John P. Flynn (Bar No. 015065)
Kevin D. Neal (Bar No. 011640)
GALLAGHER & KENNEDY, P.A.
2575 East Camelback Road
Phoenix, Arizona 85016-9225
Telephone: (602) 530-8000
Facsimile: (602) 530-8500
john.flynn@gknet.com
kevin.neal@gknet.com

(Admission Pro Hac Vice Pending)

Jay M. Spillane (Bar No. 126364)
SPILLANE TRIAL GROUP PLC
468 N. Camden Drive, Second Floor
Beverly Hills, CA 90210
Telephone: (424) 217-5980
Facsimile: (888) 590-1683
jspillane@spillaneplc.com

Attorneys for Plaintiffs

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

ALTA CENTERS, INC., a California corporation; BENCHMARK YOUNG ADULT SCHOOL D/B/A BENCHMARK TRANSITIONS, a California corporation; DESTINY RECOVERY CENTER, LLC, a California limited liability company; HOTEL CALIFORNIA BY THE SEA, LLC, a California limited liability company; JMG INVESTMENTS, INC., D/B/A HARMONY PLACE, a California corporation; and SOUTH COAST BEHAVIORAL HEALTH, a California corporation,

Plaintiffs,

v.

HEALTH NET, INC., a Delaware corporation; HEALTH NET LIFE INSURANCE COMPANY, a California corporation; MANAGED HEALTH NETWORK, INC., a Delaware corporation; CENTENE CORPORATION, a Delaware corporation; and JOHN DOES I-X, JANE DOES I-X, BLACK CORPORATIONS I-X, AND ABC PARTNERSHIPS I-X, inclusive,

Case No.: BC630332

COMPLAINT FOR:

(1) Breach of Contract;
(2) Violation of CA Health and Safety Code;
(3) Unfair Competition;
(4) Quantum Meruit;
(5) Breach of the Implied Covenant of Good Faith and Fair Dealing (Bad Faith); and
(6) Aiding and Abetting

Defendants.

INTRODUCTION

Health Net ("Defendants") sold health insurance policies to California consumers and accepted premiums in exchange. Health Net insureds then sought medically necessary treatment from behavioral health centers, including the Plaintiffs. If required, Plaintiffs properly confirmed patients were covered by health insurance issued by Health Net through the required Health Net preauthorization process. Health Net subsequently refused to reimburse or significantly underpaid Plaintiffs for the services that were rendered to patients (generally referred to as "clients" under California law), as required by the policies of insurance and pursuant to California and federal law.

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 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 California law by providing either no, baseless, or dilatory reasons for not paying or underpaying Plaintiffs. Defendants' practices are similarly unlawful under federal law 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 actions violate other well established public policies,

including those set forth in the California Unfair Insurance Practices Act ("UIPA"), Cal. Ins. Code §§ 790 *et seq.*

Health Net's policyholders were also intentionally misled into believing that the insurance policies they chose and paid for 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 California and 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.

Plaintiffs are seeking relief under their direct rights, assigned rights from patients cheated out of their insurance benefits by Health Net and as third-party beneficiaries of patient's policies with Health Net as more fully set forth below.

PARTIES

1. Plaintiff Alta Centers, Inc. is a California corporation with its offices at 5435 Balboa Blvd. #103, Encino, CA 91316.

2. Plaintiff Benchmark Young Adult School dba Benchmark Transitions is a California corporation with its offices at 25612 Barton Rd., #286, Loma Linda, CA 92354.

3. Plaintiff Destiny Recovery Center, LLC is a California limited liability company with its offices at 23301 Bessemer Street, Woodland Hills, CA 91367.

4. Plaintiff Hotel California by the Sea, LLC is a California limited liability company with its offices at 4504 Seashore Drive, Newport Beach, CA 92663.

5. Plaintiff JMG Investments, Inc., d/b/a Harmony Place is a California corporation with its offices at 23041 Hatteras St. Woodland Hills, CA 91367.

6. Plaintiff South Coast Behavioral Health is a California corporation with its offices at 3151 Airway Avenue, Suite N1-N2, Costa Mesa, CA 92626.

