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SUPERIOR COURT OF THE STATE OF ARIZONA

COUNTY OF MARICOPA

CHAPTER 5 COUNSELING CENTER LLC; PRESCOTT HOUSE INC.; ; DESERT COVE RECOVERY CENTER LLC; and COMPASS RECOVERY CENTER LLC, Plaintiffs, v. HEALTH NET, INC., a Delaware corporation; HEALTH NET OF ARIZONA, INC., a Arizona corporation; HEALTH NET LIFE INSURANCE COMPANY, a California corporation; MANAGED HEALTH NETWORK, INC., a Delaware corporation; CENTENE CORPORATION, a Delaware corporation; and DOES 1 through 10, inclusive, Defendants.	No. CV2016-009984 **COMPLAINT**

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INTRODUCTION

Health Net ("Defendants") sold health insurance policies to Arizona consumers and accepted premiums in exchange. Health Net insureds then sought medically necessary treatment from behavioral health centers, including the Plaintiffs. Plaintiffs properly confirmed patients were covered by health insurance issued by Health Net. Health Net subsequently refused to reimburse or significantly underpaid Plaintiffs for the services that were rendered to Patients as required by the policies of insurance.

Health Net's conduct has had a severe and adverse effect on not only Plaintiffs **but** also Health Net insureds. Health Net's conduct has placed the lives of their insureds that are struggling with addiction in jeopardy, while simultaneously destroying or significantly

damaging Plaintiffs and all similarly situated treatment centers. Upon information and belief, Health Net's conduct was wanton and willful, and undertaken to improve their balance sheet in general and while Health Net aggressively sought to consummate its merger with Centene.

Health Net's practices were also unlawful in that, as a part of their scheme to not pay or underpay Plaintiffs, and to prevent Plaintiffs from learning of their scheme as long as possible, they violated their claims handling obligations under Arizona law by providing either no, baseless, or dilatory reasons for not paying Plaintiffs. Defendants' practices are unlawful in that they violate the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The MHPAEA is an antidiscrimination statute intended to ensure that coverage of mental health and substance abuse care (such as Plaintiffs provide) is in "parity" with coverage of medical and surgical care.

Health Net's policyholders and patients were also intentionally misled into believing that the insurance policies they chose would pay for care supplied by providers such as Plaintiffs. In point of fact, Health Net intended to illegally not pay or underpay treatment centers throughout Arizona. Health Net has ignored seven (7) months of Plaintiffs' efforts to resolve this matter, placing Plaintiffs in the untenable position of being forced to file this Complaint in order to recover payments due under the Health Net insurance policies.

PARTIES, JURISDICTION, AND VENUE

1. Plaintiff, Chapter 5 Counseling Center, LLC ("Chapter 5") is a limited liability corporation duly organized and existing under the laws of Arizona. Chapter 5 operates and maintains drug and alcohol treatment facilities in Arizona.

2. Plaintiff, Prescott House, Inc. ("Prescott House") is a corporation duly organized and existing under the laws of Arizona. Prescott House operates and maintains drug and alcohol treatment facilities in Arizona.

3. Plaintiff, Desert Cove Recovery Center, LLC ("Desert Cove") is a limited liability corporation duly organized and existing under the laws of Arizona. Desert Cove operates and maintains drug and alcohol treatment facilities in Arizona.

4. Plaintiff, Compass Recovery Center, LLC ("Compass Recovery") is a limited liability corporation duly organized and existing under the laws of Arizona. Compass Recovery operates and maintains behavioral health treatment facilities in Arizona.

5. Upon information and belief, Defendant Health Net, Inc. is a Delaware corporation with a principal place of business of 21650 Oxnard Street, Woodland Hills, California, 91367.

6. Upon information and belief, Defendant Health Net Life Insurance Company is a California corporation with a principal place of business of 21650 Oxnard Street, Woodland Hills, California 91367. Health Net Life Insurance Company is a foreign indemnity life and health insurance company licensed by the Arizona Department of Insurance.

7. Upon information and belief, Defendant Health Net of Arizona, Inc. is an Arizona corporation with a principal place of business of 1230 West Washington Street, Suite 401, Tempe, Arizona 85281. Health Net of Arizona is a health care services organization licensed by the Arizona Department of Insurance.

8. Upon information and belief, Defendant Centene Corporation is a Delaware corporation with a principal place of business in St. Louis, Missouri.

9. Upon information and belief, Defendant Managed Health Network, Inc. is a Delaware corporation with a principal place of business of 11931 Foundation Place, Building D, Rancho Cordova, California 95670.

10. Upon information and belief, Defendants were and are agents, representatives, servants and/or the alter ego of their codefendants. Further, that the Defendants in doing the things alleged herein were acting in the scope of their authority as such agent, servant and with their codefendants consent and permission.

11. At all times material to this Complaint, Plaintiffs are informed and believe that Defendants are and were duly authorized to do business in the State of Arizona, and have conducted business throughout the State of Arizona on a systematic and continuous basis.

12. The rehabilitation services in question were provided by Plaintiffs to Patients who had health insurance for the services that Plaintiffs provided at all relevant times and the policies of health insurance were issued by the Defendants or under the direction and control of the Defendants.

13. Defendants John Does I-X, Jane Does I-X, Black Corporations I-X, and ABC Partnerships I-X, inclusive, are individuals, corporations, partnerships or business entities which caused the events complained of to occur in the State of Arizona. Plaintiffs do not know the true identities of Defendants. However, Plaintiffs will amend this Complaint when the true names of the Defendants become known.

14. All persons acting on behalf of Defendants were employees or agents of Defendants, acting within the scope of their employment or agency.

15. Defendants, and each of them, caused the events complained of to occur in the State of Arizona.

16. The acts about which Plaintiffs complain occurred in Maricopa County, and other counties in Arizona. Therefore, venue in this Court is proper.

17. Jurisdiction and venue are appropriate for this Court. The amount in controversy exceeds the minimum jurisdictional limits of this Court.

BACKGROUND

ARIZONA TREATMENT FACILITIES

18. Plaintiffs provide behavioral health treatment services to those in the process of recovering from alcohol and substance abuse and those suffering from mental illness. Plaintiffs' rehabilitative care includes a range of services, including residential and outpatient behavioral health treatment, as well as toxicology testing.

19. Chapter 5 is a drug and alcohol treatment center dedicated to helping adult men and women overcome alcohol and substance abuse. The residential rehabilitation offers a safe, supportive, and compassionate environment for individuals to develop the skills necessary to recover from alcoholism and drug addiction. Through therapeutic interventions and the daily practice of 12-step principles, Chapter 5 believes that anyone can live a fulfilling life of sobriety. The facility welcomes all alcoholics and addicts with a desire to stop using, regardless of age, race, religion, sexual preference, or ethnic origin. Chapter 5 is a licensed care provider with the State of Arizona and the Arizona Department of Health Services. Chapter 5 is also a Behavioral Health Accredited provider by the Joint Commission. The Joint Commission is an independent organization that conducts objective evaluation of medical facilities in several different categories, including behavioral health.

20. Prescott House provides addiction recovery services to men and their families at a male-only rehabilitation center in Prescott, Arizona. Prescott House is committed to providing excellent clinical care in a close-knit recovery community. This commitment is founded on a firm belief in recovery of the mind, body, and spirit. Prescott House is a licensed care provider with the State of Arizona and the Arizona Department of Health Services. Prescott House is also a CARF Behavioral Accredited Provider.

21. Desert Cove is a behavioral health treatment provider. Its program combines traditional methods with cutting-edge techniques for custom addiction treatment. Desert Cove is a licensed care provider with the State of Arizona and the Arizona Department of Health Services. Desert Cove is also a Behavioral Health Accredited Provider by the Joint Commission.

22. Compass Recovery provides intensive outpatient behavioral health treatment programs for drug, alcohol and substance abuse. Compass Recovery's treatment program is an individualized treatment plan designed to address core issues facing clients experiencing drug and alcohol addiction issues.

HEALTH NET LIFE INSURANCE COMPANY ARIZONA POLICY FORMS

23. Health Net Life Insurance Company ("HNLIC") is an indemnity life and health insurance company authorized to transact insurance business in Arizona by virtue of a Certificate of Authority issued by the Arizona Department of Insurance. The majority of insurance policies at-issue in this dispute are indemnity preferred provider organization life and health insurance policies issued by HNLIC.

24. The HNLIC policy forms issued for 2015 and 2016 in Arizona contain benefits for both in-network and out-of-network benefits.

