TABLE OF APPENDICES

APPENDIX A — SUMMARY ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT, FILED MARCH 26, 2024

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

23-1313-cv

SONYA MUNROE,

Plaintiff-Appellant,

v.

AETNA MEDICARE, KAREN LYNCH, AETNA PRESIDENT,

Defendants-Appellees.

Filed March 26, 2024

SUMMARY ORDER

PRESENT: BARRINGTON D. PARKER, JR., DENNY CHIN, JOSEPH F. BIANCO, *Circuit Judges.*

Appeal from a judgment of the United States District Court for the Southern District of New York (Cathy Seibel, *Judge*).

UPON DUE CONSIDERATION, IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that the judgment, entered on August 22, 2023, is **AFFIRMED.**

Appendix A

Plaintiff-Appellant Sonya Munroe, proceeding *pro se*, appeals the district court's dismissal of her complaint, construed as asserting claims under the Medicare Act, 42 U.S.C. § 1395 *et seq.*, for lack of subject-matter jurisdiction. Munroe alleged that Aetna Medicare delayed coverage for her surgery and denied coverage for inpatient admission, causing her pain and suffering. The district court dismissed her complaint *sua sponte* for lack of subject-matter jurisdiction, reasoning that Munroe had failed to allege that she exhausted her administrative remedies before seeking judicial review, but provided Munroe with leave to re-plead. After Munroe's amended complaint failed to correct this jurisdictional defect, the district court dismissed the case without prejudice and directed that the case be closed. "On appeal from a district court's dismissal for lack of subject-matter jurisdiction, we review factual findings for clear error and legal conclusions *de novo*." *Avon Nursing & Rehab. v. Becerra*, 995 F.3d 305, 310-11 (2d Cir. 2021) (internal quotation marks and citations omitted). In doing so, we assume the parties' familiarity with the underlying facts, procedural history, and issues on appeal, to which we refer only as necessary to explain our decision to affirm.

Claims arising under the Medicare Act, including "any claims that are inextricably intertwined with what is in essence a claim for benefits," are subject to an administrativeexhaustion requirement under 42 U.S.C. § 405(g)-(h). *Retina Grp. of New Eng., P.C. v. Dynasty Healthcare, LLC*, 72 F.4th 488, 492-93 (2d Cir. 2023) (alteration adopted) (internal quotation marks and citations omitted). Failure to exhaust deprives the federal courts of jurisdiction over such claims. *See id.* at

493 (explaining how the jurisdiction-stripping provision in Section 405(h) "means that [Section] 405(g) [which provides for judicial review of the agency's fmal decision] . . . is the sole avenue for judicial review for all claims arising under the Medicare Act unless application of [Section] 405(h) would mean no review at all" (alterations adopted) (internal quotation marks and citations omitted)). Because Munroe challenges Aetna Medicare's actions in response to her requests for medical coverage, her claims "are inextricably intertwined with . . . a claim for benefits" and are subject to Section 405's exhaustion requirements. *Id.* at 492 (internal quotation marks and citation omitted). Such claims arise under the Medicare Act even if they also arise under some other statute or are raised in separate causes of action. *See, e.g., Heckler v. Ringer*, 466 U.S. 602, 615 (1984) (concluding that it was "of no importance that [plaintiffs] . . . sought only declaratory and injunctive relief and not an actual award of benefits as well"). In her amended complaint, Munroe does not assert that she pursued any administrative remedies as to Aetna Medicare's delay in coverage for her surgery or denial of coverage for inpatient admission. Therefore, the district court properly dismissed her complaint without prejudice for lack of subject-matter jurisdiction.

Munroe contends that her claims do not arise under the Medicare Act because they relate to a delay in benefits rather than a denial of benefits. *See* Appellant's Br. at 12 ("The substance of this complaint is that Aetna *delayed* that benefit, and *that their delay caused Appellant seven weeks of pain she would not have suffered if they had approved coverage of the surgery in the first place.*"). We fmd this argument unpersuasive because the resolution

