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Attorneys for Plaintiffs and the Proposed Class

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN JOSE DIVISION**

16 CHARLES DES ROCHES, on his own behalf and)
17 on behalf of his beneficiary son, R.D., and all others)
18 similarly situated, and SYLVIA MEYER, on her)
19 own behalf and all others similarly situated,)

Case No. __:16-cv-__

Plaintiffs,)

v.)

CLASS ACTION COMPLAINT

21 CALIFORNIA PHYSICIANS' SERVICE d/b/a)
22 BLUE SHIELD OF CALIFORNIA; HUMAN)
23 AFFAIRS INTERNATIONAL OF CALIFORNIA;)
24 and MAGELLAN HEALTH SERVICES OF)
25 CALIFORNIA, INC.-EMPLOYER SERVICES)

Defendants.)

1 Plaintiffs Charles Des Roches and Sylvia Meyer (“Plaintiffs”), by and through their
2 undersigned counsel, based on personal knowledge as to themselves and on information and
3 belief, and investigation of counsel, as to all other matters, individually and on behalf of all
4 others similarly situated, allege as follows:

5 **INTRODUCTION**

6 1. According to the National Institute of Mental Health (“NIMH”), an estimated 26
7 percent of American adults suffer from some type of mental health condition each year, with
8 six percent suffering from a severe mental health condition such as schizophrenia or major
9 depression. About 11 percent of adolescents have a depressive disorder by age 18. The
10 seriousness of this problem is highlighted by the fact that suicide consistently ranks as the third
11 leading cause of death for young people aged 15-24. Individuals with borderline personality
12 disorder, who constitute 6 percent of patients in primary care settings, 10 percent of patients in
13 outpatient clinics, and 20 percent of psychiatric inpatients, also face a significant risk of
14 suicide.

15 2. According to the Substance Abuse and Mental Health Services Administration
16 (“SAMHSA”), an estimated nine percent of Americans twelve or older were classified with
17 substance use disorder in 2010. Between 2007 and 2010, about 38 percent of Americans
18 twelve or older who needed substance abuse treatment did not receive treatment because they
19 lacked insurance coverage, and could not afford the cost of treatment without such coverage.
20 The World Health Organization (“WHO”) reports that mental health and substance use
21 disorders are among the leading causes of disability in the United States, and the Centers for
22 Disease Control and Prevention (“CDC”) reports that 25 percent of all years of life lost to
23 disability and premature mortality are a result of mental illness. When substance use disorders
24 are inadequately treated, they complicate care for co-occurring mental health disorders and
25 medical conditions.

26 3. Despite these alarming statistics, Defendants California Physicians’ Service
27 d/b/a Blue Shield of California (“Blue Shield”), Human Affairs International of California
28 (“HAI-CA”), and Magellan Health Services of California, Inc.-Employer Services (“MHSC,”

1 and together with HAI-CA, “Magellan”) (collectively, “Defendants”), which adjudicate mental
2 health and substance abuse claims for thousands of California residents, are violating legal and
3 fiduciary duties they owe to health insurance plan participants and beneficiaries by improperly
4 restricting the scope of their insurance coverage for residential and intensive outpatient mental
5 health and substance abuse treatment. These restrictions are inconsistent with the terms of the
6 relevant insurance plans and generally accepted professional standards in the mental health and
7 substance abuse disorder treatment community. They were also adopted and applied by
8 Defendants in breach of Defendants’ fiduciary duties.

9 4. Because they have been, and are likely to continue to be, harmed by Defendants’
10 misconduct, Plaintiffs bring this complaint on behalf of themselves and all others similarly
11 situated, to seek declaratory, injunctive, and other equitable relief.

12 **SUMMARY OF PLAINTIFFS’ ALLEGATIONS**

13 5. Plaintiffs are each insured by a health insurance plan that is sponsored by their
14 employer and governed by the Employee Retirement Income Security Act of 1974 (“ERISA”)
15 (the “Plans”).

16 6. The Plans are fully insured.

17 7. Blue Shield is responsible both for paying claims under the Plans and for
18 administering the Plans.

19 8. Plaintiffs’ Plans cover in- and out-of-network treatments for illnesses and
20 injuries as well as for mental illnesses and substance use disorders described in the *Diagnostic*
21 *and Statistical Manual, Fifth Edition* (“DSM-5”) of the American Psychiatric Association. As
22 such, Plaintiffs’ Plans cover residential and intensive outpatient treatment for mental illnesses
23 and substance abuse disorders.

24 9. To be entitled to insurance benefits paying for such treatment, Plaintiffs’ Plans
25 require that the treatment be “medically necessary,” as defined by generally accepted
26 professional standards.

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1 10. Plaintiffs’ Plans have delegated responsibility for adjudicating mental health and
2 substance abuse claims to a “Mental Health Service Administrator,” as referred to in Plan
3 documents.

4 11. Blue Shield selected Magellan to serve as the MHSA for Plaintiffs’ Plans.

5 12. Blue Shield retains “the right to review all claims to determine if a service or
6 supply is medically necessary,” including mental health and substance abuse claims.

7 13. Pursuant to this delegation, Magellan has adopted, and Blue Shield has approved
8 the adoption of, Medical Necessity Criteria Guidelines (“MNCG”) developed by Magellan’s
9 parent company, Magellan Health, Inc.

10 14. Magellan’s claims representatives use the MNCGs to adjudicate mental health
11 and substance abuse claims.

12 15. The sponsors of Plaintiffs’ Plans, their employers, have no role in the creation,
13 promulgation, or content of Defendants’ guidelines or in the decision to approve or deny any
14 claim.

15 16. The MNCGs distinguish eight different “levels of care”: (1) hospitalization; (2)
16 subacute hospitalization; (3) 23-hour observation; (4) residential treatment; (5) supervised
17 living; (6) partial hospitalization; (7) intensive outpatient programs; and (8) outpatient
18 treatment. Magellan defines these levels of care purportedly to ensure that “optimal, high-
19 quality care” may be delivered “in the least-intensive, least-restrictive setting possible,” and
20 imposes specific criteria that mental health and substance abuse claimants must satisfy in order
21 to obtain the treatment and level of care prescribed by their healthcare providers.

22 17. The MNCGs under which mental health and substance abuse claims are
23 adjudicated provide that coverage for residential treatment will be authorized only where the
24 claimant has had “recent (*i.e.*, in the past 3 months), appropriate professional intervention at a
25 less intensive level of care.” Defendants have thus adopted a “fail-first” criterion in their
26 MNCGs.

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1 18. Fail-first protocols are inconsistent with generally accepted professional
2 standards in the mental health and substance abuse disorder treatment community, as shown
3 below.

4 19. Moreover, the MNCGs condition coverage for residential treatment on whether
5 the claimant can prove a “clear and reasonable inference of serious, imminent physical harm to
6 self or others” absent residential treatment.

7 20. However, under generally accepted professional standards in the mental health
8 and substance abuse disorder treatment community, as shown in more detail below, the
9 presence of such a risk of harm typically necessitates the highest level of treatment, *i.e.*,
10 hospitalization.

11 21. The MNCGs also improperly condition residential substance use rehabilitation
12 on a “demonstrat[ion of] motivation to manage symptoms or make behavioral change.”

13 22. Under generally accepted professional standards in the mental health and
14 substance abuse disorder treatment community, however, lack of motivation in adolescents is a
15 factor that, in particular, warrants placement at the residential level of care. Thus, this
16 requirement, too, is inconsistent with generally accepted professional standards.

17 23. Next, the MNCGs ignore a host of residential placement criteria enumerated by
18 national medical specialty organizations such as the American Association of Child and
19 Adolescent Psychiatry (“AACAP”) and the American Society for Addiction Medicine
20 (“ASAM”), including the necessity of erring on the side of caution and approving levels of care
21 consistent with the judgments of the treating mental health professionals based on the
22 professionals’ direct access to their patients, in the absence of compelling evidence that such
23 levels of care are unwarranted.

24 24. Similarly, the MNCGs deviate from ASAM standards by conditioning
25 residential rehabilitation treatment on a “*severely*” dysfunctional living environment, which is a
26 far more restrictive condition than ASAM provides. The ASAM standards call for
27 consideration of a large variety of familial and environmental factors, and are not consistent
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1 with denying care where a patient’s living environment is demonstrably “dysfunctional” but not
2 “severely dysfunctional.”

3 25. The MNCGs are similarly problematic with respect to intensive outpatient
4 treatment for substance abuse disorders. Just as with the residential treatment admission
5 criteria, the intensive outpatient treatment guidelines impose an improper “motivation”
6 requirement.

7 26. In addition, the intensive outpatient treatment guidelines require that the
8 treatment plan for the patient is “reasonably expected to bring about *significant* improvement.”

9 27. This requirement for a demonstration of “significant” improvement has no basis
10 in generally accepted medical practices. Indeed, the American Association of Community
11 Psychiatrists (“AACCP”) explains that the treatment should be considered medically necessary if
12 the intervention would cause any *one* of the following results: (a) prevent deterioration; (b)
13 alleviate symptoms; (c) improve level of functioning; or (d) assist in restoring normal
14 development in a child.

15 28. Likewise, the Centers for Medicare & Medicaid Services has indicated that even
16 for inpatient psychiatric hospital services, providers are only required to show that the
17 treatment would “reasonably [be] expected to improve the patient’s condition”

18 29. Accordingly, Defendants systematically deny mental health and substance abuse
19 claimants the residential and intensive outpatient treatment they need unless such claimants can
20 meet a set of requirements entirely different from, and often conflicting with, the generally
21 accepted professional standards for treatment.

22 30. Although the Plans expressly require Defendants to apply generally accepted
23 professional standards in making mental health and substance use claims determinations,
24 Defendants have imposed a set of internally developed criteria—the MNCGs—that are far
25 more restrictive than such standards, in order to minimize the number of claims accepted and
26 thereby maximize their own profits.

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1 31. In light of their central role in the mental health and substance abuse claim
2 adjudication process, and the discretionary authority that they exercise, Defendants are ERISA
3 fiduciaries, as defined by 29 U.S.C. § 1104(a).

