IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

NATALIE BARBICH and BRUCE LINDVAL, individually and as the representatives of a class of similarly situated persons, and on behalf of the NORTHWESTERN UNIVERSITY EMPLOYEE WELFARE PLAN, Plaintiffs, v. NORTHWESTERN UNIVERSITY, NORTHWESTERN UNIVERSITY EXECUTIVE DIRECTOR, BENEFITS & WORK/LIFE RESOURCES, and, DOES 1-20 Defendants.	Case No. 25-cv-6849 Hon. Jeremy C. Daniel

DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF
MOTION TO DISMISS

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INTRODUCTION

Plaintiffs Natalie Barbich and Bruce Lindvall (collectively, "Plaintiffs") are former employees of Defendant Northwestern University ("Northwestern"). In their putative class action, Plaintiffs allege that Northwestern and its Executive Director for Work/Life Benefits breached their fiduciary duties under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 *et seq*. ("ERISA"), when they offered employees the option to participate in the Northwestern University Health and Welfare Plan's (the "Plan") Premier Preferred Provider Organization ("PPO"), which is just one of the health insurance options available under the Plan.

Specifically, Plaintiffs claim that Northwestern charged too much for the Plan's Premier PPO. But Plaintiffs admit that the Plan offered employees the choice to select health insurance coverage from among multiple options, and that the price of each coverage option was fully disclosed in the materials made available to Plan participants. Plaintiffs further admit that they voluntarily chose to enroll in the Premier PPO during the years at issue. Put simply, Plaintiffs admit that they received the health insurance coverage they selected, at the prices quoted in the Plan documents—but they think they should have been charged less. Such a claim fails.

First, Plaintiffs lack Article III standing because they do not allege a cognizable injury-in-fact. Plaintiffs admit that they received all of the benefits to which they were entitled under the Plan's terms. Further, Plaintiffs do not allege that they were charged more for their health insurance coverage than allowed under the Plan documents or that Defendants mismanaged Plan assets. Following the Supreme Court's decision in *Thole v. U.S. Bank N.A.*, 590 U.S. 538 (2020), courts have regularly held that health plan participants do not have Article III standing to sue where, as here, they have received the benefits they were promised under the plan and they do not otherwise allege any fiduciary breach affected their promised benefits.

Second, Defendants acted as settlors when they set the price at which the Premier PPO was made available to participants. It is black-letter law that employers act as "settlors," and not ERISA fiduciaries, when making plan design decisions such as setting contribution amounts and cost-sharing obligations (such as deductibles, coinsurance, and copayments). *See Larson v. United Healthcare Ins. Co.*, 723 F.3d 905, 908 (7th Cir. 2013). Plaintiffs attempt to avoid this bedrock principle of ERISA by analogizing Northwestern's decision to offer health plan coverage options to its decision to offer 401(k) plan investment options to eligible employees. But Plaintiffs ignore that in a 401(k) plan, a participant's benefit is the value of the money in each participant's individual account, which fluctuates based on the performance of the market and the fees charged by each investment manager. As a result, an employer has a fiduciary duty to confirm that each investment option is prudent. By contrast, in a health plan, participants purchase a "defined"—*i.e.*, fixed—set of coverages at a quoted price. The plan benefit is contractually determined and does not fluctuate. For this reason, Northwestern acts as a "settlor" when deciding (1) whether to offer health insurance coverage to its employees, (2) which health insurance options (if any) it offers, (3) the amount of monthly contributions charged to employees, and (4) what cost-share obligations are associated with each option.

Third, Plaintiffs do not allege plausibly that Defendants breached any fiduciary duties under ERISA. Defendants are aware of no case law holding that it is imprudent for health plans to offer participants a menu of coverage options from which they may choose how and when their cost-share obligations are structured. Further, Plaintiffs fail to allege any injury to the Plan as a whole. Plaintiffs also fail to allege that Defendants made any intentionally misleading statements or material omissions regarding the Plan's coverage. To the contrary, Plaintiffs admit that Defendants fully disclosed the cost of each coverage option.

Fourth, to the extent Plaintiffs' claims are predicated on violations of ERISA Section 502(a)(3), they fail as a matter of law because Plaintiffs solely demand legal relief. Relief under ERISA Section 502(a)(3) is limited to injunctive and appropriate equitable relief. Plaintiffs do not allege that Defendants were unjustly enriched by the alleged fiduciary breaches nor do they identify any funds in Defendants' possession to which they are entitled.

For all of these reasons, and as further explained below, the Court should dismiss Plaintiffs' Complaint in its entirety.

BACKGROUND

I. The Plan

Northwestern sponsors the Plan for its employees. The Plan offers health, dental, vison, life and disability insurance coverage, as well as tuition and other benefits. *See* Ex. 1.[1]

With regard to health insurance coverage, the Plan offers employees the choice of five coverage options: a Health Maintenance Organization ("HMO") option and four PPO options. *See id.* at 2.1-2.2. The Plan's HMO option is fully insured,[2] while the Plan's PPO options are self-

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[1] The Court may consider the Plan documents, including the Employee Welfare Benefit Plan, the Summary Plan Description ("SPD") and Benefits Guide, at this stage because they are "referred to in [Plaintiffs'] complaint and are central to [their] claim." *Adams v. City of Indianapolis*, 742 F.3d 720, 729 (7th Cir. 2014) (citations and alteration omitted). In ERISA cases, courts routinely hold that a plan's governing documents may be considered on a motion to dismiss. *See, e.g.*, *Kolbe & Kolbe Health & Welfare Benefit Plan v. Med. Coll. of Wisc., Inc.*, 657 F.3d 496, 501 (7th Cir. 2011). Defendants have attached as exhibits the 2022 Plan Year SPD ("2022 SPD") (Ex. 1) and 2022 Benefits Guide (Ex. 2) because both Plaintiffs allege to have been enrolled in the Premier PPO in 2022. *See* Compl. ¶¶ 17-18. Defendants also have attached the 2018 Welfare Benefit Plan, the 2023 Welfare Benefit Plan, and the Brief for the U.S. Dep't of Labor as Amicus Curiae, *Winsor v. Sequoia Benefits & Ins. Servs. LLC*, 62 F.4th 517 (9th Cir. 2023) as Exhibits 3, 4, and 5 respectively.

