EILEEN R. RIDLEY, CA Bar No. 151735
eridley@foley.com
MICHAEL A. NARANJO, CA Bar No. 221449
mnaranjo@foley.com
ALAN R. OUELLETTE, CA Bar No. 272745
aouellette@foley.com
FOLEY & LARDNER LLP
555 CALIFORNIA STREET
SUITE 1700
SAN FRANCISCO, CA 94104-1520
TELEPHONE: 415.434.4484
FACSIMILE: 415.434.4507

Attorneys for the Anthem Defendants[1]

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SOUTHERN DIVISION

DUAL DIAGNOSIS TREATMENT CENTER, INC., a California corporation, et al.,

Plaintiffs,

vs.

BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS, et al.,

Defendants.

Case No. 8:15-cv-00736-DOC-RNB

REPLY BRIEF IN SUPPORT OF DEFENDANTS' OMNIBUS MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT

Date: April 18, 2016
Time: 8:30 a.m.
Location: Courtroom 9D

Judge: Honorable David O. Carter

Complaint Filed: May 8, 2015

[1] Exhibit A, attached hereto, identifies the individual defendants that are referred to collectively herein as the "Anthem Defendants."

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I. INTRODUCTION

The Opposition Brief filed by Plaintiffs fails to advance any argument capable of salvaging the claims alleged in their First Amended Complaint ("FAC") against Defendants.[2] Desperate to avoid dismissal of their claims, Plaintiffs misrepresent key legal authority and try to generate fact issues where none exist. As shown in Defendants' Omnibus Motion and below, Plaintiffs' claims are subject to dismissal as a matter of law. Initially, neither purported assignment Plaintiffs rely on stands up to scrutiny. Plaintiffs' Form A "Assignment" ("Form A") is merely a direct-payment request form, while the Form B "Assignment" ("Form B") is both procedurally and substantively unconscionable and therefore unenforceable. Thus, as a matter of law, Plaintiffs cannot survive a motion to dismiss based on the purported assignments.

Even if Form A and Form B are construed as valid and enforceable assignments of benefits, neither form can sustain Plaintiffs' ERISA claims for breach of fiduciary duty and equitable relief. Further, each of Plaintiffs' ERISA claims fail as a matter of law because many of the plans contain enforceable anti-assignment provisions. Plaintiffs' remaining claim for alleged violations of California's Business and Professions Code § 17200 is both preempted by ERISA and fails to state a claim on which relief can be granted under the statute. As a result, each of Plaintiffs' causes of action in the FAC fails as a matter of law.

II. PLAINTIFFS' CLAIMS SHOULD BE DISMISSED WITH PREJUDICE

A. Plaintiffs ERISA Claims Based On Form A Fail As A Matter Of Law.

The Opposition Brief's repeated insistence on the primacy of Form B is tacit confirmation of the shortcomings of Form A as an "assignment." Form A provides, in relevant part, as follows:

> I hereby authorize and request that payment of authorized insurance company benefits be made on my behalf to directly to [Plaintiff entity] for the amount due to me for any medical or psychological/psychiatric treatment or services that are

[2] Exhibit B, attached hereto, identifies the individual defendants that are referred to collectively herein as "Defendants" for purposes of this Motion and join in the filing of this Motion.

rendered to me by [Plaintiff entity].

[FAC, Ex. A (Form A).] On its face, Form A neither transfers nor assigns any of the patients' legal rights. While Form A *permits* the direct payment of the patients' benefits to Plaintiffs, its terms do not *mandate* it. Moreover, it assigns no legal rights whatsoever. The absence of such language is fatal to each of Plaintiffs' ERISA claims.

Plaintiffs do not dispute that "[i]t is essential to an assignment of a right that the [assignor] manifest an intention to transfer the right to another person." *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1292 (9th Cir. 2014) (citing *Britton v. Co-Op Banking Grp.*, 4 F.3d 742, 746 (9th Cir. 1993) (internal quotation marks omitted)).[3] Plaintiffs instead seek to circumvent this standard by arguing: (1) as to Count 1, that a direct-payment request is tantamount to an assignment of benefits for purposes of 29 U.S.C. § 1132(a)(1)(B); and (2) as to Counts 2 and 3, that Plaintiffs may assert claims arising from Defendants' alleged breach of fiduciary duty under 29 U.S.C. § 1132(a)(2) and (a)(3) even though such claims were admittedly not expressly assigned to Plaintiffs. Neither argument is persuasive.

1. A Direct-Payment Request Does Not Effectuate An Assignment Of The Right To Pursue Benefits Under 29 U.S.C. § 1132(a)(1)(B).

Referring to the text of Form A, Plaintiffs cite to *Spinedex* for the proposition that the Ninth Circuit "has held such language sufficient to constitute a valid assignment of a 29 U.S.C. § 1132(a)(1)(B) claim." [Opp. Brief, p. 9.] Far from supporting Plaintiffs' position, the language of the assignment at issue in *Spinedex* stated that the form constitutes "A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY." *Id.* at 1292. In contrast, Form A's request that Defendants pay Plaintiffs directly does not convey, expressly or otherwise, any of the patients' rights or

[3] Plaintiffs also do not dispute that an alleged assignment form is evaluated not by its header but by its terms. *Brown v. Blue Cross Blue Shield of Tenn. Inc.*, No. 1:14-CV-00223, 2015 U.S. Dist. LEXIS 74306, at *8 n.3 (E.D. Tenn. June 9, 2015) (citing *United States v. Leslie Salt Co.*, 350 U.S. 383, 389 (1956)).

benefits under their plans.

Plaintiffs' citation of *N. Jersey Brain & Spine Ctr. v. Aetna, Inc.*, 801 F.3d 369 (3d Cir. 2015), is similarly misplaced. There, the Third Circuit considered whether the plaintiff health care provider obtained derivative standing to file suit under 29 U.S.C. § 1132(a)(1)(B) where the provider obtained a valid assignment of benefits that did not expressly refer to the patient's right to file a legal claim. *Id.* at 372. That is not the issue before the Court here. Nor did the Third Circuit (as Plaintiffs claim) consider whether a direct-payment request, such as Form A, constitutes an assignment of benefits. This is due to the fact that, much like the assignment language in *Spinedex*, the text of the assignment in *N. Jersey Brain* contained an express acknowledgement that the patient "**hereby assign[s]** to [NJBSC] **all payments for medical services** rendered to myself or my dependents." *Id.* at 370-71 (emphasis added). Plaintiffs' Form A does not *assign* anything to the provider; it merely *requests* that payments be directed to the provider.

Courts presented with forms virtually identical to Form A hold that direct-payment requests are not assignments of benefits. In *MHA, LLC v. Aetna Health*, No. Civ. A. 12-2984 (SRC), 2013 U.S. Dist. LEXIS 25743 (D.N.J. Feb. 25, 2013), the district court held that the following language did *not* constitute an assignment:

> I authorize payment directly to Meadowlands Hospital Medical Center for hospital medical insurance benefits (from Medicare, Medicaid, commercial insurance, worker's compensation, auto insurance, etc.) that I may be entitled to for the charges of the care/treatment provided to me.

Id. at *13. The district court reasoned that "[i]t was […] 'plain … that the quoted General Consent/Authorization language merely authorizes an insurer to make payments to MHA directly rather than through the patient as an intermediary'" and concluded that "this authorization is precisely the kind" of document that is "insufficient to confer ERISA standing upon a provider." *Id.* at *14-15. Other courts agree. *See, e.g., Brown*, 2015 U.S. Dist. LEXIS 74306, at *29.

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2. Form A Does Not Encompass Counts 2 Or 3 Under 29 U.S.C. § 1132(a)(2) And (a)(3).

Even if construed as an assignment of benefits, Form A does not, by its terms, confer statutory standing on Plaintiffs to assert ERISA claims seeking the removal of the plan fiduciaries under 29 U.S.C. § 1132(a)(2) and equitable relief under 29 U.S.C. § 1132(a)(3). Notably, Plaintiffs do not dispute that Form A does not encompass Counts 2 and 3. Instead, Plaintiffs sidestep this issue by arguing that Counts 2 and 3 are both "ERISA fiduciary claims" that arise from Defendants' alleged failure to comply with ERISA's Claims Procedure Regulation, 29 C.F.R. § 2560.503-1, *et seq*. [Opp. Brief, p. 20-21.] Plaintiffs contend, without citing any supporting authority, that because Form A allegedly confers standing on Plaintiffs to bring claims under 29 U.S.C. § 1132(a)(1)(B) (which, as discussed above, is not the case), Plaintiffs can also bring a "related fiduciary breach claim" since "anyone whose colorable benefit claim is ignored (or otherwise mishandled) is authorized to sue under ERISA not only to recover the benefit *but also* to remedy the procedural misconduct of the fiduciary." [*Id*. at 22.] Plaintiffs' argument fails for two reasons.