4 32. As such, they are legally required to discharge their duties “solely in the
5 interests of the participants and beneficiaries” and for the “exclusive purpose” of “providing
6 benefits to participants and their beneficiaries” and paying reasonable expenses of
7 administering the Plans. They must do so with reasonable “care, skill, prudence, and diligence”
8 and in accordance with the terms of the Plans they administer, so long as such terms are
9 consistent with ERISA.

10 33. As fiduciaries, Defendants owe a duty of loyalty and care to Plan participants
11 and beneficiaries, including Plaintiffs. They must also refrain from any conduct that violates
12 state or federal law.

13 34. Defendants suffer from inherent conflicts of interest in their role as mental
14 health and substance abuse claims administrators.

15 35. Plaintiffs’ Plans are “fully-insured,” meaning that health care benefits are paid
16 by the insurance carrier, rather than the employer.

17 36. In the case of Plaintiffs’ Plans, either Blue Shield or Magellan is responsible for
18 paying costs associated with mental health and substance abuse claims.

19 37. Whichever is the case, Defendants benefit when Magellan denies claims.

20 38. To the extent mental health and substance abuse claims are paid by Blue Shield,
21 every mental health and substance abuse claim denied by Magellan allows Blue Shield to save
22 money and artificially increases its profits, while currying the favor of Blue Shield toward
23 Magellan in order to strengthen their business relationship.

24 39. Blue Shield is an important customer of Magellan’s. It purchased \$20 million of
25 Magellan’s shares when it entered into its contract with Magellan in 2011. And its customers
26 account for more than \$180 million a year in net revenue. In fact, Blue Shield generated in
27 excess of ten percent of all of Magellan’s net revenues in the commercial segment in each of
28 the years ending December 31, 2012, December 31, 2013, and December 31, 2015.

1 40. Magellan’s performance, and the costs it causes Blue Shield to incur, are
2 particularly salient considerations for Magellan because beginning January 1, 2018, Blue
3 Shield may terminate its contract with Magellan without cause.

4 41. In addition, pursuant to an Alliance Agreement executed in 2011, Blue Shield
5 has agreed to allow Magellan to offer additional services in the event Blue Shield decides to
6 replace an existing service provider or introduce a new health insurance product.

7 42. Consequently, it is in Magellan’s interest to reduce the costs Blue Shield incurs
8 by denying mental health and substance abuse treatment claims.

9 43. To the extent Magellan itself pays costs associated with mental health and
10 substance abuse claims, it directly benefits from the denial of such claims.

11 44. As acknowledged in a filing with the U.S. Securities and Exchange Commission
12 by Magellan’s parent, Magellan Health Inc., in this type of “risk-based” arrangement, Magellan
13 assumes responsibility for costs of treatment in exchange for a fixed fee. Therefore, if the costs
14 associated with paying claims exceed the fixed fee Magellan receives from Blue Shield, its
15 profitability would be negatively affected.

16 45. Against this backdrop, Magellan has violated its fiduciary duties, as detailed
17 herein. Although Magellan asserts in its guidelines and communications with insureds that its
18 MNCGs are consistent with generally accepted professional standards, and that it applies
19 generally accepted professional standards in the mental health and substance abuse disorder
20 treatment community in making mental health and substance abuse claim determinations,
21 neither is true.

22 46. Generally accepted professional standards related to mental health and substance
23 abuse treatments are promulgated by the American Psychiatric Association (“APA”), the
24 American Association of Child and Adolescent Psychiatry (AACAP, as defined above), the
25 American Association of Community Psychiatrists (AACCP, as defined above), the American
26 Society for Addiction Medicine (ASAM, as defined above), the Association for Ambulatory
27 Behavioral Healthcare (“AABH”), and a body of published, peer-reviewed research.

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1 47. Generally, these standards identify a host of criteria as being relevant to
2 determining which kind of treatment, and with what conditions, is the appropriate level of care
3 for any particular patient, recognize that residential and intensive outpatient treatment levels are
4 less restrictive than hospitalization, and call for residential treatment (but typically not
5 hospitalization) when the patient's condition may not involve any risk of harm to self or others.

6 48. Magellan's MNCGs are much more restrictive than the generally accepted
7 professional standards in the mental health and substance abuse disorder treatment community.

8 49. As detailed herein, whereas Magellan's guidelines regarding admission to
9 residential care impose (1) an improper "fail-first" criterion, (2) a "serious, imminent" risk of
10 harm standard proper only for hospitalization claims, (3) an improper "motivation" condition,
11 (4) a burden-shifting condition that favors denial of coverage for treatment recommended by
12 treating mental health and substance abuse professionals, and (5) an elevated burden on the
13 claimant with respect to factors demonstrating a dysfunctional living environment or failure to
14 respond to less-intensive treatment regimens, such restrictions on residential treatment are not
15 found in any of the generally accepted professional standards or, for that matter, in any of the
16 Plaintiffs' Plans.

17 50. Similarly, Magellan's guidelines regarding continued stay in intensive outpatient
18 treatment contravene generally accepted professional standards and therefore Plaintiffs' Plans,
19 because they (1) impose an improper "motivation" condition and (2) require that the treatment
20 plan is reasonably expected to bring about "significant improvement"(rather than reasonable
21 improvement, prevention of deterioration, etc.) in the patient's substance abuse disorder.

22 51. Plaintiffs' Plans provide mental health and substance abuse coverage, but
23 exclude coverage where the treatment is inconsistent with generally accepted professional
24 standards.

25 52. Thus, in developing its guidelines, Magellan had a fiduciary duty to Plaintiffs
26 (and to all other members of Plans administered by Magellan) to promulgate and apply
27 guidelines that are consistent with Plaintiffs' Plans and generally accepted professional
28 standards.

1 53. Magellan breached this duty by supplanting generally accepted treatment
2 standards in the mental health and substance abuse field with standards that promote the self-
3 serving, cost-cutting preferences of Magellan and Blue Shield.

4 54. By adopting guidelines that are inconsistent with, and much more restrictive
5 than, those that are generally accepted in the relevant professional community, Magellan
6 breached its fiduciary duty to act solely in the interests of participants and beneficiaries for the
7 “exclusive purpose” of providing benefits with reasonable “care, skill, prudence, and diligence”
8 and in accordance with Plaintiffs’ Plans.

9 55. Magellan also violated its fiduciary obligations under ERISA by improperly
10 denying residential and intensive outpatient treatment claims that were covered by Plaintiffs’
11 Plans. These claims would have been covered based on the terms of Plaintiffs’ Plans and
12 generally accepted treatment standards, but were denied as a result of Magellan’s improper
13 adoption and application of restrictive benefit determination guidelines.

14 56. To remedy Magellan’s breach of fiduciary duty and other ERISA violations,
15 Plaintiffs bring class claims against Magellan under 29 U.S.C. §§ 1132(a)(1)(B),
16 1132(a)(3)(A), and 1132(a)(3)(B). Through this action, Plaintiffs seek appropriate declaratory,
17 equitable, and injunctive relief under ERISA to compel Magellan to change its policies and
18 practices so as to comply with its fiduciary obligations and to make benefit determinations
19 which are consistent with Plaintiffs’ Plans, generally accepted professional standards in the
20 mental health and substance abuse disorder treatment community, and applicable law.

21 57. Blue Shield is also in breach of its fiduciary obligations due to its role in
22 selecting Magellan as claims administrator, ratifying Magellan’s deficient benefits
23 determination and claims adjudication processes (including the restrictive MNCGs), and its
24 failure to review and/or correct Magellan’s deficient benefits determination and claims
25 adjudication processes (including the MNCGs).

26 58. Similarly, Blue Shield breached its fiduciary obligations under ERISA by
27 improperly denying residential and intensive outpatient treatment claims that were covered by
28 Plaintiffs’ Plans. These claims would have been covered based on the terms of Plaintiffs’ Plans

1 and generally accepted treatment standards, but were denied as a result of Blue Shield's
2 improper adoption and ratification of Magellan's restrictive benefit determination guidelines
3 and claims adjudication process.

4 59. To remedy Blue Shield's breach of fiduciary duty and other ERISA violations,
5 Plaintiffs bring class claims against Blue Shield under 29 U.S.C. §§ 1132(a)(1)(B),
6 1132(a)(3)(A), and 1132(a)(3)(B). Through this action, Plaintiffs seek appropriate declaratory,
7 equitable, and injunctive relief under ERISA to compel Blue Shield to change its policies and
8 practices so as to comply with its fiduciary obligations and to make benefit determinations
9 which are consistent with Plaintiffs' Plans, generally accepted professional standards in the
10 mental health and substance abuse disorder treatment community, and applicable law.

11 **JURISDICTION AND VENUE**

12 60. This Court has subject matter jurisdiction over this matter pursuant to 28 U.S.C.
13 § 1331.

14 61. This Court has personal jurisdiction over Defendants and this District is the
15 proper venue because Defendants conduct operations in this District, regularly communicate
16 with insureds residing in this District, and maintain offices in this District.

17 **PARTIES**

18 62. Plaintiff Charles Des Roches, a resident of Salinas, California, brings this action
19 on behalf of himself, his minor son ("R.D."), and all others similarly situated. Mr. Des Roches
20 is insured under a Blue Shield of California health plan through his employer.

21 63. Plaintiff Sylvia Meyer, a resident of California, brings this action on behalf of
22 herself and all others similarly situated. Ms. Meyer is insured under a Blue Shield of California
23 health plan through her employer.

24 64. Defendant Blue Shield, a California company with its principal place of business
25 in San Francisco, California, is an independent member of the BlueCross BlueShield
26 Association. Its annual revenues exceed \$13 billion dollars. Blue Shield lost its tax-exempt,
27 not-for-profit status in 2014 following an audit by the California Franchise Tax Board.

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1 65. Defendant HAI-CA is a California subsidiary of Magellan Healthcare, Inc.,
2 which is a subsidiary of Magellan Health, Inc.

3 66. Defendant MHSC is a corporation registered in California with its principal
4 place of business in Columbia, Maryland. MHSC is a subsidiary of Magellan Pharmacy
5 Services, Inc., which itself is a subsidiary of Magellan Health, Inc.

