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BY FAX

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES, CENTRAL DISTRICT

ALMONT AMBULATORY SURGERY CENTER, LLC, a California limited liability company; BAKERSFIELD SURGERY INSTITUTE, LLC, a California limited liability company; INDEPENDENT MEDICAL SERVICES, INC., a California corporation; MODERN INSTITUTE OF PLASTIC SURGERY & ANTIAGING, INC., a California corporation; NEW LIFE SURGERY CENTER, LLC, a California limited liability company, dba BEVERLY HILLS SURGERY CENTER; ORANGE GROVE SURGERY CENTER, LLC, a California limited liability company; SAN DIEGO AMBULATORY SURGERY CENTER, LLC, a California limited liability company; SKIN CANCER & RECONSTRUCTIVE SURGERY SPECIALISTS OF BEVERLY HILLS, INC., a California corporation
VALENCIA AMBULATORY SURGERY CENTER, LLC, a California limited liability company; WEST HILLS SURGERY CENTER, LLC, a California limited liability company,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC.; UNITED HEALTHCARE SERVICES, INC., UNITEDHEALTHCARE INSURANCE COMPANY; OPTUMINSIGHT, INC., and DOES 1 through 20,

Defendants.

CASE NO. BC540056

COMPLAINT FOR:

1. **VIOLATION OF BUSINESS AND PROFESSIONS CODE SECTION 17200, et seq.**
2. **BREACH OF IMPLIED-IN-FACT CONTRACTS**
3. **SERVICES RENDERED**
4. **ESTOPPEL**
5. **DECLARATORY RELIEF**

Trial Date: None Set

JURY TRIAL DEMANDED

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Plaintiffs Almont Ambulatory Surgery Center, LLC, Bakersfield Surgery Institute, LLC, Independent Medical Services, Inc., Modern Institute Of Plastic Surgery & Antiaging, Inc., New Life Surgery Center, LLC dba Beverly Hills Surgery Center, Orange Grove Surgery Center, LLC, San Diego Ambulatory Surgery Center, LLC, Skin Cancer & Reconstructive Surgery Specialists Of Beverly Hills, Inc., Valencia Ambulatory Surgery Center, LLC, and West Hills Surgery Center, LLC (collectively, the "Plaintiff Providers") bring this action, alleging as follows:

II. INTRODUCTION

1. This lawsuit alleges a deliberate, willful and concerted effort by United Healthcare to indefinitely avoid paying for Lap-Band services for its morbidly obese members.

2. The patients whose claims are at issue in this lawsuit are all morbidly obese individuals who are suffering from serious medical problems associated with their obesity.

3. All of these patients choose Preferred Provider Organization ("PPO") insurance, rather than HMO insurance, through their employers so that they could receive their medical services from the physicians and other medical providers of their choice, regardless of whether those physicians are in-network or out-of-network. United Healthcare, who administers the PPO insurance for these employers, advertises that the benefits of its PPO policy include: "The freedom to choose any doctor for your health care needs."

4. All of these patients requested and received authorization from United Healthcare to undergo the extensive pre-operative tests necessary to determine whether they are qualified to receive Lap-Band surgery. After receiving the authorizations, the patients went through months of pre-operative tests.

5. Despite authorizing the procedures, United Healthcare has refused to pay for the vast majority of the tests.

6. In some cases, United Healthcare authorized the patients to receive the Lap-Band surgery. However, despite authorizing the surgeries, United Healthcare has refused to pay for the surgeries.

7. United Healthcare has created a number of pretextual excuses for refusing to process or to pay the claims. The most common excuse is that it needs certain medical records

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from the patients' healthcare providers – the plaintiffs in this case. However, the plaintiff healthcare providers have provided all the medical records to United Healthcare on multiple occasions. Nevertheless, United Healthcare continues to falsely claim that it needs additional records.

8. When the healthcare providers call United Healthcare to ask what records are missing, United Healthcare cannot say what records are missing. Instead, the United Healthcare representatives who answer the phones say that United's claims processor, Optuminsight, which is located in the Philippines, says that it is missing records, but cannot tell United Healthcare what records are missing.

9. United Healthcare, on behalf of the employer defendants, therefore delays paying for any of the claims by repeatedly asserting that it needs unspecified medical records, but cannot state what records are missing. In fact, United Healthcare has all the medical records for all the claims at issue in this case.

10. Many patients have been afraid to have the Lap-Band surgeries, even though their insurance covers the surgeries and they are authorized to have them, because they do not want to be saddled with the liability for paying for the surgeries given that United Healthcare has refused to pay for any of the pre-operative tests.

11. Some patients have had the Lap-Band surgeries and need to have their Lap-Bands adjusted because they have lost weight, or require other follow-up medical procedures related to their surgeries. However, these patients are afraid to have these follow-up procedures because they do not want to further increase their liability for payment due to United Healthcare's failure to pay.

12. The refusal of United Healthcare to pay for the Lap-Band procedures for their morbidly obese members and employees constitutes discrimination against morbidly obese individuals and unfair business acts and practices in violation of California Business and Professions Code section 17200, *et seq.*

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13. This case does not involve claims which are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). Those claims are the subject of a concurrently filed federal court action.

14. Plaintiffs bring these claims in their own right and not based on any assignment of benefits.

15. Millions of dollars are owed by defendants for the services plaintiffs healthcare providers have provided to defendants' members and insureds.

A. Plaintiffs Provide Much-Needed Health Care to Morbidly Obese Patients.

16. Plaintiffs Almont Ambulatory Surgery Center, LLC, Bakersfield Surgery Institute, LLC, Independent Medical Services, Inc., Modern Institute Of Plastic Surgery & Antiaging, Inc., New Life Surgery Center, LLC dba Beverly Hills Surgery Center, Orange Grove Surgery Center, LLC, San Diego Ambulatory Surgery Center, LLC, Skin Cancer & Reconstructive Surgery Specialists Of Beverly Hills, Inc., Valencia Ambulatory Surgery Center, LLC, and West Hills Surgery Center, LLC are a network of health providers that specialize in providing laparoscopic adjustable gastric band ("Lap-Band") surgery and other surgical procedures and medical services to individuals who are morbidly obese.

17. Lap-Band surgery is a widely used and minimally invasive surgical procedure that involves tying a silicone band around a portion of the stomach pouch. Individuals who receive this procedure experience a feeling of satiety, or fullness, more quickly, and therefore eat less, which in turn promotes weight loss. Compared to other forms of bariatric surgery, such as gastric sleeve surgery or gastric bypass procedures, one expert publicly commented that "Lap-Band really has the fewest complications and is the least invasive."[1]

18. Since 2010, Plaintiffs have helped thousands of morbidly obese individuals to undergo Lap-Band surgery as well as other medical procedures that assist those individuals in

[1] ABC News, Christie's Weight-Loss Surgery: Less Invasive but Slower Weight Loss, May 7, 2013, http://abcnews.go.com/Health/chris-christies-lap-band-surgery-left-stomach-intact/story?id=19126013 (comments of Dr. Richard Besser, ABC News' chief health and medical correspondent, regarding the recent announcement by New Jersey governor Chris Christie that he had received Lap-Band surgery).

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obtaining effective treatment for their disability. Plaintiffs estimate that roughly 90% of their patients are morbidly obese.

19. The Equal Employment Opportunity Commission has formally recognized "severe" or "morbid" obesity as a disability under the Americans with Disabilities Act, 42 U.S.C. §12101 *et seq*. Morbidly obese individuals are therefore protected from discrimination based upon their disability status. This includes discrimination with respect to the provision of health care benefits that those individuals obtain through their employer.

20. Indeed, the morbidly obese, who represent nearly 4% of America's population, are frequently discriminated against in the provision of medical care. This trend was illustrated by a recent blog post in the New York Times, which reported that in a recent study, one out of five doctors' offices in four major cities across the country refused to even book an appointment when researchers attempted to do so on behalf of a hypothetical overweight, disabled patient, and made unfounded assumptions about that patient without even meeting him.[2] The Provider Plaintiffs therefore perform a valuable role in providing much-needed care to an underserved and misunderstood population.

B. Defendants' Blanket Refusal to Pay for Plaintiffs' Services Continues to Cause Serious and Ongoing Harm to Patient Care.

21. This lawsuit arises from a deliberate, willful and concerted effort by Defendants UnitedHealth Group, Inc., United Healthcare Services, and UnitedHealthcare Insurance Company (collectively, "United") to indefinitely avoid paying for services that Plaintiffs rendered to their largely morbidly obese patient population.

22. Plaintiffs are not members of UnitedHealth Group's in-network health care providers, and they are not signatories to any contracts with UnitedHealth Group. Each of the claims which Plaintiffs submitted was pursuant to an authorization that they obtained from United prior to the procedure being performed. In fact, for nearly every claim, United represented in

[2] Pauline W. Chen, New York Times Well Blog, May 23, 2013, *Disability and Discrimination at the Doctor's Office*, http://well.blogs.nytimes.com/2013/05/23/disability-and-discrimination-at-the-doctors-office/ (last visited June 3, 2013).

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response to inquiries by the various Plaintiff providers that they would reimburse the cost of the procedure at the **provider's** "usual and customary rates" ("UCR"). In reality, however, United had no intention of paying anything at all.

