Jordan M. Lewis, pro hac vice
KELLEY UUSTAL, PLC
700 S.E. 3rd Ave., Suite 300
Fort Lauderdale, FL 33316
Telephone: (954) 522-6601
Facsimile: (954) 522-6608
jml@kulaw.com

Teresa S. Renaker, Cal. Bar No. 187800
Margaret E. Hasselman, Cal. Bar No. 228529
RENAKER HASSELMAN LLP
235 Montgomery St., Suite 944
San Francisco, CA 94104
Telephone: (415) 653-1733
Facsimile: (415) 727-5079
teresa@renakerhasselman.com
margo@renakerhasselman.com
Attorneys for Plaintiff and the Putative Class

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

ANNA M. SANSONE-ORTIZ, individually and on behalf of all others similarly situated, Plaintiff, vs. AETNA HEALTH OF CALIFORNIA, INC., AND AETNA, INC., Defendants.	Case No. 3:15-CV-3334-WHO **PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION TO COMPEL ARBITRATION**

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I. INTRODUCTION

Defendants Aetna Health of California, Inc. and Aetna, Inc.'s motion to compel arbitration teeters, principally, on two false premises. *First*, the defendants assume – almost without discussion – that an ERISA[1] regulation that prohibits the same mandatory arbitration they seek to enforce applies only to their internal remedies procedure. Neither the regulation nor the cases that have analyzed the regulation supports, in any sense, the defendants' interpretation. *Second*, the defendants don't discuss at all the 9th Circuit case of *Graphic Communications Union v. GCIU-Employer Retirement Benefit Plan,*[2] which provides that arbitration isn't required where – as here – the ERISA participant challenges the defendants' violation of the ERISA statute itself, as opposed to an ERISA plan provision.

Consistent with the ERISA regulations and controlling 9th Circuit law, defendants' motion should be denied.

II. BACKGROUND

This case involves the intersection of the only peer-reviewed treatment for autism and the federal Mental Health Parity and Addiction Equity Act. Plaintiff Anna M. Sanzone-Ortiz is a participant in an ERISA-governed health plan sponsored by her employer. Her son has autism, and his treating physicians recommended a minimum of 36 hours a week of Applied Behavioral Analysis (known as "ABA") treatment. ABA's treatment approach is endorsed by more than 550 peer-reviewed studies as well as by (among others) the U.S. Surgeon General, the National Standards Project and the National Professional Development Center on Autism.[3]

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[1] Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 *et seq*.
[2] 917 F.2d 1184 (9th Cir. 1990).
[3] Complaint, ¶¶ 2, 6.

Aetna Health of California, Inc. is a California health maintenance organization that underwrites Sanzone-Ortiz's coverage. Under the terms of its group agreement with Sanzone-Ortiz's employer, Aetna Health promises to cover all services that are "medically necessary," which are

> (a) [i]n accordance with generally accepted standards of medical or health care practice;
> (b) [c]linically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's condition, illness, injury or disease;
> (c) [n]ot primarily for the convenience of the patient, Physician or other health care provider; and
> (d) [n]ot more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's condition, illness, injury, or disease.[4]

To determine whether a service is "medically necessary," Aetna Health represents that it will consider

> • information provided on the Member's health status;
> • reports in peer-reviewed medical literature;
> • reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
> • professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
> • the opinion of Health Professionals in the generally recognized health specialty involved;
> • the opinion of the attending Physicians, which have credence but do not overrule contrary opinions; and
> • any other relevant information brought to HMO's attention.[5]

Co-defendant Aetna Inc. is the corporate parent of Aetna Health of California, Inc. Its headquarters are in Hartford, Connecticut.[6] Both Aetna, Inc. and Aetna Health of

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[4] *Id.* at ¶ 10, 20, and Att. B at 16.
[5] *Id.*
[6] *Id.* at ¶ 10.

