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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SUZANNE KISTING-LEUNG, SAMANTHA DABABNEH, RANDALL RENTSCH, and CHRISTINA THORNHILL, individually and on behalf of all other similarly situated,

Plaintiffs,

v.

CIGNA CORPORATION, CIGNA HEALTH AND LIFE INSURANCE COMPANY, and DOES 1 through 50, inclusive,

Defendants.

Case No. 2:23-cv-01477-DAD-KJN

CIGNA'S NOTICE OF MOTION AND MOTION TO DISMISS THE SECOND AMENDED CLASS ACTION COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES

Date: June 4, 2024
Time: 1:30 P.M.
Judge Hon. Dale A. Drozd
Courtroom: 4, 15th floor
Second Am. Compl. Filed: December 18, 2023

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PLEASE TAKE NOTICE that on June 4, 2024 at 1:30 p.m. (or as soon thereafter as the matter may be heard in Courtroom 4, 15th Floor of the above-entitled Court), The Cigna Group (f/k/a Cigna Corporation) and Cigna Health and Life Insurance Company (together, "Cigna" or "Defendants") will move the Court for an for an order dismissing the Second Amended Complaint of Plaintiffs Suzanne Kisting-Leung, Samantha Dababneh, Randall Rentsch, and Cristina Thornhill, pursuant to Federal Rules of Civil Procedure 9(b), 12(b)(1), and 12(b)(6). The Motion is based on this Notice of Motion and Motion to Dismiss, the accompanying Memorandum of Points and Authorities, argument of counsel, and other such matters as the Court may consider.

Dated: February 1, 2024

Respectfully submitted,

By: */s/ Dmitriy Tishyevich*
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TABLE OF CONTENTS

INTRODUCTION 1
FACTUAL BACKGROUND 3
A. Overview of Plaintiffs' Allegations. 3
B. Cigna's PxDx Claims Review Process, and Plaintiffs' Lack of Showing of Any Plan Breach. 4
ARGUMENT 7
I. Plaintiffs Kisting-Leung and Thornhill Lack Article III Standing Because Their Claims Were Not Denied Through PxDx. 7
II. The Contract, Quasi-Contract, and Intentional Interference with Contract Claims (First, Third, Fourth and Fifth Causes of Action) Should All Be Dismissed. 8
A. The Claim for Breach of the Implied Covenant of Good Faith and Fair Dealing (First Cause of Action) Should Be Dismissed. 8
B. The Intentional Interference with Contractual Relations Claim (Third Cause of Action) Should Be Dismissed. 9
C. The Unjust Enrichment Claim (Fourth Cause of Action) Should Be Dismissed. 10
D. The Breach of Contract Claim (Fifth Cause of Action) Should Be Dismissed. 11
III. Plaintiffs' California UCL Claim (Second Cause of Action) Should Be Dismissed. 12
A. Plaintiffs Fail To Plead Count II With Particularity Under Rule 9(b). 12
B. Plaintiffs Fail To Plausibly Plead a UCL Claim Under Rule 8. 14
IV. ERISA Preempts Plaintiffs' State-Law Claims. 16
CONCLUSION 18

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1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

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TABLE OF AUTHORITIES

Page(s)

Cases

Adtrader, Inc. v. Google LLC,
2018 WL 3428525 (N.D. Cal. July 13, 2018)....10

Aerojet Rocketdyne, Inc. v. Glob. Aerospace, Inc.,
2020 WL 3893395 (E.D. Cal. July 10, 2020)....14

Aetna Health Inc. v. Davila,
542 U.S. 200 (2004)....16, 17, 18

In re Ambry Genetics Data Breach Litig.,
567 F. Supp. 3d 1130 (C.D. Cal. 2021)....11

Ashcroft v. Iqbal,
556 U.S. 662 (2009)....16

Brodsky v. Apple Inc.,
445 F. Supp. 3d 110 (N.D. Cal. 2020)....10

Caraccioli v. Facebook, Inc.,
167 F. Supp. 3d 1056 (N.D. Cal. 2016), *aff'd*, 700 F. App'x 588 (9th Cir. 2017)....11