25. The HNLIC policies issued in Arizona are relatively standard indemnity health insurance policies in that they provide richer benefits for treatment and services that are obtained from a listing of in-network providers. Such providers contract with HNLIC to become part of their "network." In-network providers generally agree to accept a set, reduced rate of reimbursement in exchange for steerage of patients/policyholders to their practices or facilities.

26. All of the Plaintiff treatment centers in this dispute are out-of-network providers for the at-issue HNLIC indemnity health insurance policies.

27. Upon information and belief, HNLIC had virtually no contracted, in-network drug and alcohol treatment centers in the Prescott, Arizona area in 2015 and the first-half of 2016.

28. The reimbursement rate to out-of-network providers is often significantly less than the reimbursement rate for in-network providers. This generally results in higher out-of-pocket expenses for policyholders.

29. The 2015 HNLIC Arizona indemnity health policy form issued in Arizona contains the following reimbursement language relating to out-of-network drug and alcohol treatment services:

OUT-OF-NETWORK PROVIDERS

> The maximum amount Health Net will pay for Covered Expenses when services or supplies are received from an Out-

of-Network Provider is based on the lesser of the billed charge or the Maximum Allowable Amount as defined in the Glossary of Terms section. Once the Maximum Allowable Amount is determined, the amount that Health Net pays an Out-of-Network Provider and the amount which will be Your responsibility are determined as follows:

- Health Net pays an Out-of-Network Provider an amount equal to the Maximum Allowable Amount, less any Deductible(s), Copayments and /or Coinsurance applicable to the Covered Expense for the service or supply that You receive.

- The portion of Maximum Allowable Amount that will be Your responsibility is any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.

- Unless the Out-of-Network provider has agreed to accept the Maximum Allowable Amount as payment in full, as described in the definition of Maximum Allowable Amount, the amount billed by the Out-of-Network provider may exceed the Maximum Allowable Amount. You will be responsible for that excess amount, in addition to any applicable Deductible(s), Copayments and/or Coinsurance payment required. In addition, You are always responsible for services or supplies not covered by this health Plan.

* * *

2015 EOC pages 11 and 12 (emphasis in original).

Maximum Allowable Amount is the amount on which Health Net bases its reimbursement for Covered Services provided by an Out-of-Network Provider, which may be less than the amount billed for those services or supplies.

Health Net calculations Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth herein. Maximum Allowable Amount is not the amount that Health Net pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this Evidence of Coverage.

- For Emergency Services, Maximum Allowable Amount is 100% of the amount billed by the Provider.

- For non-Emergency Services, the Maximum Allowable Amount is determined by reference to the amount listed as 100% of the applicable Medicare fee schedule maintained by the Centers for Medicare and Medicaid Services (CMS) for the services provided. If CMS has not established an amount

for the services, Maximum Allowable Amount is 100% of the amount billed by the Provider.

- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See ***Schedule of Benefits***, **Description of Benefits** and **Limitations and Exclusions** sections for specific benefit limitations, maximums, pre-certification requirements and surgery payment policies that limit the amount Health Net pays for certain services.

From time to time, Health Net also contracts with vendors that have contracted fee arrangements with Providers ("Third Party Networks"). In the event Health Net contracts with a Third Party Network that has a contract with the Out-of-Network Provider, Health Net may, at its discretion, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case you will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Co-payment and/or Coinsurance amount at the Out-of-Network level.

In addition, Health Net may, at its discretion, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for any Deductible, Copayment and/or Coinsurance amount at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's Fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever you obtain Covered Services from an Out-of-Network Provider, You are responsible for applicable Deductibles, Copayments and Coinsurance.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help You further understand Your potential financial responsibilities for Covered Out-of-Network Services please log on to healthnet.com or contact Health Net Customer Service at the number on Your Member identification card.

2015 EOC pages 76 and 77 (emphasis in original).

30. The 2016 HNLIC Arizona indemnity health policy form originally filed in Arizona contains the following reimbursement language relating to out-of-network drug and alcohol treatment services:

OUT-OF-NETWORK PROVIDERS

The Maximum amount Health Net will pay for Covered Expenses when services or supplies are received from an Out-of-Network Provider is based on the lesser of the billed charge or the Maximum Allowable Amount as defined in the Glossary of Terms section. Once the Maximum Allowable Amount is determined, the amount that Health Net pays an Out-of-Network Provider and the amount which will be Your responsibility are determined as follows:

- Health Net pays an Out-of-Network Provider an amount equal to the Maximum Allowable Amount, less any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the services or supply that You receive.

- The portion of the Maximum Allowable Amount that will be Your responsibility is any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expenses for the service or supply that You receive.

- Unless the Out-of-Network Provider has agreed to accept the Maximum Allowable Amount as payment in full, as described in the definition of Maximum Allowable Amount, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. You will be responsible for that excess amount, in addition to any applicable Deductible(s), Copayments and/or Coinsurance payment required. In addition, You are always responsible for services or supplies not covered by this Health Plan.

Important Note: Even if a Hospital is a Participating Provider, You should not assume that all Physicians and other individual Providers of health care at the Hospital are Participating Providers. If You are admitted to a Hospital You should request that all services be performed by Participating Providers whenever You enter a Hospital.

In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Marketplace and regardless of income, have no cost sharing obligation under the Policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (HIS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost sharing means copayments, including coinsurance and deductibles.

Subject to the Limitations and Exclusions provision of this Evidence of Coverage, and any attached riders, the following Covered Services and Supplies will be considered Covered Expenses under the Evidence of Coverage:

* * *

Maximum Allowable Amount is the amount on which Health Net bases its reimbursement for Covered Services and Supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. Health Net calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-network Provider or the amount determined as set forth herein. Maximum Allowable Amount is not the amount that Health Net pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance; Copayments, Deductibles and other applicable amounts set forth in the *Evidence of Coverage*.

- For all services received from an Out-Of-Network Provider or for Emergency Care received during Foreign Travel or Work Assignment, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 100% of the Medicare allowable amount.

- In the event that Medicare allowable does not include an amount for the service or supply provided, Maximum Allowable Amount shall be deemed to be 75% of the covered charges billed by the provider. The Maximum Allowable Amount determined as described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.

- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See ***Schedule of Benefits***, **Description of Benefits** and **Limitations and Exclusions** sections for specific benefit limitations, maximums, pre-certification requirements and surgery payment policies that limit the amount Health Net pays for certain Covered Services and Supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

From time to time, Health Net also contracts with vendors that have contracted fee arrangements with Providers ("Third Party Networks"). In the event Health Net contracts with a Third Party Network that has a contract with the Out-of-Network Provider, Health Net may, at its discretion, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case You will not be responsible for the difference between the Maximum Allowable Amount and the

billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance amount at the Out-of-Network level.

In addition, Health Net may, at its discretion, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance amount at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowed Amount.

Please note that whenever You obtain Covered Services from an Out-of-Network Provider, You are responsible for applicable Deductibles, Copayments and Coinsurance.

For More information on the determination of Maximum Allowable Amount, or for information, services and tools to help You further understand Your potential financial responsibilities for Covered Out-of-Network Services please log on to heatlhnet.com or contact Health Net Customer Service at the number on Your Member identification card.

31. Arizona law requires that such policy forms be filed with and approved by the Arizona Department of Insurance ("ADOI").

32. On November 17, 2015, Health Net of Arizona, on behalf of HNLIC, filed the following amendment with the ADOI relating to out-of-network reimbursement language for its 2016 policy form:

A. The following is a revision to the definition currently in the Glossary of Terms section of your EOC:

Maximum Allowable Amount is the amount on which Health Net bases its reimbursement for Covered Services and Supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. Health New calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or

the amount determined as set forth herein. Maximum Allowable Amount is not the amount that Health Net pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Evidence of Coverage*.

- For all services received from an Out-of-Network Provider or for Emergency Care received during Foreign Travel or Work Assignments, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 100% of the Medicare allowable amount, and the Maximum Allowable Amount for facility services is 150% of the Medicare Allowable Amount.

- In the event that Medicare allowable does not include an amount for the service or supply provided, Maximum Allowable Amount shall be deemed to be 75% of the covered charges billed by the provider. The Maximum Allowable Amount determined as described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.

- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See ***Schedule of Benefits***, **Description of Benefits** and **Limitations and Exclusions** sections for specific benefit limitations, maximums, pre-certification requirements and surgery payment policies that limit the amount Health Net pays for certain Covered Services and Supplies. HNL uses available guidelines of Medicare and its contractors, other government regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

From time to time, Health Net also contracts vendors that have contracted fee arrangements with Providers ("Third Party Networks"). In the event Health Net contracts with a Third Party Network that has a contract with the Out-Of-Network Provider, Health Net may, at its discretion, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance amount at the Out-of- Network level.