California, Inc. are "fiduciaries" as that term is defined by ERISA because both entities have discretionary authority in the administration of Sanzone-Ortiz's health plan and both have discretionary authority in the management of her plan and its assets.[7]

Aetna Health of California Inc. applies and is subject to a 12-page guideline, written by Aetna Inc. This guideline, which isn't attached to or incorporated into Sanzone-Ortiz's plan, caps ABA coverage to "no more than 20 hours per week for 60 consecutive days."[8]

This unilateral limitation, which finds no parallel in Sanzone-Ortiz's plan for medically necessary treatment for physical illnesses, violates the federal Mental Health Parity and Addiction Equity Act,[9] which is incorporated within the ERISA statute at 29 U.S.C. § 1185a. It also violates California's counterpart, the California Mental Health Parity Act, at Cal. Health & Safety Code § 1374.72.[10]

On July 20, 2015, Sanzone-Ortiz commenced this action with the filing of a three-count complaint. The Complaint is styled as a class action, and proposes two distinct classes. The California Aetna Health Class is defined as

> All current and former participants and beneficiaries of any ERISA-governed Aetna Health of California health plan who were denied benefits for ABA treatment based on the 20-hour limitation at any time after June 30, 2011, excluding officers, directors, and managing agents of either Defendant.[11]

The Aetna National Class is defined as

> All current and former participants and beneficiaries of any ERISA-governed health plan that has adopted the Aetna, Inc. 12-page set of guidelines for determining coverage limits for ABA treatment, who have been denied benefits for ABA treatment for autism based on the 20-hour limit since June 30,

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[7] *Id.* at ¶¶ 10, 12.
[8] *Id.* at ¶ 4, Att. A at 3.
[9] *Id.* at ¶ 5.
[10] *Id.* at ¶ 50.
[11] *Id.* at ¶ 33.

2011, excluding officers, directors, and managing agents of either Defendant.[12]

The Aetna Health Class brings claims under 29 U.S.C. § 1132(a)(3) for breach of the ERISA statute (Count 1[13]) and under the California Health & Safety Code § 1374.72 (Count 2[14]) for breach of that statute. The Aetna National Class also brings a claim under 29 U.S.C. § 1132(a)(3) for violation of the ERISA statute (Count 3[15]).

The defendants have responded to the Complaint with a motion to compel arbitration. This memorandum addresses the defendants' arguments.

III. LEGAL STANDARD

"Arbitration under the [Federal Arbitration] Act is a matter of consent, not coercion."[16] Consistent with that directive, it is Aetna's burden to show that an enforceable arbitration agreement exists and that its terms bind the other party.[17] "This burden is a substantial one:

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[12] *Id.* at ¶ 34.
[13] *Id.* at ¶¶ 42 – 46.
[14] *Id.* at ¶¶ 47 – 52.
[15] *Id.* at ¶¶ 53 – 59.
[16] *Volt Information Sciences v. Board of Treasurers of Leland Stanford Junior Univ.*, 489 U.S. 468, 479 (1989).
[17] *See, e.g., Sanford v. Memberworks, Inc.,* 483 F.3d 956, 962 n.9 (9th Cir. 2007)("The district court, when considering a motion to compel arbitration which is opposed on the ground that no agreement to arbitrate had been made between the parties, should give to the opposing party the benefit of all reasonable doubts and inferences that may arise.")(internal quote marks omitted); *Three Valleys Municipal Water District v. E.F. Hutton & Co.,* 925 F.2d 1136, 1139–41 (9th Cir. 1991)("Only when there is no genuine issue of fact concerning the formation of the agreement should the court decide as a matter of law that the parties did or did not enter into such an agreement. The district court, when considering a motion to compel arbitration which is opposed on the ground that no agreement to arbitrate had been made between the parties, should give to the opposing party the benefit of all reasonable doubts and inferences that may arise.")(internal indenting and citation omitted).