Cleghorn v. Blue Shield of Cal.,
408 F.3d 1222 (9th Cir. 2005)....18

Egelhoff v. Egelhoff ex rel. Breiner,
532 U.S. 141 (2001)....17

Fresno Motors, LLC v. Mercedes Benz USA, LLC,
771 F.3d 1119 (9th Cir. 2014)....9

Gilliland v. Chase Home Fin., LLC,
2014 WL 325318 (E.D. Cal. Jan. 29, 2014)....9

Gobeille v. Liberty Mut. Ins. Co.,
577 U.S. 312 (2016)....17

Gonzaba v. Bd. of Trs. of S. Cal. Const. Laborers,
2013 WL 1694602 (S.D. Cal. Apr. 18, 2013)....17

Great Pac. Sec. v. Barclays Cap., Inc.,
743 F. App'x 780 (9th Cir. July 30, 2018)....13

Hadley v. Kellogg Sales Co.,
243 F. Supp. 3d 1074 (N.D. Cal. 2017)....16

Height St. Skilled Care, LLC v. Liberty Mut. Ins. Co.,
2022 WL 1665220 (E.D. Cal. May 25, 2022) 14

Hunt v. Zuffa, LLC,
2021 WL 4355728 (9th Cir. Sept. 24, 2021) 10

Kearns v. Ford Motor Co.,
567 F.3d 1120 (9th Cir. 2009) 12, 13

Lopez v. Stages of Beauty, LLC,
307 F. Supp. 3d 1058 (S.D. Cal. 2018)....................1, 16

Meridian Treatment Servs. v. United Behav. Health,
2020 WL 7000073 (N.D. Cal. July 20, 2020)....................9

Miller v. Taryle,
2013 WL 12205851 (C.D. Cal. Sept. 10, 2013) 14

Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41 (1987)....................17, 18

Plastino v. Wells Fargo Bank,
873 F. Supp. 2d 1179 (N.D. Cal. 2012) 8, 9

PM Grp., Inc. v. Stewart,
154 Cal. App. 4th 55 (2007) 9

Rutledge v. Pharm. Care Mgmt. Ass'n,
592 U.S. 80 (2020)....................17

Rutter v. Apple Inc.,
2022 WL 1443336 (N.D. Cal. May 6, 2022)....................9, 11

Saloojas, Inc. v. Cigna Healthcare of Cal., Inc.,
2022 WL 5265141 (N.D. Cal. Oct. 6, 2022)....................12

Sarkisyan v. CIGNA Healthcare of Cal., Inc.,
613 F. Supp. 2d 1199 (C.D. Cal. 2009) 17, 18

Satvati v. Allstate Northbrook Indem. Co.,
634 F. Supp. 3d 792 (C.D. Cal. 2022) 11

Spokeo, Inc. v. Robins,
578 U.S. 330 (2016)....................7

Swartz v. KPMG LLP,
476 F.3d 756 (9th Cir. 2007) 14

In re Toyota Motor Corp. Unintended Accel. Mktg., Sales Pracs., & Prod. Liab. Litig.,
754 F. Supp. 2d 1145 (C.D. Cal. 2010) 13

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United Food & Com. Workers Cent. Pa. & Regional Health & Welfare Fund v. Amgen, Inc., 400 F. App'x 255 (9th Cir. 2010) 12

Vang v. Geil Enters. Inc., 2023 WL 3168513 (E.D. Cal. Apr. 28, 2023)....18

Vess v. Ciba-Geigy Corp. USA, 317 F.3d 1097 (9th Cir. 2003) 12

Way v. JP Morgan Chase Bank, N.A., 2018 WL 2117630 (E.D. Cal. May 8, 2018) 2

White v. Lee, 227 F.3d 1214 (9th Cir. 2000) 2

Wise v. Verizon Commc'ns, Inc., 600 F.3d 1180 (9th Cir. 2010) 3, 17

Zhang v. Super. Ct., 57 Cal. 4th 364 (2013) 14

Statutes

Cal. Bus. & Prof. Code § 17200 ....12, 14, 18

Cal. H&S Code § 1367.01(e)....14, 15

Cal. H&S Code § 1367.01(h)(4)....15

Cal. Ins. Code § 790.03....14, 15

Other Authorities

10 C.C.R. § 2695.1....14, 15

10 C.C.R. § 2695.7....14, 15

Fed. R. Civ. P. 8....12, 14, 16

Fed. R. Civ. P. 9(b) .... *passim*

Fed. R. Civ. P. 12(b) 1, 2

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Defendants The Cigna Group (f/k/a Cigna Corporation) and Cigna Health and Life Insurance Company (together, "Cigna" or "Defendants") respectfully submit this memorandum of points and authorities in support of their motion, pursuant to Federal Rules of Civil Procedure (9)(b), 12(b)(1) and 12(b)(6), to dismiss the Second Amended Complaint ("SAC").