of her claims alleging improper delay would still require the district court to determine whether Aetna Medicare breached its duties under the Medicare Act. *See Retina Grp. of New Eng.*, 72 F.4th at 496 ("Where, as here, a district court is ultimately tasked with deciding whether a party [received] less than it was due under the Medicare Act, allowing a party to avoid the Act's jurisdictional bar ... would subvert the statutory scheme."); *see also Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc.*, 694 F.3d 340, 349 (3d Cir. 2012) ("[B]ased on [plaintiff's] own recitation of facts, it is clear that [its] action is, at bottom, nothing more than an argument that it was entitled to payments under the Medicare program, those payments were delayed or denied, and [plaintiff] suffered damages as a result. Thus, these claims are not only 'inextricably intertwined' with [plaintiff's] claim for benefits, they derive from (and are firmly rooted in) the Act."). Moreover, although Munroe is correct that exhaustion is not required if channeling claims through the agency "would mean no review at all," *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 19 (2000), nothing in the amended complaint suggests that Munroe could not bring her claims before the agency and then appeal any potential denial of relief to the district court, *see Retina Grp. of New Eng.*, 72 F.4th at 497 (emphasizing "that the *Illinois Council* exception is narrow and will be construed strictly to apply only in extraordinary circumstances" (internal quotation marks and citation omitted)). In short, Munroe has failed to demonstrate that her claims would fall within an exception to the exhaustion requirement under Section 405.

* * *

We have considered Munroe's remaining arguments and find them to be without merit. Accordingly, we **AFFIRM** the judgment of the district court.[1]

FOR THE COURT:

/s/_____
Catherine O'Hagan Wolfe,
Clerk of Court

1. Munroe also moved for summary judgment and submitted a letter requesting this Court order Aetna Medicare to issue a public apology. For the reasons stated herein, we deny Munroe's motion and letter request for lack of subject-matter jurisdiction.

APPENDIX B — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT, FILED JUNE 6, 2024

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Docket No: 23-1313

SONYA MUNROE,

Plaintiff-Appellant,

v.

AETNA MEDICARE, KAREN LYNCH, AETNA PRESIDENT,

Defendants-Appellees.

Filed June 6, 2024

ORDER

Appellant, Sonya Munroe, filed a petition for panel rehearing, or, in the alternative, for rehearing *en banc.* The panel that determined the appeal has considered the request for panel rehearing, and the active members of the Court have considered the request for rehearing *en banc.*

IT IS HEREBY ORDERED that the petition is denied.

FOR THE COURT:

/s/_____
Catherine O'Hagan Wolfe,
Clerk of Court

APPENDIX C — ORDER OF DISMISSAL OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK, FILED AUGUST 9, 2023

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 23-CV-6868 (CS)

SONYA MUNROE,

Plaintiff,

v.

AETNA MEDICARE,

Defendant.

Filed August 9, 2023

ORDER OF DISMISSAL

CATHY SEIBEL, District Judge.

Plaintiff Sonya Munroe, possibly through her husband,[1] brings this *pro se* action, for which the filing fees have been paid, alleging that Defendant Aetna Medicare

1. The beginning of the facts section of the complaint includes a note saying that the facts are "[s]tated in Sonya's 1st person voice, not her husband Patrick's who represents her pro se." (ECF 1, at 5.) As discussed below, Plaintiff 's husband may not assert claims *pro se* on Plaintiff 's behalf.

violated her rights under the Medicare and Medicaid Act of 1964. The Court dismisses the complaint for lack of subject matter jurisdiction, but grants Plaintiff 30 days' leave to replead her claims in an amended complaint.

STANDARD OF REVIEW

The Court has the authority to dismiss a complaint, even when the plaintiff has paid the filing fees, if it determines that the action is frivolous, *Fitzgerald v. First E. Seventh Tenants Corp.*, 221 F.3d 362, 363-64 (2d Cir. 2000) (*per curiam*) (citing *Pillay v. INS*, 45 F.3d 14, 16-17 (2d Cir. 1995) (*per curiam*) (holding that Court of Appeals has inherent authority to dismiss frivolous appeal)), or that the Court lacks subject matter jurisdiction, *Ruhrgas AG v. Marathon Oil Co.*, 526 U.S. 574, 583 (1999). The Court also may dismiss an action for failure to state a claim, "so long as the plaintiff is given notice and an opportunity to be heard." *Wachtler v. County of Herkimer*, 35 F.3d 77, 82 (2d Cir. 1994) (citation and internal quotation marks omitted). The Court is obliged, however, to construe *pro se* pleadings liberally, *Harris v. Mills*, 572 F.3d 66, 72 (2d Cir. 2009), and interpret them to raise the "strongest [claims] that they *suggest*," *Triestman v. Fed. Bureau of Prisons*, 470 F.3d 471, 474 (2d Cir. 2006) (internal quotation marks and citations omitted) (emphasis in original).