> Before a party to a lawsuit can be ordered to arbitrate and thus be deprived of a day in court, there should be an express, unequivocal agreement to that effect.... The district court, when considering a motion to compel arbitration which is opposed on the ground that no agreement to arbitrate had been made between the parties, should give to the opposing party the benefit of all reasonable doubts and inferences that may arise."[18]

IV. ARGUMENT

A. Aetna's arbitration provision violates ERISA

29 C.F.R. § 2560.503-1, titled "Claims procedure," regulates ERISA-governed benefit plans, as its opening two sentences declare:

> In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.[19]

Under the heading "Group health plans," is the following:

> The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—
> ....
> [t]he claims procedures do not contain any provision for the mandatory arbitration of adverse benefit

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[18] *Gelow v. Central Pacific Mortgage Corp.*, 560 F. Supp.2d 972, 979 (E.D. Cal. 2008)(citing *Three Valleys*, 925 F.2d at 1141.).

[19] 29 C.F.R. § 2560.503-1(a).

> determinations, except to the extent that the plan or procedures provide that: (i) [t]he arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements to such appeals; and (ii) [t]he claimant is not precluded from challenging the decision under section [1132](a) of the Act or other applicable law.[20]

The arbitration language in the Aetna Health of California Inc. certificate of coverage violates this rule in at least two ways. *First*, it purports to require arbitration not "as one of the two appeals described in paragraph (c)(2) of this section" but after such appeals are exhausted. *Second*, it intentionally seeks to limit the claimant "from challenging the decision under section [1132](a) of the Act." That is, in fact, the entire and only point of the defendants' motion.

Defendants don't concede the existence of this rule until page 10 of their brief, and then only in a footnote.[21] Their gloss on the rule is (1) it doesn't apply because "[n]one of ERISA's statutory provisions reflect a congressional command to override the [Federal Arbitration Act],[22] and (2) the rule only applies to benefit appeals and not what happens afterwards.[23]

As to their first argument, under the heading "Congressional findings and declaration of policy" in, literally, the first section of ERISA, is this declaration:

> It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, *and by providing for appropriate remedies, sanctions, and ready access*

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[20] 29 C.F.R. § 2560.503-1(c)(4)(i)(ii).
[21] Aetna 9/28/2015 Br. at 10 n.6.
[22] *Id.* at 11.
[23] *Id.* at 10.

to the Federal courts.[24]

Thus, the regulation is fully consistent with Congress's intent in enacting ERISA.

As to defendants' second argument – that the regulation only limits how its internal appeal is to be conducted – it does violence to the actual text of the regulation. The regulation limits the use of arbitration to a form of internal appeal, and expressly bans such use to the extent it precludes the claimant from bringing a claim under 29 U.S.C. § 1132(a).

There appear to be four cases that have analyzed the regulation in this context. None interpreted the regulation in the manner urged here by defendants.

Snyder v. Federal Ins. Co.[25] dealt with a situation where an ERISA plan participant sought to invoke his plan's arbitration provision after fully exhausting its applicable administrative appeals. Citing the regulation, the court invalidated the arbitration requirement:

> The plain language of the Regulation prohibits *"any* provision for the mandatory arbitration of adverse benefit determinations" unless the plan provides that the arbitration is one of the two permissible levels of appeal and that the claimant is free to challenge the arbitrator's decision in federal court under § 502(a) of ERISA. 29 C.F.R. § 2560.503–1(c)(4) (emphasis added). In this case, the arbitration provision in the Plan permits, in violation of the Regulation, mandatory arbitration of adverse benefits decisions. .... Furthermore, the Plan's arbitration provision does not fall within the Regulation's narrow exception to the ban on mandatory arbitration. *See* 29 C.F.R. § 2560.503–1(c)(4)(i)-(ii). The arbitration provision is not included as a level of appeal in the Plan's claim procedure, nor does the provision provide that the arbitrator's decision can be challenged in federal court under § 502(a) of ERISA. *See id.*Therefore, because the Plan's arbitration provision, which is not included

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[24] 29 U.S.C. § 1001(b)(emphasis added).

[25] 2009 WL 700708 (S.D. Ohio March 13, 2009).