In addition, Health Net may, at its discretion, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for the difference between the Maximum

Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance amount at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever You obtain Covered Services from an Out-of-Network Provider, You are responsible for applicable Deductibles, Copayments and Coinsurance.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help You further understand Your potential financial responsibilities for Covered Out-of-Network Services please log on to healthnet.com or contact Health Net Customer Service at the number on Your Member identification card.

HN-IFP.PPO.EOC.ACA.1/16.Amendment (page 1 and 2)

33. On January 20, 2016, Health Net of Arizona, again on behalf of HNLIC, filed another amendment with the ADOI relating to the HNLIC Arizona indemnity health policy form and out-of-network reimbursement language[1]:

B. Effective May 15, 2016: the following provision replaces the definition of Maximum Allowable Amount in the Glossary of Terms section of your EOC:

Maximum Allowable Amount is the amount on which Health Net bases its reimbursement for Covered Services and Supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. Health Net calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth herein. Maximum Allowable Amount is not the amount that Health Net pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Evidence of Coverage*.

- For all services received from an Out-of-Network Provider or for Emergency Care received during Foreign

[1] The January 20, 2016 Amendment (Amendment 2) was not approved by the Arizona Department of Insurance until February 16, 2016, which is after PPACA open enrollment was closed.

Travel or Work Assignment, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 100% of the Medicare allowable amount.

- In the even there is no Medicare allowable amount for a professional service, Maximum Allowable Amount is determined by applying a designated percentile from the database of Physician charges from the FAIR Health RV Benchmarks or a similar type of database of Physical professional charges. In the event there is no Medicare allowable amount for a facility service, Maximum Allowable Amount is calculated using a method developed by Data iSight, a data service that applies a profit margin factor to the estimated costs of the services rendered by the Out-of-Network Provider, or a similar type of valuation service. In the event the Maximum Allowable Amount shall be deemed to the 75% of the covered charges billed by the provider. The Maximum Allowable Amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies. If the billed charges for a claim are less than Maximum Allowable Amount, we will pay the billed charges.

- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See ***Schedule of Benefits***, **Description of Benefits** and **Limitations and Exclusions** sections for specific benefit limitations, maximums, pre-certification requirements and surgery payment policies that limit the amount Health Net pays for certain Covered Services and Supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

From time to time, Health Net also contracts with vendors that have contracted fee arrangements with Providers ("Third Party Networks"). In the event Health Net contracts with a Third Party Network that has a contract with the Out-of-Network Provider, Health Net may, at its discretion, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance amount at the Out-of-Network level.

In addition, Health Net may, at its discretion, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be

responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance amount at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever You obtain Covered Services from an Out-of-Network Provider, You are responsible for applicable Deductibles, Copayments and Coinsurance.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help You further understand Your potential financial responsibilities for Covered Out-of-Network Services please log on to healthnet.com or contact Health Net Customer Service at the number on Your Member identification card.

HN-IFP.PPO.EOC.ACA.1/16.Amendment2 (pages 1-3)

34. Upon information and belief, although all of the 2016 amendments to the 2016 HNLIC Arizona indemnity health policy form substantially adversely affected a policyholders out-of-pocket liability, neither Health Net of Arizona nor HNLIC filed corresponding rate decrease requests with the ADOI or the U.S. Department of Health and Human Services ("HHS").[2]

35. The HNLIC 2015 Arizona indemnity health policy form essentially addressed out-of-network drug and alcohol treatment by determining whether the treatment billing codes were found on the Medicare Fee Schedule. If the billing codes used by treatment centers were found on the Medicare Fee Schedule, per the policy form, the reimbursement rate was set at 100% of the applicable Medicare reimbursement fee schedule maintained by the Centers for Medicare and Medicaid ("CMS") for the services provided.

[2] The State of Arizona did not establish its own PPACA Exchange or Marketplace. Thus, it is considered a federally facilitated exchange and much of the oversight and operational authority for the Marketplace is left to the U.S. Department of Health and Human Services ("HHS").

36. For the HNLIC 2015 Arizona indemnity health policy form, if an out-of-network drug and alcohol treatment centers billing codes were not found on the Medicare Fee Schedule, per the policy form, the reimbursement rate for such treatment was 100% of billed charges.

37. Given the significant amendment history for the HNLIC 2016 Arizona indemnity policy form, the out-of-network reimbursement rate for drug and alcohol treatment became significantly (and intentionally, per HNLIC) more complex.

38. Upon information and belief, none of the amendments to the 2016 HNLIC Arizona indemnity health policy form are valid based upon the fact that they made materially adverse changes to the at-issue coverage without any corresponding decrease in premium and at least one Amendment was filed and approved after a period when policyholders had no other choices with respect to coverage (after annual open enrollment closed).

PRIOR AUTHORIZATION FOR DRUG AND ALCOHOL TREATMENT

39. The 2015 and 2016 HNLIC Arizona indemnity health policy forms require that drug and alcohol treatment be preceded by authorizations obtained by the medical provider from Health Net.

40. The 2015 and 2016 HNLIC Policies require precertification for drug and alcohol treatment.

41. Consistent with the requirements of the at-issue policy forms, all of the Plaintiff centers obtained prior authorization for drug and alcohol addiction treatment for HNLIC policyholders.

42. Based upon the language of the at-issue HNLIC policy forms and upon obtaining required prior authorization codes/numbers, the policyholders and treating medical providers reasonably expected that claims would be paid promptly and consistent with the terms of the at-issue policies and they generally were until on or about January, 2016.

43. Notwithstanding obtaining proper authorization codes/numbers, claims for the majority of drug and alcohol treatment for HNLIC policyholders by the Plaintiffs have not been paid properly and require substantial interest payments for violation of Arizona prompt pay laws.

HEALTH NET'S SUSPENSION OF ALL CLAIM PAYMENTS

44. Upon information and believe, in early January 2016, Health Net, Inc., on behalf of HNLIC, instituted a special investigation unit ("SIU") audit that involved virtually every drug and alcohol treatment center in Southern California and Arizona that had submitted claims to HNLIC.

45. As part of SIU's putative "audit", HNLIC ceased reimbursing ALL drug and alcohol treatment centers for any treatment rendered subsequent to approximately January 15, 2016.[3]

46. When reimbursement for drug and alcohol treatment for virtually the entire industry ceased in early January 2016, drug and alcohol treatment centers began receiving form letters from the Director of the Health Net SIU, Matthew Ciganek (copy attached hereto as Exhibit 1).

47. Two (2) form letters were sent from Health Net/Matthew Ciganek. One letter detailed the alleged wholesale wrongdoing of drug and alcohol treatment centers and requested the following information from each center:

- Confirmation that the policyholder properly resides in Health Net's California service area (we believe the initial letters were incorrect and should have said, "Arizona service area.")
- That policyholders are properly paying deductibles, copayments and coinsurance required by applicable policies.
- That there were no inducements to patients to obtain services at the facility.

48. The second form letter from Matthew Ciganek was more abbreviated and requested that centers sign an affidavit/attestation that they had not engaged in the

[3] Reimbursement for treatment going back to November 2015 was sporadic. But in early January 2016, ALL reimbursement for treatment ceased.

alleged wrongdoing such as paying for patient referrals and failing to properly collect patient responsibility amounts under applicable policies.

49. It initially appeared that Health Net was placing centers in two different buckets for purposes of the SIU investigation/audit—one where they boldly assumed wrongdoing on the part of the center and correspondingly requested significant amounts of information from the center to "prove" to Health Net that no wrongdoing had occurred. The second form letter appeared to require verification/attestation that the center had not been involved in wrongdoing, purportedly so that they could be swiftly cleared by the SIU as part of the sweeping putative audit.

50. Notwithstanding the two types of "audit" letters sent by the Health Net SIU, the processing for treatment claims for all centers appeared to be handled exactly the same by Health Net—that is NO CLAIMS WERE PAID FOR DRUG AND ALCOHOL TREATMENT FOR ARIZONA POLICYHOLDERS FOR APPROXIMATELY THE LAST TWO MONTHS OF 2015 AND THE FIRST FIVE MONTHS OF 2016.

51. Subsequent to the SIU audit form letters, for each pending claim, Plaintiffs received a letter (often duplicated dozens of times) requesting copies of their licenses, complete medical record for the patient and evidence that they had collected patient responsibility amounts. It often made no difference what documents had already been produced in the ordinary course or per the "audit" – duplicative requests continued.