7. 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 ("HNI").

8. 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 ("HNLIC").

9. Upon information and belief, Defendant Centene Corporation is a Delaware corporation with a principal place of business in St. Louis, Missouri ("Centene"). HNI, HNLIC and Centene will be collectively referred to herein as "Defendants".

10. Upon information and belief, Defendants were and are agents, representatives, servants of their codefendants. Upon information and belief, 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 transact business in the State of California, and have conducted business throughout the State of California on a systematic and continuous basis.

12. The treatment 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 California. 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 California.

16. The acts about which Plaintiffs complain occurred in Los Angeles County, and other counties in California.

BACKGROUND

CALIFORNIA TREATMENT FACILITIES

17. 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' treatment includes a range of services, including residential and outpatient behavioral health treatment, as well as toxicology testing.

HEALTH NET LIFE INSURANCE COMPANY

CALIFORNIA POLICY FORMS

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

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

20. The HNLIC policies issued in California 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 and payment within specified contractual timeframes.

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

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

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

Chemical Dependency	**Preferred Providers**	**Out-of-Network**
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$20	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient services)*	$0	50%
Inpatient facility	10%	50%
Physician visit to a Hospital, behavioral health facility or Residential Treatment Center	10%	50%
Inpatient detoxification	10%	50%

Notes:

- The applicable Copayment or Coinsurance for outpatient services is required for each visit.

* Includes methadone maintenance during pregnancy and two months after delivery. See "Methadone Treatment" in "General Exclusions and Limitations."

See P30601 (CA 1/15) OE page 26

MAXIMUM ALLOWABLE AMOUNT is the amount on which HNL bases its reimbursement for Covered Services and Supplies received from an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. HNL 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 HNL pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Policy*.

- The Maximum Allowable Amount for Out-of-Network Emergency Care will be the greatest of: (1) the amount negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for Out-of-Network providers, excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.
- Maximum Allowable Amount for Physician services 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 Physician charges.
- For all other types of services, 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 190% of the Medicare allowable amount.
- In the event the applicable service or database 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 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.
- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Medical Benefits" and "General Exclusions and Limitations" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL 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.

See P30601 (CA 1/15) OE page 15 (emphasis in original)

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

Chemical Dependency	**Preferred Providers**	**Out-of-Network**
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$20	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient services)	0%	50%
Inpatient facility*	10%	50%
Physician visit to Hospital, behavioral health facility or Residential Treatment Center	10%	50%
Inpatient detoxification*	10%	50%

Notes:

- The applicable Copayment or Coinsurance for outpatient services is required for each visit.

* Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a **MAXIMUM ALLOWABLE AMOUNT** is the amount on which HNL bases its reimbursement for Covered Services and Supplies received from a Hospital, Skilled Nursing Facility, Home Health Care Agency, for Outpatient surgery or for Emergency Care received during Foreign Travel or Work Assignment, provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. HNL 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 HNL pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Policy*.

- The Maximum Allowable Amount for Out-of-Network Emergency Care will be the greatest of: (1) the amount negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for Out-of-Network providers, excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.
- Maximum Allowable Amount for Physician services is determined by applying the 85th percentile from the database of Physician charges from the FAIR Health RV Benchmarks or a similar type of database of Physician charges.
- For all other types of services, 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 190% of the Medicare allowable amount.
- In the event the applicable service or database 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 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.

See P30601 (CA 1/16)OE PT page 29

- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Medical Benefits" and "General Exclusions and Limitations" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL 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.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the Out-of-Network Provider, HNL may, at its option, 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 at the Out-of-Network level.

In addition, HNL may, at its option, 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 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 and Supplies 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 and Supplies please log on to www.healthnet.com or contact HNL Customer Service at the number on Your member identification card.

See P30601 (CA 1/16) OE pages 17-18 (emphasis in original)

25. California law requires that such policy forms be filed with and approved by the California Department of Insurance ("CDOI").