> as an appealable step in the Plan's claim procedure, mandates arbitration on one party to the Plan whenever the other party demands it, the provision violates the Regulation.[26]

The court also rejected the same argument that defendants front here, that the Federal Arbitration Act, in effect, overrode the ERISA statute:

> While the Court recognizes the "liberal federal policy favoring arbitration agreements," even the most liberal policy cannot outweigh the unambiguous law prohibiting mandatory arbitration provisions in ERISA-governed insurance plans. *See Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.,* 460 U.S. 1, 24 [] (1983); *Rodriguez de Quijas v. Shearson/American Express, Inc.,* 490 U.S. 477, 483 [] (1989) (a statute overrides the mandate of the FAA when arbitration inherently conflicts with the underlying purposes of the statute). The Secretary of Labor's explicit prohibition of mandatory arbitration provisions in ERISA-governed plans supersedes the FAA's liberal policy favoring arbitration agreements. *See Rodriguez de Quijas,* 490 U.S. at 483.[27]

The court in *Sosa v. PARCO Oilfield Services, Ltd*.,[28] in enforcing the regulation, observed that the regulation didn't eliminate all forms of arbitration within ERISA plans: "While the Department of Labor allowed 'voluntary binding arbitration' in some instances … it apparently rejected binding arbitration in the claims procedures of group health plans and plans providing disability benefits."[29]

The courts in *Williams v. Association De Prevoyance Interenterprises*[30] and *Coleman v. Supervalu, Inc. Short Term Disability Plan*[31] similarly enforced the regulation's limitation

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[26] *Id.* at *6.
[27] *Id.* at *6 n.8.
[28] 2006 WL 2821882 (E.D. Tex. Sept. 27, 2006).
[29] *Id.* at *6.
[30] 2012 WL 1752687 (E.D. La. May 16, 2012).
[31] 920 F. Supp.2d 901 (N.D. Ill. 2013).

on arbitration.[32]

In sum, not one case – and certainly not the regulation itself – support defendants' position here. The regulation precludes use of the arbitration clause in exactly this setting.

B. Aetna's arbitration provision doesn't reach claims for violation of the statute

Sanzone-Ortiz's claims arise out of the defendants' violation of 29 U.S.C. § 1185a, which requires that, in a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits,

> the financial requirements applicable to such mental health … benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan…. and … the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan … and there are no separate treatment limitations that are applicable only with respect to mental health … benefits.[33]

It is the burden of Sanzone-Ortiz's case that the defendants' unilateral 20-hour a week benefit cap – for which there is no analogue or parallel in defendants' health and surgical coverage – violates this statutory requirement.

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[32] *Williams*, 2012 WL 1752687, *6 ("Thus, although federal law typically favors the enforcement of arbitration agreements, federal regulations prohibit binding arbitration regarding challenges to adverse benefit determinations."); *Coleman*, 920 F. Supp.2d at 909 ("In that respect it is noteworthy that there are ERISA regulations that limit strictly the situations in which arbitration clauses can be enforced in ERISA plans (see 29 C.F.R. § 2560.503–1(c)(4)). Indeed, those regulations prohibit any arbitration clause that prevents a beneficiary from challenging an adverse benefit determination under § 1132(a)—the very provision that permits participants and beneficiaries to bring civil actions to enforce their ERISA rights. In sum, defendants are wrong in contending that permissibility of arbitration clauses in ERISA plans calls for a conclusion different from that reached by this Court.").

[33] 29 U.S.C. § 1185a(a)(3)(A)(i)-(ii).

In this circuit, the rule is clear: where the dispute arises under ERISA, arbitration – even where purportedly required by the plan – is not required. *Graphic Communications Union v. GCIU-Employer Retirement Benefit Plan*[34] arose after a union, on behalf of its membership, challenged the plan's interpretation of its special vesting rules. The union exhausted the internal appeals but declined to appeal the trustees' decision to final and binding arbitration. Instead, it filed a claim in federal court. Its claim was dismissed by the district court for failure to arbitrate, and that holding was affirmed by the Ninth Circuit. But in so doing, the Ninth Circuit framed its analysis in this manner:

> Thus, the fundamental question here is whether the claim the Union seeks to assert arises under the employee benefit plan or under ERISA. *See Amaro,* 724 F.2d at 748, 751 (adherence to an "agreement [which] mandate[d] final and binding arbitration of contractual disputes" was not required because the disputed issue was "solely ... an alleged violation of a protection afforded by ERISA"); *Fujikawa,* 823 F.2d at 1345. When the question is properly thus framed, the answer is not difficult. The special-vesting claim which the Union asserts here arises under the trust agreement and not under ERISA itself.[35]

Graphic, which remains good law, compels the following query: Must an ERISA plaintiff who has exhausted her administrative remedies and whose claim arises because of an ERISA violation arbitrate her claim? Under *Graphic*, the answer is "no."