[2] In a fully insured arrangement, the employer and employees pay premiums to an insurance company, with the insurance company taking on the financial obligation to pay claims. The

insured.[3] *See id.* at 2.3. All of the coverage options fully cover the cost of preventive care. *See* Ex. 2 at 3. The PPO options afford employees the flexibility to go to any provider they choose, but the Plan provides greater benefits when participants see an in-network provider. *See id.* The HMO option provides employees access to providers in the HMO network, but does not offer any benefits for services rendered by out-of-network providers. *See id.*

"[T]here is no difference in the health-care coverage for participants in the . . . PPO options," Compl. ¶ 26—that is, the network of providers and the services covered by each of the PPO options is the same. The only difference among the PPO options is the price at which the Plan benefits are made available for purchase by employees. *See id.*

The cost of coverage is based on the benefit option selected by the employee. *See* Ex. 2 at 2 ("Your costs will be based on the coverage options you choose."). The Benefits Guide identifies the monthly contribution amount for each coverage option. *See id.* at 5. Further, the Benefits Guide identifies the cost-share owed if a participant incurs a claim (*i.e.*, the deductible, copay, and coinsurance amounts, as well as the cap on the maximum amount of out-of-pocket expenses to be paid by the participant). *See id.* at 4.

Among the PPO options, the Premier PPO charges the highest monthly employee contribution amounts but has the lowest cost-share obligations at the time a participant incurs a claim; the Select and Value PPO options charge lower monthly contribution amounts but have

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employer's financial responsibility is limited to the total premiums paid by the employer and its employees. The insurance company takes on the risk/reward of claim experience.

[3] In a self-insured arrangement, the employer contracts with a third-party administrator to provide access to a network of healthcare providers and to process claims for coverage. Claims are paid from contributions by the employer and employees. The employer is financially responsible for paying all claims for services covered under the plan. The employer assumes the risk/reward of claim experience.

higher cost-share obligations at the time a participant incurs a claim. *See id.* at 4-5. The monthly contributions for the HMO option generally are priced somewhat higher than the Select PPO; the HMO option, however, has the lowest cap on out-of-pocket expenses. *See id.*

The Plan's SPD and Benefits Guide explain that employees should assess the medical needs of their family prior to making a coverage election. *See* Ex. 1 at 2.3; Ex. 2 at 3. Further, the Plan's SPD and Benefits Guide encourage employees to use an online tool "to estimate the benefits you may receive and what you may pay in out-of-pocket expenses (premiums and Deductible, Coinsurance, and/or Copays combined) under different scenarios." Ex. 2 at 3; *see also* Ex. 1 at 2.3.

Defendants annually review and modify the Plan's coverage options, including employee contribution and cost-share obligations. *See, e.g.*, Ex. 2 at 2, 4-5 (identifying 2022 contribution and cost-sharing obligations). Each employee annually elects whether to purchase one of the health insurance coverage options made available under the Plan or to opt-out of such coverage. *See* Ex. 1 at 1.3-1.4. Employees are free to change their coverage elections each year. *Id.*

II. Plaintiffs' Complaint

Plaintiffs Natalie Barbich and Bruce Lindvall allege that during the time period at issue they elected coverage through the Plan's Premier PPO. *See* Compl. ¶¶ 17-18.

Plaintiffs do not allege that any of their claims for benefits were denied. Nor do Plaintiffs allege that the coverage Plaintiffs elected was somehow illusory or nonexistent. Rather, Plaintiffs complain that the amount they paid for the Plan's Premier PPO was too high in comparison to other Plan coverage options. *See id.* ¶ 44. Plaintiffs further allege that Defendants failed to "communicate to Plan participants that enrolling in the Premier PPO option results in the highest payroll deduction for premiums while providing no additional financial benefit over the lower premium options." *Id.* ¶ 45.

Plaintiffs have asserted three claims for relief under ERISA: (1) breach of fiduciary duty in offering the Premier PPO, *id.* ¶¶ 55-60 (Count I); (2) breach of fiduciary duty in failing to disclose material information about the Premier PPO, *id.* ¶¶ 61-64 (Count II); and (3) failure to monitor ERISA fiduciaries, *id.* ¶¶ 65-70 (Count III).

LEGAL STANDARDS

I. Rule 12(b)(1)

Plaintiffs' Complaint should be dismissed because Plaintiffs fail to establish Article III standing. "Standing doctrine traces its origins to Article III of the Constitution, which grants federal courts the power to resolve 'Cases' and 'Controversies.'" *Dinerstein v. Google, LLC*, 73 F.4th 502, 511 (7th Cir. 2023) (quoting U.S. Const. art. III, § 2). "As the party invoking federal jurisdiction, a plaintiff bears the burden of establishing the elements of Article III standing." *Silha v. ACT, Inc.*, 807 F.3d 169, 173 (7th Cir. 2015). A motion to dismiss for lack of Article III standing is considered under Federal Rule of Civil Procedure 12(b)(1). *Taylor v. McCament*, 875 F.3d 849, 853 (7th Cir. 2017). A "facial" challenge to Article III standing is evaluated on the sufficiency of the pleadings. *See Silha*, 807 F.3d at 173.

II. Rule 12(b)(6)

Even if the Court finds that Plaintiffs have established Article III standing, Plaintiffs' Complaint should be dismissed for failure to state a claim for relief. To survive a motion to dismiss, Plaintiff must plead "a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "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." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Factual allegations "must be enough to raise a right to relief above the speculative level," or "contain something more

than a statement of facts that merely creates a suspicion of a legally cognizable right of action." *Twombly*, 550 U.S. at 555 (alterations omitted).

Courts must take "particular care" in applying these standards to ERISA claims. *Pension Benefit Guar. Corp. ex rel. St. Vincent Cath. Med. Ctrs. Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc.*, 712 F.3d 705, 718 (2d Cir. 2013). That is because "the prospect of discovery" in an ERISA class action is "ominous." *Id.* at 719. Courts therefore must engage in "careful, context-sensitive scrutiny of a complaint's allegations" to assess whether an ERISA plaintiff has stated a plausible claim. *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 425 (2014). Recognizing that "the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs," the Supreme Court has instructed that, at the motion to dismiss stage, "courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise." *Hughes v. Nw. Univ.*, 595 U.S. 170, 177 (2022) (emphasis added).