1. United Schemed to Withhold All Payment from Plaintiffs, And Then Lied About It.

23. In 2010, Plaintiffs began submitting claims for reimbursement to United. Initially, United paid such claims. Beginning in 2010, however, United started to substantially underpay Plaintiffs' claims for reimbursement, and shortly thereafter, began to systematically withhold all payment from Plaintiffs without informing them. United did so even though for many patients it had expressly given authorization for the procedures at issue to be performed. In many cases, the providers and surgery centers performed these surgeries in reliance upon United's prior authorizations. Despite authorizing the procedures, however, United refuses to pay – and in some cases, even refuses to process – virtually any claim that is submitted by the Plaintiffs.

24. United accomplishes this delay in processing claims by using a variety of made-up excuses, all of which are procedurally improper. Each time the Plaintiffs submit claims for services rendered, United responds with a boilerplate notification that the claim cannot be processed without additional, burdensome documentation, most of which is already in the possession of United, and none of which is needed to process the claims. In many cases, United asks for numerous categories of medical records which it either already has, or which are not relevant to the claim being processed. In other cases, pretends not to have received the claim at all, or pretends not to have received medical records that Plaintiffs have submitted, forcing Plaintiffs to re-submit them. When Plaintiffs follow up to ask what information is required to perfect its claims United refuses to identify which specific records it supposedly needs. Despite having all the information it needs to process Plaintiffs' valid claim submissions, United almost always denies Plaintiffs' claims for the purported failure to provide all relevant medical records.

25. United also forwards nearly every claim submitted by the Plaintiffs to Defendant OptumInsight, Inc. (also known as Ingenix) for purported further "review," where those claims may languish for months and years without being paid. Ingenix/OptumInsight makes the same

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unintelligible, burdensome and baseless requests for records and documentation as United, even when Plaintiffs have previously provided all of the same medical records and other documents to United in response to the same requests. Ingenix/OptumInsight also refuses to identify what specific records are supposedly necessary to perfect the claims for payment. As a result, Plaintiffs are ping-ponged back and forth between United and Ingenix in what are ultimately futile attempts to understand what further information United supposedly needs to pay the claims.

26. California law requires United to state the specific reason it is asserting for denial of a claim. Insurance Code § 10123.13; Health and Safety Code § 1371. United's denial letters did not advise Plaintiffs of the specific reasons for denial of the claims. United's denial letters also did not advise Plaintiffs of the true reasons for denial of the claims. In other words, United had no intention of paying Plaintiffs' claims, but was simply making up excuses for non-payment of the claims.

27. United's communications with Plaintiffs are not only deceptive, in that they are intended to obfuscate United's true intent, which is to deny any claim submitted by Plaintiffs. After months or years of delay, United ultimately relies on the same intentionally dishonest, inadequate and spurious excuses to deny payment such as the purported failure to provide the "complete" medical records.

28. Through this deliberate and institutionalized abuse of the claims administration process, United has, in effect, successfully managed to avoid paying nearly any of Plaintiffs' claims for the past three years. The amount that United owes Plaintiffs, in the aggregate, on these unpaid claims is in excess of three million dollars.

29. United's scheme of denials and cryptic claim rejections ensure that Plaintiffs never know why their claims are being denied in violation of United's obligations to convey complete and accurate information.

30. On information and belief, the terms of the health benefit plans administered by United do not permit United to deny Plaintiffs' claims, nor do they permit United to obstruct, delay, or draw out the claims process for years at a time.

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31. Moreover, on information and belief, United was fully aware that roughly 90% of the patients who came to Plaintiffs were morbidly obese, a protected class, and in need of surgical treatment to ameliorate their condition. United's discriminatory treatment of Plaintiffs' morbidly obese patients was therefore also in violation of applicable state and federal law, including the federal Americans with Disabilities Act and California's Fair Employment and Housing Act.

2. Plaintiffs Will Suffer Irreparable Harm, Including Harm to Their Ability to Care for Existing Patients, Unless United is Ordered to Stop.

32. Plaintiffs and their morbidly obese patients have been, and continue to be, seriously harmed by United's behavior. United never directly and unambiguously informed Plaintiffs that it intended to deny payment on each and every claim. In fact, it continued to verify the availability of benefits whenever Plaintiffs inquired regarding new patients, and continued to authorize medical procedures for those patients to be performed by the Plaintiffs. In fact, during insurance verification calls, United consistently assured Plaintiffs that they would pay the reasonable and customary fees charged by Plaintiffs for their services. In reliance upon United's representations that benefits were available and that procedures would be authorized and United's promises to pay their reasonable and customary charges, Plaintiffs reasonably expected their claims would be paid and continued to see United policyholders, to their detriment.

33. United is the single largest payor for Plaintiffs, such that a very substantial percentage of all Plaintiffs' patients have benefit plans are funded and/or administered by United. United's surreptitious and dishonest scheme to withhold payment is, quite literally, driving Plaintiffs out of business.

34. United's actions also threaten the continuity of patient care. For instance, United frequently authorized initial procedures and the work-up necessary to perform bariatric surgery, and in some cases, even paid for the initial work-up, but then denied payment for surgical procedures that were performed. This prevents Plaintiffs' morbidly obese patients from receiving the treatment they desperately need to help them lose weight. Likewise, patients who have received Lap-Band surgery must return to Plaintiffs on a regular basis to receive adjustments to the Lap-Band, yet it is difficult to continue to provide care when United has still failed to pay for

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the initial procedure. For such patients, Plaintiffs cannot simply stop providing care, as that might constitute patient abandonment under California law.

35. United is also depriving its own insureds of the health benefits to which they are entitled. As patients acknowledge when they come to Plaintiffs for treatment, they are financially responsible in the event that United does not pay. Because United authorizes procedures performed by the Plaintiff providers and yet does not paid anything on the resulting claims, Plaintiffs are being placed into an adversarial position with respect to their patients. Of course, this is a costly, unpleasant, and uncertain process, and results in the loss of the peace of mind that insureds are entitled to enjoy.

36. Patient care will continue to be endangered unless this Court enjoins United's behavior, and orders United to cease abusing the claims review process as a way to indefinitely avoid paying Plaintiffs what they are entitled to be paid under the terms of the patients' benefit plans. Injunctive relief is necessary in order to stop United from hiding behind the curtain of arbitrary administrative process, and to force United to process Plaintiffs' claims according to the terms of applicable benefit plans. Otherwise, patient care and peace of mind will continue to be endangered, causing irreparable harm to Plaintiffs' ability to care for its patients.

C. <u>In Addition to Refusing to Pay, United Imposed Arbitrary and Discriminatory Barriers to Patients Obtaining Surgery.</u>

37. On information and belief, there was an overarching, and undisclosed, policy at United to withhold all payment for submitted by patients who utilized their out-of-network benefits with Plaintiffs, even though Defendants were fully aware that roughly 90% of the patients who came to the Plaintiffs were morbidly obese and in need of surgical treatment to ameliorate their condition.

38. On information and belief, as part of this unwritten policy, Defendants created unreasonable barriers for morbidly obese patients seeking to obtain the weight loss surgery offered by Plaintiffs constituted unlawful discrimination as well as an arbitrary and capricious denial of health benefits. Such benefits could and should have been made available under the health plans administered and/or funded by United.

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39. For instance, United began denying approval for certain procedures until the individuals seeking surgery enrolled in, and completed, a six-month weight loss plan and nutrition regimen. United knew that nothing in the terms of many of those individuals' health benefit plans required such draconian steps. It also knew the patients' physicians had already determined that Lap-Band surgery was medically necessary.

40. Studies published in numerous well-regarded scientific journals have found that such weight loss programs were ineffective for the morbidly obese and did not lead to better clinical outcomes than bariatric surgery alone. Individuals who enroll in such arbitrarily imposed six-month plans typically drop out and do not lose weight; in any case, United's weight loss plans typically do not even require a demonstration that weight loss has occurred. Thus, the net effect of this arbitrary and capricious barrier was to prevent morbidly obese plan beneficiaries from acquiring much-needed surgery.

41. Along the same lines, United raised an unreasonable impediment to approval by seeking written proof from a doctor's office of the patient's weight or body mass index (BMI) for each of the preceding five years to be eligible for surgery. If the morbidly obese patient did not visit a doctor and thus did not have a documented weight in just one of the previous 5 years, the request would be denied. Like the preoperative weight loss plans, this was not a requirement of many of the health benefit plan prior to the approval of bariatric surgery, and was an arbitrary and capricious barrier to prevent morbidly obese beneficiaries from obtaining surgery.

42. United, as the designated claims administrator for the plans, exercised sole discretion over claim pricing and payment of Plaintiffs' claims, and was responsible for authorizing medical treatment for its members. On information and belief, however, the terms of many patients' benefit plans did not make surgery benefits contingent upon barriers such as the completion of a six month weight-loss plan, or a five-year documentation of the patient's weight. United's refusal to approve many of these procedures until these arbitrary requirements had been met constituted arbitrary and capricious conduct that went beyond United's fiduciary duties to interpret and administer the terms of the plans.

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43. As with United's pretextual denials of payment for medical procedures actually performed, United's imposition of such barriers also constituted wrongful discrimination and failure to reasonably accommodate these patients' disabilities under both the federal Americans with Disabilities Act and California's Fair Employment and Housing Act. As a result, United has also engaged in unfair competition under California's Unfair Competition Law, and should enjoined from denying benefits to its insured based on such conduct.