C. Sanzone-Ortiz did not agree to arbitrate her claims

Sanzone-Ortiz's claims are brought under 29 U.S.C. § 1132(a)(3), which permits her, as an ERISA "participant," to "enjoin any act or practice which violates any provision of [ERISA Title I]"[36] … [or] "to obtain other appropriate equitable relief … to redress such

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[34] 917 F.2d 1184 (9th Cir. 1990).
[35] *Id.* at 1187.
[36] 29 U.S.C. § 1132(a)(3)(A).

violations."[37] Thus, *she* (and not her minor autistic son) is the plaintiff here.

The reason this warrants comments is that Aetna relies on two documents by which – it claims – Sanzone-Ortiz agreed to arbitrate this dispute. The first is the enrollment form through which her son acquired benefits.[38] To the extent that is enforceable, it is enforceable – by its terms – only against the minor son, and not against Sanzone-Ortiz. The second document through which Aetna claims Sanzone-Ortiz agreed to arbitrate is the certificate of coverage itself.[39] The problem for Aetna here is that, while Sanzone-Ortiz's employer may have agreed to arbitrate, she did not.

This rule was explained by the Ninth Circuit in *Comer v. Micor, Inc*.[40] In *Micor*, a participant in an ERISA-governed pension plan sued the investment manager alleging breach of fiduciary duty. The manager argued that the arbitration agreement in its contract with the participant's employer bound the participant, as well. The Ninth Circuit held that, only in limited circumstances, non-signatories can be bound by arbitration agreements, through the following theories: incorporation by reference, assumption, agency, veil-piercing/alter ego, and estoppel.[41]

The estoppel theory is the only theory that comes close. Under that theory, nonsignatories can be held to arbitration clauses where the non-signatory "knowingly exploits the agreement containing the arbitration clause despite having never signed the agreement."[42] This might apply if Sanzone-Ortiz's claim was premised on enforcing the plan. As explained above, however, Sanzone-Ortiz's claim is about the defendants' violations of ERISA and the parallel California statute. She doesn't seek to "exploit" her benefits; she seeks only to force the defendants to comply with ERISA's statutory

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[37] *Id.* at § 1132(a)(3)(B)(i).
[38] Aetna 9/28/2015 Br. at 5.
[39] *Id.*
[40] 436 F.3d 1098 (9th Cir. 2006).
[41] *Id.* at 1101.
[42] *Id.* (internal quote marks and citation omitted).

requirements.

Thus, because Sanzone-Ortiz didn't agree to the arbitration requirement, she is not bound by it.

D. Aetna, Inc. is not a party to any agreement and thus cannot enforce arbitration

"When deciding whether the parties agreed to arbitrate a certain matter … courts generally … should apply ordinary … principles that govern the formation of contracts."[43] A starting point in interpreting the contracts is to determine *who* is actually bound by the purported promises to arbitrate: "The right to compel arbitration stems from a contractual right [that generally] may not be invoked by one who is not a party to the agreement and does not otherwise possess the right to compel arbitration."[44]

The arbitration agreement at issue purports to control disputes between "Interested Parties,"[45] which the certificate of coverage defines as "**Contract Holder**, **Members**, the heirs-at-law or personal representative(s) of a **Member**, a **Participating Provider** and **HMO**, including affiliates, agents, employees or subcontractors of an Interested Party."[46] The bolded terms above are defined; **HMO** is specifically defined (and limited to) Aetna Health of California, Inc.[47]

Thus, even assuming that the arbitration agreement is enforceable (and it is not), defendant Aetna, Inc. is a non-party to the agreement and cannot enforce it.