ARGUMENT

I. Plaintiffs Lack Article III Standing.

To establish Article III standing, a plaintiff must show "(1) a concrete, particularized, and actual or imminent injury (an 'injury in fact') (2) that is fairly traceable to the defendant and (3) that is likely to be redressed by a favorable judicial decision." *Dinerstein*, 73 F.4th at 511.

Plaintiffs fail to establish the "first and foremost of standing's three elements," *i.e.*, an injury-in-fact. *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016) (quotation marks and alteration omitted). Plaintiffs admit that they received health insurance pursuant to the Plan coverage option they selected at the prices quoted in the Benefits Guide. Plaintiffs do not allege that the Plan improperly denied any claims for benefits, nor do Plaintiffs allege that Defendants breached any Plan terms or mismanaged Plan assets. Plaintiffs thus have not suffered any injury.

A. Plaintiffs Received All of the Benefits They Were Owed under the Plan's Terms.

When analyzing whether a plaintiff has standing to sue for ERISA breach of fiduciary duty claims, courts evaluate whether the plan is a defined benefit or defined contribution plan. *See Thole*, 590 U.S. at 540 ("Of decisive importance to this case, the plaintiffs' . . . plan is a defined-benefit plan, not a defined-contribution plan."). A defined benefit plan is "in the nature of a contract." *Id.* at 542-43. Defined benefit plans are typically "funded by employer or employee contributions, or a combination of both," and consist of "a general pool of assets rather than individual dedicated accounts." *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 439 (1999). In contrast, defined contribution plans, such as 401(k) plans, "provide[] for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses." *Scott v. UnitedHealth Grp., Inc.*, 540 F. Supp. 3d 857, 862 (D. Minn. 2021).

In *Thole*, the Supreme Court held that participants in a pension plan did not have Article III standing to assert ERISA claims related to the trustee's alleged mismanagement of the plan. *See* 590 U.S. at 541-42. The Supreme Court held that the participants did not suffer an injury-in-fact because their benefits were "fixed and w[ould] not change, regardless of how well or poorly the plan is managed." *Id.* at 543, 547. That is because the employer assumed the risk of paying benefits. *Id.* Because the participants received all of their benefits as promised and did not allege that there was any risk they would not receive their future benefits, the participants did not have a concrete stake in the outcome of the lawsuit. *Id.* at 546.

Health and welfare plans are a "kind of defined benefit plan." *Smith v. Med. Benefit Adm'rs Grp., Inc.*, 639 F.3d 277, 283 (7th Cir. 2011) (holding that a "group health insurance plan . . . [is a] kind of defined benefit plan . . . which typically holds no assets in trust for any individual participant"); *see also Navarro v. Wells Fargo & Co.*, No. 24-cv-3043, 2025 WL 897717, at *6

(D. Minn. Mar. 24, 2025) (holding that a health and welfare plan "is 'closely analogous to the defined-benefit plan at issue in *Thole*, as participants are entitled to their contractually defined benefits regardless of the value of the [Plan's] assets.'" (alterations in original)). Participants pay fixed cost-sharing obligations in exchange for a contractually defined set of benefits, and, like the pension at issue in *Thole*, the employer financially bears the risk of paying the promised benefits. *See Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598, 602 (6th Cir. 2007) (noting that employers "act as their own insurance companies with respect to their [health] benefit plans, accepting the financial risk of coverage and obligation to pay claims using [their] own funds").

Following *Thole*, multiple courts have held that health plan participants lack Article III standing to assert alleged fiduciary breaches where the participants have received all of the benefits that they were promised under the plan's terms. *See, e.g.*, *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 528 (9th Cir. 2023) (holding that the plaintiffs lacked standing to assert ERISA claims arising from allegedly excessive health insurance premiums because the "plaintiffs were contractually entitled to the insurance benefits that Sequoia agreed to purchase for them with the program's funds—benefits that plaintiffs have received"); *Gonzalez de Fuente v. Preferred Home Care of N.Y.*, 858 F. App'x 432, 434 (2d Cir. 2021) (holding that the plaintiffs lacked Article III standing to assert ERISA claims arising from higher out-of-pocket costs for health insurance coverage because the "plaintiffs did not allege that they were denied any health benefits promised under the plan, nor did they allege that the Plan was insolvent or otherwise incapable of continuing to provide covered health benefits"); *see also Navarro*, 2025 WL 897717, at *6 ("'[A] necessary predicate to a participant bringing broader claims on behalf of [a defined-benefit] plan is a showing of a concrete and particularized injury to the participant herself,' not just the plan, and that

individual harm must 'affect [the participant's] benefits' to confer standing to sue." (quoting *Scott*, 540 F. Supp. 3d at 865)).

Plaintiffs do not dispute that they received all of the benefits to which they entitled under the Plan's terms. Plaintiffs also do not dispute that they were charged the contribution and out-of-pocket cost-sharing amounts identified in the Benefits Guide for the coverage option they selected. Stated differently, Plaintiffs do not claim that Defendants' alleged fiduciary breaches affected their benefits—*i.e.*, the services covered by the Plan which were available for purchase at quoted prices. Plaintiffs accordingly fail to demonstrate that they suffered a cognizable Article III injury-in-fact.