First, applicable case law holds that a provider can only bring ERISA claims arising from the alleged breach of fiduciary duty (under 29 U.S.C. § 1132(a)(2)) and for equitable relief (under 29 U.S.C. § 1132(a)(3)) where such rights are <u>expressly and knowingly assigned</u> by the plan member. *See Spinedex*, 770 F.3d at 1292; *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1130 (C.D. Cal. 2015) (holding that an assignment of "all rights and benefits under my contract with my INSURANCE COMPANY" does not manifest an intent to assign claims for breach of fiduciary duty or claims for equitable relief under 29 U.S.C. §§ 1132(a)(2) and 1132(a)(3)); *In re WellPoint, Inc. Out-Of-Network "UCR" Rates Litig.*, 903 F. Supp. 2d 880, 892, 895, 899 (C.D. Cal. 2012) (same). Here, Form A has no such language, and Plaintiffs do not allege otherwise.

Second, Plaintiffs' argument is predicated on the incorrect assertion that Plaintiffs

became "beneficiaries" within the meaning of 29 U.S.C. § 1002(8) when they allegedly obtained assignments of benefits from Defendants' members such that Plaintiffs also became "claimants" within the meaning of ERISA's Claim Procedure Regulation. [Opp. Brief, pp. 21- 23.] While logically disjointed, Plaintiffs' argument appears to be that because "every insured to whom Plaintiffs provided services was an ERISA participant or beneficiary," [*id.* at 21] Plaintiffs obtained beneficiary status under Form A because "ERISA's definition of the term 'beneficiary […] includes persons who *may* become entitled to benefits." [*Id*. at 23 (citing 29 U.S.C. § 1002(8)).]

Plaintiffs' position does not find any support in the text of ERISA or the Claim Procedure Regulation. The Claim Procedure Regulation sets forth "minimum requirements for employee benefit plan procedures" as to Defendants' dealings with ERISA plan participants and beneficiaries (*i.e.*, Defendants' members), which are referred to as "claimants" in the regulation. [Opp. Brief, p. 23; *see also* 29 C.F.R. § 2560.503-1(a).] However, as a matter of law, providers do not become ERISA beneficiaries or claimants under the Claim Procedure Regulation when they obtain an assignment of benefits from their patients.

In *Spinedex*, the Ninth Circuit held that a provider that obtained an assignment of benefits from its patients "cannot bring claims for benefits on its own behalf"; rather, "[i]t must do so derivatively, relying on its patients' assignments of their benefits claims." 770 F.3d at 1289 (citing *Misic v. Bldg. Serv. Emps. Health & Welfare Trust*, 789 F.2d 1374, 1377-79 (9th Cir. 1986) (per curiam)). In so holding, the Ninth Circuit confirmed that providers do not become beneficiaries within the meaning of ERISA even with a valid assignment of benefits. *See id.* Similarly, in *Rojas v. Cigna Health & Life Ins. Co.*, 793 F.3d 253 (2d Cir. 2015), the Second Circuit held that an assignment of benefits does not confer ERISA beneficiary status on health care providers as a matter of law. *Id.* at 256-58. The Second Circuit reasoned as follows:

> Rojas argues that it has standing. **Rojas contends that because it is entitled to reimbursement from Cigna – a literal**

> **‘benefit’ – it is a ‘beneficiary’ entitled to bring claims under Section 502.** … **Rojas argues that it is a ‘participant-designated beneficiary’ because its patients assigned to Rojas their right to payment. … Rojas equates beneficiary status as understood under the statute with the right to receive a ‘benefit’ provided by a healthcare plan. Rojas draws no distinction between its patients’ rights to have their medical bills paid by Cigna and its right to receive those payments. Neither of these bases for standing is persuasive.**

Id. at 256-57 (emphasis added). Citing *Spinedex*, 770 F.3d at 1289, the Second Circuit concluded that “‘[b]eneficiary,’ as it is used in ERISA, does not without more encompass healthcare providers” and that “Congress did not intend to include doctors in the category of ‘beneficiaries.’” *Id*. at 257-58.

Likewise, in *Grasso Enters., LLC v. Express Scripts, Inc.*, 809 F.3d 1033 (8th Cir. 2016), the Eighth Circuit rejected the same construction of 29 U.S.C. § 1002(8) advanced by Plaintiffs here and held that providers are not entitled to the procedures established by ERISA’s Claim Procedure Regulation:

> ERISA defines a “beneficiary” as “a person designated by a [plan] participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.” 29 U.S.C. § 1002(8). While Plaintiffs may be entitled to direct payments from [Defendant] by operation of one or more ERISA plans, direct payment is simply a convenient way to reimburse health care providers, whereas the statutory term beneficiary “clearly refers to those individuals who share in the benefits of coverage -- medical services and supplies covered under their health care policy.” Thus, “**Plaintiffs are not ‘beneficiaries’ as ERISA uses that term, so they are not entitled to the procedures established by § 1133 and the [Claim Procedure Regulation].**”

Grasso, 809 F.3d at 1040-41 (citing *Rojas*, 793 F.3d at 258 and *Pa. Chiro. Ass’n v. Independence Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015)).

Tellingly, Plaintiffs fail to cite any authority that supports their argument that providers become ERISA beneficiaries when they obtain assignments of benefits such that they also are designated “claimants” for purposes of ERISA’s Claim Procedure

Regulation.[4] That is because no such case law exists. Every Circuit Court that has considered this issue has squarely rejected Plaintiffs' argument here.[5] Accordingly, Plaintiffs lack standing to assert their claims arising from the alleged breach of fiduciary duty and for equitable relief under ERISA because such claims were not expressly and knowingly assigned under Form A (as Plaintiffs' Opposition Brief concedes).

B. Plaintiffs ERISA Claims Based On Form B Fail As A Matter Of Law.

As to Form B, Plaintiffs do not dispute that the form is a contract of adhesion that all of their patients are required to sign before receiving addiction and mental health treatment. Instead, Plaintiffs disingenuously insist that their interests and the patients' interests are aligned and that Plaintiffs are in a better position to deal with health insurers and benefit plans than the members of those plans. Plaintiffs' arguments are not only unpersuasive, but are also directly undermined by the Opposition Brief's confirmation that Plaintiffs seek to fundamentally restructure their patients' benefit plans in a manner that elevates the interests of health care providers over the plan members' interests. This result is untenable, especially considering the admitted vulnerability of Plaintiffs' patients at the time they signed Form B and their lack of any meaningful bargaining power. Form B is thus unconscionable and unenforceable under the facts of this case.

Additionally, even if Form B is enforceable, Plaintiffs cannot maintain Counts 2 and 3 – their so-called "ERISA fiduciary claims" – based on Defendants' alleged failure

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[4] Plaintiffs' lone citations of two out-of-state district court cases – *Premier Health Ctr., P.C. v. UnitedHealth Grp.*, 292 F.R.D. 204 (D.N.J. 2013) and *Metcalf v. Blue Cross Blue Shield of Mich.*, No. 3:11-CV-1305-ST, 2013 WL 4012726 (D. Or. Aug. 5, 2013) – do not advance Plaintiffs' arguments. In *Premier Health Ctr.*, the district court rejected the provider's contention that an assignment of benefits converts the claimant into an ERISA beneficiary. 292 F.R.D. at 217-19. The district court reasoned that "the notion that an assignment to a healthcare provider of the right to reimbursement for services rendered by that provider automatically gives the provider standing as a beneficiary to assert a full array of claims under the ERISA statute is a facile one." *Id.* at 218. Similarly, the district court in *Metcalf* did not address this issue.

[5] The Department of Labor's (DOL's) interpretation of its own regulation is in accord noting that "[a]n assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan [and typically] are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan." *See FAQs About The Benefit Claims Procedure Regulation*, U.S. DEP'T OF LABOR, at B-2, http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (last visited Apr. 3, 2016).

to comply with the Claim Procedure Regulation, as Plaintiffs are not converted to ERISA beneficiaries or claimants as a result of Form B. Finally, the text of Form B does not extend to claims that seek the removal of ERISA plan fiduciaries, and Count 2 should be dismissed on this independent ground.

1. The Terms Of Form B Are Procedurally And Substantively Unconscionable.

Plaintiffs do not dispute that the FAC fails to plead any facts capable of supporting a finding that Plaintiffs' patients executed Form B under circumstances that are procedurally conscionable. Instead, the Opposition Brief confirms just the opposite: per the allegations of the FAC, Form B is a procedurally unconscionable contract of adhesion – a standard form that does not allow for the patient to negotiate the terms before receiving medical care. *See Shroyer v. New Cingular Wireless Servs., Inc.*, 498 F.3d 976, 983 (9th Cir. 2007). As the Ninth Circuit has recognized, "[a] finding of a contract of adhesion is essentially a finding of procedural unconscionability." *Nagrampa v. MailCoups, Inc.*, 469 F.3d 1257, 1281 (9th Cir. 2006) (internal quotation marks omitted).