6 **MAGELLAN'S MEDICAL NECESSITY CRITERIA GUIDELINES**

7 67. Blue Shield has selected Magellan as the Mental Health Service Administrator,
8 or MHSA, responsible for the determination of Plan coverage for mental health and substance
9 abuse treatment claims.

10 68. According to the terms of the Plans, Blue Shield retains “the right to review all
11 claims to determine if a service or supply is medically necessary,” including mental health and
12 substance abuse claims.

13 69. Magellan’s MNCGs guide its adjudication of all mental health and substance
14 abuse treatment claims under plans issued by Blue Shield, including Plaintiffs’ Plans.

15 70. Magellan’s MNCGs are purportedly designed to ensure that mental health and
16 substance abuse treatment occurs “at the most appropriate, least restrictive level of care
17 necessary to provide safe and effective treatment and meet the individual patient’s
18 biopsychosocial needs.”

19 71. Magellan’s MNCGs distinguish eight levels of care: (1) hospitalization; (2)
20 subacute hospitalization; (3) 23-hour observation; (4) residential treatment; (5) supervised
21 living; (6) partial hospitalization; (7) intensive outpatient programs; and (8) outpatient
22 treatment. Magellan defines these levels of care purportedly to ensure that “optimal, high-
23 quality care” may be delivered “in the least-intensive, least-restrictive setting possible,” and
24 imposes specific criteria that mental health and substance abuse claimants must satisfy in order
25 to obtain the treatment and level of care prescribed by their healthcare providers.

26 72. Magellan defines “medical necessity” in the following manner: “*Services by a*
27 *provider to identify or treat an illness that has been diagnosed or suspected. The services are:*
28 (1) consistent with: (a) the diagnosis and treatment of a condition; and (b) the standards of good

1 medical practice; (2) required for other than convenience; and (3) the most appropriate supply
 2 or level of service. *When applied to inpatient care, the term means: the needed care can only*
 3 *be safely given on an inpatient basis.”*

4 73. Magellan claims that “[e]ach criteria set, within each level of care category ... is
 5 a more detailed elaboration of the above definition for the purposes of establishing medical
 6 necessity for these health care services. Each set is characterized by admission and continued
 7 stay criteria. The admission criteria are further delineated by severity of need and intensity and
 8 quality of service. Particular rules in each criteria set apply in guiding a provider or reviewer to
 9 a medically necessary level of care For admission, both the severity of need and the
 10 intensity and quality of service criteria must be met. The continued stay of a patient at a
 11 particular level of care requires the continued stay criteria to be met (Note: this often requires
 12 that the admission criteria are still fulfilled). Specific rules for the admission and continued
 13 stay groupings are noted within the criteria sets.”

14 **A. RESIDENTIAL REHABILITATION TREATMENT CONDITIONS**

15 74. To meet the “severity of need” requirement and thus merit admission for
 16 residential rehabilitation treatment for substance abuse disorders in children and adolescents,
 17 Magellan’s 2015 MNCGs require satisfaction of the following conditions:

18 **I. Admission – Severity of Need**

19 Criteria A, B, C, D, E, F, and G must be met to satisfy the criteria for severity of need.

- 20 **A.** The patient has a substance-related disorder as defined by DSM-5 that is
 21 amenable to active behavioral health treatment.
- 22 **B.** The patient has sufficient cognitive ability at this time to benefit from
 23 admission to a residential treatment program.
- 24 **C.** The patient exhibits a pattern of severe substance abuse/dependency as
 25 evidenced by significant impairment in social, familial, scholastic or
 26 occupational functioning.
- 26 **D. One of the following must be met to satisfy this criterion:**

- 27 **1) despite recent (i.e., the past 3 months) appropriate,**
 28 **professional intervention at a less-intensive level of care the**

1 patient is continually unable to maintain abstinence and
recovery; *or*

2 2) the patient is residing in a severely dysfunctional living
3 environment which would undermine effective rehabilitation
4 treatment at a less-intense level of care and alternative living
situations are not available or clinically appropriate, *or*

5 3) there is evidence for, or clear and reasonable inference of
6 serious, imminent physical harm to self or others directly
attributable to the continued abuse of substances, which
would prohibit treatment in a less intensive setting, *or*

7 4) there is clinical evidence that the patient is not likely to
8 respond at a less intensive level of care.

9 E. The patient's condition is appropriate for residential treatment, as there is
10 not a need for detoxification treatment at an inpatient hospital level of
care. The patient does not have significant co-morbid condition(s).

11 F. **The patient demonstrates motivation to manage symptoms or make
behavioral change.**

12 G. The patient is capable of developing skills to manage symptoms or make
13 behavioral change.

14 75. Magellan's 2015 MNCGs specify further criteria that must be satisfied to merit
15 continuing residential rehabilitation treatment for substance abuse disorders in children and
16 adolescents:

17 III. Continued Stay

18 Criteria A, B, C, D, E, and F must be met to satisfy the criteria for continued stay.

19 A. Despite reasonable therapeutic efforts, clinical evidence indicates at least
20 one of the following:

21 1) the persistence of problems that caused the admission to a degree
22 that continues to meet the admission criteria (both severity of
need and intensity of service needs), *or*

23 2) the emergence of additional problems that meet the admission
24 criteria (both severity of need and intensity of service needs), *or*

25 3) that disposition planning and/or attempts at therapeutic re-entry
26 into the community have resulted in, or would result in,
27 exacerbation of the substance-related disorder to the degree that
28 would necessitate continued residential treatment. Subjective
opinions without objective clinical information or evidence are
NOT sufficient to meet severity of need based on justifying the
expectation that there would be a decompensation.

- 1 B. **The current or revised treatment plan can be reasonably expected to**
2 **bring about significant improvement in the problem(s) meeting**
3 **criterion IIIA**, and the patient’s progress is documented by the provider
4 at least three times per week. This plan receives regular review and
5 revision that includes ongoing plans for timely access to treatment
6 resources that will meet the patient’s post-residential treatment needs.
- 7 C. The individual plan of active treatment includes regular family and/or
8 support system involvement unless there is an identified, valid reason
9 why such a plan is not clinically appropriate or feasible.
- 10 D. **The patient has the capability of developing skills to manage**
11 **symptoms or make behavioral change and demonstrates motivation**
12 **for change**, as evidenced by attending treatment sessions, completing
13 therapeutic tasks, and adhering to a medication regimen or other
14 requirements of treatment.
- 15 E. A discharge plan is formulated that is directly linked to the behaviors
16 and/or symptoms that resulted in admission, and begins to identify
17 appropriate post-residential treatment resources.
- 18 F. All applicable elements in Admission Intensity and Quality of Service
19 criteria are applied as related to assessment and treatment, if clinically
20 relevant and appropriate.

21 76. Although Magellan states that these criteria reflect merely “a more detailed
22 elaboration” of the definition of “medical necessity,” they are substantially more restrictive
23 than generally accepted professional standards.

24 77. Condition I.D(1) is a “fail-first” criterion. Fail-first conditions are inconsistent
25 with generally accepted professional standards in the substance abuse treatment field.

26 78. As the National Center on Addiction and Substance Abuse reports, “There is no
27 clinical evidence to support the use of fail-first policies in addiction treatment. Clinical
28 practice guidelines call for a comprehensive assessment of each patient to determine the
29 appropriate therapies and level of care given the severity of the patient’s addiction and the
30 presence of co-occurring health conditions and other social/environmental factors. **Requiring**
31 **a patient to fail treatment at one level of care or to fail one specific therapy before starting**
32 **clinically indicated care does not accord with these guidelines.”**

33 79. These statements are strongly supported by clinical research. *See, e.g., MEE-*
34 *LEE, D., ET AL., THE ASAM CRITERIA: TREATMENT CRITERIA FOR ADDICTIVE, SUBSTANCE-*

1 RELATED, AND CO-OCCURRING CONDITIONS (3d ed. 2013); AMERICAN PSYCHIATRIC
2 ASSOCIATION, PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SUBSTANCE USE
3 DISORDERS (2d ed. 2010). As the ASAM observes, “fail-first” criteria “ha[ve] been used by
4 some reimbursement or managed care organizations as a prerequisite for approving admission
5 to a more intensive level of care (for example, ‘failure’ in outpatient treatment as a prerequisite
6 for admission to inpatient treatment). **In fact, the requirement that a person ‘fail first’ in
7 outpatient treatment before inpatient treatment is approved is no more rational than
8 treating every patient in an inpatient program or using a fixed length of stay for all.** It
9 also does not recognize the obvious parallels between addictive disorders and other chronic
10 diseases, such as diabetes or hypertension. For example, failure of outpatient treatment is not a
11 prerequisite for acute inpatient admission for diabetic ketoacidosis or hypertensive crisis. **A
12 ‘treatment failure’ approach potentially puts the patient at risk because it delays a more
13 appropriate level of treatment,** and potentially increases health care costs, if restricting the
14 appropriate level of treatment allows the addictive disorder to progress.”

15 80. Condition I.D(3) requires “evidence for, or clear and reasonable inference of
16 **serious, imminent physical harm to self or others** directly attributable to the continued abuse
17 of substances, which would prohibit treatment in a less-intensive setting.” Under generally
18 accepted professional standards, such a criterion is inappropriate.

19 81. The presence of such a risk would require the highest level of treatment, *i.e.*,
20 hospitalization, rather than residential treatment. ASAM’s level of care analysis requires that if
21 an adolescent is at “severe risk of harm”—or even “moderate risk of harm needing high-
22 intensity 24-hour monitoring or treatment, or secure placement, for safety”—hospitalization is
23 required.

24 82. Condition I.D(3) is also inconsistent with California law. *See* California
25 Welfare & Institutions Code § 5585.50, *et seq.* Under that regulation, a minor suffering from a
26 mental disorder and representing a danger to self or others may be taken into custody and
27 placed in a State-approved facility for treatment and observation.

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1 83. Condition I.F requires a “demonstrat[ion of] motivation to manage symptoms or
2 make behavioral change.” (Condition III.D imposes substantially the same requirement for
3 continued stay.) This is the *antithesis* of the generally accepted professional standard for
4 adolescent substance abuse treatment with respect to lack of motivation. This criterion is
5 improper and inconsistent with generally accepted professional standards because lack of
6 motivation in adolescents suggests a *need for* residential rehabilitation treatment. That
7 Defendants use this criterion to exclude such treatment and deny otherwise valid residential
8 treatment claims is demonstrative of their disregard for their fiduciary duties.