There are limited circumstances in which a nonsignatory can compel a signatory to arbitrate, and they are when a non-signatory is a third-party beneficiary or under an "alternative estoppel theory."[48] Neither applies. As to the third-party beneficiary theory,

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[43] *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 944 (1995).
[44] *Britton v. Co-op Banking Group*, 4 F.3d 742, 744 (9th Cir. 1993)(citation omitted).
[45] Complaint, Att. B, at p. 52.
[46] *Id.*
[47] *Id.* at p. 1.
[48] *Lucas v. Hertz Corp.*, 875 F. Supp.2d 991, 1000-01 (N.D. Cal. 2012).

"it takes more than the 'any and all disputes' –type language to support a finding of third party beneficiary enforceability."[49] And as to the "alternative estoppel theory," it is generally based on the interdependence of the claims against the signatory.[50] Here, Sanzone-Ortiz's claim against Aetna, Inc. is independent of her claims against Aetna Health of California, Inc. It is premised, *first*, on Aetna, Inc.'s status as an ERISA fiduciary that owes obligations to her without regard to either her or its relationship to Aetna Health of California, Inc., and *second*, Aetna Inc.'s adoption and imposition of an autism benefit cap that violates ERISA. Sanzone-Ortiz could have brought her claim against Aetna *without bringing a companion claim* against Aetna Health of California, Inc.

As a nonsignatory not subject to the limited applicable exceptions, Aetna can't enforce the arbitration agreement.

E. Aetna's authority is uniformly off the mark

Defendants cite six cases[51] to support their proposition that "courts within the Ninth Circuit and across the country repeatedly have compelled arbitration in ERISA cases."[52] On close inspection, there's much less here than Aetna suggests. Four of the cases[53] predate the January 1, 2002 effective date of the current version of the regulation containing the arbitration limitation, and thus are not relevant.[54] Three cases involve

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[49] *Id.* at 1002.
[50] *Id.*
[51] *Chappel v. Laboratory Corporation of America*, 232 F.3d 719 (9th Cir. 2000); *Kramer v. Smith Barney*, 80 F.3d 1080 (5th Cir. 1996); *Bird v. Shearson Lehman/American Exp., Inc.*, 926 F.2d 116 (2nd Cir. 1991), *cert. denied*; *Luchini v. Carmax, Inc.*, 2012 WL 2995483 (E.D. Cal. July 23, 2012); *Hornsby v. Macon County Greyhound Park, Inc.*, 2012 WL 2135470 (M.D. Ala. June 13, 2012); *Toledo v. Kaiser Permanente Medical Group,* 987 F. Supp. 1174 (N.D. Cal. 1997).
[52] Aetna 9/28/2015 Br. at 9.
[53] *Chappel*, *Kramer*, *Bird*, and *Toledo.*
[54] *See Solien v. Raytheon Long Term Disability Plan #590*, 2008 WL 2323915, *5 (D. Ariz. June 2, 2008)(*Chappel* "was based on code provisions prior to amendments effective January 1, 2002.").

pension benefit plans,[55] and thus are not regulated by 29 C.F.R. § 2560.503-1(c)(4), which applies to group health plans and, by way of 29 C.F.R. § 2560.50-3-1(d), to plans providing disability benefits. That leaves only *Hornsby v. Macon County Greyhound Park, Inc.*,[56] which simply doesn't mention the regulation, much less explain why it doesn't control.

V. CONCLUSION

Under both controlling law and regulation, the defendants' arbitration agreement is ineffective against the claims brought by Sanzone-Ortiz. The Court should deny the defendants' motion and require them to answer the Complaint on its merits.

Dated: October 23, 2015

Respectfully submitted,

KELLEY UUSTAL, PLC

By: _____

Jordan M. Lewis

RENAKER HASSELMAN LLP

Attorneys for Plaintiff and the Putative Class

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[55] *Kramer* (pension) *Bird* (pension), *Luchini* (employment agreement).
[56] 2012 WL 2135470 (M.D. Ala. June 13, 2012).