26. The HNLIC 2015 California 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 (non-physician services), per the policy form, the reimbursement rate was set at 190% of the applicable Medicare reimbursement fee schedule maintained by the Centers for Medicare and Medicaid ("CMS") for the services provided.

27. For the HNLIC 2015 California indemnity health policy form, if non-emergency, non-physician 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 75% of billed charges.

PRIOR AUTHORIZATION FOR DRUG AND ALCOHOL TREATMENT

28. The 2015 and 2016 HNLIC California indemnity health policy forms require that certain types of drug and alcohol treatment be preceded by authorizations obtained by the medical provider from Health Net.

29. Consistent with the requirements of the at-issue policy forms, if required by the policy forms, all of the Plaintiff centers' standard operating procedure was to obtain prior authorization for certain drug and alcohol addiction treatment for HNLIC policyholders.

30. Based upon the language of the at-issue HNLIC policy forms and upon obtaining required prior authorization codes/numbers (where necessary), 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 late 2015 and early 2016.

31. Notwithstanding obtaining proper authorization codes/numbers where necessary, 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 California prompt pay laws.

HEALTH NET'S SUSPENSION OF ALL CLAIM PAYMENTS

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

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33. As part of SIU's "audit", HNLIC ceased reimbursing all or certainly most drug and alcohol treatment centers for any treatment rendered subsequent to approximately January 15, 2016.[1]

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

35. Several form letters were sent from HNI/Matthew Ciganek. At least 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.
- 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.

36. Other form letters required treatment centers to sign attestations about whether they performed specific wrongdoing alleged by Matthew Ciganek of HNI.

37. Upon information and belief, Defendants had no specific evidence of wrongdoing in connection with the centers targeted through the attestation letters.

38. Notwithstanding the several types of "audit" letters sent by the HNI SIU, the processing for treatment claims for all centers appeared to be handled exactly the same by HNI—that is-- SIGNIFICANT CLAIMS WERE UNPAID FOR DRUG AND ALCOHOL TREATMENT FOR CALIFORNIA AND ARIZONA POLICYHOLDERS MANY MONTHS IN 2015 AND 2016.

39. Subsequent to the SIU audit form letters, for each pending claim, Plaintiffs received letters (often duplicated dozens of times) requesting copies of their licenses,

[1] While the facts differ somewhat between facilities, reimbursement for treatment going back to November 2015 was sporadic. But in early January 2016, ALL reimbursement for treatment apparently ceased.

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 by Plaintiffs and other treatment centers in the ordinary course, or per the "audit", as the duplicative requests continued unabated.

40. For many California and Arizona policyholder treated for drug and alcohol addiction for the last few months of 2015 and the first approximate six (6) months of 2016, treatment facilities were required to respond to the same form letter from Defendants over and over – even long after the required documents had been submitted to Defendants by Plaintiffs.

41. As part of the SIU investigation/audit and pursuant to follow-up letters sent by or on behalf of one or more of the Defendants, Defendants initially refused to 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 or on behalf of Defendants.

42. For any center that had provided treatment for a significant number of HNLIC policyholders, responses to the "audit" were extremely costly and resulted in thousands of dollars of copying and mailing costs and enormous administrative burdens.

43. Other than the form letters sent by Matthew Ciganek, Defendants 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 while HNI sought to consummate its merger with Centene.

44. Upon information and belief, Defendants 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 and timely claim adjudication.

45. Defendants also 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 Defendants

refused to provide street address where records could be sent via overnight mail. Thus, all hard-copy responses were required to be sent regular postal mail to the noted P.O. Boxes (the "audit" letters contained conflicting information on this point) instead of more efficient overnight mail.

46. Even when the requested records were copied, sent and evidence of receipt was obtained, Defendants did not begin properly paying for drug and alcohol treatment for California and Arizona policyholders for many months and when the claims were paid, they were inaccurate and underpaid.

47. When centers contacted HNI/HNLIC/Centene for some idea about when extremely stale treatment claims would be paid, they were given a litany 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".

48. Regardless of the statements and promises made by HNI, and then Centene, proper claim payments for drug and alcohol treatment have not been forthcoming.