9 84. According to the ASAM standards, adolescents suffering from substance use
10 disorders often lack “readiness to change” and require motivational intervention in a residential
11 rehabilitation facility for precisely that reason. As ASAM notes, where an adolescent “has
12 limited insight into and little awareness of the need for continuing care or the existence of his
13 or her substance use or mental health problem and need for treatment”; or has “marked
14 difficulty in understanding the relationship between his or her substance use, addiction, mental
15 health, or life problems and his or her impaired coping skills and level of functioning, often
16 blaming others for his or her addiction problem”; or “demonstrates passive or active opposition
17 to addressing the severity of his or her mental health problem or addiction, or does not
18 recognize the need for such treatment”; among other examples, the adolescent requires
19 intensive residential rehabilitation treatment.

20 85. Next, Magellan’s MNCGs ignore the AACAP’s and ASAM’s key standard that
21 insurers (and professionals) must approve levels of care consistent with treating mental health
22 professionals’ judgments based on direct access to their patients in the absence of compelling
23 evidence that such levels of care are unwarranted. *See, e.g., AACAP/AACP Child and*
24 *Adolescent Level of Care Utilization System (CALOCUS), Part V (“Placement Methodology”)*
25 *(“In most cases, the higher level of care should be selected, unless there is a clear and*
26 *compelling rationale to do otherwise. This again will lead us to err on the side of caution and*
27 *safety, rather than risk and instability.”) (emphasis in original).*

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1 86. In other words, the insurer must defer to the highest level of care appropriate,
2 and there must be evidence that a level of care lower or less intensive than that prescribed by
3 the treating professional is warranted. This is the only way to put the patient's interest in
4 recovery ahead of the insurer's interest in minimizing its expenses. Were the balance reversed,
5 insurers would deny valid substance abuse treatment claims by default, in the absence of
6 compelling evidence that a prescribed level of care is proper.

7 87. Defendants thwart generally accepted professional standards by reversing that
8 balance and imposing upon the patient the burden of demonstrating that the treating
9 professional's prescribed residential rehabilitation treatment program is appropriate and
10 warranted.

11 88. Indeed, Magellan makes no secret that its objective in designing and
12 implementing the MNCGs is to approve only the "least-intensive" level of care (2015 MNCGs
13 at iv), allowing it to shirk its duty to assure that the treatment approved is effective and
14 consistent with prescribed care.

15 89. The CALOCUS standard, developed by AACAP and AACAP, expressly notes
16 that "it may be desirable for a child or adolescent to remain at a higher level of care to preclude
17 relapse and unnecessary disruption of care, and to promote lasting stability. A child or
18 adolescent may make the transition to another level of care when, *after an adequate period of*
19 *stabilization and based on the family's and treatment team's clinical judgment*, the child or
20 adolescent meets the criteria for the other level of care."

21 90. These generally accepted professional standards further support the conclusion
22 that Defendants' decision to shift onto the patient the burden of proving the appropriateness of
23 a treating professional's residential rehabilitation treatment program is fundamentally improper.

24 91. Next, condition I.D(2) deviates from ASAM standards by conditioning
25 residential treatment on a "*severely*" dysfunctional living environment.

26 92. The ASAM standards call for inclusive consideration of a large variety of
27 familial and environmental factors in assessing suitability of residential treatment, and do not
28

1 support application of a “severe” dysfunction requirement to merit residential rehabilitation
2 treatment.

3 93. The ASAM standards are not consistent with condition I.D(2), or the notion that
4 care should be denied where a patient’s living environment is demonstrably “dysfunctional” but
5 not “severely dysfunctional.” The MNCGs’ use of “severely dysfunctional” renders them
6 overly restrictive and non-inclusive, contrary to ASAM standards.

7 94. Finally, condition III.B requires patients’ treatment plans to “bring about
8 **significant** improvement” in the patient’s substance abuse disorder. This is inconsistent with
9 generally accepted professional standards, including standards promulgated by ASAM, AACP,
10 and other authorities.

11 95. For instance, AACP states that intensive outpatient treatment should be
12 considered medically necessary if the intervention would cause any *one* of the following
13 results: (a) prevent deterioration; (b) alleviate symptoms; (c) improve level of functioning; or
14 (d) assist in restoring normal development in a child.

15 96. Likewise, the Centers for Medicare & Medicaid Services has indicated that even
16 for inpatient psychiatric hospital services, providers are only required to show that the
17 treatment would “reasonably [be] expected to improve the patient’s condition”

18 97. The generally accepted criterion of *reasonable* improvement—which may
19 include prevention of deterioration rather than specific forms or measurements of
20 progression—is a far cry from Magellan’s overly-restrictive *significant* improvement condition.

21 **B. INTENSIVE OUTPATIENT TREATMENT CONDITIONS**

22 98. The MNCGs define intensive outpatient programs as programs with “the
23 capacity for planned, structured, service provision of at least 2 hours per day and 3 days per
24 week, although some patients may need to attend less often. These encounters are usually
25 comprised of coordinated and integrated multidisciplinary services,” including “group,
26 individual, family or multi-family group psychotherapy, psychoeducational services, and
27 adjunctive services such as medical monitoring.”
28

1 99. Magellan’s 2015 MNCGs specify criteria that must be satisfied to merit
2 continuing intensive outpatient treatment for substance abuse disorders in adults:

3 III. Continued Stay

4 Criteria A, B, C, and D must be met to satisfy the criteria for continued stay.

5 A. Despite reasonable therapeutic efforts, clinical evidence indicates at least
6 one of the following:

- 7 1) the persistence of problems that caused the admission to a degree
8 that continues to meet the admission criteria (both severity of
9 need and intensity of service needs), *or*
10 2) the emergence of additional problems that meet the admission
11 criteria (both severity of need and intensity of service needs), *or*
12 3) that disposition planning and/or attempts at therapeutic re-entry
13 into a less intensive level of care have resulted in, or would result
14 in exacerbation of the substance-related disorder to the degree
15 that would necessitate continued intensive outpatient treatment.
16 Subjective opinions are NOT sufficient to meet severity of need.
17 There must be objective clinical evidence or objective
18 information to justify the expectation that there would be a
19 decompensation.

20 B. **The current or revised treatment plan can be reasonably expected to
21 bring about significant improvement in the presenting or newly
22 defined problem(s) meeting criterion IIIA**, and this is documented by
23 progress notes for each day the patient attends the intensive outpatient
24 program, written and signed by the provider.

25 C. **The patient has the capability of developing skills to manage
26 symptoms or make behavioral change and demonstrates motivation
27 for change**, as evidenced by attending treatment sessions, completing
28 therapeutic tasks, and adhering to a medication regimen or other
requirement of treatment.

D. All applicable elements in Admission Intensity and Quality of Service
criteria are applied as related to assessment and treatment, if clinically
relevant and appropriate.

100. Although Magellan states that these criteria reflect merely “a more detailed
elaboration” of the definition of “medical necessity,” they are substantially more restrictive
than generally accepted professional standards.

1 101. Condition III.B requires patients’ treatment plans to “bring about **significant**
2 improvement” in the patient’s substance abuse disorder. This is inconsistent with generally
3 accepted professional standards, including standards promulgated by ASAM, AACP, and other
4 authorities.

5 102. For instance, AACP states that intensive outpatient treatment should be
6 considered medically necessary if the intervention would cause any *one* of the following
7 results: (a) prevent deterioration; (b) alleviate symptoms; (c) improve level of functioning; or
8 (d) assist in restoring normal development in a child.

9 103. Likewise, the Centers for Medicare & Medicaid Services has indicated that even
10 for inpatient psychiatric hospital services, providers are only required to show that the
11 treatment would “reasonably [be] expected to improve the patient’s condition”

12 104. The generally accepted criterion of *reasonable* improvement—which may
13 include prevention of deterioration rather than specific forms or measurements of
14 progression—is a far cry from Magellan’s overly restrictive *significant* improvement condition.

15 105. Finally, condition III.C is—like conditions I.F and III.D in the residential
16 rehabilitation context—overly restrictive and inconsistent with generally accepted professional
17 standards. That condition requires demonstrable motivation for change, when, as shown above,
18 lack of motivation for change is a well-known sign of the *need* for professional, medical
19 intervention in substance abuse disorders.

20 106. That Magellan’s MNCGs are more restrictive than the Plans they purportedly
21 serve, and more restrictive than generally accepted professional standards, is fully consistent
22 with Magellan’s dereliction of its duties to insureds. As early as 2009, ASAM cautioned in its
23 *Public Policy Statement on Managed Care, Addiction Medicine, and Parity* that when an
24 insurer (or claims adjudicator working on behalf of an insurer) “develops its own addiction
25 treatment level of care admission and continuing stay guidelines for authorizing or denying
26 requested treatment rather than adhering to nationally validated, reliable, and accepted
27 guidelines, it may appear that decision-influencing factors such as cost considerations outweigh
28 valid evidence-based authorization requests for medically necessary treatment.”

1 107. This concern is well founded in this case. By imposing and/or approving the
2 imposition of unduly restrictive criteria for admission and continuing stay in residential
3 rehabilitation and intensive outpatient treatment for substance abuse disorders in children and
4 adolescents, Blue Shield and Magellan have put cost (and profit) considerations far above the
5 wellbeing of their insureds. In doing so, they have violated their fiduciary duties to Plaintiffs
6 and the other members of the Class.

7 108. Magellan's MNCGs concerning treatment of substance abuse disorders are
8 substantially similar to the MNCGs concerning treatment of mental health disorders. They
9 suffer, therefore, from the same defects. Defendants are thus liable for the development and
10 use of MNCGs in the denial of mental health claims to the same extent as they are for the use
11 of the guidelines in the case of substance abuse disorders.