Plaintiffs' sole retort, confined to a footnote of the Opposition Brief, baldly states that Plaintiffs' patients are free to go elsewhere for services, and they are not surprised by the terms of Form B, so it cannot be procedurally unconscionable. [Opp. Brief, p. 8 n. 5.] But the standard for procedural unconscionability is not whether patients have the option to seek out another conscionable contract elsewhere. The proper inquiry is whether (a) patients have the opportunity to negotiate contractual terms before signing and (b) whether there is oppression due to unequal bargaining power between Plaintiffs and patients. *Nagrampa*, 469 F.3d at 1281. Plaintiffs presented Form B to their prospective patients on a take-it-or-leave-it basis, as in *Nagrampa*. Plaintiffs allege that "**all** patients" must accept the terms of Form B **before** treatment, when they are suffering from addiction and mental health issues. [FAC, ¶ 51 (emphasis added).] Moreover, the inequality in bargaining power between Plaintiffs and their potential patients is manifest – the potential patients suffer from addiction and mental health issues, and Plaintiffs hold

the key to needed medical care. Because Plaintiffs admittedly present Form B to patients on a take-it-or-leave-it basis as a condition of receiving needed medical care, it is, as a matter of law, procedurally unconscionable and therefore unenforceable.

Rather than meaningfully dispute the procedural unconscionability of Form B, Plaintiffs devote much of their focus to discussing whether the terms of Form B are substantively unconscionable. [*See* Opp. Brief, pp. 7-8.] However, the more procedurally unconscionable a contract term is, the less evidence of substantive unconscionability is required to conclude the contract term is unenforceable, and vice-versa. *Armendariz v. Found Health Psychcare Servs., Inc.*, 24 Cal.4th 83, 114 (2000). A substantively unconscionable contract is one-sided to the extent that it "shocks the conscience" with its "unduly harsh or oppressive" terms. *Chavarria v. Ralphs Grocery Co.*, 733 F.3d 916, 923 (9th Cir. 2013). Although Plaintiff contends that "[a]ssigning benefit rights to a provider is not substantively unconscionable *because doing so clearly advantages the patient*," the advantage, if any, is far from clear. [Opp. Brief, p. 7.] Patients who sign Form B purport to irrevocably give up a substantial portion of their rights under their health benefit plans – including prospective claims that Plaintiffs now seek to utilize to fundamentally restructure their patients' plans. It is hard to see how giving up their rights without any meaningful limitation is advantageous to the patients, particularly where Plaintiffs seek to reform plan terms and to remove the named plan fiduciaries without *any* member input whatsoever. [Opp. Brief, pp. 16-19.] This is untenable, in no small part because the relief sought by Plaintiffs would impact the plan and patients' rights on a far broader scope than the claims at issue in the FAC.

Plaintiffs' attempt to assume virtually all of the members' rights under their plans is particularly concerning in light of the well-established principle that a valid assignment divests the assignor of all interest in the right-assigned. *Spinedex*, 770 F.3d at 1293. While Plaintiffs assert that they and their patients "have the same interests," [Opp. Brief, p. 8] Plaintiffs' attempt at elevating the rights of health care providers over the rights of the plan members themselves belies Plaintiffs' contention. Plaintiffs' claim that "[t]here

is nothing unconscionable about assigning rights to a similarly interested party better situated to handle the demanding paperwork associated with obtaining benefits" is similarly unavailing. [*Id*. at 8.] As discussed above, if Plaintiffs are right, Form B requires patients to give up substantially more than just the right to "handle … paperwork." [*Id*.] Moreover, the patient gives up those rights even though they may need treatment from another provider in the future. Consequently, Form B is unenforceable, and each claim predicated on Form B necessarily fails as a matter of law.

2. Even If Form B Is Enforceable, Defendants Are Still Entitled To The Dismissal Of Counts 2 And 3 With Prejudice.

First, as set forth above, the Opposition Brief confirms that Plaintiffs' Count 2 for removal of the ERISA plan fiduciaries and Count 3 for equitable relief are both premised on Defendants' alleged breach of fiduciary duty by failing to comply with the Claim Procedure Regulation's notice and appeal procedures as to Plaintiffs, not as to Defendants' members. [Opp. Brief, p. 20-21.] Because health care providers do not become ERISA beneficiaries or claimants within the meaning of the Claim Procedure Regulation by obtaining assignments of benefits, Counts 2 and 3 fail for the same reasons set forth in Part II.A.2 above, even where Plaintiffs' claims are premised on Form B.[6]

Second, the terms of Form B do not confer derivative standing on Plaintiffs to bring ERISA claims seeking the removal of the named plan fiduciaries under 29 U.S.C. §§ 1132(a)(2) and 1109(a). In Count 2, Plaintiffs seek "an order removing and dismissing the named fiduciaries" of the ERISA plans at issue and "permanently barring the Blue Cross Defendants from serving as fiduciaries for any of the Welfare Plan Defendants" under 29 U.S.C. §§ 1132(a)(2) and 1109(a). [FAC, ¶ 379.] Form B neither mentions nor assigns the right to assert ERISA claims that seek the removal of the plan

[6] Additionally, because Plaintiffs are not ERISA beneficiaries or claimants with the meaning of the Claim Procedure Regulation, Plaintiffs' contention that Defendants' alleged conduct constituted an "adverse benefit determination" as to Plaintiffs is entirely without merit. [*See, e.g.*, Opp. Brief, p. 20-21.] There is no allegation that Defendants' alleged conduct constituted an adverse benefit determination as to Defendants' members because Plaintiffs allege that Defendants did, in fact, pay the applicable benefit for the claims to the ERISA plan participants and beneficiaries. [*See* FAC, ¶ 72.]

fiduciaries or an order permanently barring Defendants from serving as fiduciaries under 29 U.S.C. §§ 1132(a)(2) and 1109(a). In short, Form B does not include any provision demonstrating "that the [assignor] manifest[ed] an intention to transfer the right to another person." *Spinedex*, 770 F.3d at 1292. Instead, the introductory paragraph of Form B manifests a contrary intention by predicating the transfer of rights in each of the nine subparagraphs that follow as assigned to the extent they relate to "the recovery of Benefits." [FAC, Ex. B (Form B Assignment).] Form B reiterates this in the paragraph following the nine subparagraphs, which states, "the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide" and that the form "shall be construed in favor of assigning Provider all rights that will assist it in recovering Benefits." [*Id*.] Because claims that seek the removal of the plan fiduciaries involve remedies beyond the mere recovery of benefits, Count 2 is not among the rights expressly assigned by Form B and should be dismissed on this independent ground.

C. Plaintiffs' Claims Must Be Dismissed Where the Applicable Plans Prohibit Assignments

As a threshold matter, Plaintiffs' argument that this Court should decline to consider the Anti-Assignment Plans because they were not attached to the FAC lacks merit.[7] [Opp. Brief, p. 14.] The weight of authority supports the Court considering these documents. *See, e.g., Marder v. Lopez*, 450 F.3d 445, 448 (9th Cir. 2006) ("A court may consider evidence on which the complaint 'necessarily relies' if: (1) the complaint refers to the document; (2) the document is central to the plaintiff's claim; and (3) no party questions the authenticity of the copy attached to the 12(b)(6) motion."). It is indisputable that the FAC refers to the Anti-Assignment Plans, which are central to Plaintiffs' claims of benefit entitlement. Further, Plaintiffs have failed to effectively

[7] Plaintiffs have provided to the Court three charts, totaling 82 pages, attached to the declaration of Victor O'Connell. The declaration contains impermissible legal argument and characterizations of the Anti-Assignment Plans that should not be considered by the Court for the reasons set forth in Defendants' evidentiary objections.

challenge the authenticity of the Anti-Assignment Plans, as Plaintiffs have now reviewed each Plan and, tellingly, have failed to point to any specific discrepancies that would legitimately call into question their authenticity or completeness.