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

50. Unfortunately, virtually every payment made to California and Arizona drug and alcohol treatment centers subsequent to the SIU "audit" are incorrect and the claim adjudication methodology is frequently inconsistent.

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

52. 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.

53. While unilaterally changing treatment codes billed by medical professionals may be a key method for Defendants to more effectively manage and lower

loss ratios and fatten bank accounts, no such process is allowed in the HNLIC 2015 or 2016 California filed policies.

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

VIOLATION OF HIPAA PRIVACY AND SECURITY

55. Upon information and belief, Defendants have also violated the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") as part of the SIU "audit".

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

57. In connection with the sweeping, indiscriminate SIU "audit", Defendants 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 or other connection with those patients/policyholders.

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

59. HNLIC's policy forms and HIPAA Notice of Privacy Practices similarly promise that their policyholders' PHI will be protected and used only consistent with applicable law.

60. 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.

61. The HIPAA violations are referenced here to demonstrate the breadth of issues and problems created for Health Net policyholders in the context of the sweeping,

indiscriminate SIU "audit" conducted on all drug and alcohol treatment centers in Arizona and California in the first half of 2016.

62. 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 dampen 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

63. Insurance companies, including those in the HNI (and Centene) holding company system, are required to make statutory financial filings with states where they transact insurance business.

64. 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.

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

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

67. 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 HNI insurance company statutory financial statements look better than they would if accurate reporting occurred.

68. Upon information and belief, the improperly withheld claim payments in Arizona and California constitute well in excess of $150,000,000.00 in billed claims.

69. Upon information and belief, the false financial filings submitted by the HNI insurers were designed to cover up the claim volume that had been incurred and reported to the HNI insurers.

70. Upon information and belief, the false financial filings submitted by the HNI insurers appear to have been designed to cover-up the massive unlawful suspension of claim payments and the related SIU "audit" for mental health and addiction treatment properly rendered to HNLIC policyholders in 2015 and early 2016.

71. 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 make detailed substantive inquires about the SIU "audit" by the HNI insurers that inappropriately suspended claim payments for an entire industry of medical providers.

72. During the time that incorrect financial filings were being submitted to California and Arizona regulators, Centene was in the process of merging with HNI 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's had been provided accurate information in connection with the incurred, reported and suspended drug and alcohol treatment claims for the HNI 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, HNI and HNLIC arguably robbed the Arizona and California DOI's of their ability to properly regulate the Form A acquisition of HNI by Centene.

73. By filing what reasonably appears to be false and/or incomplete financial statements, HNI and HNLIC hid their 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.

74. On or about July 26, 2016, Centene announced an approximate $300,000,000.00 projected loss which it attributed, in part, to "unforeseen issues within the Health Net book of business, including some design issues and some high rates of substance abuse." *See* Congressional Quarterly (7/26).

MENTAL HEALTH PARITY AND EQUITY ADDICTION ACT

75. 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 California by virtue of the required "essential health benefits" which must be offered for individual health insurance policies and plans subsequent to enactment of the Patient Protection and Affordable Care Act.

76. The MHPAEA generally 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.

77. The HNLIC 2015 and 2016 California indemnity health insurance policy forms include mental health and addiction benefits.

78. 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.

79. 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.

80. Upon information and belief, Defendants have never suspended claim payments for an entire grouping of medical providers while undertaking a complex and unlawful manual process for "clearing" such medical providers of purported wrongdoing.

ROBO-SIGNING MEDICAL NECESSITY DENIALS BY HEALTH NET

81. In approximately May 2016, HNI, directly and on behalf of HNLIC, began categorically denying substance abuse claims submitted by California treatment centers.

82. The claim denials were done via form letters (copy attached as Exhibit 2 hereto), signed by Matthew Wong, M.D.

83. The claim denials based upon lack of medical necessity contained no distinction based upon the type of substance abuse or any other key details surrounding treatment.

84. Also during May 2016, it reasonably appears Matthew Ciganek, of the HNI SIU department (copy attached as Exhibit 3 hereto) began robo-signing medical necessity denials, regardless of the underlying treatment details.