III. THE PARTIES

A. Plaintiff Surgery Centers

44. The Plaintiff Surgery Centers are Limited Liability Companies and Corporations organized and existing under the laws of the State of California, with their principal places of business in the State of California. Plaintiff Surgery Centers operate ambulatory surgery centers that provide a variety of surgical services, including but not limited to the Lap-Band procedure. At all relevant times, none of the Plaintiff Surgery Centers were under contract with any of the Defendants, and none of them participated in any of Defendants' provider networks.

a) Plaintiff Almont Ambulatory Surgery Center LLC is, and at all relevant times was, a California limited liability company organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff Almont Ambulatory Surgery Center operates an ambulatory surgery center in Beverly Hills, California. At all relevant times, Almont Ambulatory Surgery Center was not under contract with any of the Defendants, and did not participate in any of their provider networks.

b) Plaintiff Bakersfield Surgery Institute, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Bakersfield, CA. Plaintiff Bakersfield Surgery Institute, LLC operates an ambulatory surgery center in Bakersfield, California. At all relevant times, Bakersfield Surgery Institute, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

c) Plaintiff Modern Institute of Plastic Surgery & Antiaging, Inc. ("Modern Institute") is, and at all relevant times was, a California corporation organized and existing under

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the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff Modern Institute operates an ambulatory surgery center in Beverly Hills, California specializing in plastic surgery and also in bariatric surgery, including the Lap-Band procedure. At all relevant times, Plaintiff Modern Institute was not under contract with any of the Defendants, and did not participate in any of their provider networks.

d) Plaintiff New Life Surgery Center LLC dba Beverly Hills Surgery is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff New Life Surgery Center LLC operates an ambulatory surgery center in Beverly Hills, California specializing in bariatric surgery, including in the Lap-Band procedure. At all relevant times, New Life Surgery Center LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

e) Plaintiff Orange Grove Surgery Center, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Pomona, CA. Plaintiff Orange Grove Surgery Center, LLC operates an ambulatory surgery center in Pomona, California. At all relevant times, Orange Grove Surgery Center, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

f) Plaintiff San Diego Ambulatory Surgery Center, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in San Diego, CA. Plaintiff San Diego Ambulatory Surgery Center, LLC operates an ambulatory surgery center in San Diego, California. At all relevant times, San Diego Ambulatory Surgery Center, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

g) Plaintiff Skin Cancer & Reconstructive Surgery Specialists of Beverly Hills ("Reconstructive Specialists") is, and at all relevant times was, a California corporation organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. Plaintiff Skin Cancer & Reconstructive Surgery Specialists of Beverly

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Hills operates an ambulatory surgery center in Beverly Hills, California. At all relevant times, Plaintiff Skin Cancer & Reconstructive Surgery Specialists of Beverly Hills was not under contract with any of the Defendants, and did not participate in any of their provider networks.

h) Plaintiff Valencia Ambulatory Surgery Center, LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in Valencia, CA. Plaintiff Valencia Ambulatory Surgery Center, LLC operates an ambulatory surgery center in Valencia, California. At all relevant times, Valencia Ambulatory Surgery Center, LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

i) Plaintiff West Hills Surgery Center LLC is, and at all relevant times was, a limited liability company organized and existing under the laws of the State of California, with its principal place of business in West Hills, California. Plaintiff West Hills Surgery Center LLC operates an ambulatory surgery center in West Hills, California. At all relevant times, West Hills Surgery Center LLC was not under contract with any of the Defendants, and did not participate in any of their provider networks.

B. Plaintiff Independent Medical Service

45. Plaintiff Independent Medical Service, Inc. ("IMS") is, and at all relevant times was, a California professional corporation organized and existing under the laws of the State of California, with its principal place of business in Beverly Hills, California. IMS is a physicians' medical group that bills for professional services. At all relevant times, IMS was not under contract with any of the Defendants, nor did they participate in any of Defendants' provider networks.

C. United Defendants

46. Plaintiffs are informed and believe that Defendant UnitedHealth Group, Inc. ("UnitedHealth") is a Minnesota corporation with its corporate headquarters located in Minneapolis, Minnesota. Defendant UnitedHealth Group is a publicly traded corporation which is not qualified to do business in the State of California, but is engaged in business in the State of

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California and County of Los Angeles through its subsidiaries UnitedHealthcare Insurance Company, and United HealthCare Services, Inc.

47. Plaintiffs are informed and believe that Defendant UnitedHealthcare Insurance Company ("UHIC") is a corporation organized and existing under the laws of the State of Connecticut, a wholly owned and controlled subsidiary of Defendant UnitedHealth Group, with its principal place of business in Connecticut. Defendant UHIC is qualified to engage in business in the State of California and engaged in business in the Country of Los Angeles as an insurance company.

48. Plaintiffs are informed and believe that Defendant United HealthCare Services, Inc. ("United HealthCare") is a Minnesota corporation with its corporate headquarters located in Minneapolis, Minnesota. United HealthCare is wholly-owned by UnitedHealth, and serves as UnitedHealth's operating division. United HealthCare is licensed to conduct insurance operations in California and, on information and belief, every other State in the United States, whether it be under the name United HealthCare or some other operating name.

49. Plaintiffs are informed and believes that Defendant OptumInsight, Inc. ("Optum") is a Delaware corporation with its corporate headquarters located in Eden Prairie, Minnesota. Plaintiff is informed and believes that as of April 2011, Ingenix, Inc. also has been doing business under the trade name "Optum."[3] Optum is a wholly-owned subsidiary of UnitedHealth

50. UnitedHealth, United Healthcare, UHIC, and Optum/Ingenix will be collectively referred to herein as "United" or the "United Defendants."

51. With respect to all of the claims at issue herein, Plaintiffs are informed and believe that the United Defendants:

a) drafted and provided plan members with plan documents;

b) operated a centralized verification and authorization telephone number which handled calls for members;

[3] See OptumInsight News Room, April 11, 2011 press release, UnitedHealth Group Announces "Optum" Master Brand for its Health Services Businesses, http://www.optuminsight.com/news-events/press-releases/2011/457/

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c) authorized Plaintiffs to provide medical services to beneficiaries;

d) received and processed electronic bills from Plaintiffs;

e) communicated with Plaintiffs regarding authorization of surgical procedures;

f) issued remittance advices and EOBs;

g) priced claims;

h) communicated with Plaintiffs with respect to the processing of claims;

i) processed appeals, and sent appeal response letters; and

j) issued payment.

IV. GENERAL ALLEGATIONS

A. United's Health Insurance Business

52. United is one of the nation's largest health insurers. It underwrites and issues thousands of health insurance plans. It also contracts with other entities that provide health benefits in order to provide administrative services for those entities' health plans, such as claim pricing.

53. Individuals who do not receive employer-sponsored health insurance often purchase health insurance policies directly from United, who typically has sole responsibility and discretion to administer and pay claims submitted under such policies.

54. When the plan is insured by United, United not only is responsible for administering a claim brought under the plan, but is also financially responsible for the payment of the claim. United provides plan members with plan documents, interprets and applies the plan terms, makes coverage and benefits decisions, handles appeals of coverage and benefits decisions, and provides for payment in the form of medical reimbursements.

1. Out-Of-Network UCR Reimbursement

55. Various ambulatory surgery centers in the industry, other than the Provider Plaintiffs, have written contracts with United under which they agree to accept United's set and scheduled reimbursement that is discounted from the centers' total billed charges. In exchange, these "in network" providers receive referrals of patients from United and the associated benefits

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of being a participating or "in-network" provider. These benefits typically include an increased volume of business that results because the health plans provide financial incentives to their members to utilize the services of "in-network" providers, such as reduced co-insurance payments and/or deductibles.

56. Conversely, some surgery centers and physicians, such as the Plaintiffs, do not have written contracts with United. They are "out-of-network." As a result, these surgery centers and physicians receive less volume of patients from the plans, but they are not governed by any contractual requirements of defendants' plans and they are not required to accept reduced amounts as payment in full for their charges for the services rendered. They are free to charge whatever amounts they deem appropriate for their services.

57. Typically, United pays benefits to in-network surgery centers at the lower, in-network contract amount charged by those centers. However, benefit plans typically contain provisions for paying out-of-network surgery centers and physicians at an UCR rate or a percentage of the UCR rate. The language varies from plan to plan, and may be described as the "Usual, Customary and Reasonable" rate, the "Reasonable and Customary" amount, the "Usual and Customary" amount, the "Reasonable Charge," the "Prevailing Rate," the "Usual Fee," the "Competitive Fee," or some other similar phrase. In the context of the healthcare industry, and in United's own parlance, these phrases are all synonymous with UCR.

2. Payment Authorizations and UCR Industry Standards

58. When an out of network surgery center or health care provider has a patient who is insured by United, the standard practice is to request authorization from United to provide out-of-network services to that patient. United has developed a general practice and standard in the industry to grant such authorizations. United does not impose its plan terms on such out-of-network surgery centers and providers, but rather as a standard of custom and industry practice commits to paying UCR no matter what the actual billed amount might be from the surgery center or provider.

59. Whether the claims are from out-of-network or in-network surgery centers or providers, when the claims are submitted to United, they reflect the actual billed charges for the

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claim. Even though in-network surgery centers and providers are sometimes reimbursed according to contracted rates that include discounts, they still submit their full billed charges on the claim. This is industry standard for all providers, and reflects the well-established fact that charges are not the same as the discounted contract rates. Therefore, United has for many years acquired a wealth of charge data from which it can use to price claims by comparing the prevailing charges for similar healthcare services by similar types of surgery centers within the same geographical market at the time.