Substantively, the Anti-Assignment Plans expressly prohibit a plan participant or beneficiary from assigning plan benefits and thus bar any attempt by Plaintiffs to sue on the basis of such assignments. Cases are legion in which district courts have properly granted motions to dismiss where, as here, Plaintiffs' claims for relief were based on ERISA-governed plans containing anti-assignment clauses like those in the Anti-Assignment Plans at issue.[8] Tellingly, ***none*** of these cases considers the four purported and novel "requirements" Plaintiffs discuss in their Opposition Brief before dismissing the providers' claims. [*See* Opp. Brief, pp. 14-16.] This is because *no court* has adopted Plaintiffs' theory that Defendants must establish these "requirements" before a motion to dismiss may be granted. Further, none of the purported authorities Plaintiffs cite requires that an anti-assignment provision "be properly described in an ERISA-compliant [SPD]" or that Defendants furnish SPDs to "participant-assignees" as a precondition to enforceability.[9] [Opp. Brief, p. 15.] Nor can Plaintiffs overcome the fact that courts enforcing anti-assignment provisions routinely rely on the same types of documents Defendants submitted.[10]

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[8] *See, e.g., Long Beach Mem'l Med. Ctr. v. Cal. Mart Emp. Benefit Plan*, No. 97-56624, 1999 U.S. App. LEXIS 3346, at *2 (9th Cir. Feb. 22, 1999); *Almont*, 99 F. Supp. 3d at 1119-20; *Care First Surg. Ctr. v. ILWU-PMA Welfare Plan*, No. CV-14-01480 MMM (AGRx), 2014 WL 6603761, at *24 (C.D. Cal. July 28, 2014); *Merrick v. UnitedHealth Grp., Inc.*, No. 14-Civ-8071-ER, 2016 U.S.Dist. LEXIS 39566, at *2 (S.D.N.Y. Mar. 25, 2016).

[9] None of the statutes or regulations Plaintiffs cite mentions anti-assignment provisions, let alone any purported requirements for enforcing anti-assignment provisions. *See* 29 U.S.C. §§ 1022(a)-(b), 1024(b); 29 C.F.R. §§ 2520.102-3, 104b-1. The same is true for the sole case relied on by Plaintiffs – *Osberg v. Foot Locker, Inc.*, No. 07-Civ-1358-KBF, 2015 U.S. Dist. LEXIS 132054 (S.D.N.Y. Sept. 29, 2015).

[10] *Riverview Health Inst. LLC v. Med. Mut. of Ohio*, 601 F.3d 505, 521 (6th Cir. 2010) (enforcing anti-assignment provision in "health certificates"); *Griffin v. Focus Brands, Inc.*, No. 15-12137, 2015 WL 9487801, at *3 (11th Cir. Dec. 30, 2015) (enforcing anti-assignment provision in "Certificate Booklet"); *Merrick*, 2016 U.S.Dist. LEXIS 39566, at 8 n.3 (enforcing anti-assignment provision in "sample plans"); *Almont*, 99 F. Supp. 3d at 1125 (enforcing anti-assignment provision in "plan-related documents" that "reflect the terms of the plans"); *Care First*, 2014 WL 6603761, at *12 (enforcing anti-assignment provision in SPDs); *Quaresma v. BC Life & Health Ins. Co.*, 623 F. Supp. 2d 1110, 1127

Care First is instructive on this score. 2014 WL 6603761. There, providers alleged that a defendant ERISA-governed plan improperly failed to pay claims directly to non-participating providers where the plan beneficiaries executed alleged assignments of benefits to the providers. *Id.* at *1. No plan documents were attached to the complaint, but the court considered the authenticated plan documents defendants offered under the incorporation by reference doctrine. *Id.* at *4-5. The plan contained anti-assignment provisions, which the court considered "because Care First's standing to bring this lawsuit depends on them." *Id.* at *5. The court did not consider any of the four "requirements" Plaintiffs now attempt to impose on Defendants in determining the validity or enforceability of the anti-assignment provisions. Instead, in a meticulous opinion, the *Care First* court dismissed plaintiffs' ERISA claims because it found that the anti-assignment provisions were valid under *Davidowitz v. Delta Dental Plan of Cal.*, 946 F.2d 1476 (9th Cir. 1991), and that plaintiffs therefore lacked standing to bring the claims. *Care First*, 2014 WL 6603761, at *13, 20. The same reasoning applies to the instant case. The anti-assignment clauses in the plan documents at issue here are properly considered under the incorporation by reference doctrine because Defendants have authenticated them, and Plaintiffs cannot and do not reasonably question their authenticity. The anti-assignment provisions have full legal force because *Davidowitz* and its progeny hold that anti-assignment clauses are valid and enforceable. Defendants have not waived their rights to enforce the anti-assignment provisions regardless of whether Plaintiffs allege that Defendants represented that the claims were assignable, and therefore, Plaintiffs lack standing to bring their claims.

Plaintiffs' argument that Defendants waived the right to rely on the anti-assignment provisions is unsupported by the case law, which holds that even where defendants did not assert anti-assignment provisions during the claims administration process, defendants do not waive their right to rely on the provisions. *Spinedex*, 770 F.3d

(enforcing anti-assignment provision in "Combined Evidence of Coverage and Disclosure Form").

at 1296-97; *Almont*, 99 F. Supp. 3d at 1140, 1147; *Griffin v. Health Sys. Mgmt.*, No. 15-12138, 2015 U.S. App. LEXIS 22780, at *3-4, 10-13.

Finally, Plaintiffs' arguments that the Court should reform the Anti-Assignment Plans and that Defendants should be estopped from asserting the anti-assignment provisions are also unavailing. Plaintiffs' new assertion that the FAC articulates a theory of fiduciary breach, even if true, is not helpful, because the Ninth Circuit has established that including an anti-assignment clause in a plan and then failing to honor assignments is not a violation of a fiduciary duty. *Davidowitz*, 946 F.2d at 1481. Even where a defendant misinforms a plaintiff that plan benefits are assignable, the defendant is not estopped from enforcing the anti-assignment clause. *Almont*, 99 F. Supp. 3d at 1135-47.[11]

D. Each Of Plaintiffs' Claims Must Be Dismissed Because Plaintiffs Do Not Allege That They Gave Sufficient Notice Of The Terms Of The Purported Assignments To Defendants.

Defendants' Omnibus Motion to Dismiss explains that the law requires an assignee to provide adequate notice of the existence of an assignment that is "clear and positive" in order to protect the obligor—and, in the case of assignments of ERISA benefits, the members—from invalid claims, and from uncertainty over the party legally entitled to performance. [Omnibus Mot., pp. 21-24.] Plaintiffs counter that they provided Defendants such notice by entering a "Y" in Box 53 of their UB-04 claims forms. Plaintiffs base their argument on the premise that a "Y" in this field has a well-established meaning denoting a lawful and enforceable assignment, and that courts have found a checked box sufficient to deprive members of their rights to plan benefits. [Opp. Brief, pp. 11-12.] Neither assertion holds water.

Even if Plaintiffs were correct that the entry of a "Y" in Box 53 has a well-

[11] In addition, the doctrine of estoppel is inapplicable where, as here, there is no allegation that Plaintiffs were unable to access the plan documents at issue. *Care First*, 2014 WL 6603761, at *17; *DeBartolo v. Health & Welfare Dep't of the Const. & Gen. Laborers' Dist. Council of Chi.*, No. 1:09-cv-0039, 2010 WL 3273922 (N.D. Ill. Aug. 17, 2010); *Merrick*, 2016 U.S.Dist. LEXIS 39566. In fact, the FAC specifically alleges that "Sovereign was able to obtain for some welfare plans the operative plan documents governing the terms of the Former Patient's coverage." [FAC, ¶ 91.]

established meaning, that meaning is not what Plaintiffs claim it is. The "Official UB-04 Data Specifications Manual" published by the National Uniform Billing Committee ("NUBC")—the entity Plaintiffs acknowledge "created and promulgated the UB-04 form" and is "uniquely positioned to know … what [the form] means" [Opp. Brief, p. 11]—explicitly states that Box 53 simply "indicates [the] provider has a signed form authorizing the third party payer to remit payment directly to the provider."[12] In other words, it merely denotes that the patient has authorized the insurer to pay benefits "directly to the provider." The Manual says nothing about an assignment of the patient's legal rights to plan benefits to the provider. And Plaintiffs make no factual allegations regarding the form that support a different reading.

Plaintiffs' case citations fare no better. None found that a "Y" in Box 53 provides adequate notice to payers that the legal rights to ERISA benefits have been lawfully assigned. If anything, they each confirm the ambiguity ERISA plans and administrators face when presented with a mere ticked box on a claim form. Indeed, in three of the cases, the plaintiff providers argued that they were ***not*** assignees, notwithstanding their UB-04 form entries. *See Spring E.R., LLC v. Aetna Life Ins. Co.*, No. H-09-2001, 2010 WL 598748, at *4 (S.D. Tex. Feb. 17, 2010) (explaining plaintiff's argument that the purpose of the "Y" in Box 53 was only "to convey to Defendants that they could and should pay Plaintiff directly"); *Montefiore Med. Ctr. v. Teamsters Local 272*, No. 09 Civ.