85. After complaints to the California Department of Insurance were filed by policyholders and treatment centers, the denials were quietly reversed by HNI and HNLIC.

86. Even now, after the claim denials were reversed, the at-issue claims have not been paid properly by Defendants pursuant to the terms of the underlying policies.

87. Categorical, robo-signed denials of substance abuse and mental health claims similarly violate the MHPAEA.

88. Upon information and belief, Defendants do not subject medical/surgical treatment facilities to sweeping and indiscriminate "audits" or apparent robo-signed denials concerning the validity of treatment and the collection of patient responsibility amounts.

89. Upon information and belief, Defendants do not subject medical/surgical treatment facilities to categorical coding denials based upon robo-signed medical necessity denials.

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 opioid addiction rates.

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

92. Upon information and belief, HNLIC also violated the MHPAEA in the enrollment/application process. In a number of instances, individuals applied for HNLIC coverage and treatment was provided by drug and alcohol treatment centers only to have HNLIC 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. Centene has failed to ensure proper claim payments subsequent to the merger with HNI as of March 28, 2016.

94. 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. All this is occurring while placing patients'/policyholders' lives and well-being at risk.

95. The actions of the Defendants, both in the sweeping and indiscriminate "audit" they initiated and the refusal to pay or properly reimburse Plaintiffs for services

already provided to HNLIC/HNI insureds, has caused significant and undue hardship to Plaintiffs and the insured patients.

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

97. Defendants' misconduct in the handling of payment for treatment provided to their insureds by Plaintiffs is part of a pattern of—profits over people.

UNFAIR INSURANCE PRACTICES ACT

98. Defendants' conduct as alleged herein also violated numerous principle and policies set forth in California's Unfair Insurance Practices Act, Cal. Ins. Code § 790 et seq.

99. Without limitation, Defendants' practices violate numerous subsections of Cal. Ins. Code § 790.03(h), including misrepresentations to patients, failing to acknowledge and act reasonably promptly on communications, failing to adopt and implement reasonable standards for investigations, failing to affirm or deny coverage of claims, not attempting in good faith to effectuate prompt, fair and equitable settlement of claims and compelling insureds to institute litigation to recover amounts due.

CAUSES OF ACTION

CAUSE OF ACTION 1: BREACH OF CONTRACT

(Against HNLIC)

100. Plaintiffs incorporate by reference all paragraphs alleged above.

101. Beginning in January 2015, Plaintiffs treated hundreds of patients after confirming with HNLIC that the patients were covered under its policies and obtaining an assignment of benefits from each patient.

102. Plaintiffs were assignees and beneficiaries of the written contract between HNLIC and its Insureds treated by Plaintiffs as patients. HNLIC and its insureds intended that Plaintiffs directly benefit from the contract; HNLIC and its insureds intended to recognize HNLIC 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 HNLIC's insureds.

103. 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.

104. Plaintiffs confirmed that each patient was covered by a policy issued by HNLIC 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.

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

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

107. Upon information and belief, there is no legally operative term in the policies that allow HNLIC 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 HNLIC.

108. HNLIC is in breach of the subject insurance policies and applicable California 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.

109. Plaintiffs have performed all duties required of them under the contracts alleged herein, except as excused by HNLIC's material breaches.

110. 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.

111. Upon information and belief, Centene is liable for these damages, as it has assumed the liabilities of the other Defendants.

CAUSE OF ACTION 2: VIOLATION OF CALIFORNIA HEALTH AND SAFETY CODE

(Against All Defendants)

112. Plaintiffs incorporate by reference all paragraphs alleged above.

113. California Health and Safety Code § 1371 and common law require that health insurers handle submitted claims carefully, promptly, transparently, and in good faith.

114. California Claims Handling Laws are designed so that denial or partial payment of a submitted claim is based on an analysis of the facts and of the terms of the insurance policy.

115. These Defendants breached their duty and legal requirements under the law by failing to fully reimburse Plaintiffs for services provided to Defendants' insureds in a way not expressly excluded by the policy terms, and without a factual or legal basis to do so.