B. Defendants Did Not Breach Any Plan Term or Mismanage Plan Assets.

Further, Plaintiffs cannot establish an injury-in-fact because they do not allege that Defendants breached any Plan term or mismanaged Plan assets. Some courts have embraced a narrow exception to *Thole,* holding that a participant in a self-funded health plan ***may*** be able to allege an Article III injury even if the participant has received all promised plan benefits. These courts have held that a health plan participant who alleges an employer's "mismanagement of plan assets" or breach of plan terms "increased his/her out-of-pocket expenses" ***theoretically*** could assert an Article III injury because "[a] contrary conclusion[] would mean that [an employer] could charge Plan participants thousands of dollars more in premiums than is allowed under Plan documents, resulting in potential ERISA violations, and Plan participants would have no judicial recourse to seek return of their overpayments." *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 580 (3d Cir. 2024); *see also Navarro*, 2025 WL 897717, at *8.[4]

[4] The *Knudsen* and *Navarro* courts embraced this theory of standing as a "purely theoretical proposition." *Knudsen*, 117 F.4th at 578; *Navarro*, 2025 WL 897717, at *8. Both courts dismissed the plaintiffs' allegations that they paid higher out-of-pocket costs for health insurance coverage as a result of the employer's ERISA fiduciary breaches as speculative and lacking in causation. *See Knudsen*, 117 F.4th at 578-83; *Navarro*, 2025 WL 897717, at *8-12.

But Plaintiffs' allegations do not fit into this narrow exception. Plaintiffs do not allege that Defendants charged them more for their health insurance coverage than is allowed under Plan documents. *See generally* Compl. Nor could they. The Plan does not guarantee that participants will be charged any specific amount for health insurance coverage; to the contrary, the Plan makes clear that Defendants have sole discretion to set employee contribution amounts. *See* Ex. 3 § 6.2 ("Employee contribution requirements may be increased . . . from time to time"); Ex. 4 § 6.3 (same). As a result, Plaintiffs cannot establish an injury-in-fact as a result of "excessive" health insurance costs. *Cf. Knudsen*, 117 F.4th at 582 (holding that the plaintiffs failed to allege that they had an "individual right" to prescription drug rebates such that their employer's "purportedly unlawful retention of the [rebates] harmed Plaintiffs").

Plaintiffs also do not allege that Defendants mismanaged Plan assets—*i.e.*, their contribution amounts. Plaintiffs do not dispute that their contributions were used to pay Plan benefits in accordance with the Plan's terms. *See* Ex. 3 § 7.15 (employee contributions will be used "for the sole purpose of providing benefits"); Ex. 4 § 7.15 (same). For these reasons, Plaintiffs have not alleged an injury-in-fact, even under *Knudsen* and *Navarro*.

II. Defendants Acted as Settlors with Regard to the Conduct at Issue in the Complaint.

Even if Plaintiffs had sufficiently pleaded Article III standing, their claims should still be dismissed under Rule 12(b)(6) because Plaintiffs do not allege any facts that could establish that Defendants' conduct was subject to ERISA. Plaintiffs claim that the price at which participants have the choice to purchase the Premier PPO option was "excessive." Compl. ¶¶ 60, 64. But it is black-letter law that employers are not acting as ERISA fiduciaries when making plan design decisions regarding the form and content of plan benefits, including participant contribution and cost-sharing amounts.

To avoid this settled principle, Plaintiffs attempt to recast Defendants' alleged fiduciary breach as the selection of the "specific health insurance options" offered to participants, which Plaintiffs claim is analogous to an employer's selection of investment options offered to 401(k) plan participants. *Id.* ¶¶ 32-34. Plaintiffs, however, ignore the fundamental differences between health plans and 401(k) plans. In a health plan, benefits are contractually "defined" or fixed in the plan's terms. The price at which the plan's benefits are made available for purchase is part of the defined benefit itself. And, as discussed below, employer decisions regarding the design of such benefits, including their purchase price, is not a fiduciary function under ERISA.

A. ERISA Fiduciary Status Depends on the Type of Function Being Performed.

The "threshold question" in "every case charging breach of ERISA fiduciary duty" is whether the defendant was "acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). If Defendants did not act as ERISA fiduciaries when setting contribution and out-of-pocket cost-sharing amounts for the Premier PPO, Plaintiffs' claims fail as a matter of law.

There are two types of ERISA fiduciaries: "named" and "functional" fiduciaries. A party that is "designated" in the plan document as a fiduciary is a "named fiduciary." 29 U.S.C. § 1102(a)(2). As relevant here, a person is a "functional" fiduciary only "***to the extent*** (i) he exercises any discretionary authority or discretionary control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." *Id.* § 1002(21)(A) (emphasis added). Plaintiffs (incorrectly) claim that Defendants were acting as functional fiduciaries. *See, e.g.*, Compl. ¶¶ 56, 62.

A functional fiduciary "owes a duty to a plan through its actions." *Leimkuehler v. Am. United Life Ins. Co*., 713 F.3d 905, 914 (7th Cir. 2013). A person "may be an ERISA fiduciary for some purposes and not for others." *Chi. Dist. Council of Carpenters Welfare Fund v.*

Caremark, Inc., 474 F.3d 463, 472 (7th Cir. 2007); *see also Larson*, 723 F.3d at 917 ("ERISA's functional definition of 'fiduciary' [] means that an ERISA fiduciary does not always 'wear the fiduciary hat.'" (quoting *Pegram*, 530 U.S. at 225)).

Employers act as fiduciaries when they are "acting in the capacity of [a] manager, administrator, or financial adviser to a 'plan.'" *Pegram*, 530 U.S. at 222. An ERISA "plan" is a "scheme [that is] decided upon in advance," *i.e.*, it is a "set of rules that define the rights of a beneficiary and provide for their enforcement." *Id.* at 223. When an employer manages or administers this "scheme," it acts as a fiduciary. *See id.* That is, the employer has the duty to act "for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1)(A).

Employers do not act as ERISA fiduciaries when deciding to adopt, modify, or terminate a welfare plan. *See Curtiss-Wright Corp. v. Schoonegjongen*, 514 U.S. 73, 78 (1995). That is because ERISA "does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits." *Id.* at 78; *see also Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan."). An employer's actions in adopting or altering the terms of a plan are "analogous to the settlors of a trust." *Lockheed Corp.*, 517 U.S. at 890. An employer accordingly is free to amend a plan to reduce benefits or terminate a plan altogether. *Curtiss-Wright*, 514 U.S. at 78; *see also Pegram,* 530 U.S. at 225 ("Employers . . . can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as . . . plan sponsors (*e.g.*, modifying the terms of a plan as allowed by ERISA to provide less generous benefits).").