[12] The Manual is available to the public for purchase from the NUBC website: http://www.nubc.org/subscriber/index.dhtml. Defendants have not attached the Manual here because its licensing terms purport to restrict purchasers from sharing it. But a 2007 version of the Manual—which Defendants can confirm is identical in relevant part to the current version—is located at the following link, and shows the language quoted above: http://www.alphacm.net/MCSuniversity/documents/general/UB-04_2007.pdf. While the Court need not rely on the Manual to rule in Defendants' favor, Defendants respectfully submit that the Manual is judicially noticeable. Plaintiffs acknowledge in their opposition brief and complaint that the UB-04 form was "created" and "approved" by the NUBC, and that the NUBC is "uniquely positioned to know what the form means." [FAC, ¶¶ 65-66; Opp. Brief, p. 11]. The Manual indisputably documents the meaning NUBC ascribes to codes a provider may enter in the form's various fields and is accordingly incorporated by reference into at least one state's medical billing guidelines. *See* California Division of Workers' Compensation Medical Billing and Payment Guide 4-5, *available at* https://www.dir.ca.gov/dwc/DWCPropRegs/ICD10/FinalRegulations/MedicalBillingandPaymentGuide.pdf (last accessed Apr. 3, 2016).

3096 (HB), 2009 WL 3787209, at *5 (S.D.N.Y. Nov. 12, 2009) (explaining plaintiff's argument that UB-04 entries were "ineffectual to assign any real Plan benefits"); *Paragon Office Servs., LLC v. UnitedHealthGroup, Inc.*, No. 3:11-CV-2205-D, 2012 WL 1019953, at *5 (N.D. Tex. Mar. 27, 2012) (explaining "plaintiff's contentions that it did not receive assignments of benefits from its patients"). In the final case, the court characterized the box on the claim form precisely as Defendants did in their opening brief. The forms "did not affirmatively show that an assignment occurred nor do they contain any language regarding assignment"— the "Y" on the form "could possibly reflect assignment" but not without other evidence. *N. Shore-Long Island Jewish Health Care Sys., Inc. v. MultiPlan, Inc.*, 953 F. Supp. 2d 419, 429 (E.D.N.Y. 2013) (referring to plaintiffs' position as the "unable-to-confirm-assignment" argument).[13]

That the cases found that there was sufficient evidence of the providers' potential status as assignees to establish federal jurisdiction under ERISA's complete preemption doctrine is of no moment. *See, e.g., Multiplan*, 953 F. Supp. 2d at 434-35 (explaining that given the important purposes served by ERISA's complete preemption doctrine, the ambiguity created by the providers' claim forms "should not be held against defendants" in deciding the providers' motion to remand).[14] This dispute is not about whether a federal court should hear Plaintiffs' claims under ERISA's expansive jurisdictional provisions. It is about whether Defendants were duty-bound—simply on the basis of a

[13] Plaintiffs' reliance on *Metcalf* is unhelpful for similar reasons. [*See* Opp. Brief, p. 12.] In *Metcalf v. Blue Cross Blue Shield of Mich.*, the magistrate reasoned that defendant possessed more than just a claim form with a checked box—unlike here, the form itself noted that the defendant had a signed assignment on file, plaintiff had sent defendant a letter explaining that it was in possession of an assignment, and defendant actually possessed copies of the assignment forms at the time it received the claims, which it had obtained in earlier litigation with the provider. 57 F. Supp. 3d 1281, 1295 (D. Or. 2014).

[14] While these courts declined to remand to state court, and found by a preponderance of the evidence that the providers were attempting to stand in the shoes of their patients, they did so not simply because the providers checked Box 53 or its analog, but rather, ***in spite*** of the ambiguities surrounding the providers' claims forms. For instance, the *Multiplan* court cautioned that it did "not base its conclusion as to an assignment solely on whether or not a 'Y' is contained in Box 53 of the UB-04s," but rather reacted to contextual evidence that the provider was seeking "to stand in the shoes of the ERISA plan participants on behalf of whom it seeks payment." *Multiplan*, 953 F. Supp. 2d at 434; *see also Montefiore*, 2009 WL 3787209, at *5 (S.D.N.Y. Nov. 12, 2009).

checked box—to pay all plan benefits to Plaintiffs, rather than to Plaintiffs' patients, the primary obligees under the ERISA plans. The question answers itself: the claim form entry Plaintiffs rely on does not "contain any language regarding assignment" and, viewed in the light most favorable to Plaintiffs, at best "could possibly reflect assignment." *Multiplan*, 953 F. Supp. 2d at 429 (internal quotation marks omitted). That checked box leaves everything to the imagination, including whether (assuming that the provider obtained a signed writing) the patient has simply authorized the payer to remit plan benefits directly, without legally assigning anything. Indeed, the myriad of "Form A" writings that Plaintiffs have offered are nothing more than payment authorizations, and yet Plaintiffs still checked Box 53.[15] Plaintiffs here had the ability to put Defendants on clear notice of the nature of the rights that had purportedly been assigned to them by their patients by furnishing a copy of the patient-signed form but neglected to do so.

The law of assignment does not tolerate this kind of ambiguity.[16] To the contrary, the law demands "clear and positive" evidence of an assignment, and reasonable identification of the rights that have been assigned, in order to protect an obligor subject to potential claims from the primary obligee. *Cockerell v. Title Ins. & Trust Co.*, 42 Cal.2d 284, 292 (1954);[17] *see also Parker v. First Am. Title Ins. Co.*, No. D044409, 2005 WL 1394633, at *4 (Cal. App. June 14, 2005) ("If A writes to B 'Please pay to C the balance due me,' such language is insufficient to establish an assignment or to give B

[15] Notably Plaintiffs checked Box 53 regardless if Form A or Form B was in effect – highlighting the ambiguous nature of the checked box – *i.e.*, the mere check mark provides no information of the actual terms of the document referenced.

[16] This ambiguity is compounded in instances where the patient claims at issue were not submitted by any of the Plaintiffs in this action. For many of the underlying patient claims, the services were apparently rendered and billed by an entity called "Medical Concierge, Inc." or "Medlink." For such claims, Plaintiffs have not (and, indeed, cannot) plausibly state a claim for relief based on the contention that payment should have been rendered to Plaintiffs under an assignment of benefits when Plaintiffs were not identified as either the rendering or billing health care provider to Defendants in the first instance. [*See* Reply Brief ISO Anthem Defendants' Addendum, filed concurrently herewith.]

[17] Plaintiffs attempt to distinguish *Cockerell* on the grounds that, unlike the putative assignee in that case, Plaintiffs here have "clear and unambiguous" assignments. [Opp. Brief, p. 13 n.10.] Plaintiffs' actual possession of allegedly unambiguous assignments for some of their patients is irrelevant to whether Defendants ever had adequate notice of the assignments that Plaintiffs admittedly never provided to Defendants.

notice of an assignment") (other internal quotations omitted). Under this legal standard, with Defendants having already rendered full performance to their primary obligees, Plaintiffs cannot now be heard to complain that their ambiguous representations on their claim forms should have been understood to mean one thing, and one thing only.

Finally, Plaintiffs assert that even if the assignments they possess are not valid, Defendants should still have paid them because Defendants' obligations would have been discharged if they had rendered performance without any reason to know that Plaintiffs were claiming a right to payment without a valid assignment. [Opp. Brief, p. 13 (citing Rest. 2d Contracts § 338).] This argument goes nowhere, as the collective experience of payers and providers, as reflected in the case law, makes clear that a checked box on a claim form does not necessarily indicate that the provider has been assigned his patient's rights to plan benefits. ERISA's primary purpose is not to protect health care providers, but rather to protect the interests of plan beneficiaries. *See* 29 U.S.C. § 1001(b). If Plaintiffs want to put Defendants on notice that they have legally become entitled to their patients' benefits by assignment, they must furnish a copy of the purported assignment to Defendants—there is no shortcut here.[18]

E. Plaintiffs' Fourth Count For Alleged Violations Of Business And Professions Code § 17200 Fails As A Matter Of Law.

Plaintiffs cannot escape ERISA preemption of their § 17200 claim. In an effort to save this claim, Plaintiffs distance themselves from their self-identification as assignees of their patients. However, the crux of Plaintiffs' § 17200 claim (as well as the entire FAC) is that Defendants allegedly unlawfully paid ERISA plan benefits to Plaintiffs' patients, rather than Plaintiffs directly, pursuant to an alleged assignment of benefits. [FAC, ¶ 3.] Thus, Plaintiffs' § 17200 claim necessarily relates to the ERISA-governed benefit plans at issue and falls within ERISA's express preemption provision. Plaintiffs'

[18] For similar reasons, any suggestion that Defendants were under a duty to investigate the assignment forms before paying is misplaced. As Plaintiffs are responsible for any ambiguity here, Plaintiffs were obliged to resolve it—or accept the risk that performance would be rendered to the plan members directly.

cited authority on this point recognizes that "ERISA preempts the state claims of a provider suing as an assignee of the beneficiary's rights to benefits under an ERISA plan." *Cedars-Sinai Med. Ctr. v. Nat'l League of Postmasters of the United States*, 497 F.3d 972, 978 (9th Cir. 2007) (citing *The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995)). Similarly, Plaintiffs' reliance on *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 947 (9th Cir. 2009), is misplaced since the plaintiff hospital in that case did not contend that it was owed additional funds under the ERISA plan; rather, it contended it was owed funds due to an alleged oral contract with a plan administrator. *Id.* at 950. Here, Plaintiffs allege they should have been paid under the alleged assignments of the insureds' ERISA-governed benefit plans. Consequently, Plaintiffs' § 17200 claim clearly falls within the preemptive scope of ERISA's express preemption provision, and it should be dismissed with prejudice.[19]