INTRODUCTION[1]

On March 25, 2023, a media organization called ProPublica published a misleading and inflammatory article about Cigna's use of a claims review process called Procedure-to-Diagnosis (PxDx). A series of lawsuits followed, including this one—all based on a fundamental misunderstanding about how the PxDx claims review process works and when Cigna uses it.

After Plaintiffs filed their original complaint, Cigna's counsel had multiple discussions with Plaintiffs' counsel about its various deficiencies, after which Plaintiffs filed two amended complaints. But despite having now had three opportunities to plead their claims, Plaintiffs still have not stated one. The problems start with Plaintiffs' assumption that PxDx is an "illegal scheme" (SAC ¶ 1) that Cigna implemented to deny plan members their covered benefits, because Plaintiffs do not plead any facts to show such a fraudulent and unlawful scheme. Indeed, the ProPublica article from which Plaintiffs borrow most of their factual allegations itself provides a much more pedestrian explanation of PxDx from Dr. Alan Muney—Cigna's former Chief Medical Officer, who helped develop the PxDx process.[2]

As Dr. Muney explained it, the PxDx process was "designed to prevent claims for care that Cigna considered unneeded or even harmful to the patient," and it "simply allowed Cigna to cheaply identify claims that it had a right to deny"—i.e., non-covered claims. (*See* https://perma.cc/4RPS-

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[1] Unless otherwise noted, all emphasis has been added, and all citations, alterations, and internal quotation marks have been omitted. References to "Ex. __" are to the corresponding exhibits attached to the Declaration of Dmitriy Tishyevich filed herewith. References to "Kessel Decl." are to the Declaration of Dr. Julie B. Kessel filed herewith, and references to "Kessel Ex. __" are to the corresponding exhibits attached to the Kessel Declaration.

[2] *See* https://perma.cc/4RPS-5QL3. Because the SAC cites to and relies on this article (*see, e.g.*, SAC ¶ 66 ("On or around March 25, 2023, Mr. Rentsch discovered through an article published by ProPublica that the Cigna Defendants had been using the PXDX algorithm to review patients' claims")), the Pro Publica article is "incorporated by reference" into the complaint. *Lopez v. Stages of Beauty, LLC*, 307 F. Supp. 3d 1058, 1064 (S.D. Cal. 2018).

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5QL3.) Thus, rather than being some unlawful scheme to fill Cigna's pockets, PxDx simply checks whether certain specific treatments that providers are ordering are actually covered by the member's benefit plan. And as Dr. Muney also described it, other payors have similar systems too: "[Dr.] Muney and his team had solved the problem once before. At UnitedHealthcare, where [Dr.] Muney was an executive, he said his group built a similar system to let its doctors quickly deny claims in bulk." (*Id.*)

Not surprisingly in light of this background, Plaintiffs have not plausibly alleged any of their claims. To start, the claims that two of the named Plaintiffs—Kisting-Leung and Thornhill—allege were improperly denied were not actually denied through PxDx, as shown in the declaration of Cigna's Dr. Julie Kessel, which defeats their allegation that Cigna's use of PxDx deprived them of their covered benefits.[3] (*See* SAC ¶ 1 (alleging that Cigna's use of PxDx results in denial of payments for procedures "owed to them under Cigna's health insurance policies"—*i.e.*, covered procedures).) For this reason alone, these two named Plaintiffs' claims should be dismissed for lack of Article III standing.