52. For virtually every Arizona policyholder treated for drug and alcohol addiction for the last few months of 2015 and the first five months of 2016, treatment facilities were required to respond to the same form letter from MHN over and over – even long after the required documents had been submitted to Health Net/MHN.

53. As part of the SIU investigation/audit and follow-up MHN letters, Health Net unlawfully would not accept any of the requested records electronically. Rather, each Plaintiff center had to manually copy hundreds (and typically thousands) of pages of

medical records in response to the myriad of audit letters (often duplicative) being sent by Health Net.

54. For any center that had provided treatment for a significant number of Health Net policyholders, responses to the "audit" were extremely costly and resulted in thousands of dollars of copying and mailing costs and enormous staff time and often work with outside advisors or counsel.

55. Other than the form letters sent by Matthew Ciganek, Health Net provided **no** specific evidence of wrongdoing or any other facts in support of their bald allegations that ALL centers were engaged in the noted acts or practices.

56. Upon information and belief, Health Net created a manual, hard-copy process for centers to respond to the audit in order to further delay claim payments and infuse the process with inefficiencies and complexities that further bogged down any possibility of efficient claim adjudication.

57. Health Net refused to provide street addresses for the delivery of the requested records which created additional delay in the form of "snail mail". Overnight mail vendors will not provide overnight mail delivery to post office boxes and Health Net refused to provide street address where records could be sent via overnight mail.

58. Even when the requested records were copied, sent and evidence of receipt was obtained, Health Net did not begin properly paying for drug and alcohol treatment for Arizona policyholders.

59. When centers contacted Health Net for some idea about when extremely stale treatment claims would be paid, they were given a host of excuses. They were told things like, "your claims have cleared SIU and are now in the claims queue", or "your claims have now moved to a quality assurance review".

60. Regardless of the statements and promises made by Health Net (and then Centene), proper claim payments for drug and alcohol treatment have not been forthcoming.

61. On or about May 6, 2016, Health Net began slowly releasing the long-overdue payments to drug and alcohol treatment centers for treatment rendered to HNLIC policyholders.

62. Unfortunately, virtually every payment made to drug and alcohol treatment centers subsequent to the SIU "audit" are incorrect and the putative claim adjudication methodology is frequently varied.

63. Subsequent to the SIU audit, Health Net is paying out-of-network drug and alcohol treatment claims at remarkably varying reimbursement rates that bear little resemblance to the requirements of the underlying policies.

64. Upon information and belief, Health Net is unilaterally and unlawfully recoding treatment by drug and alcohol treatment centers where the submitted claims/codes do not have a corresponding Medicare fee schedule listing.

65. While unilaterally changing treatment codes billed by medical professionals may be a key method for Health Net to more effectively manage and lower its loss ratios and fatten its bank account, no such protocol is allowed in the HNLIC 2015 or 2016 policies.

66. Unilaterally changing treatment codes to minimize claim reimbursements also violates a host of unfair business practices statutes and regulations and the MHPAEA (it is highly unlikely that Health Net unilaterally recodes claims submitted by medical/surgery providers to facilitate lower claim reimbursements).

VIOLATION OF HIPAA PRIVACY AND SECURITY

67. Upon information and belief, Health Net has also violated the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") as part of its SIU "audit".

68. HIPAA allows the use and disclosure of protected health information ("PHI") for payment, treatment and healthcare operations without a specific authorization.

69. In connection with the sweeping, indiscriminate SIU "audit", Health Net used and disclosed PHI for its policyholders in violation of HIPAA. Specifically, they sent PHI for policyholders in treatment at one center, to other centers who had no treatment relationship with those patients/policyholders.

70. While Health Net could ordinarily use and disclose such records for purposes of payment and healthcare operations, they sent highly sensitive, confidential information about their policyholders to treatment centers that had absolutely no reason to see such information.

71. Treatment centers receiving PHI to which they had no entitlement sent such PHI to the proper treatment facility when they could ascertain where the records properly belonged. However, by that time the HIPAA violations had already occurred.

72. The HIPAA violations are referenced here to demonstrate the issues and problems created for Health Net policyholders in the context of the sweeping, indiscriminate SIU "audit" conducted on all Arizona drug and alcohol treatment centers in Arizona and California in the first half of 2016.

73. Based upon the stigma associated with drug and alcohol treatment, this improper use and disclosure could have an even greater adverse impact on affected policyholders as it could impact the desire of people to seek treatment for drug and alcohol addiction issues if they cannot count on the fact that such treatment will be kept completely confidential.

INACCURATE REGULATORY FILINGS

74. Insurance companies, including those in the Health Net, Inc. holding company system, are required to make statutory financial filings with states where they transact insurance business.

75. Insurance companies are required to make quarterly and annual financial filings with state departments of insurance to clearly and accurately depict their financial health and to give regulators warnings about financial issues that could become more significant.

76. Upon information and belief, the Health Net insurers appear to have filed inaccurate statutory financial statements for the third quarter and annual statement for 2015 and the first quarter of 2016.

77. Upon information and belief, it appears the Health Net insurers did not accurately report claim payments that were due to drug and alcohol treatment centers that had been completely suspended since approximately November 2015. It appears that the SIU investigation and the suspended material filed claim amounts were likewise not reported in the Management Discussion and Analysis required to be filed with state insurance regulators.

78. Failing to "book" the improperly suspended claim payments for drug and alcohol treatment center claims for dates of service in 2015 and the first quarter of 2016 would make the Health Net insurance company statutory financial statements look better than they would if accurate reporting occurred. Upon information and belief, the improperly withheld claim payments in Arizona and California likely constitute well in the excess of $150,000,000.00 in claims.

79. Upon information and belief, the false financial filings submitted by Health Net insurers were designed to cover up the claim volume that had been incurred and reported to Health Net. Upon information and belief, the false financial filings submitted by Health Net reasonably appear to have been designed to cover-up the massive unlawful suspension of claim payments and the related SIU "audit" for properly provided mental health and addiction treatment rendered to Health Net policyholders in 2015 and early 2016.

80. Upon information and belief, if the suspended claim amounts had been reported properly, it is likely the California and Arizona insurance regulators would have been more inclined to ask questions about such numbers and made substantive inquires about the SIU "audit" by Health Net that inappropriately suspended claim payments for an entire grouping of medical providers.

81. During the time that incorrect financial filings were being submitted to California and Arizona regulators, Centene was in the process of merging with Health Net and required holding company act Form A filings were pending in numerous states. In fact, the California Department of Insurance did not approve the Centene Form A filing until March 22, 2016. If the Arizona and California DOI had been provided accurate information in connection with the incurred, reported and suspended drug and alcohol treatment claims for Health Net insurers—the approvals may have been postponed or withheld. Since it reasonably appears that accurate reporting of those amounts on statutorily required quarterly and annual financial filings was not provided, Health Net arguably robbed the Arizona and California Departments of Insurance of their ability to properly regulate the Form A acquisition of Health Net by Centene.

82. By filing what reasonably appears to be false and/or incomplete financial statements, Health Net hid its violations of insurance prompt pay laws and unfair claim practices so that regulators charged with enforcing such laws were unable to properly and timely respond, thus compounding the injury to Plaintiffs and other similarly situated providers.

MENTAL HEALTH PARITY AND EQUITY ADDICTION ACT

83. The Mental Health Parity and Equity Addiction Act ("MHPAEA") was enacted into law in 2008. It is made applicable to the HNLIC individual health insurance indemnity policies issued in the State of Arizona by virtue of the required "essential health benefits" which must be offered for individual health insurance policies and plans subsequent to enactment of the PPACA.

84. The MHPAEA essentially requires that policies offering drug and alcohol treatment must align mental health and medical/surgical benefits such that no greater limits may be imposed on mental health benefits than are imposed on medical/surgical benefits.

85. The HNLIC 2015 and 2016 Arizona indemnity health insurance policy forms include mental health and equity addiction benefits.

86. Upon information and belief, the decision to completely suspend claims for all drug and alcohol treatment for California and Arizona policyholders for a period of approximately 7 months while an indiscriminate, sweeping "audit" of treatment centers occurred, violated the MHPAEA.

87. Getting a family member into treatment for drug and alcohol addiction can be an extremely complicated and messy proposition. To then threaten successful treatment and perhaps months of sobriety by suspending all related claim payments is contrary to the requirements of the underlying policies and the MHPAEA.

88. Upon information and belief, Health Net has never suspended claim payments for an entire subset of the medical treatment industry before while undertaking a complex, manual process for "clearing" treatment centers of wrongdoing.