Plaintiffs also fail, as a matter of law, to properly assert a § 17200 claim since they fail to assert the conduct alleged in the FAC is both unlawful and unfair within the meaning of the statute. To succeed on the unlawful prong, Plaintiffs must show that Defendants' business practices violated a "borrowed" law. *Davis v. v. HSBC Bank Nev., N.A.*, 691 F.3d 1152, 1168 (9th Cir. 2012) citing *Cel-Tech Commc'ns., Inc. v. L.A. Cellular Tel. Co.*, 20 Cal.4th 163, 180 (1999); *Khan v. CitiMortgage, Inc.*, 975 F. Supp. 2d 1127, 1145 (E.D. Cal. 2013). The FAC fails to allege a violation of any borrowed law, and Plaintiffs' Opposition cannot remedy this failure. The Opposition Brief's vague statement that Defendants' conduct "is forbidden by numerous California laws" does not illuminate any allegation in the FAC that Defendants' conduct violated any specific law. [Opp. Brief, p. 32.] Further, Plaintiffs' belated reference to constructive fraud in their Opposition Brief does not create a sufficient allegation of unlawful conduct. [*Id*. at pp.

[19] Plaintiffs apparently do not take issue with Defendants' argument that in the event that the Court finds that Plaintiffs stated a claim under 29 U.S.C. § 1132(a)(1)(B), Plaintiffs' § 17200 claim is also completely preempted by ERISA's civil enforcement provision. *Marin*, 581 F.3d at 946 (internal quotation marks omitted) ("[A] state-law cause of action is completely preempted if (1) an individual, at some point in time, could have brought [the] claim under ERISA § 502(a)(1)(B), and (2) where there is no other independent legal duty that is implicated by a defendant's actions.").

32-33.] Not only is there no such allegation in the FAC, the allegations that are made do not meet the heightened pleading standards required for pleading fraud in federal courts. *See* Fed. Rule Civ. P. 9(b). The FAC also fails under the "unfair" prong of the statute. Plaintiffs cannot meet the *Cel-Tech* test requiring allegations of conduct violating antitrust and competition principles. *Cel-Tech*, 20 Cal.4th at 187. Plaintiffs' unsupported argument that Defendants' conduct "obviously qualifies as 'unfair' under *any* test" hardly rectifies the problem. [Opp. Brief, p. 33.] The FAC simply has no allegations supporting Plaintiffs' contention that Defendants acted unfairly under § 17200.

Plaintiff also cannot avoid the fact that, as non-consumers and non-competitors to Defendants, Plaintiffs lack standing to state a claim under the unfairness prong of § 17200. *See Ctr. for Neuro Skills v. Blue Cross of Cal.*, No. 1:13-cv-00743-LJO-JLT, 2013 U.S. Dist. LEXIS 148432, at *26-27 (E.D. Cal. Oct. 15, 2013); *Almasi v. Equilon Enters., LLC*, No. 5:10-cv-03458 EJD, 2012 U.S. Dist. LEXIS 128623, at *27 (N.D. Cal. Sept. 10, 2012). Indeed, Plaintiffs' cited cases in opposition to this point do not directly discuss the issue of standing under the unfairness prong of § 17200 and are therefore unavailing. *See Coast Plaza Doctors Hosp. v. UHP Healthcare*, 105 Cal. App. 4th 693, 704-05 (2002) (no direct discussion of standing under the unfair prong of § 17200); *Bell v. Blue Cross of Cal.*, 131 Cal. App. 4th 211, 217-218 (2005) (discussing standing with regard to the unlawful, not the unfair, prong of § 17200).

F. Plaintiffs' Demand For A Jury Trial Should Be Stricken.

Plaintiffs agree that none of their ERISA claims, nor their § 17200 claim, is triable by jury. [Opp. Brief, p. 35.] Thus, Plaintiffs' jury demand should be stricken.[20]

III. CONCLUSION

For the reasons set forth above, Defendants respectfully request that the Court dismiss each and every claim averred in Plaintiffs' FAC without leave to amend.

[20]Plaintiffs' argument that the FAC's allegations *may* give rise to a claim of constructive fraud is both desperate and unsupported. Plaintiffs not only have failed to allege constructive fraud in the FAC, the allegations of the FAC fail to meet the heightened federal pleading requirements for such claims. *See* Fed. Rule Civ. P. 9(b).

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FOLEY & LARDNER LLP
Eileen R. Ridley
Michael A. Naranjo
Alan R. Ouellette

/s/ Eileen R. Ridley
Eileen R. Ridley
Attorneys for Defendants BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS, ANTHEM HEALTH PLANS, INC., dba ANTHEM BLUE CROSS AND BLUE SHIELD, ANTHEM HEALTH PLANS OF KENTUCKY, INC., dba ANTHEM BLUE CROSS AND BLUE SHIELD, ANTHEM INSURANCE COMPANIES, INC., dba ANTHEM BLUE CROSS AND BLUE SHIELD, COMMUNITY INSURANCE COMPANY, dba ANTHEM BLUE CROSS AND BLUE SHIELD, EMPIRE HEALTH CHOICE ASSURANCE, INC., dba EMPIRE BLUE CROSS AND BLUE SHIELD, ROCKY MOUNTAIN HOSPITAL AND MEDICAL SERVICE, INC., dba ANTHEM BLUE CROSS AND BLUE SHIELD, ANTHEM HEALTH PLANS OF VIRGINIA, INC., BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC., BLUE CROSS BLUE SHIELD OF WISCONSIN, erroneously sued as THE ANTHEM COMPANIES, INC., ACWA/JPIA EMPLOYEE BENEFITS PROGRAM, AMERIFLIGHT, LLC GROUP LIFE & HEALTH INSURANCE PLAN, BANK OF THE WEST EMPLOYEE BENEFIT PLAN, BLOOMBERG L.P. HEALTH AND WELFARE PLAN, CNS HEALTH AND WELFARE BENEFITS PLAN, EINSTEIN NOAH RESTAURANT GROUP, INC. EMPLOYEE BENEFIT PLAN, ERNST & YOUNG MEDICAL PLAN, FERGUSON ENTERPRISES INC. FLEXIBLE BENEFITS PLAN, FOLLETT CORPORATION WELFARE BENEFIT PLAN, erroneously sued as FOLLETT CORPORATION EMPLOYEES BENEFIT TRUST, GENTIVA HEALTH SERVICES HEALTH & WELFARE PLAN, GLOBECAST HEALTH AND WELFARE BENEFITS PLAN, HOME DEPOT MEDICAL AND DENTAL PLAN, erroneously sued as HOME DEPOT WELFARE BENEFITS PLAN, INTEL

CORPORATION HEALTH AND WELFARE BENEFIT PLAN, INTEVAC LIFE AND WELFARE PLAN, KENTUCKY CONSTRUCTION INDUSTRY TRUST, LECROY HEALTH AND DISABILITY BENEFIT PLAN, LIVE NATION ENTERTAINMENT, INC. GROUP BENEFITS PLAN, NORTHROP GRUMMAN CORPORATION GROUP BENEFITS PLAN, PEAK FINANCE COMPANY GROUP HEALTH PLAN, PEPSICO EMPLOYEE HEALTH CARE PROGRAM, SAGE SOFTWARE INC. AND CO-SPONSORING AFFILIATES HEALTH AND WELFARE PLAN, SALLIE MAE EMPLOYEES COMPREHENSIVE WELFARE BENEFITS PLAN, SHEET METAL WORKERS LOCAL NO. 40 HEALTH FUND, THE AEROSPACE CORPORATION GROUP HOSPITAL-MEDICAL PLAN, THE KROGER CO. HEALTH & WELFARE BENEFIT PLAN, THE LILLY EMPLOYEE WELFARE PLAN, THE LINCOLN ELECTRIC COMPANY WELFARE BENEFITS PLAN, THE STEAK N SHAKE EMPLOYEE BENEFIT PLAN, VERIZON NATIONAL PPO WEST, VIASAT INC. EMPLOYEE BENEFIT PLAN and XEROX CORPORATION WELFARE PLAN

DATED: April 4, 2016

GORDON AND REES LLP
Ronald K. Alberts
Hilary E. Feybush
Jennifer Marks Ghozland

/s/ Ronald K. Alberts
Ronald K. Alberts
Attorneys for Defendants ALLTECH, INC. BENEFIT PLAN, CORRECTIONS CORPORATION OF AMERICA SCA EMPLOYEES BENEFIT PLAN and EHEALTHINSURANCE SERVICES INC.