116. Defendants sent summary rejections to Plaintiffs without conducting a factual or legal analysis neither into the facts nor in compliance with the policy terms. The across the board underpayment without any meaningful or legally permissible justification and the delayed and non-payment on claims without justification were in violation of the California Cal. Health and Safety Code.

117. Plaintiffs did not receive timely, specific, good-faith explanations for Defendants nonpayment or underpayment or delayed payment of claims submitted to them in repeated and willful violation of the relevant claims handling obligations imposed by law. Defendants should be ordered to pay Plaintiffs, in full, for the services rendered.

118. In the alternative, Defendants should be equitably barred from asserting any newly minted defenses to payment that were not set forth, in writing, at the appropriate time in the claims process.

CAUSE OF ACTION 3: UNFAIR COMPETITION

(Against All Defendants)

119. Plaintiffs incorporate by reference all paragraphs alleged above.

120. Defendants conduct as set forth in this Complaint constitutes unlawful, unfair, and fraudulent business practices in violation of California's Unfair Competition Law, Bus. & Prof. Code §§ 17200, et seq.

121. Defendants' conduct involved a pattern and practice of unlawfully instituting a plan to not pay or under pay or unnecessarily delay payment for behavioral health services provided to their insureds by Plaintiffs. By instituting a plan to not pay or underpay Plaintiffs, and to prevent Plaintiffs from learning of their scheme as long as possible, Defendants actions violate California's Unfair Competition Law.

122. Plaintiffs have suffered injury in fact and have lost money or property as a result of Defendants' acts of unfair competition.

123. Defendants' actions violate federal, state and common laws and policies.

124. The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") provides that coverage of mental health and substance abuse care (such as Plaintiffs provide) is in "parity" with coverage of medical and surgical care. As set forth in this Complaint, MHPAEA was violated by Defendants' conduct.

125. Defendants' actions violate laws and policies set forth in California's UIPA.

126. Defendants' actions constitute common law "bad faith."

127. Plaintiffs are entitled to injunctive relief. Cal. Bus. & Prof. Code § 17203.

128. Plaintiffs are entitled to an order appointing a receiver over Defendants and restoring to Plaintiffs any money or property that was acquired through the foregoing acts of unfair competition. Cal. Bus. & Prof. Code § 17203.

CAUSE OF ACTION 4: QUANTUM MERUIT

(Against All Defendants)

129. Plaintiffs incorporate by reference all paragraphs alleged above.

130. Plaintiffs are entitled to recover the reasonable value of the services rendered to Defendants as the parties knew Plaintiffs services were not being provided to Defendants insureds free of charge, communicated with Plaintiffs concerning these services, and it is unfair for Defendants to receive the benefit of Plaintiffs' services without paying for them.

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

132. 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.

133. 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.

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

CAUSE OF ACTION 5: BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING (BAD FAITH)

(Against All Defendants)

135. Plaintiffs incorporate by reference all paragraphs alleged above.

136. Plaintiffs, by assignment or operation of law, stand in the shoes of the patients who have been provided services, who were all insured under a policy of insurance issued by Defendants.

137. For all the patients, Plaintiffs suffered a loss covered under insurance policies issued by HNLIC and presented HNLIC and/or the other Defendants as HNLIC's

agent or representative with a valid claim for the payment of benefits covered by the subject insurance policy under which a particular patient was treated.

138. 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.

139. Defendants' failure to deal fairly and in good faith caused Plaintiffs to suffer damages. Defendant's failure to and delay in paying policy benefits was a substantial factor in causing Plaintiffs' harm.

140. 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.

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

CAUSE OF ACTION 6: AIDING AND ABETTING

(Against All Defendants)

142. Plaintiffs incorporate by reference all paragraphs alleged above.

143. On information and belief, Defendants, with knowledge that the aforesaid conduct of each other constituted breaches of duty, gave substantial assistance or encouragement to each other to so act.

144. On information and belief, Defendants gave substantial assistance to each other in accomplishing a tortious result and their own conduct, separately considered, constituted a breach of duty to Plaintiffs.