89. Upon information and belief, Health Net does not subject medical/surgical treatment facilities to sweeping and indiscriminate "audits" concerning the validity of treatment and the collection of patient responsibility amounts.

90. The disparate treatment of drug and alcohol treatment centers, including the Plaintiffs in this action, have caused significant damage to such facilities and their ability to properly treat individuals facing life and death addiction issues. This is particularly problematic given the dire public health emergency associated with astronomical opioid addiction rates.

91. HNLIC not only violated the MHPAEA in connection with its treatment of valid drug and alcohol addiction treatment/services, but they breached their contract with policyholders who paid their premiums and expected that such treatment would not be stigmatized and treated differently than the medical/surgical component of their benefits. For those individuals forced out of treatment due to the extreme delays by Health Net in properly reimbursing centers for such treatment, the damage is particularly significant and frequently life threatening.

92. Upon information and belief, Health Net also violated the MHPAEA in the enrollment/application process. In a number of instances, individuals applied for Health

Net coverage and treatment was provided by drug and alcohol treatment centers only to have Health Net wait 3-4 months to reject the original application(s). Once again, this behavior appears to be unique to those seeking drug and alcohol treatment rather than general HNLIC enrollment/underwriting protocols that apply to all applicants regardless of their city of residence and initial medical treatment.

93. This lawsuit involves behavioral health treatment services rendered by Plaintiffs to individuals who Plaintiffs are informed and believe possessed health insurance covering some or all of the services that Plaintiffs provided at all relevant times.

94. Plaintiffs' Patients agreed to pay for services through health insurance coverage provided by Defendants.

95. When each Patient sought treatment, Plaintiffs or their agents verified that he or she was insured and ascertained the scope of his or her coverage.

96. Plaintiffs are informed and believe that the relevant health insurance of each Patient was provided by Defendants or entities controlled by Defendants.

97. Plaintiffs are out-of-network (OON) providers to Health Net Life Insurance Company.

98. Upon the inception of treatment, Plaintiffs obtained assignment of benefits for HNLIC policy benefits and took HNLIC policyholders through their standard intake procedures.

99. When Plaintiffs or its agents contacted the Defendants, they confirmed that their Patient's health insurance policy provided coverage for substance abuse/mental health treatment, and OON coverage.

100. Plaintiffs are out-of-network with respect to Defendants and thus not contracted with Defendants to provide services to their insureds at a specific network discounted rate.

101. Plaintiffs provided medically necessary drug and alcohol treatment services to the Patients that were covered by their policies.

102. Plaintiffs or their designee (contracted billing company) timely submitted their claims for payment to Defendants using industry-standard coding and electronic claim submission protocols.

103. Since Plaintiffs began accepting Defendants' insureds in 2015, Defendants reimbursed Plaintiffs for their services properly in most respects until on or about late October 2015, when proper claims payments started to slow, ceasing in January 2016.

104. In 2015, Plaintiffs treated many Patients and have sought reimbursement for properly rendered and billed drug and alcohol treatment. To date, Plaintiffs have received far less than stated policy reimbursement rates they are entitled to from Defendants, with the reimbursement decreasing with every amendment filed by Health Net (without any corresponding premium decrease) throughout the year.

105. Starting in late 2015 and continuing to the present, Defendants have either refused to pay or greatly reduced the payments owed to Plaintiffs for services provided to HNLIC policyholders. Upon information and belief, Health Net's scheme in this regard has allowed it to unlawfully withhold payment of hundreds of millions of dollars in claims to treatment centers in Arizona and California, including claims payments due to Plaintiffs.

106. Defendants have provided no timely, let alone meritorious reasons for their refusals to fully pay (or sometimes pay at all) Plaintiffs for treating the Patients insured by Defendants.

107. Defendants are all Health Net insurance entities (and thus collectively referred to as "Health Net") who engaged in a scheme to enrich themselves by violating their contractual obligations to recovering addicts and the mentally ill at the expense of medical providers who have helped Health Net's insureds.

108. Defendants have arbitrarily, discriminatorily, and in bad faith refused to reimburse Plaintiffs for medically necessary services that were pre-authorized and rendered to hundreds of patients covered by policies issued by Defendants.

109. Health Net began directing a great deal of attention toward addiction treatment providers in 2015 by aggressively monitoring and investigating claims from substance abuse treatment facilities, and then dramatically expanded its attestation requests to a limited subset of providers.

110. Beginning in January 2016, many residential treatment and outpatient providers of addiction treatment services in Arizona and other states received letters from Matthew Ciganek, Director of Health Net's Special Investigation Unit (SIU) requesting sworn responses to questions regarding possible fraud and abuse.

111. Health Net's inquiry sought information concerning (i) the procurement of insurance policies for individuals who do not reside in Arizona; (ii) the failure to collect deductibles, copayment, and coinsurance from residents as required by insurance policies; (iii) the charging of inconsistent rates to different payors for drug treatment services; (iv) the payment of kickbacks in marketing to induce the referral of drug rehab patients; and (v) the lack of medical necessity.

112. The investigation purportedly stemmed from a range of alleged anti-kickback violations, including claims that some drug treatment programs assisted inappropriate patients in obtaining insurance in order to pay for their services, ignoring patient financial responsibility in the process.

113. Health Net suspended payments to numerous treatment providers even before the audit scheme was rolled out via the Ciganek letters.

114. Among other things, Health Net scrutinized referral practices, the medical necessity of services, and whether providers were waiving required patient financial responsibility payments (deductibles, coinsurance) from patient/policyholders. Providers throughout Arizona, as well as in California, and Utah, received attestation requests regardless of whether Health Net had any specific evidence of fraud and abuse.

115. Providers confirmed that Health Net payments had been suspended completely, including payments for previously-submitted claims that pre-dated the attestation letters.

116. While some providers are beginning to receive some (typically inadequate) claim payments from Health Net, the Arizona and California Departments of Insurance have opened inquiries into the improper suspension of all claim payments, specifically for drug and alcohol treatment for Health Net policyholders.

117. Health Net's putative audit requests were generally not accompanied by any evidence or allegations against the specific providers, but rather were sent out indiscriminately, based upon geography.

118. Both the Arizona and California Departments of Insurance and the California Department of Managed Health Care have received complaints from numerous providers, and are now investigating Health Net's failure to properly pay drug and alcohol abuse treatment claims.

119. Plaintiffs, and other similarly situated providers, have been put in the tenuous position of refusing patients the care they desperately need or assuming the full financial risk of providing care that may never be properly reimbursed.

120. While Health Net and Centene have contacted some providers to make payment, or in other cases, to promise that payment would be forthcoming, numerous providers are still in the dark about if and when they may ever be properly reimbursed.

121. Even with payments beginning to trickle in, addiction treatment providers, particularly smaller businesses, are struggling to keep up with patient demand. They are also struggling to retain key staff members and programs given the immediate and inappropriate suspension of claim reimbursements for treatment already provided.

122. By refusing coverage or withholding payment even in situations where there is no articulable suspicion of fraud or abuse, Health Net is effectively preventing patients from obtaining potentially life-saving care that has been paid for and promised in the at-issue policy forms.

123. When a patient is denied service because of the likelihood that her health insurance company will delay or completely deny payment, the Affordable Care Act's purposes and protections are eroded.

1 124. Health Net has a legal obligation to cover mental health and addiction
2 treatment and make timely payments to providers for such treatment. However, their
3 commitment to fulfilling this obligation is not being met.
4 125. Plaintiffs were not paid consistent with the HNLIC policy language
5 concerning OON providers and maximum allowable charges.
6 126. Defendants have refused to reimburse Plaintiffs without any credible effort
7 to comply with governing law or fair business practices.
8 127. Even where payments were made, the reimbursement rates were drastically
9 lower than Health Net's reimbursement rates prior to the audit/attestation campaign—and
10 bear little connection to the approved policy forms that detail OON drug and alcohol
11 payment methods.
12 128. Health Net owes the Plaintiffs for medically necessary, covered drug and
13 alcohol treatment rendered, as well as substantial interest on those amounts and other
14 penalties required by law.
15 129. HNLIC is in breach of contract as it is the insurance carrier that has failed
16 to comply with its contractual obligations specific reimbursement for OON drug and
17 alcohol treatment claims.
18 130. Health Net, Inc., through its agent Matthew Ciganek of the Special
19 Investigations Unit, sent letters to Plaintiffs and other providers on behalf of Health Net,
20 Inc. Upon information and belief, Health Net, Inc. initiated the decision and subsequent
21 program to cease payment to Plaintiffs and the indiscriminate audit scheme.
22 131. MHN is the business of managing behavioral health claims and processing
23 and paying claims for Defendants; the underpaid and unpaid claims were generally
24 executed by MHN.
25 132. MHN also handled the pre-authorizations and medical necessity reviews
26 for insurance companies in the Health Net, Inc. system.
27 133. In recent weeks, communications to Plaintiffs, notably miscommunications
28 about the immediacy of proper claim payments, came directly from Centene employees.