For the same reason, employers do not act as ERISA fiduciaries when they make plan design decisions, *i.e.*, "decision[s] regarding the form or structure of the Plan such as who is entitled to receive Plan benefits and in what amounts." *Hughes Aircraft Co.*, 525 U.S. at 444; *see also Pegram*, 530 U.S. at 226 ("The specific payout detail of the plan was, of course, a feature that the employer as plan sponsor was free to adopt without breach of any fiduciary duty under ERISA, since an employer's decisions about the content of a plan are not themselves fiduciary act[]."); *United Paperworkers Int'l Union v. Jefferson Smurfit Corp.*, 771 F. Supp. 992, 999 (E.D. Mo. 1991), *aff'd*, 961 F.2d 1384 (8th Cir. 1992) ("Consequently, an employer's decision to provide a less favorable plan of benefits and related decisions regarding plan design fall into the category of settlor acts and are not subject to review under the fiduciary standards of ERISA.").

B. Defendants Acted as Settlors When They Set Contribution and Cost-Share Amounts.

Defendants acted in a settlor capacity when they annually set the monthly contribution and out-of-pocket cost-sharing amounts for the Premier PPO because devising the structure and amount of employee cost-share obligations is designing the content of the plan itself, *i.e.*, the "scheme decided upon in advance." *Pegram*, 530 U.S. at 223

In the context of a health plan, an "[employer] plan sponsor can annually change both the amount of the premium (and other out-of-pocket costs) and the benefits to which a participant is entitled." *Knudsen*, 117 F. 4th at 579. An employer acts as a settlor when it adopts the package of benefits and cost-structure for those benefits each year—the employer may act in its own interest when making these decisions. *See Doe One v. Express Scripts*, 348 F. Supp. 3d 967, 1002 (N.D. Cal. 2018) (holding that an employer's "'[a]greement' to provide a [prescription drug] benefit plan that has terms Plaintiffs feel are unfavorable" was non-fiduciary conduct concerning the "form or structure of the Plan" (first alteration in original) (quoting *Hughes Aircraft Co.*, 525 U.S. at 444)); *Moeckel v. Caremark, Inc.*, 622 F. Supp. 2d 663, 693 (M.D. Tenn. 2007) (holding that an

employer's decisions as to what and how to pay a PBM for services and what formularies to adopt "relate to plan design decisions" that are "non-fiduciary in nature").

Courts have specifically held that employers act in a settlor capacity when setting employee contributions and out-of-pocket cost-sharing amounts for health insurance coverage. *See Pegram*, 530 U.S. at 223 ("***Rules governing the collection of premiums***, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services ***are the sorts of provisions that constitute a plan***." (emphases added)); *Larson*, 723 F.3d at 908 ("Setting policy terms, ***including copayment requirements***, determines the content of the policy, and 'decisions about the content of [the] plan are not themselves fiduciary acts.'" (emphasis added) (quoting *Pegram*, 530 U.S. at 211)); *Argay v. Nat'l Grid USA Serv. Co.*, 503 F. App'x 40, 42 (2d Cir. 2012) (holding that the defendants "did not act in a fiduciary capacity in setting premiums"); *United Paperworkers Int'l Union*, 771 F. Supp. at 999 (holding that an employer acted in a settlor capacity when increasing retiree health insurance premiums where the plan reserved the employer's right to terminate, amend or modify the retiree medical benefits plan); *see also Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183, 1201 (10th Cir. 2023) (holding that a "plan's prescription-drug benefit design comprises the formulary, ***cost-sharing terms***, and pharmacy network" (emphasis added)).[5]

[5] In the analogous context of defined benefit pension plans, the Seventh Circuit has held that setting contribution amounts is settlor activity that is outside the scope of ERISA. *See Bator v. District Council 4*, 972 F.3d 924, 932 (7th Cir. 2020) ("When a union sets, changes or enforces contribution rates, the union acts as a settlor . . . ."); *see also Hartline v. Sheet Metal Workers' Nat'l Pension Fund*, 134 F. Supp. 2d 1, 13-16 (D.D.C. 2000) (holding that setting the contribution rate structure for a multi-employer pension plan was a plan design function exempt from ERISA); *Rush v. Greatbanc Trust Co.*, No. 19-cv-00738, 2025 WL 975214 at *15 (N.D. Ill. Mar. 31, 2025) ("[A]n ERISA fiduciary does not act in a fiduciary capacity . . . when acting as a settlor who sets, changes, or enforces contribution rates, . . . or when adopting amending or terminating a benefits plan." (quotations and citations omitted)).

Plaintiffs invoke a United States Department of Labor ("DOL") information letter and a DOL advisory opinion to support their theory (*see* Compl. ¶¶ 34-35), but their attempt falls flat. The DOL information letter—which is nonbinding in any event—simply provided that when plan trustees select health plan service providers, they may consider not only the cost, but also the quality, of the services offered. *See* Dep't of Labor Information Letter from Bette J. Briggs to Diane Orantes Ceresi, 1998 WL 1638068, at *1-2 (Feb. 19, 1998). The DOL advisory opinion addressed whether expenses incurred with maintaining a plan's tax-qualified status can be paid out of plan assets. *See* Dep't of Labor Advisory Op. No. 2001A, 2001 WL 125092, at *2 (Jan. 18, 2001). The DOL did ***not*** opine that an employer acts as a fiduciary when making (or implementing) decisions regarding contribution and cost-sharing obligations for a health plan in either document. To the contrary, consistent with the above-cited case law, the DOL has expressly stated that an "employer acts as a settlor" when "setting contribution rates" and copayment amounts for a health plan. Ex. 5 at 25 & n.5.

This authority makes clear that the actions at issue in the Complaint—*i.e.*, setting monthly contributions and out-of-pocket cost-sharing obligations for the Premier PPO coverage option—were not ERISA fiduciary functions. Indeed, the Plan expressly reserved Northwestern's right to "restructure[] or terminate" Plan coverage options[6] and set the amount that employees contributed toward their coverage.[7] As a result, when Defendants annually reviewed and designed the coverages offered by the Plan and the price at which those coverages were made available to participants, they did so in a settlor capacity.

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[6] *See* Ex. 3 § 3.1(k); Ex. 4 § 3.1(j).