Even setting that aside, Plaintiffs have not pled key elements of any of their claims. Count I (breach of the implied covenant of good faith and fair dealing) should be dismissed because Plaintiffs have failed to "identify the specific contractual provision [in their benefit plans] that was frustrated" by Cigna's use of PxDx, as they must. *See Way v. JP Morgan Chase Bank, N.A.*, 2018 WL 2117630, at *3 (E.D. Cal. May 8, 2018). Count II (a claim under California's Unfair Competition Law) should be dismissed for multiple reasons, including most fundamentally because Plaintiffs' complaint sounds in fraud, yet they fail to plead their UCL claim in accordance with the heightened requirements of Rule 9(b).

Count III (intentional interference with contractual relations) should be dismissed because Plaintiffs have alleged that Cigna is a signatory to the contracts (the benefit plans) with which it allegedly interfered, but Cigna cannot tortiously interfere with its own contract. Count IV (unjust

[3] In challenging standing, Cigna is permitted to make a fact-based Rule 12(b)(1) motion and proffer evidence beyond the pleadings. *See, e.g.*, *White v. Lee*, 227 F.3d 1214, 1242 (9th Cir. 2000) ("With a factual Rule 12(b)(1) attack . . . a court may look beyond the complaint[.]"). The Court may thus consider Cigna's declaration in deciding Cigna's challenge to Kisting-Leung's and Thornhill's standing.

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enrichment) should be dismissed because a quasi-contract claim fails as a matter of law when plaintiff alleges that there is a valid and enforceable contract at issue, as Plaintiffs do here. Count V (breach of contract) should be dismissed because Plaintiffs do not identify the specific provision of their plans that Cigna allegedly breached by using PxDx.

Finally, all of Plaintiffs' state-law claims should also be dismissed because they are preempted by ERISA. All these state-law claims are premised on Cigna allegedly using PxDx to deny Plaintiffs their covered benefits, and they hinge on whether the services that Plaintiffs obtained were actually required to be covered by their benefit plans. Where, as here, "the existence of an ERISA plan is a critical factor in establishing liability under a state cause of action, the state law claim is preempted." *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010).

For all these reasons, and more below, all of Plaintiffs' claims should be dismissed.

FACTUAL BACKGROUND

A. Overview of Plaintiffs' Allegations.

Plaintiffs bring this suit challenging Cigna's PxDx review process. Drawing primarily on a March 2023 ProPublica article, Plaintiffs allege (without any factual basis) that PxDx was an "illegal scheme to systematically, wrongfully, and automatically deny its insureds the thorough, individualized physician review of claims guaranteed to them by California law ***and, ultimately, the payments*** for necessary medical procedures owed to them under Cigna's health insurance policies." (SAC ¶ 1.) Thus, the core premise of Plaintiffs' lawsuit is that Cigna supposedly used PxDx to deny claims for services that should have been covered under their benefit plans. As detailed below, however, Plaintiffs do not offer any facts to support this premise.

Plaintiffs also describe PxDx as essentially a scheme to defraud—accusing Cigna of making "deceptive and misleading representations to Plaintiffs and Class members" about Cigna's use of PxDx. (*Id.* ¶ 8.) Plaintiffs do not identify any specific alleged misrepresentations, however. Instead, they point to a phrase on Cigna's website that states "we've got you covered," and Plaintiffs say that this phrase translates to an actionable promise that "Cigna would conduct a thorough, fair, and objective review of their claims." (*See id.*) But the broad and general phrase "we've got you covered" on a website is not a promise of coverage for a specific claim, nor does it even mention PxDx or

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medical necessity review. And that Cigna website moreover includes a disclaimer that "[a]ll insurance policies and group benefit plans contain exclusions and limitations." (Ex. A at 12.)

The four named Plaintiffs—Suzanne Kisting-Leung ("Kisting-Leung"), Samantha Dababneh ("Dababneh"), Randall Rentsch ("Rentsch"), and Cristina Thornhill ("Thornhill")—are all California citizens. (SAC ¶¶ 13-16). They bring five state-law claims, and they purport to represent a class of "all persons who had purchased health insurance from Cigna in the State of California during the period of four years prior to the filing of the complaint through the present" (*id.* ¶ 79), and a subclass consisting of all such persons "whose claims were reviewed and denied using the PXDX algorithm" in that same time period. (*Id.* ¶ 81.)