BACKGROUND

The following allegations are taken from the complaint. Plaintiff, who resides in Westchester County, receives health care coverage through the Aetna Medicare Elite Plan. On March 22, 2023, Plaintiff began experiencing

pain in her left leg. A doctor recommended an MRI, which showed "a synovial cyst between two vertebrae . . . constricting the sciatic nerve on [Plaintiff's] left leg." (ECF 1, at 5.) Plaintiff's spine surgeon recommended surgery to remove the cyst, which was scheduled for May 31, 2023. On May 16, 2024, however, Aetna denied medical coverage for the surgery and for Plaintiff's inpatient hospital visit, and instead required that Plaintiff first undergo "presurgical physical therapy." (*Id.*) On May 23, 2023, Plaintiff's surgeon appealed Aetna's denial. The Aetna representative, who was also a retired spine surgeon, agreed that physical therapy was unnecessary and would have "no effect on the cyst," but stated that "it was Aetna protocol and he was bound to it." (*Id.*) Plaintiff's appeal was denied, and Plaintiff's surgeon "acceded to Aetna's physical therapy requirement and scheduled the surgery for July 18th." (*Id.*) In the weeks leading up to the surgery, Plaintiff experienced significant pain while she underwent physical therapy. She took ibuprofen for the pain, but "[i]t had a dangerous side effect that was diagnosed as chronic kidney insufficiency." (*Id.* at 6.)

On June 24, 2023, Aetna approved the surgery for July 18, 2023. On June 26, 2023, Plaintiff was informed that Aetna approved outpatient admission but not inpatient admission, even though Plaintiff's surgeon had recommended inpatient admission. On July 18, 2023, Plaintiff underwent the surgery, and the cyst was removed. At 5:00 PM, "the wound was still bleeding, leaking outside the dressing." (*Id.*) Plaintiff's dressing was replaced, and she was discharged at 6:00 PM. Her dressing was again soaked through with blood later that night.

Appendix C

In the section of the complaint form asking Plaintiff to state her injuries, she writes, "None." (*Id.*)

Plaintiff seeks reimbursement of her $360 co-pay for presurgical physical therapy and an order directing that "Aetna publicly admit responsibility for [Plaintiff's] seven weeks of suffering, and that they give a corrective protocol to the Court for its approval—how from now on Aetna will treat plan members humanely and accordance with their legal and moral obligations." (*Id.*)

DISCUSSION

A. Plaintiff's husband may not bring claims on her behalf

Although it appears that Plaintiff signed the complaint, the complaint also states that Plaintiff's husband is bringing claims on her behalf. Because Plaintiff's husband does not indicate that he is a lawyer, he cannot bring claims *pro se* on behalf of his wife. *See* 28 U.S.C. § 1654; *U.S. ex rel. Mergent Servs. v. Flaherty*, 540 F.3d 89, 92 (2d Cir. 2008) ("[A]n individual who is not licensed as an attorney may not appear on another person's behalf in the other's cause." (internal quotation marks and citation omitted)); *Eagle Assocs. v. Bank of Montreal*, 926 F.2d 1305, 1308 (2d Cir. 1991) (noting that Section 1654 "allow[s] two types of representation: 'that by an attorney admitted to the practice of law by a governmental regulatory body, and that by a person representing himself'"). Plaintiff's husband may assist her in drafting the complaint, but he may not assert claims on her behalf. If Plaintiff submits an amended complaint, she must sign the amended complaint

and include an attestation that she is personally bringing claims on her own behalf.

B. Subject matter jurisdiction

The Court construes Plaintiff's claims against Medicare as brought under the Medicare Act and the Social Security Act, in which she challenges the denial of her Medicare benefits. With respect to such claims, 42 U.S.C. § 405(h) mandates that the judicial review method set forth in 42 U.S.C. § 405(g) is the exclusive method for judicial review, and bars judicial review under other grants of subject matter jurisdiction, "irrespective of whether the individual challenges the agency's denial on evidentiary, rule-related, statutory, constitutional, or other legal grounds."[2] *Shalala v. Ill. Council on Long*

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2. 42 U.S.C. § 405(h) provides, in relevant part, that:

> [t]he findings and decision of the [Secretary of the United States Department of Health and Human Services ("HHS Secretary")] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [HHS Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [HHS Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(g) provides, in relevant part, that:

> [a]ny individual, after any final decision of the [HHS Secretary] made after a hearing to which he was

Term Care, Inc., 529 U.S. 1, 10 (2000). In order to challenge the denial of Medicare benefits under Section 405(g), a plaintiff must exhaust her administrative remedies before seeking judicial review. 42 U.S.C. § 405(g), (h); *see Abbey v. Sullivan*, 978 F.2d 37, 41-44 (2d Cir. 1992). This requirement is jurisdictional. *Shalala*, 529 U.S. 1; *Weinberger v. Salfi*, 422 U.S. 749, 757-66 (1975); *see Heckler v. Ringer*, 466 U.S. 602, 622 (1984) ("Because Ringer has not given the Secretary an opportunity to rule on a concrete claim for reimbursement, he has not satisfied the nonwaivable exhaustion requirement of § 405(g). The District Court, therefore, had no jurisdiction as to respondent Ringer.").

A plaintiff dissatisfied with a Medicare contractor's initial determination of Medicare benefits must follow certain procedures before filing suit in federal court: (1) a plaintiff must request that the contractor perform a redetermination of the claim if the requirements for obtaining a redetermination are met; (2) if dissatisfied with the redetermination, a plaintiff must seek reconsideration

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> a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the [HHS Secretary] may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.

from the contractor; (3) if still dissatisfied, the plaintiff must request a hearing by an Administrative Law Judge ("ALJ") with the United States Department of Health and Human Services; (4) if dissatisfied with the decision of the ALJ, a plaintiff must request that the Medicare Appeals Council ("MAC") review the case; and (5) if the plaintiff is still dissatisfied with the decision made by the MAC, only then may the plaintiff file suit in federal court if the amount remaining in controversy and other requirements for judicial review are met. *See* 42 C.F.R. § 405.904(a)(2); *Townsend v. Cochran*, 528 F. Supp. 3d 209, 212-13 (S.D.N.Y. 2021).

The Second Circuit has determined that judicial waiver of this exhaustion requirement is appropriate in only three circumstances: (1) where the claim is collateral to a demand for benefits; (2) where exhaustion would be futile; and (3) where the plaintiff would suffer irreparable harm if required to exhaust administrative remedies before obtaining relief. *See Abbey*, 978 F.2d at 44. Thus, "[e]xhaustion is the rule, waiver the exception." *Id.*

Here, Plaintiff does not allege that she exhausted her administrative remedies. She states that her surgeon appealed Aetna's May 16, 2023 decision denying coverage of the surgery unless Plaintiff first underwent physical therapy and denying inpatient admission, but she does not allege that she or her doctor took any further steps to exhaust her administration remedies. Plaintiff does not allege that she took any steps to appeal Aetna's June 26, 2023 decision to deny inpatient admission. Nor does Plaintiff allege any facts suggesting that waiver of

the exhaustion requirement is appropriate in this case. Because Plaintiff does not allege that she has exhausted her administrative remedies, the Court dismisses her claims for lack of subject matter jurisdiction. *See* Fed. R. Civ. P. 12(h)(3).

In light of Plaintiff's *pro se* status, the Court grants her 30 days' leave to replead her claims in an amended complaint demonstrating the Court has subject matter jurisdiction of her claims by alleging facts showing that she has exhausted her administrative remedies.

LEAVE TO AMEND

Plaintiff proceeds in this matter without the benefit of an attorney. District courts generally should grant a self-represented plaintiff an opportunity to amend a complaint to cure its defects, unless amendment would be futile. *See Hill v. Curcione*, 657 F.3d 116, 123-24 (2d Cir. 2011); *Salahuddin v. Cuomo*, 861 F.2d 40, 42 (2d Cir. 1988). Indeed, the Second Circuit has cautioned that district courts "should not dismiss [a *pro se* complaint] without granting leave to amend at least once when a liberal reading of the complaint gives any indication that a valid claim might be stated." *Cuoco v. Moritsugu*, 222 F.3d 99, 112 (2d Cir. 2000) (quoting *Gomez v. USAA Fed. Sav. Bank*, 171 F.3d 794, 795 (2d Cir. 1999)). The Court grants Plaintiff 30 days' leave to replead her claims in an amended complaint alleging facts demonstrating that the Court has subject matter jurisdiction of her claims.