12 109. Because Magellan's MNCGs contravene terms of the plan documents
13 themselves, and have no basis in generally accepted professional standards, they generate
14 results that are unpredictable, arbitrary, and untethered to any plan requirements. The threshold
15 question of whether care meets generally accepted standards is a necessary condition for a
16 finding of medical necessity, but the guidelines used to make that determination have no basis
17 in the governing Plan documents. When beneficiaries' coverage determinations, therefore, are
18 "correct" (i.e., consistent with what the Plan terms actually provide for), it is only by chance.
19 Thus, by applying these guidelines, Magellan is essentially rolling a loaded dice as to whether
20 beneficiaries receive coverage for the care they are due.

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1 **DEFENDANTS’ BREACHES OF FIDUCIARY DUTY AND**
2 **IMPROPER DENIAL OF R.D.’S CLAIMS**

3 110. Charles Des Roches is a Blue Shield PPO subscriber residing in Salinas,
4 California. Charles Des Roches shares joint custody of R.D., a minor, with R.D.’s mother.

5 111. R.D. is a beneficiary of Charles Des Roches’s Blue Shield PPO plan (the “Des
6 Roches Plan”), a non-grandfathered, large group plan that is fully insured by Blue Shield with
7 an effective date of October 1, 2014. The Des Roches Plan renews annually.

8 112. According to the Evidence of Coverage (“EOC”) that governs the Des Roches
9 Plan, all mental health services are “provided through the Plan’s Mental Health Service
10 Administrator (MHSA).” The EOC also provides that “[n]o benefits are provided for
11 Substance Abuse Conditions, unless substance abuse coverage is provided as an optional
12 Benefit by your Employer.” The Des Roches Plan includes substance abuse coverage.

13 113. With respect to mental health and substance abuse benefits, the EOC states,
14 “Blue Shield’s Mental Health Service Administrator (MHSA) arranges and administers Mental
15 Health Services for Blue Shield Members within California.”

16 114. As alleged above, the MHSA to which the EOC refers is Magellan.

17 115. Accordingly, Blue Shield has delegated responsibility for administering mental
18 health and substance abuse benefits, and adjudicating mental health and substance abuse
19 claims, to Magellan.

20 116. The EOC further provides that, “[t]he Benefits of this Plan are intended only for
21 Services that are Medically Necessary. Because a Physician or other provider may prescribe,
22 order, recommend, or approve a service or supply does not, in itself, make it medically
23 necessary even though it is not specifically listed as an exclusion or limitation. ... Blue Shield
24 of California may limit or exclude benefits for services which are not necessary.”

25 117. The EOC defines Medical Necessity in the following manner: “Services which
26 are medically necessary include only those which have been established as safe and effective,
27 are furnished under generally accepted professional standards to treat illness, injury or medical
28 condition, and which, as determined by Blue Shield, are: a. consistent with Blue Shield of

1 California medical policy; b. consistent with the symptoms or diagnosis; c. not furnished
2 primarily for the convenience of the patient, the attending Physician or other provider; and d.
3 furnished at the most appropriate level which can be provided safely and effectively to the
4 patient.”

5 118. The EOC does not condition delivery of medically necessary treatment to the
6 “least-intensive” level of care, as do Magellan’s MNCGs.

7 119. Nor does the EOC allow Blue Shield or Magellan to deviate from generally
8 accepted professional standards in approving coverage of care.

9 120. The EOC also sets forth a grievance and appeal process for mental health and
10 substance abuse claims. This process allows subscribers (or their representatives or providers)
11 to submit requests for review of initial claims determinations by phone, letter, or online, or to
12 submit a Grievance Form by mail or online. The EOC requires grievances to be submitted
13 within 180 days following the incident complained of, and resolved within 30 days.

14 121. On August 26, 2015, R.D.—then fifteen years old—was urgently admitted for
15 residential rehabilitation treatment at Evolve Treatment Center in Topanga Canyon, California,
16 due to substance abuse, major depression, and severe emotional disturbance of a child.

17 122. For the preceding two years, R.D. had abused cannabis, alcohol, hallucinogens,
18 cough syrup, painkillers, and nitrous oxide. R.D. has a documented history of shoplifting and
19 theft, including breaking into cars to steal money for drugs, and of excessive anxiety,
20 aggression, and anger, including punching a hole in a parent’s wall and breaking his hand as a
21 result. R.D.’s divorced parents have joint custody of R.D., and R.D. sleeps an average of 12
22 hours per day, exhibiting a general disinterestedness in normal activities and a lack of
23 motivation, as well as fluctuations in weight. R.D. had undergone multiple outpatient
24 treatments, including psychopharmacological treatment (Zoloft and Wellbutrin for over a year),
25 psychotherapy, and EMDR, prior to admission at Evolve Treatment Center.

26 123. R.D.’s parents are unable to present a unified parenting front, as evidenced in
27 R.D.’s clinical records, and neither can effectively supervise or support R.D. on an outpatient
28 basis, or contain R.D. in their homes.

1 124. On August 28, 2015, Blue Shield issued a letter denying coverage for R.D.'s
2 residential rehabilitation treatment based on Magellan's adjudication of the claim (the "Denial
3 Letter").

4 125. The Denial Letter states that "residential substance use rehabilitation treatment
5 is not medically necessary based on 2015 Magellan Medical Necessity Criteria Guidelines, as
6 adopted by Blue Shield of California MHSA, Residential Treatment Substance Use Disorders,
7 Rehabilitation, Child and Adolescent, I-C and I-D," and enumerates the following as "reasons"
8 for the denial:

9 Your substance use/dependency has not caused significant impairment that
10 cannot be managed at a lower level of care. You have not had recent,
11 appropriate professional intervention at a less intensive level of care. Your
12 living situation does not undermine treatment, or alternative living situations
13 are appropriate. There is no evidence for serious, imminent danger outside
14 residential treatment. There is no clinical evidence that you are unlikely to
15 respond to treatment at a less intensive and less restrictive level of care.

14 126. Instead of approving the residential rehabilitation treatment R.D. required, as
15 prescribed by R.D.'s treating provider, Defendants instructed R.D. to "actively participate in
16 self-help groups and to make use of community resources for substance use recovery."

17 127. R.D. appealed Defendants' August 28, 2015 denial on August 31, 2015.

18 128. On September 3, 2015, Defendants denied the appeal by letter (the "Appeal
19 Denial Letter"). Defendants explained that:

20 The principal reason [for denial] is that the medical necessity of treatment at a
21 residential level of care was not established. A review of your medical
22 records submitted to Blue Shield indicates that on August 25, 2015, you did
23 not meet the Blue Shield of California / Magellan guidelines for treatment at a
24 residential program since:

- 24 • Your doctor has not shown that you can benefit from residential
25 rehabilitation treatment
- 26 • Your substance use/dependency has not caused significant impairment
27 that cannot be managed at a lower level of care
- 28 • You have not had recent, professional outpatient intervention

- 1 • Your living situation does not undermine treatment, or alternative living
situations are appropriate
- 2 • There is no evidence for serious, imminent danger outside of residential
3 treatment
- 4 • Based on the information from your provider, you can be safely treated
5 at a lower level of care such as Intensive Outpatient Psychiatric (IOP)
chemical dependency and mental health treatment level of care.

6 129. The Appeal Denial Letter continued, “In addition, your appeal has been
7 reviewed by a psychiatrist who agrees that care in a residential care program from August 25,
8 2015, going forward is not medically necessary.”

9 130. R.D. submitted extensive clinical records substantiating R.D.’s need for
10 residential rehabilitation treatment to the persons responsible for conducting appeal.

11 131. Defendants based their denials of coverage on criteria inconsistent with
12 generally accepted professional standards.

13 132. In particular, Defendants rejected R.D.’s claim because:

- 14 a. R.D. did not show that he “failed first” at a lower level of care, despite that this
15 generally accepted professional standards reject “fail first” criteria;
- 16 b. R.D. was purportedly not in danger or a risk to others—although this standard is
17 typically associated with criteria for hospitalization;
- 18 c. R.D.’s living situation was purportedly adequately supportive—although, as
19 noted above, R.D.’s divorced parents are unable to effectively supervise or
20 support R.D. on an outpatient basis, or contain R.D. in their homes;
- 21 d. R.D. purportedly failed to show that R.D. could not benefit from a lower level of
22 care—although, as noted above, generally accepted professional standards,
23 including CALOCUS and LOCUS, require a “clear and compelling rationale”
24 for selecting a lower level of care than that prescribed by a treating professional;
25 and
- 26 e. R.D. purportedly failed to show that R.D. could benefit from residential care—
27 although, again, generally accepted professional standards require a “clear and
28 compelling rationale” for selecting a lower level of care than that prescribed by

1 a treating professional, and R.D.'s clinically documented lack of motivation may
2 not properly be construed by Defendants as showing an incapacity to benefit
3 from residential care, under generally accepted professional standards.

4 133. Thus, Defendants ignored generally accepted professional standards in applying
5 Magellan's overly restrictive MNCGs in adjudicating and denying R.D.'s claim for residential
6 rehabilitation treatment.

7 134. Accordingly, R.D. exhausted all internal administrative remedies. However,
8 administrative exhaustion is not a prerequisite for a breach of fiduciary duty claim.

9 135. R.D. received the necessary residential rehabilitation treatment from August 26,
10 2015, to October 25, 2015, and consequently incurred tens of thousands of dollars of
11 unreimbursed expenses. In light of R.D.'s severe substance abuse disorder and co-morbid
12 mental health conditions, it is expected that R.D. will require such treatment again in the future.
13 Indeed, following treatment at Evolve Treatment Center, R.D. was transported directly to a
14 secured therapeutic boarding school staffed by licensed psychologists, a psychiatrist, and
15 medical doctors.

16 **DEFENDANTS' BREACHES OF FIDUCIARY DUTY AND**
17 **IMPROPER DENIAL OF D.V.'S CLAIMS**

18 136. Sylvia Meyer is a Blue Shield PPO subscriber residing in Los Angeles County,
19 California. D.V. is Sylvia Meyer's son.

20 137. D.V. is a beneficiary of Sylvia Meyer's Blue Shield PPO plan (the "Meyer
21 Plan"), a non-grandfathered, large group plan that is fully insured by Blue Shield. The Meyer
22 Plan renews annually.

23 138. As with the Des Roches Plan, the Meyer Plan EOC provides that all mental
24 health services are "provided through the Plan's Mental Health Service Administrator
25 (MHSA)."