B. Cigna's PxDx Claims Review Process, and Plaintiffs' Lack of Showing of Any Plan Breach.

Cigna administers "benefits for covered health services" for its clients' health benefit plans. (*See id.* ¶ 20.) Cigna does so in accordance with plan terms: as Plaintiffs recognize, Cigna members have benefit plans that set the terms and limits of their healthcare coverage. (*See, e.g.*, *id.* ("The Cigna Defendants provided plaintiffs and Class members with ***written terms*** explaining the plan coverage Cigna offered them"); *id.* ¶ 1 (challenging Cigna's denials of payments for procedures allegedly "owed to [Plaintiffs] under Cigna's health insurance policies").)

A key part of claims administration services that Cigna provides to plans is to ensure that the plan only pays for services that (among other things) the plan actually covers. (*See id.* ¶ 20 (alleging that according to plan terms, "Cigna must provide benefits for ***covered*** health services[.]").) PxDx is one way that Cigna checks incoming claims for compliance with plan benefit limitations—because as Dr. Muney described it in the Pro Publica article on which Plaintiffs rely, the PxDx process was intended to "simply allow[] Cigna to cheaply identify claims that it had a right to deny."

As Plaintiffs acknowledge, if the PxDx system identifies such a non-covered claim, Cigna will send the member a letter explaining why the claim was denied. (*See, e.g.*, *id.* ¶¶ 47-48 (Dababneh acknowledging that she "received a denial letter from Cigna stating that Cigna was denying her claim because it was 'not medically necessary,'" and that "the denial letter indicated that the PXDX algorithm reviewed her claim"); *id.* ¶ 56 (same allegations for Rentsch).)

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A core premise of Plaintiffs' case is that all these denials were supposedly contrary to the terms of their benefit plans—*i.e.*, that Cigna should have adjudicated their claims as covered, but it instead improperly denied them through PxDx. (*See id.* ¶ 1 (alleging that Cigna used PxDx to deny "payments for necessary medical procedures owed to [Plaintiffs] under Cigna's health insurance policies").) But as described below, not one of these named Plaintiffs has shown that their claim denials were contrary to plan terms.

Dababneh alleges that she received a test for a Vitamin D deficiency in September 2022, and that she then "received a denial letter from Cigna stating that Cigna was denying her claim because it was 'not medically necessary.'" (*Id.* ¶¶ 46-47.) Dababneh likewise does not identify any plan terms to show that any of these denials were contrary to plan terms or that anything in her benefit plan would preclude Cigna from using a claims review process like PxDx. (*See id.* ¶¶ 45-51.)

Rentsch alleges that he received four transforaminal epidurals between June 2016 and February 2017 as treatment for a pinched nerve, with Cigna denying coverage for these claims as "not medically necessary." (*Id.* ¶¶ 53-54, 56, 58-59, 62-65). Like the other named Plaintiffs, Rentsch does not identify any plan terms to show that any of these denials were incorrect, nor does he identify anything in his benefit plan that would preclude Cigna from using a claims review process like PxDx. (*See id.* ¶¶ 52-68.)

Unlike Plaintiffs Dababneh and Rentsch, Kisting-Leung and Thornhill do not allege that they had received denial letters which indicated that their claims were denied through PxDx. There is good reason why: as explained in the Declaration of Cigna's Dr. Julie B. Kessel, their claims as referenced in the SAC in fact were not denied through Cigna's PxDx review process.

Kisting-Leung alleges that she underwent two transvaginal ultrasounds, on October 17 and November 30, 2022, and that Cigna denied these services as "not medically necessary." (*Id.* ¶¶ 33-34, 37-38.) She does not identify anything in her benefit plan to show that these services were, in fact, medically necessary or that they should have been covered. Nor does she identify anything in her benefit plan that would preclude Cigna from using a claims-review process like PxDx to review claims for compliance with benefit plan limitations. (*See id.* ¶¶ 32-44.)