[7] *See* Ex. 3 § 6.2; Ex. 4 § 6.3.

C. Defendants Acted as Settlors When Selecting the "Specific Health Insurance Options to Offer" Participants.

Defendants also acted as settlors when selecting the "specific health insurance options to offer" participants. Compl. ¶ 34.[8] This Court should reject Plaintiffs' attempt to analogize coverage options available in a health plan to the menu of investment options offered in a defined contribution plan. *See id.* ¶¶ 32-35. In the context of defined contribution plans, the Supreme Court has held that ERISA fiduciary duties apply to the selection and monitoring of each plan investment option made available to participants. *See Hughes*, 595 U.S. at 173 (citing *Tibble v. Edison Int'l*, 575 U.S. 523, 530 (2015)). However, an employer's decision to offer a health plan coverage option, *i.e.*, a contractually delineated set of coverages, is fundamentally different from an employer's decision to make an investment option available to participants in a 401(k) plan.

In a defined contribution plan, the participant's benefit is the value of the money in their individual account—*i.e.*, the benefit is a product of the performance of the market and the fees of the investments selected by the participant. *See Tibble*, 575 U.S. at 525; *see also Scott*, 540 F. Supp. 3d at 862 (defined contribution plans "provide[] for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses."). An employer has a fiduciary duty to confirm that each investment option offered by the plan is a prudent investment choice—the fees, expenses and performance of the investment options directly impact the value of a participant's benefit, which is not "defined" by the plan's terms. *See Tibble*, 575 U.S. at 525 ("Expenses, such as management

[8] Notably, Plaintiffs are ***not*** challenging the quality or breath of the healthcare services covered by the Plan. *See* Compl. ¶ 26 (acknowledging that there is "no difference in the health-care coverage for participants in the Premier, Select, and Value PPO options"). Plaintiffs are ***only*** challenging the "***financial terms***" at which ***one*** of the Plan's coverage options is offered to participants. *Id.*

or administrative fees, can sometimes significantly reduce the value of an account in a defined-contribution plan.").

By contrast, in a health plan, participants do not have individual accounts and the participants' benefits do not fluctuate based on the plan's performance or expenses. *See Smith*, 639 F.3d at 283 (holding that a "group health insurance plan . . . [is a] kind of defined benefit plan . . . which typically holds no assets in trust for any individual participant"). Instead, participants purchase a "defined" set of benefits offered by the plan at a quoted price—that is, participants pay the monthly contribution and cost-sharing amounts set forth in the plan documents in exchange for a contractually defined suite of coverages, to which they are entitled "regardless of the value of the [Plan's] assets." *Navarro*, 2025 WL 897717, at *6. As a result, when an employer offers a health plan coverage option and determines the price at which that option will be available for purchase, it is defining the content of the plan. This is a settlor decision.

III. Plaintiffs Fail to Allege Any Plausible Fiduciary Breaches.

A. Defendants Did Not Breach Any Fiduciary Duties When Offering the Premium PPO.

Even if Defendants were acting as ERISA fiduciaries when taking the actions at issue in the Complaint, Count I fails to state a claim for relief because Plaintiffs do not allege plausibly that Defendants breached any fiduciary duties when offering the Premium PPO. Plaintiffs incorrectly assume that there is no financial benefit to participants to pay a higher monthly premium in exchange for paying lower deductibles, copays or coinsurance if and when a claim is incurred. But, a participant may prefer to pay a higher monthly premium, knowing that if they incur a medical expense, their financial outlay will be fixed at a lower amount. Likewise, a participant may prefer to pay a lower monthly premium as a matter of cash management or given the likelihood (or lack thereof) of an adverse health event. Defendants are aware of no case law holding that it is imprudent for health plan fiduciaries to offer participants coverage options that

afford participants a choice regarding how and when their cost-share obligations are structured—*i.e.*, that offering a menu of coverage options at varying price points is outside of "the range of reasonable judgments a fiduciary may make based on her experience and expertise." *Hughes*, 595 U.S. at 177. Further, Plaintiffs' theory is undermined by their express admission that there are scenarios where the Premium PPO results in ***lower*** aggregate out-of-pocket expenses in comparison to other coverage options. *See* Compl. ¶ 41 n.13.

B. Plaintiffs Cannot Assert an ERISA Section 502(a)(2) Claim Because They Are Not Seeking Relief on Behalf of the Plan as a Whole.

To the extent Plaintiffs' claims are predicated on a violation of ERISA Section 502(a)(2), they should be dismissed because Plaintiffs do not allege that the alleged fiduciary breaches caused harm ***to the Plan***. ERISA Section 502(a)(2) only authorizes claims "brought in a representative capacity on behalf of the plan as a whole," in the interest of the "financial integrity of the plan." *Mass. Mut. Life ins. Co. v. Russell*, 473 U.S. 134, 142 n.9 (1985).

Losses to an individual plan participant or a class of plan participants are insufficient to allege a cause of action under Section 502(a)(2). *See, e.g.*, *Smith*, 639 F.3d at 282 (holding that the plaintiff failed to allege a Section 502(a)(2) claim where his "complaint [was] plainly aimed at obtaining relief that he, rather than his plan, suffered as a result of [the defendant's] alleged actions"); *N.R. v. Raytheon Co.*, 24 F.4th 740, 751 (1st Cir. 2022) (holding that the plaintiff's claims could not be brought under ERISA Section 502(a)(2) because the "only losses alleged [were] benefits which were not paid out to [plaintiff] and putative class members" and the plaintiff did "not allege any losses to the Plan itself"); *K.H.B. v. UnitedHealthcare Ins. Co.*, No. 18-cv-00795, 2019 WL 4736801, at *3 (D. Utah Sept. 27, 2019) ("Although the denial of coverage for [mental health benefits] . . . is alleged to be systemic . . . the alleged injury is class-wide, not plan-wide . . . [I]n the absence of sufficient factual allegations suggesting the Plan suffered monetary

losses, this fails to adequately plead relief on behalf of the Plan."); *see also Kauffman v. Gen. Elec. Co.*, No. 14-cv-1358, 2014 WL 7405698, at *4 (E.D. Wis. Dec. 30, 2014) (holding that the proposed relief of "requiring defendant to provide additional funding for participants' health care costs[] seem[ed] geared more towards protecting participants from the increased costs of healthcare than undoing any harm to the Plans").