Centene has failed to ensure proper claim payments subsequent to the acquisition of Health Net as of March 28, 2016.

134. Defendants' refusal to pay claims has threatened the ability of Plaintiffs to keep their doors open and provide care to those who desperately need it. Such conduct risks driving Plaintiffs out of business, narrowing the treatment options for patients and reducing the frequency of claims Defendants would have to pay in the future while placing patients' lives and wellbeing at risk.

135. The actions of the Defendants, both in the putative audit they initiated and the refusal to pay or fully reimburse Plaintiffs for services already provided to Health Net insureds, has caused significant and undue hardship to Plaintiffs and the insured Patients.

136. The actions of Defendants have also deprived their policyholders of benefits for medically necessary drug and alcohol treatment services covered by the policy of insurance they purchase from Defendants.

137. Health Net's misconduct in the handling of payment for treatment provided to their insureds by Plaintiffs is part of a pattern of profits over people.

CLAIMS FOR RELIEF

COUNT 1: BREACH OF CONTRACT

138. Plaintiffs incorporate by reference all paragraphs alleged above.

139. Beginning in January 2015, Plaintiffs treated hundreds of Patients after confirming with Defendants that the Patients were covered under Defendants' policies and obtaining an assignment of benefits from each Patient.

140. Plaintiffs were assignees and beneficiaries of the contract between Defendants and its Insureds treated by Plaintiffs as patients. Defendants and its Insureds intended that Plaintiffs directly benefit from the contract; Defendants and its Insureds intended to recognize Defendants and its Insureds as the primary party in interest for payment of services provided; and the policies indicated intent to benefit Plaintiffs by payment for the services they provided to Defendants' Insureds.

141. As assignees of the benefits of the Patients, Plaintiffs are entitled to be paid for the services rendered based on the existence and terms of the insurance policies that cover the Patients. Plaintiffs are also express and intended third-party beneficiaries of the subject insurance contracts and are entitled to recover on that basis.

142. Plaintiffs confirmed that each Patient was covered by a policy issued by Defendants through a required prior authorization process before rendering services. At great expense, Plaintiffs thereafter provided medically necessary substance abuse and/or mental health treatment and toxicology testing to the Patients.

143. After providing those services, Plaintiffs submitted appropriate claims forms to Defendants or their agents, requesting compensation for the care and treatment they provided to the patient-insureds.

144. Plaintiffs either did not receive full, reasonable and often no compensation for the services they provided.

145. Upon information and belief, there is no legally operative term in the policies governing the Patients that allow Defendants to deny Plaintiffs full and/or reasonable compensation for services provided to the Patients in good faith. Plaintiffs properly performed under the insurance contract, and must be paid by Defendants.

146. In failing to promptly and correctly adjudicate claims submitted by the Plaintiffs, Defendants have also violated the Arizona Prompt Pay Laws found at A.R.S. Section 20-3101 et seq.

147. Defendants are in breach of the subject insurance policies and applicable Arizona law and have damaged Plaintiffs by withholding payment. Plaintiffs are entitled to compensatory damages equal to the full value of their services, plus interest and costs.

148. Plaintiffs are entitled to recover damages naturally and directly from the breach and violations of applicable law, and consequential damages, including an award of pre-judgment interest, attorneys' fees and costs.

149. Defendant Centene is liable for these damages, as it has assumed the liabilities of the other Defendants.

COUNT 2: BREACH OF IMPLIED COVENANT OF GOOD FAITH

150. Plaintiffs incorporate by reference all paragraphs alleged above.

151. Defendants impliedly agreed that they would not act in a fashion which would impair the rights of their insureds or Plaintiffs to receive the benefits which flowed from health insurance policies issued to their insureds.

152. A party to a contract has a duty to act fairly and in good faith. This duty is implied by law and need not be in writing. This duty requires that neither party do anything that prevents the other party from receiving the benefits of their agreement. As set forth in this Complaint, Defendants haves breached the duty of good faith and fair dealing.

153. These Defendants breached their implied covenant of good faith by failing to fully reimburse Plaintiffs for services provided to Defendants insureds and participating in a way inconsistent with Plaintiffs' reasonable expectations and by action in a way not expressly excluded by the contract terms, but which nevertheless adversely affected Plaintiffs' reasonably expected.

154. These Defendants' actions were willful, done with an evil mind and designed to and did damage Plaintiffs.

155. Defendants are jointly and severally liable for the concerted action and Plaintiffs' damages.

156. Plaintiffs have been damaged in an amount to be proven at trial and they are further entitled to an award of pre-judgment interest, attorneys' fees and costs.

157. Defendant Centene is liable, as it has assumed the liabilities of these Defendants.

COUNT 3: INTERFERENCE WITH CONTRACT OR BUSINESS EXPECTANCY

158. Plaintiffs incorporate by reference all paragraphs alleged above.

159. Defendants improperly interfered with Plaintiffs' ability to recover for treatment provided to Defendants policyholders, including receiving payment for those services.

160. Defendants' policyholders had a contract with Defendants to pay for drug and alcohol treatment provided the Plaintiffs.

161. Defendants knew about the contract and business expectancy;

162. Defendants intentionally interfered with Plaintiffs and their contractual relationship or business expectancy with Defendants policyholders which caused a breach or termination of that relationship or expectancy to be realized;

163. Defendants' conduct was improper.

164. Plaintiffs suffered damage caused by the breach or termination of the relationship with Defendants policy holders.

165. These Defendants' actions were willful and done with an evil mind.

166. These Defendants are jointly and severally liable for this concerted action, Plaintiffs' damages and for prejudgment interest and costs.

COUNT 4: CONSUMER FRAUD

167. Plaintiffs incorporate by reference all paragraphs alleged above.

168. The Arizona Consumer Fraud Act defines an unlawful practice as the act, use or employment by any person of any deception, deceptive or unfair act or practice, fraud, false pretense, false promise, misrepresentation, or concealment, suppression or omission of any material fact with intent that others rely on such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise whether or not any person has in fact been misled, deceived or damaged thereby.

169. As defined in A.R.S. § 44-1521(5), "Merchandise" includes any service.

170. As defined in A.R.S. § 44-1521(6), “Person” means any partnership, corporation, company, association or business entity.

171. Defendants were at all times relative hereto engaged in the sale of insurance and the providing of payment of services under the policies of insurance issued to its insureds, including for OON Providers such as the Plaintiffs.

172. In this case, and as set forth in the paragraphs above, Defendants: (1) used deception, used a deceptive act or practice, used fraud, used false pretense, made a false promise, made a misrepresentation, or conceal, suppressed or omitted a material fact in connection with their underpayment and nonpayment of services provided by Plaintiffs; (2) intended that Plaintiffs and others rely upon the defendant’s unlawful practice; (3) and, Plaintiffs suffered damages as a result of relying on the Defendants’ unlawful practice.

173. These Defendants’ actions were willful and done with an evil mind.

174. These Defendants are jointly and severally liable for Plaintiffs’ damages caused by their concerted actions, including an award of prejudgment interest and costs. Plaintiffs are further entitled to recover their costs and attorneys’ fees.

175. In addition to having a right to recover actual damages, Plaintiffs are entitled to an award of punitive damages due to the defendant’s wanton and reckless conduct, spite or ill-will, and reckless indifference to the interests of others.

COUNT 5: QUANTUM MERUIT

176. Plaintiffs incorporate by reference all paragraphs alleged above.

177. Plaintiffs are entitled to recover the reasonable value of the services rendered to Defendants as the parties knew Plaintiffs services were being provided to Defendants insureds free of charge and it is unfair for Defendants to receive the benefit of Plaintiffs’ services without paying for them.

178. Plaintiffs are entitled to an award for the reasonable value of the services provided to Defendants Insureds.

179. Recovery in *quantum meruit* is appropriate when the plaintiff has enriched the defendant such that the defendant cannot conscientiously refuse to make restitution to the plaintiff.