26 139. The EOC also provides that "[n]o benefits are provided for Substance Abuse
27 Conditions, unless substance abuse coverage is provided as an optional Benefit by your
28 Employer." The Meyer Plan includes substance abuse coverage.

1 140. With respect to mental health and substance abuse benefits, the EOC states that
2 “Blue Shield has contracted with the Plan’s MHSA [which] . . . will underwrite and deliver
3 Blue Shield’s Mental Health Services”

4 141. As alleged above, the MHSA to which the EOC refers is Magellan.

5 142. Accordingly, with respect to the Meyer Plan as well as the Des Roches Plan,
6 Blue Shield has delegated responsibility for administering mental health and substance abuse
7 benefits, and adjudicating mental health and substance abuse claims, to Magellan.

8 143. The EOC further provides that, “[t]he Benefits of this Plan are intended only for
9 Services that are Medically Necessary. Because a Physician or other provider may prescribe,
10 order, recommend, or approve a service or supply does not, in itself, make it medically
11 necessary even though it is not specifically listed as an exclusion or limitation. . . . Blue Shield
12 of California may limit or exclude benefits for services which are not necessary.”

13 144. The EOC for the Meyer Plan, like the Des Roches Plan, defines Medical
14 Necessity as follows: “Services which are medically necessary include only those which have
15 been established as safe and effective, are furnished under generally accepted professional
16 standards to treat illness, injury or medical condition, and which, as determined by Blue Shield,
17 are: a. consistent with Blue Shield of California medical policy; b. consistent with the
18 symptoms or diagnosis; c. not furnished primarily for the convenience of the patient, the
19 attending Physician or other provider; and d. furnished at the most appropriate level which can
20 be provided safely and effectively to the patient.”

21 145. The Meyer Plan’s EOC does not condition the delivery of medically necessary
22 treatment to the provision of the “least-intensive” level of care, yet Magellan’s MNCG do.

23 146. Nor does the EOC allow Blue Shield or Magellan to deviate from generally
24 accepted professional standards in approving care.

25 147. The Meyer Plan provides for the same internal appeals process as the Des
26 Roches Plan.

27 148. On July 6, 2015, D.V. was admitted to an intensive outpatient psychiatric
28 program at Evolve Treatment Center.

1 149. For more than four years before his admission, D.V. suffered from major
2 depression, which was compounded by abuse of alcohol as well as cocaine, marijuana,
3 benzodiazepine (i.e., “benzos”) and other drugs. D.V. had been involved in criminal activity
4 and was suspended from school for fighting with a classmate.

5 150. D.V.’s parents are divorced. His father abuses marijuana and pain pills, as well
6 as alcohol, and had attempted suicide in the past. Two of his paternal aunts died of drug
7 overdoses. D.V. had an unstable childhood, with widespread interfamily conflict. He has a
8 strained relationship with his mother and no relationship with his older brother. D.V. had
9 undergone psychiatric treatment at UCLA, residential care, and partial hospitalization.

10 151. After treatment in residential care and in partial hospitalization, D.V. was
11 admitted to an intensive outpatient psychiatric level of care at Evolve Treatment Center on July
12 6, 2015.

13 152. On August 11, 2015, Sylvia Meyer and D.V. received a letter from Blue Shield
14 denying coverage for D.V.’s intensive outpatient treatment from August 7, 2015, going forward
15 (the “D.V. Denial Letter”).

16 153. The D.V. Denial Letter states that “intensive outpatient substance abuse
17 treatment is not medically necessary based on 2015 Magellan Medical Necessity Criteria
18 Guidelines, as adopted by Blue Shield of California MHSA, Intensive Outpatient Treatment,
19 Substance Abuse Disorders, Rehabilitation, Adult and Geriatric, IID, IIB, IIC, IID” and
20 enumerates the following as “reasons” for the denial:

21 Your treatment plan does not consider the use of medications to help with
22 cravings and relapse prevention. Your provider has not shown that the
23 treatment plan will bring about further significant improvement in the
24 problems that required an intensive outpatient treatment program. Your
25 provider has not shown that you have the motivation, and the ability, to follow
26 your treatment plan. Outpatient psychiatric and substance use rehabilitation
27 treatment should be considered. Your provider has not shown that your
28 treatment plan meets the expectations for intensity and quality of service for
this level of care.

1 154. Instead of approving the intensive outpatient psychiatric treatment D.V.
2 required, as prescribed by D.V.'s treating provider, Defendants instructed D.V. "to participate
3 in self-help groups and to make use of community resources."

4 155. On August 21, 2015, the denial was appealed.

5 156. On September 15, 2015, Defendants denied the appeal by letter (the "D.V.
6 Appeal Denial Letter").

7 157. Defendants explained that:

8 The principal reason [for denial] is that the medical necessity of treatment at
9 an intensive outpatient program level of care was not established. As of
10 August 7, 2015, you did not meet the Blue Shield of California / Magellan
11 guidelines to be at an intensive outpatient psychiatric (IOP) level of care
12 since:

- 13 • You have improved and no longer require a structured intensive
14 outpatient treatment setting for care
- 15 • Your provider has not shown that the treatment plan will bring about
16 significant further improvement in the problems that required an
17 intensive outpatient treatment program
- 18 • The medical necessity criteria appear to be met for outpatient psychiatric
19 and substance use treatment, which is available to you
- 20 • A short period of traditional outpatient treatment could help you solidify
21 and maintain your abstinence and recovery
- 22 • You are also encouraged to participate in both individual and family
23 psychotherapies as well as in self-help groups and to make use of
24 community resources.

25 158. The D.V. Appeal Denial Letter continued, "In addition, your appeal has been
26 reviewed by a psychiatrist who agrees that continued care at an intensive outpatient program
27 level of care was not medically necessary as of August 7, 2015."

28 159. Defendants based their denials of coverage on criteria inconsistent with
generally accepted professional standards. In particular, Defendants rejected D.V.'s claim
because:

- 1 a. D.V. purportedly failed to show that D.V. could not benefit from a lower level
2 of care (i.e., “traditional outpatient treatment”)—although, as noted above,
3 generally accepted professional standards, including CALOCUS and LOCUS,
4 require a “clear and compelling rationale” for selecting a lower level of care than
5 that prescribed by a treating professional;
- 6 b. D.V. purportedly failed to show that D.V. would obtain “significant further
7 improvement” from intensive outpatient psychiatric care—although, again,
8 generally accepted professional standards do not require a showing of
9 “significant” improvement; and
- 10 c. D.V. purportedly failed to show that he was motivated for treatment, although
11 generally accepted professional standards recognize that lack of motivation
12 warrants care.

13 160. Thus, Defendants ignored generally accepted professional standards in applying
14 Magellan’s overly restrictive MNCGs in adjudicating and denying D.V.’s claim for intensive
15 outpatient treatment.

16 161. Accordingly, D.V. exhausted all internal administrative remedies. However,
17 administrative exhaustion is not a prerequisite for a breach of fiduciary duty claim.

18 162. D.V. received the prescribed intensive outpatient psychiatric treatment from
19 August 7, 2015, to September 4, 2015, and consequently incurred significant in unreimbursed
20 expenses. In light of D.V.’s severe substance abuse disorder and co-morbid mental health
21 conditions, it is expected that D.V. may require such treatment again in the future.

22 **CLASS ACTION ALLEGATIONS**

23 163. Plaintiffs incorporate by reference the preceding paragraphs as though set forth
24 fully herein.

25 164. Blue Shield and Magellan serve as the claims administrators for mental health
26 and substance abuse treatment claims for other health insurance plans that define covered
27 treatment in the same way as the Plaintiffs’ Plans.

1 165. The policies and practices that Defendants followed with respect to the claims
2 filed by Plaintiffs are the same as those that have been applied by Defendants to other
3 similarly-situated insureds seeking mental health and substance abuse treatment benefits under
4 their health plans.

5 166. As such, pursuant to Federal Rule of Civil Procedure 23, Plaintiffs bring their
6 claims on behalf of themselves and a putative class of similarly situated individuals as noted in
7 the counts below.

8 167. The class (“Class”) is defined as follows:

9 All participants or beneficiaries in an insurance plan governed by ERISA, for
10 which Blue Shield and/or Magellan make coverage decisions with respect to
11 claims for mental health and substance abuse-related treatment, who sought
12 and were denied coverage for all or a portion of residential treatment for
13 mental health or substance use disorders, or intensive outpatient treatment for
14 mental health or substance use disorders, within the applicable statute of
15 limitations.

14 168. There are so many persons within the putative Class that joinder is
15 impracticable.

16 169. Certification of the Class is desirable and proper because there are questions of
17 law and fact in this case that are common to all members of the Class. Such common questions
18 of law and fact include, but are not limited to, the following:

- 19 a. The nature of the legal duties ERISA imposes upon Blue Shield and/or Magellan
20 as claims administrators for mental health and substance abuse claims;
- 21 b. Whether Magellan engages in a fiduciary act when it develops and utilizes
22 mental health and substance abuse MNCGs;
- 23 c. Whether Blue Shield engages in a fiduciary act when it adopts and approves
24 Magellan’s mental health and substance abuse level-of-care and coverage
25 determination guidelines;
- 26 d. Whether Magellan’s MNCGs are consistent with generally accepted
27 professional standards in the mental health and substance abuse disorder
28 treatment community;

- e. Whether Blue Shield's adoption and approval, and/or Magellan's development and utilization, of the MNCGs constitutes a breach of fiduciary duty;
- f. Whether Magellan engages in a fiduciary act when it adjudicates a claim for benefits pursuant to delegation by Blue Shield;
- g. Whether Blue Shield engages in a fiduciary act when it approves or ratifies Magellan's adjudication of a claim for benefits;
- h. What remedies are available if any or all Defendants are found liable for the claims asserted.

170. Certification is desirable and proper because Plaintiffs' claims are typical of the claims of members of the proposed Class that Plaintiffs seek to represent.

171. Certification is also desirable and proper because Plaintiffs will fairly and adequately protect the interests of the Class members that they seek to represent. There are no conflicts of interest between Plaintiffs and members of the Class, and Plaintiffs are cognizant of their duties and responsibilities to the entire Class. Plaintiffs' counsel are qualified, experienced, and able to conduct the proposed class action litigation.