60. No provisions in those benefit plans, whether in their Summary Plan Descriptions (SPDs) and Evidences of Coverage (EOCs), justified the failure to pay the usual and customary fees for services charged by outpatient surgical centers such as those managed and operated by the Plaintiffs, and to instead pay nothing. It was arbitrary, capricious and improper for United to do so. In fact, during the insurance verification process for most if not all of the patients in this case, United represented to Plaintiffs that it would pay the Plaintiff Providers' usual and customary fees. Plaintiffs sought information during this process about potential limitations on the reimbursement of Plaintiffs fee each time prior to providing services, and specifically inquired each time prior to providing services as to how United's fee provisions would apply to their situation. Defendants withheld information in response to such requests, and therefore misled plaintiffs into thinking that the entire Plaintiffs' usual and customary fees would be paid.

61. Likewise, no provisions anywhere in those plans justified the failure to issue a final decision or denial on any of Plaintiffs' claims. This was therefore arbitrary, capricious, and a breach of United's fiduciary duties to plan participants. It was also a violation of California statutes which require that claims be adjudicated by United within 30 working days after receipt of the claim. Insurance Code § 10123.13; Health and Safety Code § 1371.

62. Moreover, despite making thousands of requests for plan documents and information about United's UCR methodology, the Defendants failed to provide any of the requested documents or information to Plaintiffs. Therefore, Plaintiffs have been unable to confirm exactly how United purports to administer the terms of the benefit plans, or how United prices Plaintiffs' claims.

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63. Even in those rare instances where Defendants paid Plaintiffs' claims, they paid far less than Plaintiffs' usual and customary fees. On information and belief, United did not uniformly apply UCR to all service providers in the same geographic area, and in fact, discriminated against the Plaintiffs.

B. United's Systematic, Surreptitious, and Unlawful Withholding of Payment For Services Rendered

64. United did not intend not to pay for the services rendered by Plaintiffs. Rather than inform Plaintiffs directly of this fact, however, United chose to carry out their intentions through subterfuge and deceit. Specifically, United manufactured various pretextual rationales unrelated to the actual benefits available under the plans in order to unlawfully prolong the claims administration process and ultimately deny Plaintiffs' claims outright on grounds not justified by the terms of the benefit plans.

65. United knows full well that the terms of Plaintiffs' benefit plans obligated it to pay Plaintiffs for the valuable medical services they had provided to beneficiaries and participants of those plans. United does not have the ability to substantively change the terms of the plans, or to create hurdles for beneficiaries to obtain such benefits, or new reasons for denial of such benefits that were contrary to, or inconsistent with, plan terms. Thus, in making up false reasons to withhold and deny payment from the Plaintiffs, United was acting beyond the scope of its authority, and abused its discretion.

66. In many cases, United conveyed these fabricated rationales to Plaintiffs by issuing Explanation of Benefits ("EOBs") forms, which United typically issues when a claims decision is made, or through appeal denial letters. Though these forms and letters purported to be claim denials, they contained no actual reasons explaining why the claim was being denied according to the terms of the applicable benefit plan, as required by state law. Instead, they merely requested additional documentation or suggested that further review was required.

67. Instead of responding to Plaintiffs' requests by providing access to the material that the regulations entitle Plaintiffs to review, Defendants elected to completely ignore and reject the requests, and make spurious and pretextual reasons for refusing to process and pay the claims.

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The spurious and pretextual tactics utilized by United included, but were not limited to, the following:

- Making repeated and redundant requests for medical records, even where records had already been provided on multiple occasions, and then denying in follow-up conversations that records had ever previously been received;
- Routinely requesting physician's orders approving the use of Durable Medical Equipment (DME) that Plaintiffs did not use or provide in connection with the medical services at issue;
- Forwarding all or nearly all of Plaintiffs' claims for "further review" by United's wholly owned subsidiary, Ingenix (also known as OptumInsight), and promising that review by Ingenix / OptumInsight would take 15-30 days, while in fact causing the so-called review to last for months or even years with no payment resulting from the "review";
- Requiring Plaintiffs to separately submit medical records or other documentation to Ingenix / OptumInsight when Plaintiffs had already submitted such documentation directly to United, on the pretextual ground that Ingenix / OptumInsight did not have access to the records that had already been submitted to United;
- Denying claims solely because the patients on whose behalf reimbursement was sought had allegedly failed to "authorize" Plaintiffs to appeal on their behalf, even though Plaintiffs always submitted a proper assignment of benefits demonstrating such authority, and even though Defendants in practice acknowledged that assignment had occurred by dealing directly with Plaintiffs, rather than with the patients;
- Claiming that one or more of the surgical facilities where the surgery was performed was not listed in United's database of health providers as a reason for non-payment, even though claims had previously been paid to those same facilities and even though United sometimes paid the surgeon who selected the facility;

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- Demanding surgery center licenses, even though California does not require any such license (surgery centers are "certified" by one or more entities, such as the Joint Commission on Accreditation for Health Care Organizations under Health & Safety Code § 1248 *et. seq.*);
- Denying claims for containing procedures with incorrect "modifier" codes, even though the claims that Plaintiffs submitted never included or required such codes;
- Denying claims because the patient purportedly did not have coverage, for instance, because of a pre-existing condition, when such coverage in fact existed;
- Denying claims on the basis that they were not timely filed, though Plaintiffs' submissions were timely.

68. While the rationale for denying any given claim varied, the outcome was always the same: the complete denial of nearly all payment for surgeries and procedures performed by Plaintiffs. When examined closely, none of United's rationales hold up to scrutiny. Yet they were repeatedly used to withhold payment to Plaintiffs, without informing Plaintiffs at any time of United's true intent to do so.

69. United has admitted that it has received the Patients' medical records, but intentionally uses its corporate structure to obscure the reasons for its failure to properly process and pay for claims. This deliberate and systematic obfuscation opacity has been glaringly apparent each time Plaintiffs have contacted United for guidance in understanding what additional records United supposedly needs to process and pay for the Patients' claims. Plaintiffs have asked again and again for clarification as to what specific medical records United considers necessary to process the claims, and were rebuffed repeatedly. United's responses offered no guidance as to how plaintiffs could perfect their claims. For example, United representatives have responded as follows in response to questions regarding what additional documents United requires to process the Patients' claims:

- "So this claim on this date of service, looks like a different department, Optum Insight[, a.k.a. Ingenix], was requesting treatment records."
- "I do show that it was submitted multiple times,... I'm showing that [Optum Insight, a.k.a. Ingenix] received the information but they're still needing additional

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information. They said they received it and are unable to process it, meaning that one or more items are missing, history and physical, um findings, meaning labs, radiology, pathology, anesthesia, just things of that nature. Any op note, procedure report, daily progress treatment records, medication notes, physician orders, um, anything of that nature.... [M]aybe they'll be able to give you more, um, elaborate information."

- "Um, actually, it's not [Optum Insight, a.k.a. Ingenix]... the request actually would be the United Healthcare since technically it's them who has the right to request those records, and then it would be routed to us [at Optum Insight/Ingenix]."

- "[T]he thing is, we just need those medical records. I know you have submitted them perhaps to a different department of United Healthcare, but as you can see here, whatever goes to us are the only ones that was reviewed, and I do see here a one page of lap band follow up visits, office visits."

- "The thing is, um, this one, actually, **we are not even communicating directly to them**. We only have, um, certain departments who are handling this and they're located in the United States, okay.... [**Optum Insight is located] in the Philippines, for your commercial account**."

- "Okay, so it initially shows that the claim was denied for incomplete medical records. Then it is being indicated here that it was filed for an appeal. But um that was received on 8/14 but basically that appeal is being closed out because there's no patient authorization here.... So I just checked on the records here one by one and I'm going to have it sent back again to the appeals department about this information because I can see that, um the... [assignment of] benefits as indicated there. Also the op notes are also indicated there."

- "[I]t looks like what they're stating is that information was received but some of the information was still missing that we needed. Um, and it doesn't tell me specifically, just that it's – the information may have included the history and physical findings upon examination, labs, radiology, pathology and anesthesia test results, consult report."

70. Contrary to what the United representatives promised, Defendants had no intention of processing or paying the claim even if Plaintiffs re-submitted the requested medical records.

71. Clearly, Defendant Ingenix/OptumInsight, to whom the United Defendants delegated their responsibility for administering Plaintiffs' claims in a timely and accurate manner, was in fact unqualified to do so. The delegation of the United Defendants' responsibilities to its wholly owned subsidiary was not in order to facilitate the processing of Plaintiffs' claims, but to delay it indefinitely, and to obscure from Plaintiffs the real reasons why Plaintiffs' claims were not being paid.

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72. United's repeated requests for additional records, without specifying what particular records were missing, provided no meaningful guidance on what specific further evidence might be required.

C. United Received Illegal Commissions In Return For Improperly Denying Plaintiffs' Claims

73. Plaintiffs strongly suspect that another primary motivation that United had for denying Plaintiffs' claims is that United is substantially compensated by the Plans for doing so. Plaintiffs are informed and believe that when United refuses to pay the Plaintiffs for the services that they have rendered, it is paid a commission by the Plans, that is based upon a percentage of how much money the Plans "save" by not having to pay Plaintiffs their usual and customary fees. Thus, United effectively sets its own commission. This not only violates California law, but also violates the terms of the plans, which require usual and customary payment, as these artificial "savings," which are determined arbitrarily by United, bear no relation to a proper determination of Usual and Customary fees.