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Kisting-Leung alleges—only "upon information and belief"—that "Cigna Defendants used the PXDX system to 'review' and deny [her] claims." (*Id.* ¶ 41.) But that is not true. Rather than being denied through PxDx, the Explanation of Benefit forms for these claims indicate that they were denied as non-covered under Ms. Kisting-Leung's benefit plan, with a code stating that "the submitted code is denied because it's related to a service that your plan doesn't cover. Please refer to your plan booklet." (*See* Kessel Decl. ¶ 12; *see also* Kessel Ex. 1 at 3; Kessel Ex. 2 at 3.) Thus, Cigna's records do not show that these claims for transvaginal ultrasound were denied through PxDx.

Thornhill alleges that after discovering an "asymmetric mol[e] on her skin,"[4] she received some unspecified "oncology and gene expression profiling" in September 2022, which Cigna denied as "not medically necessary." (SAC ¶¶ 70, 72-73.) Thornhill also does not identify any plan terms to show that this "oncology and gene expression profiling" procedure should have been covered, nor any plan terms that would preclude Cigna from using PxDx.

Like Kisting-Leung, Thornhill alleges—also "upon information and belief" only—that her claim was denied through PxDx. (*See id.* ¶¶ 75-76.) Here, again, that was not the case. In fact, Cigna's review indicates that Ms. Thornhill's claim was denied after Cigna issued an Explanation of Benefits form that stated that Cigna "need[s] more information about this claim to determine if the services received were medically necessary," and that if Cigna does not "receive the information[,] we'll have to close the claim." (Kessel Decl. ¶ 16; *see also* Kessel Ex. 3 at 3.) Two months later, Cigna issued another EOB that stated: "We need medical records to process this claim. We have requested but not yet received it. We've closed the claim." (Kessel Decl. ¶ 18; *see also* Kessel Ex. 4 at 3.) Thus, Cigna's records do not show that this claim was denied through PxDx, contrary to Thornhill's allegations.

[4] The SAC refers to an "asymmetric mold" rather than "mole" throughout, but from context, Cigna assumes that these references are meant to be to an "asymmetric mole."

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ARGUMENT

I. Plaintiffs Kisting-Leung and Thornhill Lack Article III Standing Because Their Claims Were Not Denied Through PxDx.

Plaintiffs allege that they were injured because by using PxDx, Cigna denied their claims for services that allegedly should have been covered under the terms of their benefit plans. (*See* SAC ¶ 1 ("This action arises from Cigna's illegal scheme to systematically, wrongfully, and automatically deny its insureds the thorough, individualized physician review of claims guaranteed to them by California law and, ultimately, ***the payments*** for necessary medical procedures owed to them under Cigna's ***health insurance policies***.").) And all Plaintiffs—including Kisting-Leung and Thornhill—tie their alleged injuries to these PxDx denials, alleging that they "had their claims rejected by Cigna using the PXDX system." (*Id.* ¶ 5.)

But this injury theory does not square with the claims that Kisting-Leung and Thornhill allege Cigna improperly denied—because the records for these claims show that they were not, in fact, denied through Cigna's PxDx claims review process. (*See supra* 5-6; Kessel Decl. ¶¶ 12-20.) Because Kisting-Leung and Thornhill have not shown an "injury in fact"—"an invasion of a legally protected interest that is concrete and particularized and actual or imminent, not conjectural or hypothetical," *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016), they have no Article III standing to pursue recovery for these claims and they should be dismissed from this suit.

Kisting-Leung (but not Thornhill) alleges that if she had "known that the Cigna Defendants would evade the legally required process for reviewing her claims and delegate that process to its PXDX algorithm to review and deny claims, she would not have enrolled with Cigna or at most would only have paid less for it." (SAC ¶ 44.) But Kisting-Leung does not support this speculative statement with any alleged facts. Moreover, this theory would still turn on whether Cigna had in fact denied her claims using PxDx—otherwise Kisting-Leung would have felt no impact from her plan's use of PxDx, because she personally would have received the exact coverage she bargained for. Because Kisting-Leung does not identify any claims under her plan that were actually subject to PxDx, she cannot make that showing.

Thus, with no Article III standing, Kisting-Leung's and Thornhill's claims should be dismissed.