Appendix C

In the "Statement of Claim" section of the amended complaint form, Plaintiff must provide a short and plain statement of the relevant facts supporting each claim against each defendant. If Plaintiff has an address for any named defendant, Plaintiff must provide it. Plaintiff should include all of the information in the amended complaint that Plaintiff wants the Court to consider in deciding whether the amended complaint states a claim for relief. That information should include:

a) the names and titles of all relevant people;

b) a description of all relevant events, including what each defendant did or failed to do, the approximate date and time of each event, and the general location where each event occurred;

c) a description of the injuries Plaintiff suffered; and

d) the relief Plaintiff seeks, such as money damages, injunctive relief, or declaratory relief.

Essentially, Plaintiff 's amended complaint should tell the Court: who violated her federally protected rights and how; when and where such violations occurred; and why Plaintiff is entitled to relief.

Because Plaintiff 's amended complaint will completely replace, not supplement, the original complaint, any facts or claims that Plaintiff wants to include from the original complaint must be repeated in the amended complaint.

Appendix C

CONCLUSION

The Court dismisses the complaint for lack of subject matter jurisdiction. *See* Fed. R. Civ. P. 12(h)(3).

The Court grants Plaintiff 30 days' leave to replead her claims in an amended complaint that complies with the standards set forth above. Plaintiff must submit the amended complaint to this Court's Pro Se Intake Unit within 30 days of the date of this order, caption the document as an "Amended Complaint," and label the document with docket number 23-CV-6868 (CS). An Amended Complaint form is attached to this order. No summons will issue at this time. If Plaintiff fails to comply within the time allowed, and she cannot show good cause to excuse such failure, the complaint will be dismissed for lack of subject matter jurisdiction.

The Court certifies under 28 U.S.C. § 1915(a)(3) that any appeal from this order would not be taken in good faith, and therefore IFP status is denied for the purpose of an appeal. *Cf. Coppedge v. United States*, 369 U.S. 438, 444-45 (1962) (holding that an appellant demonstrates good faith when he seeks review of a nonfrivolous issue).

SO ORDERED.

Dated: August 9, 2023
White Plains, New York

/s/
CATHY SEIBEL
United States District Judge

APPENDIX D — LETTER FROM PATRICK MUNROE, SIGNED AUGUST 9, 2023

Patrick Munroe
63 New Broadway
Sleepy Hollow NY 10591-1723
(914) 631-2983
pjjmunroe@gmail.com

August 9, 2023

Dear Ms. Lynch:

The return receipt for the June 4th letter I sent you at Aetna in Hartford says it was received in Cleveland on June 26th. Could you please answer today's letter by email, phone, or USPS?

My wife Sonya is 76 and I'm 79. We appeal to you because no one else at Aetna has been willing to answer her questions about the company's treatment of her during her recent ordeal. We now ask if you would please give us the name and street address of somebody who can accept service of the summons the Federal District Court in White Plains issued in her complaint against Aetna. (Copies of it and of the complaint are enclosed. If it isn't resolved beforehand, I'll represent her at the trial though I'm not a lawyer.)

We hope you agree that a lawsuit is a bad way to resolve this. We hope that you're a person with compassion for others—who has loved ones you wouldn't want a corporation to make suffer this way, and that you would want someone in that corporation to take responsibility for

it; that you believe no one is above the law, is unaccountable when a beautiful person like Sonya has to ask a court to enforce her rights under the Medicare Act.

Forbes lists you among a group they regard as most powerful. Please show us you're also among the most human.

/s/_____
Patrick Munroe

Enclosed: 5 sheets, 3 of them [illegible]

ATTACHMENT

- Print your name and address on the reverse so that we can return the card to you.

- Attach this card to the back of the mail piece, or on the front if space permits.

1. Article Addressed to:

   Karen Lynch
   President Aetna Insurance
   151 Farmington Ave.
   Hartford, CT 06105

   [BAR CODE]
   9500 9402 8291 3094 3540 39

Appendix D

X /s/

B. Received by (Printed Name)

[Illegible]

D. Is delivery address different from Item 1? If YES, enter delivery address below:

[Stamp dated August 8, 2023]

3. Service Type
- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☒ Certified Mail
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Insured Mail
- ☐ Priority Mail Express
- ☐ Registered Mail
- ☐ Registered Mail Restricted Delivery
- ☐ Signature Confirmation
- ☐ Signature Confirmation Restricted Delivery