74. Plaintiffs are informed and believed that the Plans make these kickbacks to United pursuant to a program called the "Facility Reasonable Charge Determination Program" or the "Facility Reasonable & Customary Program," which the Plans agree to as part of their agreements with United by which United provides claims adjudication services for the Plans. The goal of the Facility Reasonable Charge Determination Program is to underpay, or even reject outright, claims made by ASCs such as the Plaintiff providers.

75. United is compensated under the Facility Reasonable Charge Determination Program at a specific percentage of the money that Defendants would otherwise have had to pay to Plaintiffs, had United correctly paid Plaintiffs' claims. This provided a major incentive for United to find ways not to pay Plaintiffs' claims, and to deny those claims on pretextual grounds, such as repeated and unfounded requests for irrelevant and nonexistent medical records.

76. United's receipt of kickbacks and/or commissions for denying Plaintiffs' claims is a clear and willful violation of California Health & Safety Code § 1399.56 and/or Insurance Code § 796.02, which provide that claims reviewers may not be compensated on the basis of (a) a

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percentage of the amount by which a claim is reduced for payment; or (b) the number of claims or the cost of services that were denied and not paid. The Facility Reasonable Charge Determination Program is tied to precisely these illegitimate metrics.

D. United Retaliated Against Plaintiffs and their Patients

77. Further, United has retaliated against Plaintiffs and their Patients because Plaintiffs exercised the rights to which those participants and beneficiaries were entitled under their insurance policies.

78. Specifically, the patients who were treated by Plaintiffs lawfully attempted to exercise their rights and benefits under their respective plans to receive out-of-network payment.

79. However, for the sole reason that those participants and beneficiaries chose to receive care from the Plaintiffs at the Surgery Centers, United retaliated against the participants and beneficiaries, and by extension, against Plaintiffs.

80. Moreover, United also retaliated against Plaintiffs because Plaintiffs sought to appeal United's determinations denying payment.

81. Among other retaliatory measures, United directed the vast majority of Plaintiffs' claims to its Special Investigations Unit, known variously as Ingenix and/or OptumInsight. The United Defendants, including but not limited to Defendant Ingenix/OptumInsight, further retaliated against the Plaintiffs by generating various pretextual, unsupported, unwarranted and fraudulent reasons for prolonging the claims review process, including by repeatedly asking for medical records that did not exist and/or were not necessary to adjudicate the claims submitted by Plaintiffs.

E. Defendants Have Discriminated Against Plaintiffs' Morbidly Obese Patients

82. In addition to arbitrarily and capriciously withholding and/or denying payment, Defendants have actively discriminated against Plaintiffs' other potential patients who were morbidly obese, thus violating both the ADA and FEHA. Since passage of the Americans with Disabilities Act Amendments Act of 2008, which expanded the definition of disability, the EEOC has made clear that "severe" or "morbid" obesity is a recognized disability under the ADA.

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83. Title I of the ADA expressly prohibits employers from discriminating against a "qualified individual" (e.g., employee) on the basis of disability, including through "participating in a contractual... relationship that has the effect of subjecting a covered entity's... employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs)." 42 U.S.C. § 12112 (emphasis added).

84. Likewise, California's Fair Employment and Housing Act (FEHA) prohibits discrimination in the provision of such benefits on the basis of "physical disability" except where the discrimination is based upon a "bona fide occupational qualification." Cal. Gov't Code § 12940(a).

85. Moreover, employers, such as the Plans and their sponsors, must attempt to make good faith, reasonable accommodations for their employees' disabilities, and the failure to do so is discriminatory. 42 U.S.C. § 12112(b)(5)(A); Cal. Gov't Code § 12940(m). By not even attempting to accommodate morbidly obese individuals in their attempt to receive health benefits through their employers, Defendants have therefore discriminated against Plaintiffs' patients who were morbidly obese, and/or aided and abetted employers in discriminating against their morbidly obese employees, by arbitrarily denying authorization and/or payment for Lap-Band surgery and related services, even though the employees' plans clearly covered these procedures or should have covered those procedures in order to be considered non-discriminatory. Defendants did not deny authorizations or payment for other, non-morbidly obese patients.

1. Defendants Targeted the Morbidly Obese for Discrimination.

86. The requirement that patients participate in, and certify compliance with, a preoperative weight loss and diet regimen further constituted a prohibited "examination and inquiry" under the ADA "as to the nature or severity of the [patients'] disability." *See* 42 U.S.C. § 12112(d)(4)(A). This is because monitoring compliance with the regimen necessarily requires inquiry into the "nature or severity" of the patients' morbid obesity.

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87. Similarly, the requirement that patients provide proof from a doctor's office of their weight or BMI for the each of the past five years also presents an unreasonable barrier to the morbidly obese. It is unreasonable to demand that a morbidly patient must have documented his or her weight and BMI in each of the five preceding years before he or she can be approved for treatment.

88. Indeed, on information and belief, Defendants were fully aware that the overwhelming majority of Plaintiffs' patients were morbidly obese, and that, more likely than not, these patients had come to Plaintiffs seeking treatment for their disability. Nonetheless, in violation of the ADA and FEHA, Defendants elected to apply these heightened and unreasonable tests to Plaintiffs' patients – even though Plaintiffs are informed and believed that other beneficiaries and participants of the plans administered by United were not subjected to this heightened level of scrutiny.

2. Defendants Imposed Scientifically Unjustified Requirements on Morbidly Obese Patients Prior to Surgery

89. Numerous of scientific studies and formal reviews of the scientific literature have found that insurance-mandated weight loss and diet plans of the sort imposed by Defendants, through United, fail to improve patient outcomes and are less effective than bariatric surgery alone.

90. For instance, a 2011 study published in the peer-reviewed journal Surgery for Obesity and Related Diseases reviewed outcomes for 440 patients who underwent gastric surgery by the same surgeon. *See* Kuwada TS, Richardson S, El Chaar M, Norton HJ, Cleek J, Tomcho J, Stefanidis D., Insurance-mandated medical programs before bariatric surgery: do good things come to those who wait?, Surg Obes Relat Dis. 2011 Jul-Aug;7(4):526-30. The study concluded: "Patients who underwent a standardized MMP [insurance-mandated medical program] had a significant delay in their time to surgery **and did not experience significant benefit in their preoperative or postoperative weight loss**. Insurance companies should abandon the policy of mandating preoperative medical weight loss programs."

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91. Likewise, a 2012 meta-analysis of the scientific literature on pre-surgery weight loss programs required by insurance companies concluded that "the insurance-mandated preoperative requirements **confer no appreciable benefit** to bariatric patients. The ultimate goal of such requirements is questionable, particularly considering that no actual weight loss is required." Ochner CN, Dambkowski CL, Yeomans BL, Teixeira J, Xavier Pi-Sunyer F, Pre-bariatric surgery weight loss requirements and the effect of preoperative weight loss on postoperative outcome, International Journal of Obesity (2012) 36, 1380-1387. The article found that requiring a preoperative plan might even be associated with "less-positive postoperative outcomes." It also concluded that preoperative weight loss requirements would have the perverse effect of rendering patients "ineligible to receive a surgical procedure that would have likely improved their health and quality of life." Even if enforcing such a policy might have some small benefit to *some* patients, it might be still "unethical" because it would "exclude otherwise eligible candidates from a beneficial surgical procedure in the hopes of improving the postoperative outcomes of others."

92. Other sources are in accord. For instance, on March 23, 2011, the American Society for Metabolic & Bariatric Surgery (ASMBS), the largest and most prestigious association of bariatric surgeons, released a Position Statement on Preoperative Supervised Weight Loss Requirements which also reviewed the scientific literature and came to similar conclusions. The scientific evidence, it concluded, simply does not show that preoperative diet and weight loss programs have any effect: "[t]here are no Class I large, adequately powered randomized, prospective trials or meta-analyses to validate the hypothesis that preoperative diet attempts improve bariatric surgery outcomes." ASMBS Position Statement at 5.[4] Based on its review of the literature, the ASMBS concluded that it is "inappropriate, capricious, and counter-productive given the **complete absence of a reasonable level of medical evidence to support such practice**." *Id*. at 6.

[4] At the time of filing of this Complaint, this document was available at: http://asmbs.org/2012/01/preoperative-supervised-weight-loss-requirements/.

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93. Likewise, California's Department of Managed Health Care recently commissioned its own review of the literature on this subject, and concluded quite bluntly that "[m]andated weight loss prior to indicated bariatric surgery ***is without evidence-based support***." Department of Managed Health Care, Review of Weight Loss Prior to Bariatric Surgery, at 2.[5] The DMHC found that the practice was "not medically necessary" and that [t]he risks of delaying bariatric surgery... are real and can be measured." *Id.*

94. Nor is there any doubt that the benefits of bariatric surgery for morbidly obese individuals are also real, measurable, and significant. A 2004 meta-analysis published in the prestigious Journal of the American Medical Association, for instance, concluded that "bariatric surgery in morbidly obese individuals reverses, eliminates, or significantly ameliorates diabetes, hyperlipidemia, hypertension, and obstructive sleep apnea. These benefits occur in the majority of patients who undergo surgery." Henry Buchwald, Yoav Avidor, Eugene Braunwald, et al., Bariatric Surgery: A Systematic Review and Meta-analysis, JAMA, 2004; 292(14):1724-1737. Conversely, "diet therapy, with and without support organizations, is relatively ineffective in treating obesity in the long term." *Id.* In addition, "there are currently no truly effective pharmaceutical agents to treat obesity, especially morbid obesity."