II. The Contract, Quasi-Contract, and Intentional Interference with Contract Claims (First, Third, Fourth and Fifth Causes of Action) Should All Be Dismissed.[5]

Plaintiffs premise their First, Third, Fourth, and Fifth Causes of Action on their assumption that Cigna breached some obligation to them by using the PxDx process to review their claims. Plaintiffs have not plausibly pled their breach of contract or implied covenant claims, because they have not identified any contractual provisions that Cigna allegedly breached or frustrated. Plaintiffs' quasi-contract claims should be dismissed because their and Cigna's rights and obligations are governed by written contracts—Plaintiffs' benefit plans. Finally, Plaintiffs' claim for intentional interference should also be dismissed because Plaintiffs allege that Cigna is a party to the contracts with which it is allegedly interfering (Plaintiffs' benefit plans), and that claim is not available against a party to the contract.

A. The Claim for Breach of the Implied Covenant of Good Faith and Fair Dealing (First Cause of Action) Should Be Dismissed.

Plaintiffs' claim for breach of the implied covenant of good faith and fair dealing should be dismissed because to state this claim, "a plaintiff must identify the specific contractual provision that was frustrated," *Plastino v. Wells Fargo Bank*, 873 F. Supp. 2d 1179, 1191 (N.D. Cal. 2012), and Plaintiffs have not done that here.

Plaintiffs say that Cigna breached the implied covenant by "improperly delegating their claims review function to the PXDX system," by "allowing their medical directors to sign off on the denials in batches without reviewing each patient's file," and by "failing to have its medical directors conduct a thorough, fair, and objective investigation of each submitted claim[.]" (SAC ¶ 94.) But Plaintiffs do not try to link any of these supposed violations to any actual provisions in their benefit plans. (*See id.* ¶¶ 91-101.) Absent such allegations, Plaintiffs have not shown how Cigna's alleged use of PxDx would have frustrated any specific provisions in their benefit plans—which in turn means that they

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[5] As addressed in Section IV below, all these state-law counts are also preempted by ERISA, and should be dismissed for that reason as well.

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have not stated this implied covenant claim. *See Plastino*, 873 F. Supp. 2d at 1191 (dismissing where "Plaintiff has pointed to no specific contractual provision that was frustrated"); *Rutter v. Apple Inc.*, 2022 WL 1443336, at *7 (N.D. Cal. May 6, 2022) (dismissing because "implied covenants exist to protect express contractual provisions, and the Amended Complaint has failed to identify any"); *Gilliland v. Chase Home Fin., LLC*, 2014 WL 325318, at *4 (E.D. Cal. Jan. 29, 2014) (dismissing because "Plaintiff has not alleged a contractual obligation as required to establish a breach of an implied covenant of good faith and fair dealing").

B. The Intentional Interference with Contractual Relations Claim (Third Cause of Action) Should Be Dismissed.

In their tortious interference claim, Plaintiffs allege that they "entered into written contracts with Defendants [Cigna]" whereby Cigna was "required to pay for Plaintiffs' and Class Members' medically necessary services rendered by healthcare providers," and that Cigna "interfere[d] with the performance" of these benefit plan-contracts by allegedly "denying payments for medically necessary services without any basis." (SAC ¶¶ 125, 128.)

Plaintiffs' Third Cause of Action hinges on Plaintiffs' allegation that by using PxDx, Cigna interfered with contracts—benefit plans—to which Cigna is a party. This claim fails as a matter of law because it is a "long-standing proposition" of California law that "the tort cause of action for interference with contract does not lie against a party to the contract because one contracting party owes no general tort duty to another not to interfere with performance of the contract; its duty is simply to perform the contract according to its terms." *Fresno Motors, LLC v. Mercedes Benz USA, LLC*, 771 F.3d 1119, 1126 (9th Cir. 2014); *see also, e.g.*, *Meridian Treatment Servs. v. United Behav. Health*, 2020 WL 7000073, at *6 (N.D. Cal. July 20, 2020) (dismissing intentional interference claim because "the tort cause of action for interference with contract does not lie against a party to the contract"); *PM Grp., Inc. v. Stewart*, 154 Cal. App. 4th 55, 64-65 (2007) (reversing jury award because "the tort of intentional interference with contractual relations is committed only by strangers—interlopers who have no legitimate interest in the scope or course of the contract's performance," and "consequently, a contracting party is incapable of interfering with the performance of his or her own contract[.]").