Plaintiffs only allege that participants who enrolled in the Premier PPO suffered an injury. *See* Compl. ¶¶ 1, 47, 59. Plaintiffs do ***not*** allege that enrollees in any another Plan coverage option paid excessive healthcare expenses. *See generally id.* Because Plaintiffs fail to allege an injury to the Plan as a whole, Counts I-III should be dismissed to the extent they are predicated on violations of ERISA Section 502(a)(2).[9]

C. Plaintiffs Fail to Allege a Plausible Disclosure Claim (Count II).

Plaintiffs also fail to allege a disclosure claim because they do not dispute that Defendants provided complete and accurate information regarding the pricing of each Plan coverage option.

ERISA fiduciaries breach the duty of loyalty by "mislead[ing] plan participants or misrepresent[ing] the terms or administration of a plan." *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 640 (7th Cir. 2004); *see also Peoria Union Stock Yards Co. v. Penn Mut. Life Ins. Co.*, 689 F.2d 320, 326 (7th Cir. 1983) ("Lying is inconsistent with the duty of loyalty[.]"). That being said, "[n]ot all errors in communicating information regarding a plan violate a fiduciary's duty under ERISA[.]" *Kamler v. H/N Telecomm. Serv., Inc.*, 305 F.3d 672, 681 (7th Cir. 2002). "[N]egligence [is] not [] enough to show a violation of ERISA's disclosure duty." *Howell v. Motorola, Inc.*, 633

[9] Moreover, Plaintiffs' ERISA 502(a)(2) claims are not redressable. To the extent the Court enters a judgment in Plaintiffs' favor, any amounts awarded would go back to the Plan. ***Northwestern*** would not be obligated to reduce participants' contribution amounts or otherwise distribute the funds to participants. *See Winsor*, 62 F.4th at 525-27; *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1125-27 (9th Cir. 2006).

F.3d 552, 571 (7th Cir. 2011). To allege a disclosure claim, a plaintiff must allege "either an intentionally misleading statement, or a material omission where the fiduciary's silence can be construed as misleading." *Id.*; *see also Vallone*, 375 F.3d at 641 (holding that a fiduciary "must have set out to deceive or disadvantage" to establish a breach of ERISA's disclosure requirements).

Plaintiffs do not allege that Defendants made any intentionally misleading statements regarding the Plan's coverage or that Defendants "set out to disadvantage or deceive" Plan participants. *Vallone*, 375 F.3d at 640. Plaintiffs' disclosure claim fails on this basis alone.

Moreover, Plaintiffs' allegation that Defendants failed to "disclose that the Premier PPO option provides no financial benefit to participants in comparison to the Select and Value PPO options," Compl. ¶ 63, is directly contradicted by the Plan documents. The cost structure of each Plan option is expressly set forth in the Benefits Guide. *See, e.g.*, Ex. 2 at 4-5.[10] Further, the SPD and Benefits Guide set forth the factors that impact an employee's contribution amount and explain that employees should evaluate each coverage option based on their anticipated medical expenses and financial preferences. *See* Ex. 1 at 1.5; Ex. 2 at 3. And, the SPD and Benefits Guide encourage employees to use a "decision support tool"—which "estimate[s] the cost of each of the medical plans based on different assumptions regarding usage that [the participant] can direct." Ex. 1 at 2.3; *see also* Ex. 2 at 3.

The Plan documents thus disclosed the material information employees needed to make their coverage selection—the total cost of coverage. *See Albert v. Oshkosh Corp.*, 47 F.4d 570, 586 (7th Cir. 2022) (holding that the disclosure of the total fee of an investment option "is the

[10] It also is available on Northwestern's website. *See* Northwestern University Health Insurance Plans for 2025, https://hr.northwestern.edu/benefits/health-insurance/health-insurance-plans/ (last visited Oct. 6, 2025).

critical figure for someone interested in the cost of including a certain investment in her portfolio and the net value of that investment." (quoting *Hecker v. Deere & Co.*, 556 F.3d 575, 585 (7th Cir. 2009)); *cf. In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 676 (S.D.N.Y. 2018) ("Plaintiffs do not, for example, argue that they were unable to see their co-insurance rate and therefore could not have discerned the total prescription drug prices ESI was charging.").

Plaintiffs further claim that a ***single*** statement in the 137-page SPD is misleading, *see* Compl. ¶ 38, but this too fails to allege a disclosure claim. Plaintiffs allege that the SPD states the following: "'[i]f a participant chose a plan with lower monthly Premium [the Value PPO option], you will likely pay more in out-of-pocket costs – though Copayments, Coinsurance Deductibles, and the like – than you would if you chose a plan with higher monthly Premiums [the Premier PPO option].'" *Id.* (alterations in original). But Plaintiffs make self-serving modifications to the text of this sentence and take it entirely out of context.

The quoted statement is in a section of the SPD discussing the differences among the Plan's ***five*** coverage options—it is not an explanation of how to compare the Value and Premier PPO plan options against each other. *See* Ex. 1 at 2.3 (containing the heading "How PPO and HMO Coverage Differ" and discussing the differences among the "five medical plans" available to employees). Moreover, the text immediately preceding this statement correctly explains that the coverage options differ based on various factors, including "[h]ow much you pay in monthly Premiums towards the cost of coverage" and "[h]ow much you pay out of pocket at the time you receive a health care service or the amount will you owe once a claim is processed." *Id.* Plaintiffs do not dispute that that the Premium PPO option has the highest monthly premiums but the lowest out-of-pocket costs ***at the time a participant incurs a claim***.

Even if Plaintiffs' reading of this single sentence in the SPD was accurate (and it is not), it is telling that Plaintiffs do ***not*** allege that they were misled by this statement or relied on it to their detriment. This is fatal to their disclosure claim. *See Boyd v. ConAgra Foods, Inc.*, 879 F.3d 314, 322 (8th Cir. 2018) ("In asserting a breach of fiduciary duty, [a plaintiff] must show that he reasonably relied, to his detriment, on a material misrepresentation or omission.").