95. At least two other studies have found similar results. One is the long-term, Swedish Obese Subjects Study, a longitudinal study which tracks 2,000 subjects who underwent Lap-Band surgery and other kinds of bariatric surgery, along with 2,000 contemporaneously matched obese control subjects receiving usual care, and is still ongoing. L. Sjöström, Review of the key results from the Swedish Obese Subjects (SOS) trial – a prospective controlled intervention study of bariatric surgery, J Intern Med 2013; 273: 219–234. This study is in agreement with the results of the JAMA meta-analysis, and in particular, concludes that current drug-only treatments are insufficient and that "[u]ntil more efficient antiobesity drugs are available, surgical treatment of obesity must be more universally accessible." Results from 2004 to

[5] At the time of filing of this Complaint, this document was available at: http://www.hmohelp.ca.gov/aboutthedmhc/org/boards/cap/BariatricREV.pdf

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2012 from the SOS study have demonstrated that "maintained effects on risk factors over 10 years require 10%–30% maintained weight loss."[6] The SOS concluded that "Surgery is the only treatment for obesity resulting in an average of more than 15% documented weight loss over 10 years." Id at 8. Similar to the JAMA analysis, a 2010 review of roughly eight hundred patients in a single Wisconsin hospital during a seven-year span who had either received bariatric surgery, or been denied such surgery by their insurance companies found that those denied obesity surgery had strongly increased incidence of hypertension, diabetes, sleep apnea, and acid reflux, among other disorders. Harakeh A, Burkhamer K, Kallies K, Mathiason M, Kothari S, Natural history and metabolic consequences of morbid obesity for patients denied coverage for bariatric surgery. Surgery for Obesity and Related Diseases 6 (2010) 591–596.

3. Defendants' Conduct is a Subterfuge for Discrimination.

96. The overwhelming scientific evidence drives home the reality that Defendants' denial of the Lap-Band procedure to morbidly obese individuals is outright discrimination which has nothing to do with underwriting risks. Instead, Defendants' conduct has everything to do with denying benefits to which those individuals were rightfully entitled. Thus, Defendants' denials, in addition to being a breach of their fiduciary duties to the plans, were nothing more than subterfuge in order to circumvent the policy goals of the ADA and FEHA and discriminate against individuals who participated in various employer-sponsored health benefit plans or other plans that offered both out-of-network benefits and coverage for bariatric surgery. See 42 U.S.C. § 12201(c).

97. Plaintiffs are also informed and believe that in certain situations, Defendants denied payment for bariatric surgery and related services based upon the purported terms of the patient's benefit plan, which Defendants represented did not cover bariatric surgery, such as the Lap-Band surgery or other procedures. To the extent that the applicable benefit plans themselves in fact

[6] At the time of filing of this Complaint, this document was available at: http://onlinelibrary.wiley.com/doi/10.1111/joim.12012/pdf.

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denied coverage for the treatment of obesity, including Lap-Band surgery, however, the design of those plans themselves was discriminatory and violated the ADA and FEHA.

98. Moreover, to the extent that the applicable benefit plans themselves in fact denied coverage, Defendants failed to make any reasonable accommodation for morbidly obese patients under these plans, and failed to have any discussions with the affected individuals and/or with any plan sponsors or employers about making such accommodations. Defendants are thus, at the very least, guilty of aiding and abetting the violation of the ADA and FEHA in this respect.

4. Plaintiffs Have Suffered Injury In Fact.

99. As a result of Defendants' violations of FEHA and the ADA, Plaintiffs have suffered injury in fact, because the potential patients who came to them seeking Lap-Band surgery for their disability were directly or indirectly denied that opportunity as a result of Defendants' discrimination. Likewise, Plaintiffs have lost money and/or property as a result of Defendants' denials as alleged above. Indeed, Defendants' outright refusal to pay any claim submitted by any of the Plaintiffs has impaired their ability to carry out their business affairs, to the point that Plaintiffs may be forced to close their doors and cease providing needed medical services to their morbidly obese patient population.

100. The Defendants have unlawfully shifted the full liability of payment for medical services rendered onto the patients, who have been billed for those services. Defendants' unlawful denial of benefits for those services thereby results in injury in-fact to both the patients and to the Plaintiffs.

101. Moreover, Defendants' denials for the various professional and facility claims at issue in this case has interfered with Plaintiffs' physician-patient relationships and the ability of physicians to care for their patients, such as those needing follow-up appointments for adjustments to their Lap-Band (which are necessary after the band is implanted). Defendants' conduct resulted in injuries to its insureds' safety and wellbeing and violated their rights to "security" and "peace of mind," which are protected rights for those who maintain insurance. Defendants' persistent discrimination and failure to pay benefits injured Plaintiffs because it made it impossible for the patients to receive weight loss treatment at Plaintiff's facilities, violated the ADA and FEHA, and

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constituted unfair competition against Plaintiffs. Defendants' actions also inflict injury on both its insureds and Plaintiffs because they violate fiduciary responsibilities to the beneficiaries in both their role as an insurer and a third party administrator.

F. Example Patient Claims

102. The following examples amply illustrate why Plaintiffs' claims must be deemed exhausted and that substantive remedies are warranted. They illustrate the consistency with which United raises, in each example, disingenuous grounds for denial manufactured by United, as well as the ineffectiveness of Plaintiffs' appeals. (To comply with rules regarding protected health information and patient confidentiality, patients' actual names have not been used. A list of all the patient claims at issue will be provided to United.)

Patient A

103. Patient A, a female who has had a history of over five years of morbid obesity, came to Plaintiffs for a cholecystectomy (surgical removal of the gallbladder) on June 3, 2010 in preparation for receiving Lap-Band surgery. In December 2010, United issued an EOB to Plaintiffs stating that the claim could not be processed because "one or more of the following items are missing. History and physical; findings of examination; lab, radiology, pathology, and anesthesia test results; consult reports; operative/procedure report; daily progress / treatment / medication notes; physician orders for DME [Durable Medical Equipment] along with copy of invoice and delivery statement." The EOB also stated that "we cannot pay this claim because we are unable to verify state licensure of a facility or criteria to support the provider billing time. Proof of facility licensure or hospital affiliation is required."

104. In fact, however, many of the categories of documents that United demanded, such as physician orders for DME, were completely irrelevant to the surgical services provided and did not exist. The request for proof of facility licensure was similarly pretextual, as the identity of the Plaintiffs' facilities was already known to United.

105. After making a follow-up call, Plaintiffs sent all relevant medical records to United the following month. Plaintiffs also provided United with the relevant W-9 forms in response to the request for proof of facility licensure.

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106. However, United referred the claim to Ingenix for further review, incurring additional delay. Ingenix continued to request medical records, even though records had already been sent. Plaintiffs' claims were ultimately denied by United in an EOB dated December 2011 due to a purported failure to provide medical records.

107. United subsequently denied Plaintiffs' appeal only a few months later on the grounds that it was untimely, even though the appeal was not, in fact, untimely. Thus, to this day, United has failed to pay Plaintiffs for its professional and facility charges for valuable medical services that Plaintiffs provided to Patient A.

Patient B

108. Patient B is a morbidly obese female who came to Plaintiffs for Lap-Band surgery. United authorized various pre-operative tests and procedures for Patient B, including cystoscopy, ultrasounds, esophagogastroduodenoscopy ("EGD"), and polysomnography. These procedures were performed between June and November 2011. To date, United has not paid the claims and has not even issued Explanations of Benefits ("EOBs") for all the claims.

109. For instance, on June 6, 2011, Plaintiffs performed an EGD for Patient B. United refused to pay anything relating to this procedure, including the doctor for performing the procedure; the anesthesiologist for anesthesia services provided during the procedure; or for the use of Plaintiffs' surgical facilities. Plaintiffs billed these claims with the medical reports to United via certified mail. United did not pay Plaintiffs' claims. Plaintiffs called United repeatedly to find out about the status of each the claim, including as late as April and August 2012. Though United confirmed that they had received Plaintiffs' claims and that Plaintiffs had provided medical records, United claimed that the claims were still being processed because additional medical records were still needed. United subsequently denied them claims due to the purported failure to provide medical records. However, other claims submitted by Plaintiffs in connection with Patient B were referred to Defendant OptumInsight for further review; and to this day, United refuses to admit or deny these claims.

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Patient C

110. Patient C, a morbidly obese female, received various medical services, including ultrasound, polysomnography, and an EGD with biopsies, at the facilities of Plaintiff San Diego Ambulatory Surgery Center in early 2011. Immediately after Plaintiffs submitted their claims for reimbursement, their claims were forwarded to Ingenix for "further review." The United Defendants requested, and Plaintiffs provided, medical records and further information about the claims. Some of Plaintiffs' claims regarding the services provided to Patient C were subsequently denied for a variety of pretextual reasons, including the purported failure to provide medical records and/or the purported failure to provide provider W-9 forms. Other of Plaintiffs' claims remained pending due to the purported failure to provide medical records. In addition, United received, and ignored, multiple appeal letters regarding Plaintiffs' claims. Plaintiffs have called United numerous times to request the status of payment, and United has repeatedly stated that the claims are pending or in review.