180. Defendants sold the subject policies and accepted the premiums, then sat back as their insureds sought medically necessary behavioral health treatment, confirmed to Plaintiffs that the subject patient-insureds were covered, and then, on unspecified and/or putative and unlawful technical grounds, have refused to fully compensate Plaintiffs for the services that were rendered to, and benefited, Defendants' patient-insureds. Defendants were and are enriched by keeping premiums without having to pay for care as promised in the policies.

181. Plaintiffs are entitled to receive the full value of the treatment they provided to the patient-insureds which inequitably enriched Defendants.

COUNT 6: PROMISSORY ESTOPPEL

182. Plaintiffs incorporate by reference all paragraphs alleged above.

183. Defendants should be bound by their promise as set forth in their health insurance policies issued to their insureds, and relied upon by Plaintiffs, even if there was no binding contract between the parties.

184. Defendants made such a promise to pay for services provided by Plaintiffs; it was reasonably foreseeable to Defendants that Plaintiffs would rely upon that promise; Plaintiffs justifiably relied upon the promise; and Plaintiffs incurred loss or suffered detriment as the result of such reliance.

185. Defendants are jointly and severally liable for the payment of damages to Plaintiffs, plus pre-judgment interest, attorneys' fees.

186. Defendant Centene in liable for theses damages, as it has assumed the liabilities of these Defendants.

COUNT 7: EQUITABLE ESTOPPEL

187. Plaintiffs incorporate by reference all paragraphs alleged above.

188. Defendants' authorized agent's made representations to Plaintiffs who the promised payments were to be provided. Defendants' authorized agents intended that Plaintiffs act upon the representations and Plaintiffs relied upon those representations and acted thereon, such that they suffered prejudice when Defendants refused to satisfy the promised payment for services provided.

189. Defendants are jointly and severally liable for the payment of damages to Plaintiffs, plus pre-judgment interest, attorneys' fees and costs.

COUNT 8: BAD FAITH

190. Plaintiffs incorporate by reference all paragraphs alleged above.

191. Plaintiffs, by assignment or operation of law, stand in the shoes of the Former Patients, who were all insured under a policy of insurance issued by Defendants.

192. For all the Patients, Plaintiffs asserted a valid claim for the payment of benefits covered by the subject insurance policy under which a particular Patient was treated.

193. Defendants failed to deal fairly and in good faith with Plaintiffs by unreasonably failing to pay the claim, to pay the claim fully, or by paying claims late.

194. Defendants' failure to deal fairly and in good faith caused Plaintiffs to suffer damages.

195. Defendants' bad faith was an intentional and malicious component of a larger scheme to not pay Plaintiffs and other similarly situated treatment centers that treat individuals seeking to recover from drug and alcohol addiction.

196. Plaintiffs are therefore entitled to compensatory and punitive damages as allowed by law.

COUNT 9: CIVIL CONSPIRACY

197. Plaintiffs incorporate by reference all paragraphs alleged above.

198. Defendants intentionally withheld payment, or made diminimus payments to Plaintiffs, which they knew should have been paid.

199. Defendants' deceptive acts and misrepresentations represented a concerted plan to engage in fraudulent misrepresentations.

200. Defendants' agreements and resulting conduct were for unlawful purposes.

201. The Defendants' acts have caused Plaintiffs damages for which Defendants are jointly and severally liable.

202. Plaintiffs are entitled to an award of punitive damages.

COUNT 10: AIDING AND ABETTING

203. Plaintiffs incorporate by reference all paragraphs alleged above.

204. Defendants engaged in knowing acts that substantially aided Health Net to commit wrongful and prohibited conduct which damaged the Plaintiffs, including Bad Faith Breach of Contract, Interference with Contract or Business Expectancy, and Consumer Fraud.

205. Defendants are jointly and severally liable for aiding and abetting Health Net in committing these tortious acts and for the resulting damages that the Plaintiffs suffered.

COUNT 11: EQUITABLE RELIEF

206. Plaintiffs incorporate by reference all paragraphs alleged above.

207. Under Arizona's Unfair Claim Settlement Practices Act, A.R.S. § 20-461, that insurance companies, such as the Defendants, shall not misrepresent pertinent facts or insurance policy provisions relating to coverages at issue; Fail to acknowledge and act reasonably and promptly upon communications with respect to claims arising under an insurance policy; Fail to adopt and implement reasonable standards for the prompt investigation of claims arising under an insurance policy; Refuse to pay claims without conducting a reasonable investigation based upon all available information.

208. By their actions as described in the Complaint herein, Defendants failed to comply with the Arizona Unfair Claim Settlement Practices Act. The denial or partial payment of claims submitted by Plaintiffs was done without a good faith analysis of the facts and of the underlying terms of the insurance policy.

209. Defendants issued a cursory rejection without conducting any meaningful inquiry into the relevant facts or into the underlying terms of the covering policy for every claim Plaintiffs submitted for treating Patients insured by Defendants; Defendants unjustifiably and intentionally underpaid claims; Defendants delayed payment on claims without any meaningful or legally permissible justification. Defendants' delay and arbitrary denials intentionally misled and confused Plaintiffs.

210. Because Defendants failed to provide Plaintiffs with timely, specific, good-faith explanations of their refusal to fully reimburse Plaintiffs for services rendered to any Patient, in repeated and willful violation of the relevant claims handling obligations imposed by law, Defendants should, under applicable equitable principles such as promissory estoppel, waiver, and/or reformation be Ordered to pay Plaintiffs, in full, for the services rendered; and/or be equitably barred from asserting any newly crafted defenses to payment that were not set forth, in writing, at the appropriate time in the claims process.

211. As a remedy for their , unfair, unlawful and fraudulent practices, Defendants should be required to pay restitution, and for or all claims Plaintiffs may present in the future, as well as for any pending claims, to the degree such relief is appropriate, Defendants should also be ordered to (a) inform Plaintiffs, promptly and in writing, whether the claim is approved, partially approved, or denied; (b) inform Plaintiffs, promptly and in writing, of the particular contractual provision upon which any denial or partial denial of a claim is based (c) inform Plaintiffs of the mathematical basis upon which it has calculated the amount it has proposed to reimburse Plaintiffs, if that reimbursement is less than 100% of the submitted charge; promptly provide Plaintiffs with a complete copy of the operative policy from which any provision has been cited as justification for the denial, in whole or in part, of a submitted claim (d) fully comply with the provisions of the MHPAEA, and (e) otherwise strictly follow all governing state law concerning the handling of claims.

COUNT 12: RESPONDEAT SUPERIOR

212. Plaintiffs incorporate by reference all paragraphs alleged above.

213. The wrongful actions of Defendants employees and agents were within the course and scope of their employment with Defendants and within the course and scope of their duties.

214. Defendants are therefore liable for the acts and omissions of their employees and agents. Defendant Centene in liable for all defendants' acts and omissions, as a result of the merger of Centene and Health net into that entity and in accord with it contractual undertakings and as a matter of law.

COUNT 13: PUNITIVE DAMAGES

215. Plaintiffs incorporate by reference all paragraphs alleged above.

216. The actions of Defendants represent outrageous conduct which was done with an evil mind.

217. These Defendants intended to injure the Plaintiffs and/or consciously pursued a course of conduct, knowing that it created a substantial risk of significant harm to Plaintiffs.

218. The actions of these Defendants did, in fact, damage Plaintiffs as will be fully set forth at the time of trial.

219. The actions of these Defendants were reprehensible and represented a continuous course of willful and evil misconduct. These Defendants were fully aware of the harm or risk of harm that they were causing a deliberately continued with their offensive conduct.

220. These Defendants have attempted to conceal the misconduct from other regulatory authorities and the public at large.

221. These Defendants have made no endeavor whatsoever to remedy their willful misconduct. Because of the outrageous willful, prolonged, deceptive and damaging nature of Defendants' underlying acts, Plaintiffs are entitled to an award of punitive damages to be determined by a jury at the time of the trial in this action.

222. Defendant Centene is liable for these damages, as it has assumes the liabilities of these Defendants.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants, and that the Court award the following relief:

A. Declare Defendants' conduct unlawful;

B. Award equitable relief as necessary to stop Defendants' pattern of unlawful, unfair, and deceptive conduct;

C. Award damages, in an amount to be proven at trial, including direct and consequential damages and lost profits plus all applicable interest and costs;

D. Award all attorneys' fees and costs incurred in bringing this action, to the extent recoverable by law;

E. Issue all other relief the Court deems appropriate, proper, and just.

F. Awarding Plaintiffs' pre-judgment interest;

G. Awarding punitive damages in an amount sufficient to punish and deter Defendants for their willful, outrageous and evil misconduct.

H. Finding Defendants jointly and severally liable for any compensatory and punitive damage awards.

DATED this 22nd day of July, 2016.