At bottom, Defendants complied with ERISA's disclosure obligations. Plaintiffs do not dispute that the SPD was "written in a manner calculated to be understood by the average plan participant" and was "sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a). Defendants did not provide inadequate (or inaccurate) information to participants regarding their benefits. *Cf. Bowerman v. Wal-Mart Stores, Inc.*, 226 F.3d 590, 591 (7th Cir. 2000) (plan administrator breached its fiduciary where the plaintiff "not only received inadequate explanations in the Plan's documents, she also received inaccurate and misleading information").

To the contrary, the SPD and Benefits Guide provided complete and accurate information regarding the pricing of the Plan coverage options. As a result, Plaintiffs' disclosure claim fails. *See Vallone*, 375 F.3d at 642 ("[I]n this circuit, if accurate [] information is provided, . . . then the plaintiffs are unfortunately out of luck."); *see also Schmidt v. Sheet Metal Workers' Nat'l Pension Fund*, 128 F.3d 541, 548 (7th Cir. 1997) (holding that the plaintiffs failed to allege a disclosure claim where the "[t]rustees provided complete and accurate information in the Plan and Plan Booklet [that was] distributed to all participants"); *Rogers v. Baxter Int'l Inc.*, 710 F. Supp. 2d

722, 737 (N.D. Ill. 2010) (holding that the plaintiffs failed to allege a disclosure claim where the SPD and the other plan documents "adequately described" the plan investment option at issue).[11]

D. Plaintiffs' Duty to Monitor Claim Fails (Count III).

Count III, which alleges that Northwestern failed to monitor the Plan's Executive Director, *see* Compl. ¶¶ 65-70, fails to state a claim for relief because Plaintiffs have failed to plausibly allege a fiduciary breach claim. *See Albert*, 47 F.4th at 583 ("[A] failure to monitor claim is derivative in nature and must be premised [on] an underlying breach of fiduciary duty.").

IV. Plaintiffs' ERISA 502(a)(3) Claims Inappropriately Demand Legal Relief.

To the extent Counts I-III are predicated on violations of ERISA Section 502(a)(3), they also fail as a matter of law. Plaintiffs are seeking compensation for alleged "losses that resulted from [Defendants'] fiduciary breaches," Compl. ¶¶ 60, 64, 70, but such legal relief is unavailable under ERISA Section 502(a)(3). ERISA Section 502(a)(3) "imposes an important limitation on the type of relief that is available: it allows only injunctive and 'other appropriate equitable relief.'" *Kenseth v. Dean Health Plan, Inc*., 610 F.3d 452, 482 (7th Cir. 2010). "[C]ompensatory damages and other forms of legal relief are beyond the scope of the relief authorized." *Id.*

Equitable restitution is only available "where money or property identified as belonging in good conscience to the plaintiff c[an] clearly be traced to particular funds or property in the defendant's possession." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213 (2002); *see also Montanile v. Bd. of Trs. Nat'l Elevator Indus. Health Benefit Plan*, 577 U.S. 136, 145 (2016) ("Equitable remedies are, as a general rule, directed against some specific thing; they

[11] Plaintiffs' allegation that Defendants confirmed in an email that it is "unlikely" that a participant would be "financially better off with the Premier PPO," Compl. ¶ 41, is not only hearsay, it also undermines their disclosure claim.

give or enforce a right to or over some particular thing rather than a right to recover a sum of money generally out of the defendant's assets." (quotation omitted)).

There is no equitable relief that could be awarded here.[12] ***First***, Plaintiffs do not allege that Defendants were unjustly enriched by Plaintiffs' payment of "excessive healthcare costs." *See generally* Compl. Any such allegation would fail given that Defendants were free to raise or lower the percentage of Plan costs paid by employees each year. *See* Ex. 3 §§ 6.1, 6.2; Ex. 4 §§ 6.2, 6.3. ***Second***, Plaintiffs do not identify any funds in ***Defendants'*** possession to which they are entitled. Nor could Plaintiffs do so—Plaintiffs have no vested interest in the allegedly "excessive healthcare costs," *i.e.*, participant contributions, and Plaintiffs do not dispute that such contributions were used to pay benefits in accordance with the Plan's terms. *See* Ex. 3 § 7.15 (stating that participants have no vested interest in contributions and that contributions will be used "for the sole purpose of providing benefits"); Ex. 4 § 7.15 (same). Accordingly, Counts I-III should be dismissed to the extent they are predicated on a violation of ERISA Section 502(a)(3).

CONCLUSION

For the foregoing reasons, the Court should dismiss Plaintiffs' Complaint in its entirety.

[12] While some courts have held that surcharge is available under ERISA Section 502(a)(3) (*see, e.g.*, *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869 (7th Cir. 2013)), more recent authority has made clear that surcharge is not a remedy that was traditionally available in equity. *See Montanile*, 577 U.S. at 148 n.3; *Aldridge v. Regions Bank*, 144 F.4th 828, 847-49 (6th Cir. 2025); *Rose v. PSA Airlines, Inc.*, 80 F.4th 488, 504 (4th Cir. 2023).

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Respectfully submitted,

/s/ Mark C. Nielsen

Mark C. Nielsen (N.D. Ill. No. 90785769)
Lars C. Golumbic (admitted *pro hac vice*)
Kara P. Wheatley (admitted *pro hac vice*)
Kathryn E. Panish (admitted *pro hac vice*)
GROOM LAW GROUP, CHARTERED
1701 Pennsylvania Avenue NW, Suite 1200
Washington, DC 20006
Tel: (202) 861-5429
Fax: (202) 659-4503
mnielsen@groom.com
lgolumbic@groom.com
kwheatley@groom.com
kpanish@groom.com

Eugene A. Schoon
CROKE FAIRCHILD DUARTE & BERES
180 N. La Salle Street, Suite 3400
Chicago, IL 60601
Tel: (773) 517-2740
Email: eschoon@crokefairchild.com

Counsel for Northwestern University and Northwestern University Executive Director, Benefits & Work/Life Resources