PRAYER

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, including without limitation appointment of a receiver and

restoration to Plaintiffs of all money or property acquired by Defendants by means of their unfair competition;

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;

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

DATED: August 10, 2016

GALLAGHER & KENNEDY, P.A.
SPILLANE TRIAL GROUP PLC

By: _____
Jay M. Spillane
John P. Flynn (*Pro Hac Vice pending*)
Kevin D. Neal (*Pro Hac Vice pending*)
Attorneys for Plaintiffs

EXHIBIT 1

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

January 8, 2016

ALTA CENTERS, INC.
5435 BALBOA BLVD STE 103
ENCINO, CA 91316-1507

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.

EXHIBIT 2

Health Net Life Insurance Company
21281 Burbank Boulevard
Woodland Hills, CA 91367-6607
www.healthnet.com

Mailing Address: P.O. Box 9103
Van Nuys, CA 91409-9103

May 27, 2016

[redacted]

NOTIFICATION OF NONPAYMENT OF CLAIM FOR SERVICE

Enrollee Name:	[redacted]
DOB:	[redacted]
Enrollee ID #:	[redacted]
Health Plan:	Health Net Life Insurance Company
Date(s) of Service:	**12/17/2015 - 12/22/2015**
Claim Number:	[redacted]
Claim Amount:	$[redacted]

Dear [redacted]

Health Net Life Insurance Company (Health Net) received a claim for services rendered to the Enrollee referenced above. Based on review of available information by a Health Net Physician Reviewer, this claim has been denied for the following reason:

Date of Service:	Code:	Mod:	Denial Description:
12/17/2015 - 12/17/2015	0912		Not supported. The services billed were found to be medically unnecessary due to lack of documentation. The records provided did not contain discussions or documentation regarding recent or psycho pharmacological treatment/psychosocial treatment. Documentation regarding current mental status/physical exam, pertinent clinical lab results and the most recent urine drug screen are also lacking. There was no documentation of a detailed safety risk assessment; or assessment of the patients social supports. Overall diagnostic impressions are not completely documented and do not support the use of the submitted treatments under the InterQual criteria. Of Note, the documentation submitted does not

			support that a co-pay/co-insurance was collected by the billing provider [redacted] for date of service 12/17/2015.
12/18/2015 - 12/18/2015	0912		Not supported. The services billed were found to be medically unnecessary due to lack of documentation. The records provided did not contain discussions or documentation regarding recent or psycho pharmacological treatment/psychosocial treatment. Documentation regarding current mental status/physical exam, pertinent clinical lab results and the most recent urine drug screen are also lacking. There was no documentation of a detailed safety risk assessment; or assessment of the patients social supports. Overall diagnostic impressions are not completely documented and do not support the use of the submitted treatments under the InterQual criteria. Of Note, the documentation submitted does not support that a co-pay/co-insurance was collected by the billing provider [redacted] for date of service 12/18/2015.
12/21/2015 - 12/21/2015	0912		Not supported. The services billed were found to be medically unnecessary due to lack of documentation. The records provided did not contain discussions or documentation regarding recent or psycho pharmacological treatment/psychosocial treatment. Documentation regarding current mental status/physical exam, pertinent clinical lab results and the most recent urine drug screen are also lacking. There was no documentation of a detailed safety risk assessment; or assessment of the patients social supports. Overall diagnostic impressions are not completely documented and do not support the use of the submitted treatments under the InterQual criteria. Of Note, the documentation submitted does not support that a co-pay/co-insurance was collected by the billing provider [redacted] for date of service 12/21/2015.
12/22/2015 - 12/22/2015	0912		Not supported. The services billed were found to be medically unnecessary due to lack of documentation. The records provided did not contain discussions or documentation regarding recent or psycho pharmacological treatment/psychosocial treatment. Documentation regarding current mental status/physical exam, pertinent clinical lab results and

			the most recent urine drug screen are also lacking. There was no documentation of a detailed safety risk assessment; or assessment of the patients social supports. Overall diagnostic impressions are not completely documented and do not support the use of the submitted treatments under the InterQual criteria. Of Note, the documentation submitted does not support that a co-pay/co-insurance was collected by the billing provider [redacted] for date of service 12/22/2015.