172. It is desirable to concentrate the litigation of these claims in this forum. The determination of the claims of all Class members in a single forum, and in a single proceeding, would be a fair and efficient means of resolving the issues presented in this litigation.

173. Any difficulties likely to be encountered in maintaining this action as a class action are reasonably manageable, especially when weighed against the virtual impossibility of affording adequate relief to Class members through numerous individual actions. The burden individual litigation would impose on the courts, moreover, is avoidable by means of the class action mechanism.

CAUSES OF ACTION

COUNT I

BREACH OF FIDUCIARY DUTIES UNDER 29 U.S.C. § 1132(a)(1)(B)

174. Plaintiffs incorporate by reference the preceding paragraphs as though set forth fully herein.

1 175. Plaintiffs bring this cause of action individually and on behalf of the Class.

2 176. This cause of action is brought pursuant to 29 U.S.C. § 1132(a)(1)(B) to clarify
3 Plaintiffs' and Class members' rights to future benefits and enforce their rights under their
4 Plans, as a result of Defendants' development, adoption, approval, ratification, and utilization
5 of medical necessity criteria and claims determination guidelines that are far more restrictive
6 than those that are generally accepted in contravention of their ERISA fiduciary obligations
7 under ERISA.

8 177. As the entities responsible for making and/or approving mental health and
9 substance abuse benefit determinations under the Plans, and responsible for developing and/or
10 approving internal practices and policies to facilitate such determinations, Defendants are
11 ERISA fiduciaries.

12 178. As ERISA fiduciaries, and pursuant to 29 U.S.C. § 1104(a), Defendants are
13 required to discharge their duties "solely in the interests of the participants and beneficiaries"
14 and for the "exclusive purpose" of providing benefits to participants and their beneficiaries, and
15 to pay reasonable expenses of administering the Plans. They must do so with reasonable "care,
16 skill, prudence, and diligence" and in accordance with the terms of the plans they administer.
17 They must conform their conduct to a fiduciary duty of loyalty and may not make
18 misrepresentations to their insureds.

19 179. Defendants violated, and continue to violate, these duties by developing,
20 adopting, approving, ratifying, and utilizing the restrictive level-of-care and coverage
21 determination guidelines discussed hereinabove, and in applying them to claims submitted by
22 Plaintiffs and the other Class members. Despite the fact that the insurance plans that insure
23 Plaintiffs and the other Class members provide for insurance coverage for residential
24 rehabilitation and intensive outpatient treatment for substance abuse disorders, the fact that
25 generally accepted professional standards of care are widely available and well-known to
26 Defendants, and the fact that Defendants asserted that their guidelines were consistent with
27 those generally accepted standards, Defendants developed, adopted, approved, ratified, and
28 utilized guidelines that are far more restrictive than those that are generally accepted. In so

1 doing, Defendants did not act “solely in the interests of the participants and beneficiaries” for
2 the “exclusive purpose” of “providing benefits.” They did not utilize the “care, skill, prudence,
3 and diligence” of a “prudent man” acting in a similar capacity. They did not act in accordance
4 with the terms of Plaintiffs’ Plans, nor with the terms of the other Class members’ plans.

5 180. Instead, Defendants elevated their own financial interests, and those of their
6 corporate affiliates, above the interests of Plan participants and beneficiaries, including
7 Plaintiffs and all other Class members. By promulgating improperly restrictive guidelines,
8 Defendants artificially decreased the number and value of covered claims, thereby benefiting
9 themselves and their affiliates at the direct expense of their insureds, including Plaintiffs.

10 181. To remedy their injuries arising out of Defendants’ breaches of fiduciary duty,
11 Plaintiffs, individually and on behalf of the Class, request a judgment in their favor: (i)
12 declaring that Magellan’s internal guidelines complained of herein were developed and utilized
13 in violation of Magellan’s fiduciary duties; (ii) declaring that Blue Shield’s approval, adoption
14 and/or ratification of Magellan’s internal guidelines complained of herein, and their utilization
15 in claims adjudication, constitute a violation of Blue Shield’s fiduciary duties; (iii) issue a
16 permanent injunction ordering Defendants to cease utilization of the guidelines complained of
17 herein, and instead adopt, develop, and utilize guidelines that are consistent with general
18 accepted professional standards; and (iv) ordering Defendants to reprocess claims for
19 residential rehabilitation treatment and intensive outpatient treatment for substance abuse and
20 mental health disorders that they previously denied in whole or in part, pursuant to new
21 guidelines that are consistent with generally accepted professional standards and the Class
22 members’ plans.

23 **COUNT II**

24 **IMPROPER DENIAL OF BENEFITS UNDER 29 U.S.C. § 1132(a)(1)(B)**

25 182. Plaintiffs incorporate by reference the preceding paragraphs as though fully set
26 forth herein.

27 183. Plaintiffs bring this cause of action individually and on behalf of the Class.

28 184. This cause of action is brought pursuant to 29 U.S.C. § 1132(a)(1)(B).

1 185. Defendants denied the insurance claims for residential rehabilitation treatment
2 and intensive outpatient treatment for substance abuse disorders submitted by Plaintiffs
3 (respectively, R.D. and D.V.) and other Class members in violation of the terms of Plaintiffs'
4 Plans and the plans insuring other Class members.

5 186. Plaintiffs and the other Class members have been harmed by Defendants'
6 improper benefit denials because they were deprived of insurance benefits they were owed.

7 187. To remedy these injuries, Plaintiffs, individually and on behalf of the Class,
8 request a judgment in their favor ordering Defendants to reprocess claims for residential
9 rehabilitation treatment and intensive outpatient treatment for substance abuse and mental
10 health disorders that they previously denied in whole or in part, pursuant to new guidelines that
11 are consistent with generally accepted professional standards and the Class members' plans.

12 **COUNT III**

13 **INJUNCTIVE RELIEF UNDER 29 U.S.C. § 1132(a)(3)(A)**

14 188. Plaintiffs incorporate by reference the preceding paragraphs as though fully set
15 forth herein.

16 189. Plaintiffs bring this cause of action individually and on behalf of the Class.

17 190. Plaintiffs and the Class have been harmed, and are likely to be harmed in the
18 future, by Defendants' breaches of fiduciary duty described hereinabove.

19 191. To remedy these injuries, Plaintiffs and the Class are entitled to seek, and do
20 seek, an injunction prohibiting these acts and practices pursuant to 29 U.S.C. § 1132(a)(3)(A),
21 and seek a judgment in their favor ordering Defendants to reprocess claims for residential
22 rehabilitation treatment and intensive outpatient treatment for substance abuse and mental
23 health disorders that they previously denied in whole or in part, pursuant to new guidelines that
24 are consistent with generally accepted professional standards and the Class members' plans.

25 **COUNT IV**

26 **OTHER APPROPRIATE EQUITABLE RELIEF UNDER 29 U.S.C. § 1132(a)(3)(B)**

27 192. Plaintiffs incorporate by reference the preceding paragraphs as though fully set
28 forth herein.

1 193. Plaintiffs bring this cause of action individually and on behalf of the Class.

2 194. This cause of action is brought pursuant to 29 U.S.C. § 1132(a)(3)(B).

3 195. Plaintiffs and the Class have been harmed, and are likely to be harmed in the
4 future, by Defendants' breaches of fiduciary duty described hereinabove.

5 196. Additionally, by engaging in this misconduct, including denying Plaintiffs'
6 claims, Defendants caused themselves and their corporate affiliates to be unjustly enriched as
7 they were not required to pay benefit claims.

8 197. To remedy these injuries, Plaintiffs and the Class are entitled to seek, and do
9 seek, appropriate equitable relief pursuant to 29 U.S.C. § 1132(a)(3)(B), and they seek a
10 judgment in their favor (i) ordering Defendants to reprocess claims for residential rehabilitation
11 treatment and intensive outpatient treatment for substance abuse and mental health disorders
12 that they previously denied in whole or in part, pursuant to new guidelines that are consistent
13 with generally accepted professional standards and the Class members' plans; and (ii) ordering
14 Defendants to pay a surcharge or other make-whole relief to Plaintiffs and the other Class
15 members in an amount equivalent to the revenue Defendants generated for providing mental
16 health and substance abuse-related claims administration services with respect to claims filed
17 by Plaintiffs and the other Class members, expenses that Defendants and their corporate
18 affiliates avoided due to their wrongful denials, the additional revenue Defendants received as a
19 result of those cost-avoidances, the out-of-pocket costs that Plaintiffs and other Class members
20 incurred following Defendants' wrongful denials, and/or pre-judgment interest.

21 **REQUEST FOR RELIEF**

22 WHEREFORE, Plaintiffs, individually and on behalf of the Class, demand judgment in
23 their favor against Defendants providing the relief requested in Counts I-IV above and
24 providing the additional relief as follows:

25 198. Certifying the Class and all causes of action asserted herein for class treatment
26 under Federal Rule of Civil Procedure 23;

27 199. Appointing Plaintiffs as Class Representatives;

28

1 200. Appointing Plaintiffs' counsel (Grant & Eisenhofer P.A., Zuckerman Spaeder
2 LLP, and Psych-Appeal, Inc.) as counsel for the Class;

3 201. Awarding Plaintiffs disbursements and expenses for this action, including
4 reasonable attorneys' fees, in amounts to be determined by the Court, pursuant to 29 U.S.C. §
5 1132(g); and

6 202. Granting such other and further relief as is just and proper.