DATED: April 4, 2016

VON BEHREN AND HUNTER LLP
William E. von Behren
Carol B. Lewis
Joann V. Lee

/s/ William E. von Behren
William E. von Behren
Attorneys for Defendants ALASKA AIR GROUP, INC. WELFARE BENEFIT PLAN, ASANTE EMPLOYEE BENEFITS PLAN, BLUE CROSS BLUE SHIELD OF TENNESSEE, INC., BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. d/b/a FLORIDA BLUE, BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS HMO BLUE, INC., BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC., BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, BLUE CROSS OF NORTHEASTERN PENNSYLVANIA, C.R. BARD, INC. EMPLOYEE BENEFIT PLAN, CALIFORNIA PHYSICIANS SERVICE d/b/a BLUE SHIELD OF CALIFORNIA, CHICOS FAS, INC. HEALTH & WELFARE BENEFIT PLAN, COMMUNITY HEALTH SYSTEMS HEALTH PLAN, COVANCE, INC. HEALTH & WELFARE PLAN, DYCOM INDUSTRIES HEALTH AND WELFARE PLAN, EXCELLUS HEALTH PLAN, INC., F.N.B. CORPORATION HEALTH AND WELFARE PLAN, F5 NETWORKS, INC. EMPLOYEE BENEFIT PLAN, FASTRAC MARKETS LLC EMPLOYEE WELFARE BENEFIT PLAN, FRESENIUS MEDICAL CARE NORTH AMERICA MEDICAL PLAN, erroneously sued as NATIONAL MEDICAL CARE, INC. GROUP MEDICAL, DENTAL, LIFE AND AD&D PLAN, GKN EMPLOYEE WELFARE BENEFIT PLAN, GENERAL NUTRITION GROUP INSURANCE PLAN, GLOBYS, INC. GROUP HEALTH PLAN, HAWAII MEDICAL SERVICE ASSOCIATION d/b/a BLUE CROSS BLUE SHIELD OF HAWAII, HENRY SCHEIN, INC. MANAGED CARE PLAN, HIGHMARK BCBSD, INC., HIGHMARK BLUE CROSS BLUE SHIELD, HIGHMARK BLUE

SHIELD, HIGHMARK, INC. d/b/a HIGHMARK BLUE SHIELD, HORIZON HEALTHCARE SERVICES, INC. d/b/a HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INLANDBOATMENS UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT TRUST, INTERRAIL SIGNALS, INC. WELFARE BENEFIT PLAN, JENNINGS AMERICAN LEGION HOSPITAL EMPLOYEE BENEFIT PLAN, LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY BLUE CROSS AND BLUE SHIELD OF LOUISIANA, MACHINISTS HEALTH & WELFARE TRUST FUND, MARTIN MARIETTA MEDICAL PLAN, NATURES PATH FOODS, INC. WELFARE BENEFIT PLAN, NORTHERN CALIFORNIA SHEET METAL WORKERS, NOVARTIS CORPORATION WELFARE BENEFIT PLAN, OGLETREE, DEAKINS, NASH, SMOAK & STEWART, P.C. GROUP MEDICAL PLAN, ORASURE TECHNOLOGIES INC. HEALTH AND WELFARE PLAN, PEAK 10, INC. EMPLOYEE BENEFIT PLAN, PREMERA BLUE CROSS, PREMERA BLUE CROSS BLUE SHIELD OF ALASKA, PROFIT INSIGHT HOLDINGS LLC GROUP HEALTH PLAN, PUBLIX SUPER MARKETS, INC. GROUP HEALTH BENEFIT PLAN, PUGET SOUND PILOTS GROUP HEALTH PLAN, RAYONIER, INC. WELFARE PLANS, REGENCE BLUECROSS BLUESHIELD OF OREGON, erroneously sued herein as REGENCE INSURANCE HOLDING CORPORATION; REGENCE BLUECROSS BLUESHIELD OF UTAH, erroneously sued herein as REGENCE INSURANCE HOLDING CORPORATION; REGENCE BLUESHIELD erroneously sued herein as REGENCE INSURANCE HOLDING CORPORATION; SAS INSTITUTE INC. WELFARE BENEFITS PLAN, SCANA CORPORATION HEALTH & WELFARE PLAN, SEABRIGHT INSURANCE COMPANY GROUP HEALTH PLAN, SIMMONS WELFARE BENEFIT PLAN, SPOKANE TEACHERS CREDIT UNION EMPLOYEE MEDICAL & DENTAL PLAN, TUV AMERICA, INC. INSURANCE BENEFITS PLAN, THE MASTER BUILDERS ASSOCIATION HEALTH INSURANCE TRUST, TRINET

EMPLOYEE BENEFIT INSURANCE PLAN, UNITED STATES STEEL PLAN FOR ACTIVE EMPLOYEE INSURANCE BENEFITS, U.S. RENAL CARE, INC., WELLMARK OF SOUTH DAKOTA, INC. and WELLMARK, INC.

DATED: April 4, 2016

REED SMITH LLP
Dan J. Hofmeister, Jr.
Amir Shlesinger
Monica J. Zi

/s/ Dan J. Hofmeister, Jr.
Dan J. Hofmeister, Jr.
Attorneys for Defendants 3M EMPLOYEES' WELFARE BENEFITS ASSOCIATION (TRUST II) PLAN, BCBSM, INC. d/b/a BLUE CROSS BLUE SHIELD OF MINNESOTA, BLUE CROSS AND BLUE SHIELD OF KANSAS CITY d/b/a BLUE KC (erroneously sued as "BLUE CROSS AND BLUE SHIELD OF KANSAS CITY, INC.", BLUE CROSS AND BLUE SHIELD OF KANSAS, INC., BLUE CROSS AND BLUE SHIELD OF NEBRASKA, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., CARGILL INCORPORATED & PARTICIPATING AFFILIATES GROUP HEALTH PLAN, CONSTRUCTION INDUSTRY LABORERS WELFARE FUND, EMPLOYEES' BENEFIT PLAN OF GENERAL MILLS, INC., WALTER INVESTMENT MANAGEMENT CORP. COMPREHENSIVE WELFARE BENEFIT PLAN (formerly known as GREEN TREE COMPREHENSIVE WELFARE PLAN), HDR, INC. GROUP INSURANCE PLAN, J.R. SIMPLOT COMPANY GROUP HEALTH & WELFARE PLAN, ALBERTSON'S LLC HEALTH & WELFARE BENEFIT PLAN, LAYNE CHRISTENSEN COMPANY HEALTH AND WELFARE PLAN, MDU RESOURCES GROUP, INC. HEALTH AND WELFARE BENEFITS PROGRAM, MEDTRONIC, INC. GROUP INSURANCE PLAN, METAL-MATIC, INC. WELFARE BENEFIT PLAN, ST. LUKES LUTHERAN CARE CENTER EMPLOYEE HEALTH

CARE PLAN, TRANSPORT CORPORATION OF AMERICA, INC. EMPLOYEE HEALTH AND WELFARE BENEFIT PLAN, TWIN CITIES BAKERY DRIVERS HEALTH & WELFARE FUND and UNIVERSITY OF NEBRASKA FOUNDATION

DATED: April 4, 2016

O'MELVENY AND MYERS LLP
Brian D. Boyle
Matthew W. Close
Raymond Collins Kilgore

/s/ Brian D. Boyle
Brian D. Boyle
Attorneys for Defendants ACTIVE POWER, INC. HEALTH AND WELFARE PLAN, ARDENT HEALTH SERVICES WELFARE BENEFIT PLAN, BAXTER INTERNATIONAL INC. AND SUBSIDIARIES WELFARE BENEFIT PLAN, CONSOLIDATED GRAPHICS, INC. GROUP BENEFITS PLAN, DELTA KAPPA GAMMA SOCIETY INTERNATIONAL HEALTH BENEFIT PLAN, ELLIOTT ELECTRIC SUPPLY, L.P. HEALTH BENEFIT PLAN, ENSCO HEALTH PLAN, GROUP HEALTH & WELFARE BENEFITS PLAN OF AMERICAN EAGLE AIRLINES, INC. & ITS AFFILIATES, H.E. BUTT GROCERY COMPANY WELFARE BENEFIT PLAN, HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY d/b/a BLUECROSS BLUESHIELD OF ILLINOIS, BLUECROSS BLUESHIELD OF MONTANA, BLUECROSS BLUESHIELD OF NEW MEXICO, BLUECROSS BLUESHIELD OF OKLAHOMA, and/or BLUECROSS BLUESHIELD OF TEXAS, IESI CORPORATION EMPLOYEE WELFARE BENEFITS PLAN, ION GEOPHYSICAL CORPORATION GROUP HEALTH PLAN, PIONEER ENERGY SERVICES CORP. GROUP HEALTH PLAN, RANDALL S. FUDGE P.C. EMPLOYEE BENEFITS PLAN, SOUTHWEST SHIPYARD, L.P. CAFETERIA PLAN, THE GROUP LIFE