FIRST CAUSE OF ACTION
(For Unfair Business Practices in Violation of California Business & Professions Code §§ 17200 et seq.)

111. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

112. The Unfair Competition Law ("UCL") prohibits "unfair competition," which is defined by California Business & Professions Code Section 17200 as including "any unlawful, unfair or fraudulent business act or practice …."

113. The United Defendants have engaged in a pattern of unfair, unlawful and/or fraudulent business acts and practices against Plaintiffs as set forth below:

a. The United Defendants have illegally discriminated against patients in the provision of fringe employment benefits on the protected basis of those members' morbid obesity, in violation of the Americans with Disabilities Act, 42 U.S.C. § 12111 et seq.

b. The United Defendants have illegally discriminated against patients in the provision of fringe employment benefits on the protected basis of those members' morbid obesity,

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in violation of the California Fair Employment and Housing Act ("FEHA"), Cal. Gov't Code § 12900 et seq.

c. The United Defendants used arbitrary, capricious and improper methods to improperly deny or underpay Plaintiffs' claims.

d. The United Defendants routinely misrepresented that Plaintiffs' claims would be paid, when in fact Defendants had no intention of paying any of Plaintiffs' claims.

e. The United Defendants routinely requested medical records and provider documentation that had already been provided and were not necessary to adjudicate Plaintiffs' claims, as a way to delay adjudication of the claims.

f. The United Defendants routinely referred Plaintiffs' claims to Defendant Ingenix/OptumInsight for so-called "review."

g. The United Defendants routinely denied Plaintiffs' claims based on flimsy procedural rationales, including that medical records had not been provided or that a provider was not "recognized," that were not grounded in the terms or the language of the insurance plan.

h. For those health plans governed by the DMHC, the United Defendants engaged in an "unfair payment pattern" in violation of California Health & Safety Code § 1371.37, including but not limited, to a demonstrable and unjust pattern of reviewing and processing complete and accurate claims that resulted in payment delays; repeated and improper requests for medical records that are not reasonably relevant or reasonably necessary to determine payor liability; reducing the amount of payment and/or denying payment of claims without justification; and/or failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Health & Safety Code § 1371 *et seq*.

i. For those health plans governed by the DMHC, the United Defendants failed to correctly and accurately apply the criteria used to calculate UCR rates as set forth in Title 28 of the California Code of Regulations ("CCR"), section 1300.71(a)(3)(B), and failed to comply with Health & Safety Code § 1371 and 28 CCR § 1300.71.

j. For those health plans governed by the DMHC, the United Defendants illegally received compensation tied to the denial and/or reduction of amounts due on Plaintiffs'

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claims in willful violation of Health & Safety Code § 1399.56 (which is a misdemeanor pursuant to Health and Safety Code § 1390).

k. For those health plans governed by the DMHC, the United Defendants illegally received compensation tied to the denial and/or reduction of amounts due on Plaintiffs' claims, in violation of Insurance Code § 796.02.

l. The United Defendants interfered with Plaintiffs' contracts with Third Party Payors, including Multiplan and Three Rivers.

q. The United Defendants made materially false statements and used materially false documents in connection with the payment for health care benefits, items, or services involving a health care benefit program, as detailed in the complaint, at least tens of thousands of times, in violation of 18 U.S.C. § 1035. Pursuant to 18 U.S.C. § 24(b), the definition of "health care benefit program" includes Plaintiffs, as providers to whom payment may be made for medical services under private plans affecting commerce.

r. The United Defendants knowingly and willfully engaged in a scheme to defraud "health care benefit programs" and to obtain, by means of false or fraudulent pretenses, representations, or promises, money or property owned by, or under the custody or control of, health care benefit programs, in violation of 18 U.S.C. § 1347. Pursuant to 18 U.S.C. § 24(b), the definition of "health care benefit program" includes Plaintiffs, as providers to whom payment may be made for medical services under private plans affecting commerce.

s. With respect to health insurance plans promulgated by the United Defendants that are subject to the California Insurance Code and/or regulated by the Department of Insurance, the United Defendants engaged in acts of unfair competition under at least California Insurance Code § 790.03(h), subsections, (1), (2), (3), (4), (5), (6), and (13) by, among other things:

- misrepresenting to Plaintiffs and plan beneficiaries that United would pay the providers' reasonable and customary charges;
- failing to respond to claim-related inquiries and communications by Plaintiffs in a reasonably prompt manner;

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- failing to affirm or deny Plaintiffs' claims for reimbursement within a reasonable time after all proof of loss requirements had been submitted and liability had become reasonably clear;
- failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies, and instead, illegitimately referring claims to Defendant Ingenix/OptumInsight, Inc. for further review;
- delaying the investigation and/or payment of claims by requiring the repeated submission of medical records and other documents showing entitlement to payment;
- failing to provide promptly a reasonable explanation of the basis relied upon for the denial of Plaintiffs' claims; and
- compelling insureds (and Plaintiffs, acting on behalf of such insureds) to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

114. The conduct alleged violates the UCL. As a result of their business acts and practices in violation of the UCL, Defendants have received and retained and continue to receive and retain monies that rightfully belong to Plaintiffs as compensation for rendering covered, medically necessary services to plan members. Plaintiffs have thus suffered "injury in fact" because Defendants have unlawfully, unfairly, and fraudulently withheld monies from Plaintiffs to which Plaintiffs were entitled as compensation for rendering covered, medically necessary services to plan participants and beneficiaries.

115. Plaintiffs have further suffered "injury in fact" because Defendants obstructed and discriminated against morbidly obese individuals seeking weight loss surgery at Plaintiffs' clinics, thereby both depriving morbidly obese individuals from the benefits of such advantageous and medically necessary surgery ***and*** harming Plaintiffs' business interests.

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116. Defendants' conduct in violation of the UCL is likely to continue absent judicial intervention. This conduct threatens not only Plaintiffs' economic well-being and future viability, but also the health of the public and the needs of morbidly obese individuals in California.

117. Business & Professions Code § 17203 provides that any court of competent jurisdiction may enjoin any person from engaging in unfair competition and restore to any person who is a victim of that unfair competition any money acquired thereby. Plaintiffs seek restitution of an amount to be proved at trial, plus applicable statutory interest, which is the amount that the Defendants are obligated to pay Plaintiffs for the services Plaintiffs provided to plan participants and beneficiaries. Plaintiffs further seek an injunction prohibiting Defendants' ongoing conduct in using inappropriate methodologies to deny or underpay Plaintiffs' claims for medical treatment provided to plan members. Furthermore, the injunction should force Defendants to correctly price past and future claims by Plaintiffs by determining UCR based on appropriate UCR data.

118. Plaintiffs' legal remedies are inadequate in that Defendants' unlawful, unfair, and fraudulent conduct is ongoing and repeated litigation to correct Defendants' ongoing actions would be inefficient for the parties and the Court. Plaintiffs' damages cannot be fully compensated by money and are difficult or impossible to ascertain in terms of money alone. The loss of revenue from Defendants' illegal and unfair withholding of claim payments is severely impeding Plaintiffs' ability to provide adequate care for patients.

SECOND CAUSE OF ACTION

(For Breach of Implied-In-Fact Contract – Authorized Services/No Authorization Needed Services)

119. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

120. Plaintiffs and Defendants entered into implied-in-fact contracts through Defendants' course of conduct (i) for services that were authorized by the Defendants, and (ii) for services for which United told the Plaintiffs that no authorization was needed, whereby Plaintiffs then provided the services to the patients, and the Defendants agreed to pay for such services.

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121. This course of conduct created implied-in-fact contracts whereby Plaintiffs agreed to provide, and Defendants agreed to pay, for medical services rendered to members and insureds of insurance plans administered and/or funded by United.

122. For each of the claims at issue, Plaintiffs confirmed that the patient was an eligible member of one of the Defendants' plans by contacting United, typically by telephone. When Plaintiffs called Defendants, they also inquired as to which services required prior authorization by United, and which services did not require such authorization.

123. When the Plaintiff providers called United for insurance verification purposes, they also asked United whether United would pay the Providers' reasonable and customary fees. In virtually every instance, the United representative responded that they would pay the reasonable and customary fees charged by the Plaintiffs for their services.

124. At the time when Plaintiffs called United for insurance verification purposes, Plaintiffs made notes of those calls in a database and/or computer system maintained by Plaintiffs. Plaintiffs' notes reflect whether United represented during the call that benefits existed for a given medical service, and whether authorization was necessary. Plaintiffs are informed and believe that United maintained similar notes.

125. For medical services that United indicated required an authorization, Plaintiffs sought, and received, such authorization from United before providing such services to the patient. For medical services not requiring an authorization, Plaintiffs relied on United's representation to Plaintiffs during the initial verification phone call that no explicit authorization was required for Plaintiffs to provide the services to United's members.

126. Either way, Plaintiffs relied upon United's representations that the services were explicitly authorized or did not require authorization, and United's representations that it would pay Plaintiffs' reasonable and customary fees, when Plaintiffs provided medical services to patients. In no instance did the Plaintiffs expect that they would provide their medical services to members and insureds of United for free or at reduced rates. Rather, they expected their reasonable and customary fees to be paid as verified by United.

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127. Plaintiffs are informed and believe that United maintains records of all authorizations for medical services in its computer systems and/or databases.

128. Having authorized services, or having confirmed that no authorization was needed, and having represented that they would pay Plaintiffs' reasonable and customary charges, Defendants thereby agreed to pay the Plaintiffs at the reasonable and customary charges.