You may obtain a copy of the actual benefit provision, and relevant guideline, protocol or other similar criterion, on which the denial decision was based, upon request, by calling the Customer Contact Center at 1-800-676-6976, for the hearing impaired, please call the TTY/TDD line at 1-800-995-0852, Monday to Friday, from 8:00am – 6:00pm PST, for assistance.

How to Dispute This Determination

Disputes - If you believe that a claim has been unfairly adjusted, contested or denied, you may submit a written dispute to Health Net Provider Appeals, P.O. Box 10406, Van Nuys, CA 91410-0406 within 365 days of the date of this letter in order to have your dispute considered. For instructions and forms for submitting a dispute, visit the Provider section (California region) of Health Net's web site at www.healthnet.com or call 1-800-641-7761.

If you believe all or part of the claim has been wrongfully denied or rejected and you have been unable to resolve your dispute with Health Net, you may have the matter reviewed by the California Department of Insurance. You may contact the California Department of Insurance at 300 S. Spring Street, Los Angeles, CA 90013. The Department also has a toll-free number 1-800-927 HELP (4357) and a TDD line (1-800-482-4833) for the hearing and speech impaired. The Department's Internet web site is www.insurance.ca.gov.

Independent Medical Review – For Enrollees whose regulatory rights are governed by the California Department of Insurance (CDI):
If the appeal involves coverage that was denied modified, or delayed by Health Net on the grounds that the service was not medically necessary, in whole or in part, the Enrollee has a right to request an impartial external Independent Medical Review (IMR). Requests for IMR are made to the California Department of Insurance (CDI) in accordance with California law. You or the Enrollee must first appeal Health Net's decision and wait for at least 30 calendar days before the Enrollee requests external IMR. However, if the matter would qualify for an expedited decision, the Enrollee may immediately request an external IMR following receipt of notice of denial. The CDI will review the application and, if the request qualifies for external IMR, will select an external review agency and have the Enrollee's medical records submitted to a qualified specialist for an independent

determination of whether the care is medically necessary. There is no cost to the Enrollee for external IMR. This review is in addition to any other procedure or remedies available to the Enrollee and is completely voluntary. However, failure to participate in external review may cause the Enrollee to give up any statutory right to pursue legal action against Health Net regarding the disputed service.

If you have additional questions, you may contact the CDI by phone or visit their website at http://www.insurance.ca.gov for additional information. The CDI has a toll-free telephone number (1-800-927-4357).

Sincerely,

Matthew Wong, MD
Medical Director

EXHIBIT 3

Health Net

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

05/09/2016

[redacted]

Member Name: [redacted]
Member Number:
Date of Service: 01/11/2016-01/20/2016
Claim Amount: $[redacted]

Dear [redacted]

We have received your claim regarding the above referenced member. We have denied the following CPT/HCPCS/REV Code(s) billed following a review of medical records for the reason(s) listed below:

DOS	CODE	MOD	DENIAL DESCRIPTION
01/11/16	1002		Services are not medically necessary
01/12/16	1002		Services are not medically necessary
01/13/16	1002		Services are not medically necessary
01/14/16	1002		Services are not medically necessary
01/15/16	1002		Services are not medically necessary
01/16/16	1002		Services are not medically necessary
01/17/16	1002		Services are not medically necessary
01/18/16	1002		Services are not medically necessary
01/19/16	1002		Services are not medically necessary
01/20/16	1002		Services are not medically necessary

A Health Net participating provider may not bill a member for the difference in expected and actual reimbursement. Should you wish to dispute this determination, your objections must be submitted in writing with any additional supporting documentation within 365 days of the date of the Remittance Advice to the address noted below:

Health Net Provider Appeals Unit
P.O. Box 10406
Van Nuys, CA 91410-0406

You may also telephone Health Net Provider Services at [for CA – (800) 641-7761; for OR – (888) 802-7001; for AZ – (800) 289-2818] with any questions you have or to verify the information that was provided to Health Net during our initial review of this claim.

Sincerely,

Matthew Ciganek
Health Net SIU