AND HEALTH BENEFITS PLAN FOR EMPLOYEES OF PARTICIPATING AMR CORPORATION SUBSIDIARIES, UNITED SURGICAL PARTNERS, INTL WELFARE BENEFIT PLAN and XEROX BUSINESS SERVICES, LLC FUNDED WELFARE BENEFIT PLAN

DATED: April 4, 2016

AKIN GUMP STRAUSS HAUER AND FELD LLP
Robert B. Humphreys
Katherine M. Katchen

/s/ Katherine M. Katchen
Katherine M. Katchen
Attorneys for Defendants ARKANSAS BLUE CROSS AND BLUE SHIELD d/b/a BLUEADVANTAGE ADMINISTRATORS OF ARKANSAS, BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 PA/DE HEALTH & WELFARE FUND, INDEPENDENCE BLUE CROSS, INC., USABLE MUTUAL INSURANCE COMPANY and WAL-MART STORES, INC. ASSOCIATES HEALTH & WELFARE PLAN

DATED: April 4, 2016

MORGAN LEWIS AND BOCKIUS LLP
Nicole A. Diller
Donald L. Havermann
Anna Kim
Andrew G. Sakallaris

/s/ Nicole A. Diller
Nicole A. Diller
Attorneys for Defendants OWENS-ILLINOIS, INC. HOURLY EMPLOYEES WELFARE BENEFIT PLAN FOR ACTIVE EMPLOYEES, GEICO CORPORATION CONSOLIDATED WELFARE BENEFITS PROGRAM, and MERCY HEALTH SERVICES, INC. AND SUBSIDIARIES MEDICAL PLAN

DATED: April 4, 2016

COPPERSMITH BROCKELMAN PLC
Keith Beauchamp

/s/ Keith Beauchamp
Keith Beauchamp
Shelley Tolman
Attorneys for Defendants BLUE CROSS & BLUE SHIELD OF ARIZONA, INC. EMPLOYEE HEALTH PLAN, BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC. and TUCSON ELECTRIC POWER COMPANY EMPLOYEE GROUP INSURANCE PLAN

DATED: April 4, 2016

NEIL J. BARKER APC
Neil J. Barker

/s/ Neil J. Barker
Neil J. Barker
Attorneys for Defendants BLUE CROSS BLUE SHIELD OF MICHIGAN, BLUE CROSS AND BLUE SHIELD OF ALABAMA, MUELLER WATER PRODUCTS, INC. FLEXIBLE BENEFITS PLAN, TAC MANUFACTURING, INC. EMPLOYEE WELFARE BENEFIT PLAN and USUI INTERNATIONAL GROUP HEALTH & WELFARE PLAN

DATED: April 4, 2016

/s/ Patrick P. de Gravelles
Patrick P. de Gravelles
Attorneys for Defendants CAREFIRST OF MARYLAND, INC. d/b/a CAREFIRST BLUECROSS BLUESHIELD and GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. d/b/a CAREFIRST BLUECROSS BLUESHIELD

DATED: April 4, 2016

LAW OFFICES OF RONALD S. KRAVITZ
Ronald S. Kravitz

/s/ Ronald S. Kravitz
Ronald S. Kravitz
Attorneys for Defendants HUNTINGTON BANCSHARES INCORPORATED HEALTH CARE PLAN and WELLS FARGO & CO. HEALTH PLAN

DATED: April 4, 2016

VALLE MAKOFF LLP
John M. Moscarino

BENESCH FRIEDLANDER COPLAN & ARONOFF LLP
Maynard A. Buck
Christopher J. Lalak
Katrina O. Tesner

/s/ Maynard A. Buck
Maynard A. Buck
Attorneys for Defendant EATON CORPORATION MEDICAL PLAN FOR U.S. EMPLOYEES

DATED: April 4, 2016

HUNTON AND WILLIAMS LLP
Phillip J. Eskenazi
Alexandrea H .Young

/s/ Alexandrea H. Young
Alexandrea H .Young
Attorneys for Defendant L BRANDS, INC. HEALTH AND WELFARE BENEFITS PLAN (formerly known and sued as Limited Brands, Inc. Health and Welfare Benefits Plan)

DATED: April 4, 2016

BRYAN CAVE LLP
William B. Brockman
Christopher L. Dueringer
Nancy Franco

/s/ William B. Brockman
William B. Brockman
Attorneys for Defendant MEDIANEWS GROUP WELFARE BENEFITS PLAN

DATED: April 4, 2016

BURKE WILLIAMS AND SORENSEN LLP
Melissa M. Cowan
Keiko J. Kojima

/s/ Melissa M. Cowan
Melissa M. Cowan
Attorneys for Defendant THE MILTON S. HERSHEY MEDICAL CENTER HEALTH AND WELFARE PLAN

DATED: April 4, 2016

GOODWIN PROCTER LLP
Hong-An Vu

/s/ Hong-An Vu
Hong-An Vu
Attorneys for Defendant VERTICAL SEARCH WORKS, INC. MEDICAL PLAN

DATED: April 4, 2016

BROWNE GEORGE ROSS LLP
Eric M. George
Keith J. Wesley

/s/ Eric M. George
Eric M. George
Attorneys for Defendant WEBMD HEALTH & WELFARE PLAN

DATED: April 4, 2016

BINGHAM GREENEBAUM DOLL LLP
Janet P. Jakubowicz (*Pro Hac Vice*)
Kate B. Ward (*Pro Hac Vice*)

NOSSAMAN LLP
James H. Vorhis
Jill N. Jaffe

/s/ Jill N. Jaffe
Jill N. Jaffe
Attorneys for Defendant HL FINANCIAL SERVICES, LLC EMPLOYEE BENEFITS PLAN

DATED: April 4, 2016

MUSICK, PEELER & GARRETT LLP
Dan Woods

/s/ Dan Woods
Dan Woods
Attorneys for Defendant ALLIANT INSURANCE SERVICES WELFARE BENEFITS PLAN

DATED: April 4, 2016

DRINKER BIDDLE & REATH LLP
David R. Levin
Monica A. Novak

/s/ David R. Levin
David R. Levin
Attorneys for Defendant TIME WARNER CABLE BENEFITS PLAN

DATED: April 4, 2016

MAYNARD COOPER & GALE, LLP
Christopher J. Rillo

/s/Christopher J. Rillo
Christopher J. Rillo
Attorneys for Defendant THE HARTFORD FIRE INSURANCE COMPANY EMPLOYEE MEDICAL AND DENTAL EXPENSE BENEFITS PLAN

DATED: April 4, 2016

WILSON ELSER MOSKOWITZ EDELMAN & DICKER LLP
Gary S. Pancer
Gregory K. Lee

/s/ Gregory K. Lee
Gregory K. Lee
Attorneys for Defendant FRANK CALANDRA, INC. MEDICAL PLAN, NHS HUMAN SERVICES WELFARE PLAN and SIERRA NEVADA BREWING CO. WELFARE BENEFITS PLAN

DATED: April 4, 2016

GREENSFELDER, HEMKER & GALE, P.C.
Amy L. Blaisdell
Lauren A. Daming

ROGERS NEMETH GERMAIN PC
Christopher M. Rogers

/s/ Christopher M. Rogers
Christopher M. Rogers
Attorneys for Defendant ASCENSION SMARTHEALTH MEDICAL PLAN

DATED: April 4, 2016

ALLEN MATKINS LECK GAMBLE MALLORY & NATSIS LLP
Alan Donal Hearty

PICKREL, SCHAEFFER, AND EBELING
Michael W. Sandner

/s/ Michael W. Sandner
Michael W. Sandner (Admitted *Pro Hac Vice*)
Attorneys for Defendant U.S. LBM HOLDINGS, LLC EMPLOYEE BENEFIT PLAN

DATED: April 4, 2016

LEWIS BRISBOIS BISGAARD & SMITH LLP
Elise D. Klein

/s/ Elise D. Klein
Elise D. Klein
Attorneys for Defendant UFCW LOCAL 555-EMPLOYERS HEALTH TRUST

DATED: April 4, 2016

LAQUER, URBAN, CLIFFORD & HODGE LLP
Susan Graham Lovelace
Michael Y. Jung

/s/ Susan Graham Lovelace
Susan Graham Lovelace
Attorneys for Defendant SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND

DATED: April 4, 2016

DECHERT LLP
Timothy C. Blank

/s/ Timothy C. Blank
Timothy C. Blank
Attorneys for Defendant ROCKET SOFTWARE GROUP INSURANCE BENEFIT PLAN

Filer's Attestation: Pursuant to Local Rule 5-4.3.4(a)(2)(i), Eileen R. Ridley hereby attests that concurrence in the filing of this document and its contents was obtained from all signatories listed.