7
8 Dated: May 26, 2016

Respectfully submitted,

9 /s/ Rebecca A. Musarra

10 Meiram Bendat (Cal. Bar No. 198884)
11 PSYCH-APPEAL, INC.
12 8560 West Sunset Boulevard, Suite 500
13 West Hollywood, California 90069
14 Tel: (310) 598-3690, x. 101
15 Fax: (310) 564-0040
16 mbendat@psych-appeal.com

17 Daniel L. Berger (to be admitted *pro hac vice*)
18 Kyle J. McGee (to be admitted *pro hac vice*)
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Attorneys for Plaintiffs and the Proposed Class

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

<p>I. (a) PLAINTIFFS CHARLES DES ROCHES, on his own behalf and on behalf of his beneficiary son, R.D., and all others similarly situated, and SYLVIA MEYER, on her own behalf and all others similarly situated</p> <p>(b) County of Residence of First Listed Plaintiff <u>Monterey</u> <i>(EXCEPT IN U.S. PLAINTIFF CASES)</i></p> <p>(c) Attorneys <i>(Firm Name, Address, and Telephone Number)</i> (See attachment)</p>	<p>DEFENDANTS CALIFORNIA PHYSICIANS' SERVICE d/b/a BLUE SHIELD OF CALIFORNIA; HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA; and MAGELLAN HEALTH SERVICES OF CALIFORNIA, INC.-EMPLOYER SERVICES</p> <p>County of Residence of First Listed Defendant <u>San Mateo</u> <i>(IN U.S. PLAINTIFF CASES ONLY)</i></p> <p>NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.</p> <p>Attorneys <i>(If Known)</i></p>
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<p>II. BASIS OF JURISDICTION <i>(Place an "X" in One Box Only)</i></p> <p><input type="checkbox"/> 1 U.S. Government Plaintiff <input checked="" type="checkbox"/> 3 Federal Question <i>(U.S. Government Not a Party)</i></p> <p><input type="checkbox"/> 2 U.S. Government Defendant <input type="checkbox"/> 4 Diversity <i>(Indicate Citizenship of Parties in Item III)</i></p>	<p>III. CITIZENSHIP OF PRINCIPAL PARTIES <i>(Place an "X" in One Box for Plaintiff and One Box for Defendant)</i></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">PTF</td> <td style="text-align: center;">DEF</td> <td></td> <td style="text-align: center;">PTF</td> <td style="text-align: center;">DEF</td> </tr> <tr> <td>Citizen of This State</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td>Incorporated or Principal Place of Business In This State</td> <td style="text-align: center;"><input type="checkbox"/> 4</td> <td style="text-align: center;"><input type="checkbox"/> 4</td> </tr> <tr> <td>Citizen of Another State</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> <td>Incorporated and Principal Place of Business In Another State</td> <td style="text-align: center;"><input type="checkbox"/> 5</td> <td style="text-align: center;"><input type="checkbox"/> 5</td> </tr> <tr> <td>Citizen or Subject of a Foreign Country</td> <td style="text-align: center;"><input type="checkbox"/> 3</td> <td style="text-align: center;"><input type="checkbox"/> 3</td> <td>Foreign Nation</td> <td style="text-align: center;"><input type="checkbox"/> 6</td> <td style="text-align: center;"><input type="checkbox"/> 6</td> </tr> </table>		PTF	DEF		PTF	DEF	Citizen of This State	<input type="checkbox"/> 1	<input type="checkbox"/> 1	Incorporated or Principal Place of Business In This State	<input type="checkbox"/> 4	<input type="checkbox"/> 4	Citizen of Another State	<input type="checkbox"/> 2	<input type="checkbox"/> 2	Incorporated and Principal Place of Business In Another State	<input type="checkbox"/> 5	<input type="checkbox"/> 5	Citizen or Subject of a Foreign Country	<input type="checkbox"/> 3	<input type="checkbox"/> 3	Foreign Nation	<input type="checkbox"/> 6	<input type="checkbox"/> 6
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Citizen or Subject of a Foreign Country	<input type="checkbox"/> 3	<input type="checkbox"/> 3	Foreign Nation	<input type="checkbox"/> 6	<input type="checkbox"/> 6																				

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

<p>CONTRACT</p> <p><input type="checkbox"/> 110 Insurance</p> <p><input type="checkbox"/> 120 Marine</p> <p><input type="checkbox"/> 130 Miller Act</p> <p><input type="checkbox"/> 140 Negotiable Instrument</p> <p><input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment</p> <p><input type="checkbox"/> 151 Medicare Act</p> <p><input type="checkbox"/> 152 Recovery of Defaulted Student Loans <i>(Excludes Veterans)</i></p> <p><input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits</p> <p><input type="checkbox"/> 160 Stockholders' Suits</p> <p><input type="checkbox"/> 190 Other Contract</p> <p><input type="checkbox"/> 195 Contract Product Liability</p> <p><input type="checkbox"/> 196 Franchise</p>	<p>TORTS</p> <p>PERSONAL INJURY</p> <p><input type="checkbox"/> 310 Airplane</p> <p><input type="checkbox"/> 315 Airplane Product Liability</p> <p><input type="checkbox"/> 320 Assault, Libel & Slander</p> <p><input type="checkbox"/> 330 Federal Employers' Liability</p> <p><input type="checkbox"/> 340 Marine</p> <p><input type="checkbox"/> 345 Marine Product Liability</p> <p><input type="checkbox"/> 350 Motor Vehicle</p> <p><input type="checkbox"/> 355 Motor Vehicle Product Liability</p> <p><input type="checkbox"/> 360 Other Personal Injury</p> <p><input type="checkbox"/> 362 Personal Injury - Medical Malpractice</p> <p>PERSONAL INJURY</p> <p><input type="checkbox"/> 365 Personal Injury - Product Liability</p> <p><input type="checkbox"/> 367 Health Care/Pharmaceutical Personal Injury Product Liability</p> <p><input type="checkbox"/> 368 Asbestos Personal Injury Product Liability</p> <p>PERSONAL PROPERTY</p> <p><input type="checkbox"/> 370 Other Fraud</p> <p><input type="checkbox"/> 371 Truth in Lending</p> <p><input type="checkbox"/> 380 Other Personal Property Damage</p> <p><input type="checkbox"/> 385 Property Damage Product Liability</p>	<p>FORFEITURE/PENALTY</p> <p><input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881</p> <p><input type="checkbox"/> 690 Other</p> <p>LABOR</p> <p><input type="checkbox"/> 710 Fair Labor Standards Act</p> <p><input type="checkbox"/> 720 Labor/Management Relations</p> <p><input type="checkbox"/> 740 Railway Labor Act</p> <p><input type="checkbox"/> 751 Family and Medical Leave Act</p> <p><input type="checkbox"/> 790 Other Labor Litigation</p> <p><input type="checkbox"/> 791 Employee Retirement Income Security Act</p> <p>IMMIGRATION</p> <p><input type="checkbox"/> 462 Naturalization Application</p> <p><input type="checkbox"/> 465 Other Immigration Actions</p>	<p>BANKRUPTCY</p> <p><input type="checkbox"/> 422 Appeal 28 USC 158</p> <p><input type="checkbox"/> 423 Withdrawal 28 USC 157</p> <p>PROPERTY RIGHTS</p> <p><input type="checkbox"/> 820 Copyrights</p> <p><input type="checkbox"/> 830 Patent</p> <p><input type="checkbox"/> 840 Trademark</p> <p>SOCIAL SECURITY</p> <p><input type="checkbox"/> 861 HIA (1395ff)</p> <p><input type="checkbox"/> 862 Black Lung (923)</p> <p><input type="checkbox"/> 863 DIWC/DIWW (405(g))</p> <p><input type="checkbox"/> 864 SSID Title XVI</p> <p><input type="checkbox"/> 865 RSI (405(g))</p> <p>FEDERAL TAX SUITS</p> <p><input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant)</p> <p><input type="checkbox"/> 871 IRS—Third Party 26 USC 7609</p>	<p>OTHER STATUTES</p> <p><input type="checkbox"/> 375 False Claims Act</p> <p><input type="checkbox"/> 400 State Reapportionment</p> <p><input type="checkbox"/> 410 Antitrust</p> <p><input type="checkbox"/> 430 Banks and Banking</p> <p><input type="checkbox"/> 450 Commerce</p> <p><input type="checkbox"/> 460 Deportation</p> <p><input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations</p> <p><input type="checkbox"/> 480 Consumer Credit</p> <p><input type="checkbox"/> 490 Cable/Sat TV</p> <p><input type="checkbox"/> 850 Securities/Commodities/Exchange</p> <p><input checked="" type="checkbox"/> 890 Other Statutory Actions</p> <p><input type="checkbox"/> 891 Agricultural Acts</p> <p><input type="checkbox"/> 893 Environmental Matters</p> <p><input type="checkbox"/> 895 Freedom of Information Act</p> <p><input type="checkbox"/> 896 Arbitration</p> <p><input type="checkbox"/> 899 Administrative Procedure Act/Review or Appeal of Agency Decision</p> <p><input type="checkbox"/> 950 Constitutionality of State Statutes</p>
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V. ORIGIN *(Place an "X" in One Box Only)*

1 Original Proceeding 2 Removed from State Court 3 Remanded from Appellate Court 4 Reinstated or Reopened 5 Transferred from Another District *(specify)* 6 Multidistrict Litigation

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity):*
29 USC § 1132(a)

Brief description of cause:
Breach of fiduciary duties and improper denials of benefits under employee health insurance plans

VII. REQUESTED IN COMPLAINT: CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. DEMAND \$ _____ CHECK YES only if demanded in complaint: JURY DEMAND: Yes No

VIII. RELATED CASE(S) IF ANY *(See instructions):* JUDGE _____ DOCKET NUMBER _____

IX. DIVISIONAL ASSIGNMENT (Civil L.R. 3-2) *(Place an "X" in One Box Only)* () SAN FRANCISCO/OAKLAND (X) SAN JOSE () EUREKA

DATE: May 26, 2016 SIGNATURE OF ATTORNEY OF RECORD: /s/ Rebecca A. Musarra

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

- I. (a) Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.
- (b) County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)
- (c) Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".
- II. Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
- United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
- United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
- Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
- Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)
- III. Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.
- IV. Nature of Suit.** Place an "X" in the appropriate box. If the nature of suit cannot be determined, be sure the cause of action, in Section VI below, is sufficient to enable the deputy clerk or the statistical clerk(s) in the Administrative Office to determine the nature of suit. If the cause fits more than one nature of suit, select the most definitive.
- V. Origin.** Place an "X" in one of the six boxes.
- Original Proceedings. (1) Cases which originate in the United States district courts.
- Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
- Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
- Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
- Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
- Multidistrict Litigation. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407. When this box is checked, do not check (5) above.
- VI. Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service
- VII. Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
- Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
- Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.
- VIII. Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

ATTACHMENT TO CIVIL COVER SHEET

I (c) Attorneys For Plaintiffs

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