129. If Defendants did not intend to pay Plaintiffs, they could have withheld authorization for particular services. Defendants also could have informed Plaintiffs during the initial verification of insurance that they did not intend to pay any of the claims submitted by Plaintiff in connection with the services rendered. Defendants failed to do so, however. Therefore, Defendants entered into implied-in-fact contracts with the Plaintiffs to pay Plaintiffs' reasonable and customary charges.

130. At all relevant times, Plaintiffs were not under contract with United, and therefore were never obligated to accept less than their full billed charges. Certainly, Plaintiffs were not obligated to provide their services for free.

131. Plaintiffs have performed all of the obligations required of them under the implied-in-fact contracts with the defendants for the authorized services.

132. Each of the Defendants breached the terms of each of the implied-in-fact contracts by refusing to pay the Plaintiffs for the services according to the terms of the implied-in-fact contracts. The breaches also included, among other things, making material misrepresentations regarding status of Plaintiffs' claims; making unjustified requests for medical records and provider documentation in order to delay the processing of Plaintiffs' claims; subjecting Plaintiffs' claims to an unwarranted, fraudulent and pretextual level of scrutiny by Defendant Optum/Ingenix; denying claims and appeals without justification; and providing an arbitrary and capricious benefit determination and appeal process.

133. As a direct and proximate result of United's breaches of these implied-in-fact contracts, Plaintiffs have been damaged in an amount to be proven at trial, plus applicable statutory interest.

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THIRD CAUSE OF ACTION

(For Equitable Estoppel)

134. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

135. United was apprised of the facts concerning Plaintiffs' request to provide services to United's members. When Plaintiffs called United for insurance verification purposes, they asked whether United whether out-of-network benefits were available under the terms of the patients' plans for the medical services that Plaintiff intended to perform. In virtually every instance, United's representatives responded that they were.

136. During these calls, Plaintiffs further inquired whether United would pay the Plaintiff Providers' usual and customary charges. Again, in virtually every instance, the United representative responded that they would pay the usual and customary fees charged by the Plaintiff providers for the services specified.

137. Furthermore, for medical services that United indicated required an authorization, Plaintiffs sought, and received, such authorization from United before providing such services to the patient. For medical services not requiring an authorization, Plaintiffs relied on United's representation to Plaintiffs during the initial verification phone call that no explicit authorization was required for Plaintiffs to provide the services to United's members. In providing these responses, United intended that its conduct would be acted upon by Plaintiffs, and/or knew that, after informing Plaintiffs that the services were authorized, or that no authorization was necessary, that Plaintiffs would provide the discussed services to United's members.

138. Defendants intended that Plaintiffs rely upon the representations described above. It is common practice in the trade of the health care industry for plans to make these statements to tell providers that the providers will get paid for services to the members of the plans.

139. The language of the plans pertaining to benefits for out-of-network surgery either clearly provided that those benefits would be paid at a UCR rate, or if they did not, the terms of the plan were ambiguous.

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140. Plaintiffs were ignorant that United never intended to reimburse Plaintiffs for the services they provided to United's members. Plaintiffs were ignorant that United would create pretextual reasons for refusing to process or to pay the claims.

141. Plaintiffs reasonably and actually relied on the statements by the United Defendants that the services were authorized, or that no authorization was needed.

142. Plaintiff likewise reasonably and actually relied on the statements by the United Defendants that out-of-network surgical benefits were available under the terms of the plans and that the Defendants would pay Plaintiffs' reasonable and customary charges. In reliance on these representations, Plaintiffs rendered medical services to the patients, and did not seek potential avenues of payment other than from the United Defendants.

143. Accordingly, Defendants are estopped from contending that the services it authorized are not payable due to lack of authorization, and are estopped from refusing to pay the reasonable and customary value for these services.

FOURTH CAUSE OF ACTION

(For Recovery for Services Rendered)

144. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

145. To the extent the causes of action alleged above for any reason do not apply to the services at issue, Plaintiffs allege in the alternative that Defendants are indebted to Plaintiffs at the quantum meruit rate for the services rendered by Plaintiffs to the members and insureds of health plans administered and/or funded by Defendants.

146. Plaintiffs provided medically necessary treatment to each of the members who received health care services from Plaintiffs. By authorizing the Plaintiffs to provide health care services to the members, by verifying the members' coverage under the Health Plan, by misrepresenting, concealing and/or failing to disclose United's intent not to pay Plaintiffs for their services, and by other words and/or conduct, Defendants, on their own behalf and/or as the agent of one or more of the other Defendants, requested that Plaintiffs provide those services.

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147. Defendants received, accepted, used, enjoyed and benefited from Plaintiffs' valuable health care services. Defendants knew that the services were being provided to the members for the benefit of Defendants, and Defendants promised to pay Plaintiffs for those services.

148. As a result, each of the Defendants became indebted to Plaintiffs for the health care services rendered by Plaintiffs to the members.

149. Each of the Defendants has failed and refused, and continues to refuse, to timely and properly pay Plaintiffs for the reasonable and customary fair market value of the services Plaintiffs provided to the members. Instead, Defendants have decided to delay payment, deny payment, or pay whatever amount they arbitrarily, capriciously, and unilaterally decided was appropriate for such services, at rates far below the services' reasonable and customary fair market value.

150. The reasonable and customary fair market value of the services provided by Plaintiffs to the members for the benefit of Defendants is Plaintiffs' billed charges for the services.

151. Plaintiffs have demanded, on numerous occasions, that the Defendants pay for the health care services Plaintiffs has provided to the members, and has objected to the failure to timely and properly pay Plaintiffs for the services provided to the members.

152. Accordingly, there is now due, owing and unpaid from the Defendants to Plaintiffs an amount to be proven at trial, plus applicable statutory interest.

FIFTH CAUSE OF ACTION

(For Declaratory Relief)

153. Plaintiffs incorporate the prior paragraphs as though fully set forth herein.

154. A controversy has arisen between each of the Defendants and Plaintiffs as to Plaintiffs' right to be afforded access to an honest and unbiased claims administration process, and to be paid under the terms of the benefits plans at issue.

155. Accordingly, Plaintiffs seek a declaration that:

a. Defendants' use of the various procedural pretexts described above that are being used to delay and/or deny payment on Plaintiffs' claims, such as repeated requests for

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medical records and constant referrals to Ingenix for further review, are arbitrary and capricious, and a violation of California law concerning prompt payment of claims;

b. Defendants are now barred from relying upon any rationales for denying Plaintiffs' claims that Defendants did not raise during the administrative process and prior to litigation;

c. Defendants must immediately cease the use of such procedural pretexts;

d. Defendants are required timely re-process all claims that have been submitted by the Plaintiffs since United first began its campaign to deny payments to the Plaintiffs, and to pay those claims pursuant to the terms of the Plans;

e. Defendants must conduct a "full and fair review" for all claims being re-processed, free of dishonest and surreptitious delay and denial tactics;

f. Defendants must render timely benefit decisions on all future claims submitted by Plaintiffs in accordance with all applicable rules and regulations governing the time in which such decisions must be rendered;

g. Defendants must promptly and timely provide Explanation of Benefits and responses to appeals;

h. When denying Plaintiffs' claims, Defendants must disclose with specificity the reasons for the adverse determinations, and cite the specific provisions of the plans that support the determinations;

WHEREFORE, Plaintiffs pray for and demand judgment against the Defendants as set forth above and as follows:

1. An injunction prohibiting Defendants from engaging in the unfair business practices complained of, and requiring Defendants to restore to Plaintiffs, and otherwise to disgorge, any money that has been acquired from Plaintiffs, by means of the unfair business practices being committed by Defendants.

2. The reasonable and customary value of the medical services provided by Plaintiffs to Defendants' insureds and members.

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3. For actual damages in an amount according to proof at trial.

4. For a judicial declaration that:

a. Defendants' use of the various procedural pretexts described above that are being used to delay and/or deny payment on Plaintiffs' claims, such as repeated requests for medical records and constant referrals to Ingenix for further review, are arbitrary and capricious;

b. Defendants are now barred from relying upon any rationales for denying Plaintiffs' claims that Defendants did not raise during the administrative process and prior to litigation;

c. Defendants must immediately cease the use of such procedural pretexts;

d. Defendants are required timely re-process all claims that have been submitted by the Plaintiffs since United first began its campaign to deny payments to the Plaintiffs, and to pay those claims pursuant to the terms of the Plans;

e. Defendants must conduct a "full and fair review" for all claims being re-processed, free of dishonest and surreptitious delay and denial tactics;

f. Defendants must render timely benefit decisions on all future claims submitted by Plaintiffs in accordance with all applicable rules and regulations governing the time in which such decisions must be rendered;

g. Defendants must promptly and timely provide Explanation of Benefits and responses to appeals;

h. When denying Plaintiffs' claims, Defendants must disclose with specificity the reasons for the adverse determinations, and cite the specific provisions of the plans that support the determinations;

5. Awarding prejudgment interest and costs; and

6. Awarding such other relief as the Court deems just and proper.

DATED: March 21, 2014

HOOPER, LUNDY & BOOKMAN, P.C.

By: _____
DARON L. TOOCH
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DEMAND FOR JURY TRIAL

Plaintiffs demand a jury trial for all claims so triable.

DATED: March 21, 2014

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By: _____
DARON L. TOOCH
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