the defendant is analogous to a trustee, unlike in *Mertens.* Likewise, here, Appellees are fiduciaries, and therefore analogous to the trustee relationship in the days of the divided bench, thus equitable surcharge is a remedy that is permissible under ERISA Section 502(a)(3). *Willoughby Defs.*, No. 25-CV-101 at 11 n. 5. Even if this Court characterizes *Amara's* discussion of section 502(a)(3) as dictum, this Court must still give serious consideration to the detailed discussion of the law shared by most of the Supreme Court. *See Aldridge* 144 F. 4th at 847 (acknowledging Amara as dicta)*; See Kelly Servs., Inc. v. Creative Harbor, LLC,* 886 F. 3d 857, 875 (6th Cir. 2017) (explaining "[b]ut the fact that dicta is not binding, 'does not mean that the dicta is incorrect.'").

This Court's ruling in *Aldridge* contradicts the broad remedies that are intended to be available in the event there is a breach of fiduciary duty. This Court,

following the Fourth Circuit's limited interpretation of the remedies available under section 502(a)(3), creates a dangerously narrow scope preventing participants and beneficiaries from obtaining the relief that they deserve in the event of a fiduciary breach. The lower court's ruling when applying *Albridge* incorrectly equates a request for monetary relief as a remedy that is automatically legal, thus falling on the nonactionable side of the divide. Kenseth, 722 F.3d at 880 ("Monetary compensation is not automatically considered 'legal' rather than 'equitable.' The identity of the defendant as a fiduciary, the breach of a fiduciary duty, and the nature of the harm are important in characterizing the relief.') (Citing *Gearlds*, 709 F.3d at 450 "The Supreme Court recently stated an expansion of the kind of relief available under section 502(a)(3) when the plaintiff is suing a plan fiduciary and the relief sought makes the plaintiff whole for losses caused by the defendant's breach of fiduciary duty.")

ii. Under the equitable surcharge theory, Appellants can demonstrate Appellees caused actual harm.

To obtain relief under the surcharge theory, a plan participant is required to show harm resulting from the plan administrator's breach of a fiduciary duty. *See Amara*, 563 U.S. at 444 ("We believe that, to obtain relief by surcharge for violations of [citation omitted], a plan participant or beneficiary must show that the violation injured him or her. But to do so, he or she needs only show harm and causation. Although it is not always necessary to meet the more rigorous standard

implicit in the words 'detrimental reliance', actual harm must be shown. But it might also come from the loss of a right protected by ERISA or its trust-law antecedents"). Here, Appellant lost her life because of Appellees breach in their fiduciary's duties. Compl. ¶¶ 1—2. Nevertheless, Appellants recognize that the Sixth Circuit finds the distinction between relief sought from a nonfiduciary as in *Mertens* and a fiduciary as in *Amara* unpersuasive. *See Rose*, 80 F. 4th at 497 (finding that the identity of the defendant did not change the fundamental nature of the remedy: if the relief is measured by compensatory losses rather than traceable assets, it remains legal, equitable).

iii. Even if this court rejects equitable surcharge as permissible relief, Appellant is still entitled to relief under a theory of unjust enrichment.

Alternatively, if this court finds equitable surcharge as impermissible relief under Section 502(a)(3), and rather applies the Fourth Circuit's remedies analysis, this Court must provide monetary relief to remedy unjust enrichment. To remedy unjust enrichment, Appellant must identify the specific funds that: (1) Appellees wrongfully possessed and (2) rightfully belonged to Appellant. *See Rose* 80 F. 4th at 500 (holding a "plaintiff can recover money under section 502(a)(3) only if a court of equity could have awarded it in a concurrent-jurisdiction case, and a court of equity could award money when a plaintiff pointed to specific funds that h rightfully owned by that the defendant possessed as a result of unjust enrichment.")

B. Disgorgement is a permissible remedy because Appellants have specifically identified funds that remain in the defendant's possession.

The lower court incorrectly held that Appellant failed to specifically identify funds for disgorgement. *Montanile* provides that in courts of equity a plaintiff could ordinarily enforce an equitable lien only against either specifically identifiable funds that remained in the defendant's possession or traceable items that the defendant purchased with the funds. *Monanile v. Bd. of Trustees of Nat. Elevator Indus. Health,* 577 U.S. 136, 145-46 (2016).

The lower court does not challenge the nature of the remedy requested, but rather challenges whether Appellants have specifically identified funds warranting the appropriate equitable relief requested here, disgorgement. *Willoughby Defs.*, No. 25-CV-101 at 13—15. Thus, because the nature of the relief Appellant is seeking is appropriate equitable relief, it can therefore be concluded that Appellant is acting within the scope of the reimbursement rights provided in an ERISA healthcare benefit plan. A plan's reimbursement provides a right to recover a particular fund. *Zirbel v. Ford Motor Co.*, 980 F.3d 520, 524 (6th Cir. 2020) (citing *Hall v. Liberty Life Assur. Co. of Boz.*, 595 F. 3d 270, 275 (6th Cir. 2010). A quantified dollar amount is not necessary to specifically identify a fund for the purposes of disgorgement. *See e.g., Zirbel,* 980 F.3d at 523--25 (holding that the plan had "a right to recover a particular fund: the overpayment"). Once the

beneficiary "received the overpayment, a lien attached, permitting the plan to seek equitable restitution in the amount of the $243,190." *Id.* at 524.

Although the nature of relief in *Zirbel* is restitution and the nature of relief here is disgorgement the distinction is irrelevant for the purposes of evaluating what is required to specifically identify a fund. *See Patterson v. United HealthCare Ins. Co.*, 76 F. 4th 487, 497 (2023) ("Like disgorgement, equitable restitution 'seeks to punish the wrongdoer' by stripping 'of ill-gotten gains.'") (*citing Messing v. Provident Life & Accident Ins. Co.*, 48 F. 4th 670, 683 (6th Cir. 2022)). Restitution merely provides an additional analysis of traceability, yet this Circuit has not expressly held that claims for disgorgement must satisfy the traceability requirement. *Patterson*, 76 F. 4th at 497 (citing *Knudson*, 534 U.S. at 214 n.2).

Here, Appellant requests "disgorgement of all amounts by which Willoughby Health Care and Willoughby RX profited through application of their drug switching program." As in *Zirbel*, a specific quantified dollar amount of the funds isn't necessary to find disgorgement as a permissible remedy under section 502(a)(3). Finally, even if this Court find that funds were commingled, this Court must still grant relief because Court has granted relief even when the funds at issue were not held in a separate account. *See Tiara Yachts, Inc. v. Blue Cross Blue Shield of Mich.*, 138 F.4th 457, 459 (6th Cir. 2025). Therefore, Appellant

specifically identified funds warranting disgorgement as a permissible remedy under section 502(a)(3).