GALLAGHER & KENNEDY, P.A.

By: [signature]

John P. Flynn
Kevin D. Neal
2575 East Camelback Road
Phoenix, Arizona 85016-9225
Attorneys for Plaintiffs

EXHIBIT 1

Health Net

Health Net, Inc.
P.O. Box 2048
Rancho Cordova, CA 95741-2048
www.healthnet.com

January 8, 2016

DESERT COVE RECOVER CENTER
15170 N HAYDEN RD STE 4
SCOTTSDALE, AZ 85260-2571

Dear Provider,

Health Net Life Insurance Company is conducting an inquiry with regard to services you have provided to our insureds and the proper determination of benefits payable for those services. It is important that we receive timely and accurate responses from your facility as part of this inquiry. Therefore, we ask your prompt cooperation in confirming that services and claims for insureds on the attached spreadsheet have been handled consistently with the enrollee's insurance policy and applicable federal and State laws and regulations. While this inquiry continues we are in the process of reviewing your claims.

Our inquiry relates to a number of potential concerns. First, eligibility under the applicable individual PPO policies is limited to individuals who continually reside in our defined California service area. Second, a variety of services covered under our individual PPO policies explicitly require the insured to pay for deductibles, copayments or coinsurance, including for out-of-network providers. Waiver of the deductible, copayment or coinsurance by the provider, or payment of such amounts on behalf of the patient by the provider, could raise questions as regards determination of benefits under the policy or as regards false and/or fraudulent claims. Third, in many cases these policies tie benefit determinations to "charges billed." Therefore, billings that would not be imposed on the insured in the absence of insurance or that exceed the provider's actual charges may also not be

covered or could be a misrepresentation, so we need to confirm that the billed rates for our insureds do not differ from those for other, non-Health Net patients. Fourth, payment may not be appropriate if improper payments or other consideration has been made to patients or to others to induce procurement of services from your facility. Fifth, we need to verify that all services provided and tests ordered were medically necessary.

We therefore request that the following information and documents be provided to us within fifteen (15) days of your receipt of this letter for each of the services ("Services") rendered to patients ("Patients") listed on the attached spreadsheet:

1. All documents reflecting the residence of the Patient before and after the Patient's receipt of the Services.

2. All documents reflecting the name, address and phone number for any other person listed as a contact by the Patient.

3. All documents, including but not limited to any cash receipts, checks, or credit card receipts, reflecting the application of deductibles and coinsurance, and the collection of applicable copayments from the Patients for the Services.

4. All documents reflecting billing sent to the Patients for the Services.

5. All documents referring or relating in any way to payments made to or on behalf of the Patients for any reason.

6. All documents referring or relating in any way to any payments made to, or received from, any third party (including but not limited to any broker, testing lab, physician or other healthcare provider) in connection with or related to the Patients or Services.

7. All records documenting that the Services were medically necessary.

In addition, please return with the documents an executed copy of the attached attestation confirming that the records provided are true and correct copies as well as attesting to certain facts.

Finally, you are hereby advised to preserve all documents, including but not limited to all hardcopy and electronic information, data and emails, concerning the insureds and services listed on the attached spreadsheet. Health Net hereby reserves all legal rights in connection with this matter, including the right to institute legal proceedings to recover any amounts paid to your facility that it was not entitled to receive by reason of one or more of the potential violations of law listed in this letter, and will seek appropriate sanctions from the court for any destruction of evidence from the date of this letter forward.

All responses must be submitted to Health Net's Special Investigation Unit, P.O. Box 2048, Rancho Cordova, CA 95741-2048. In the meantime, please contact the undersigned with any questions you have. Thank you for your prompt attention to this matter.

Matthew Ciganek
Director of Special Investigations
Phone (818) 676-8654

ATTESTATION AND VERIFICATION

I, ________, hereby attest and verify as follows:

1. I am the ____________ [TITLE] of _________ [PROVIDER] and have personal knowledge of the facts in this document.

2. Attached are true and correct copies of documents maintained in the ordinary course of business by ___ [PROVIDER] that are responsive to Health Net's letter dated January __, 2016 ("Letter").

3. In connection with the Services listed on the spreadsheet attached to the Letter (with any exceptions noted below):

a. _______ [PROVIDER] has applied all deductibles and coinsurance, and has collected all applicable copayments, from the Patients in connection with the Services;

b. __________[PROVIDER] has not reimbursed any Patients for such deductibles, coinsurance and copayments, not has it paid any such amounts on behalf of any Patients;

c. _______ [PROVIDER] has submitted charges to Health Net that are the same as those billed to and collected from Patients;

d. _______ [PROVIDER] has not made any payments to or on behalf of Patients.

e. _______ [PROVIDER] has not made any payments to, or received any payments from, any third party with the intent to induce the referral of Patients for Services.

4. Any exceptions to the attestation and verification in paragraph 3 above are noted in Attachment A.

Attested and verified as true and correct.

Executed this ____ day of ___, 2016 at ________, California.

Health Net, Inc.
P.O. Box 2048
Rancho Cordova, CA 95741-2048
www.healthnet.com

February 29, 2016

CHAPTER 5 COUNSELING CENTER
726 W GURLEY ST
PRESCOTT, AZ 86305-3624

Dear Provider,

Health Net Life Insurance Company is conducting an inquiry with regard to services you have provided to our insureds and the proper determination of benefits payable for those services. It is important that we receive timely and accurate responses from your facility as part of this inquiry. Therefore, we ask your prompt cooperation in confirming that services and claims for insureds have been handled consistently with the enrollee's insurance policy and applicable federal and State laws and regulations. While this inquiry continues we are in the process of reviewing your claims.

Our inquiry relates to a number of potential concerns. First, eligibility under the applicable individual PPO policies is limited to individuals who continually reside in our defined service area. Second, a variety of services covered under our individual PPO policies explicitly require the insured to pay for deductibles, copayments or coinsurance, including for out-of-network providers. Waiver of the deductible, copayment or coinsurance by the provider, or payment of such amounts on behalf of the patient by the provider, could raise questions as regards determination of benefits under the policy or as regards false and/or fraudulent claims. Third, in many cases these policies tie benefit determinations to "charges billed." Therefore, billings that would not be imposed on the insured in the absence of insurance or that exceed the provider's actual charges may also not be

covered or could be a misrepresentation, so we need to confirm that the billed rates for our insureds do not differ from those for other, non-Health Net patients. Fourth, payment may not be appropriate if improper payments or other consideration has been made to patients or to others to induce procurement of services from your facility. Fifth, we need to verify that all services provided and tests ordered were medically necessary.

Please return an executed copy of the attached Attestation and Verification.

Finally, you are hereby advised to preserve all documents, including but not limited to all hardcopy and electronic information, data and emails, concerning the insureds and services listed on the attached spreadsheet. Health Net hereby reserves all legal rights in connection with this matter, including the right to institute legal proceedings to recover any amounts paid to your facility that it was not entitled to receive by reason of one or more of the potential violations of law listed in this letter, and will seek appropriate sanctions from the court for any destruction of evidence from the date of this letter forward.

All responses must be submitted to Health Net's Special Investigation Unit, P.O. Box 2048, Rancho Cordova, CA 95741-2048. In the meantime, please contact the undersigned with any questions you have. Thank you for your prompt attention to this matter.

Matthew Ciganek
Director of Special Investigations
Health Net, Inc.
21650 Oxnard St.
CA-102-25-05
Woodland Hills, CA 91367

ATTESTATION AND VERIFICATION

I, ______________________, hereby attest and verify as follows:

1. I am the _____________ [TITLE] of __________ [PROVIDER] and have personal knowledge of the facts in this document.

2. ________ [PROVIDER] has applied all deductibles and coinsurance, and has collected all applicable copayments, from the Patients in connection with the Services;

3. ________ [PROVIDER] has not reimbursed any Patients for such deductibles, coinsurance and copayments, nor has it paid any such amounts on behalf of any Patients;

4. ________ [PROVIDER] has submitted charges to Health Net that are the same as those billed to and collected from Patients;

5. ________ [PROVIDER] has not made any payments to or on behalf of Patients.

6. ________ [PROVIDER] has not made any payments to, or received any payments from, any third party with the intent to induce the referral of Patients for Services.

7. Any exceptions to the attestation and verification in paragraphs 2 through 6 above are noted in Attachment A.

Attested and verified as true and correct.

Executed this ____ day of ________, 2016 at ______________ [CITY], ____ [STATE].

ATTACHMENT A to the ATTESTATION AND VERIFICATION