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C. The Unjust Enrichment Claim (Fourth Cause of Action) Should Be Dismissed.

In the Fourth Cause of Action, Plaintiffs allege that Cigna was unjustly enriched "by delegating the claims review process to the automated PXDX system" and by "arbitrarily denying its insureds medical payments owed to them under Cigna's policies[.]" (SAC ¶¶ 136, 140.) Thus, like Plaintiffs' other legal theories, Count IV is premised on Plaintiffs' assumption that Cigna used PxDx to improperly deny them covered services. This claim should be dismissed for two reasons.

First and most fundamental: Plaintiffs cannot maintain this quasi-contract claim because as they repeatedly acknowledge throughout their complaint (including by bringing a breach of contract claim, Count V), their rights here are governed by valid written contracts—their benefit plans. (*See, e.g.*, *id.* ¶ 20 ("The Cigna Defendants provided Plaintiffs and Class members with ***written terms*** [i.e., terms in their benefit plans] explaining the plan coverage Cigna offered them.").)

"Courts have repeatedly held that a plaintiff may not plead the existence of an enforceable contract and simultaneously maintain a quasi-contract claim unless the plaintiff also pleads facts suggesting that the contract may be unenforceable or invalid." *Brodsky v. Apple Inc.*, 445 F. Supp. 3d 110, 133 (N.D. Cal. 2020); *see also, e.g.*, *Adtrader, Inc. v. Google LLC*, 2018 WL 3428525, at *11 (N.D. Cal. July 13, 2018) ("to assert such a claim [for unjust enrichment], Plaintiffs must allege that the parties do not have an enforceable contract"); *Hunt v. Zuffa, LLC*, 2021 WL 4355728, at *1 (9th Cir. Sept. 24, 2021) (plaintiff did not allege unjust enrichment in the alternative where he did not "allege or contend that . . . any . . . pertinent agreement is invalid."). The SAC has no such allegations. To the contrary, Plaintiffs allege that their benefit plans are valid and enforceable contracts as part of their breach of contract claim. (*See* SAC ¶ 144 ("Defendants formed an agreement and entered into a contract of insurance with Plaintiffs and the Class"); *also compare id.* ¶ 135 ("incorporate[ing] by reference all preceding allegations") *with id.* ¶ 92 (alleging that Cigna and plaintiffs "entered into written contracts . . . which provided for coverage for medical services[.]").) These allegations foreclose their unjust enrichment claim as a matter of law.

Second, Plaintiffs have not identified any terms in their benefit plans that would preclude Cigna from using a claims review process like PxDx to determine whether a claim is covered by the member's benefit plan. Nor have they identified any actionable affirmative promise by Cigna ***not*** to

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use a system like PxDx to review their claims. Absent something that would affirmatively preclude Cigna from using a process like PxDx (whether a provision in their benefit plans, or some other actionable promise that Cigna made to Plaintiffs), there is nothing "unjust" about Cigna doing so.

D. The Breach of Contract Claim (Fifth Cause of Action) Should Be Dismissed.

In Count V, Plaintiffs allege that Cigna was contractually obligated "to exercise its fiduciary duties to policyholders, abide by applicable state laws, and adequately review and inform policyholders prior to a claim denial" (*id.* ¶ 146), and they contend that Cigna's use of PxDx supposedly breached those obligations.

This claim should be dismissed for a simple reason: failure to plead breach. "To properly plead breach of contract, the complaint must identify the specific provision of the contract allegedly breached by the defendant." *Caraccioli v. Facebook, Inc.*, 167 F. Supp. 3d 1056, 1064 (N.D. Cal. 2016), *aff'd*, 700 F. App'x 588 (9th Cir. 2017); *see also, e.g.*, *Satvati v. Allstate Northbrook Indem. Co.*, 634 F. Supp. 3d 792, 797 (C.D. Cal. 2022) ("To survive a motion to dismiss, a plaintiff must identify a specific contract provision breached by the defendant."). Plaintiffs have not done so here. Their assertions about Cigna's supposed obligations are unsupported by any language from their benefit plans. (SAC ¶¶ 143-149.) And the absence of these specifics is telling: Plaintiffs have access to their own benefit plans, and they certainly could have identified supporting language from those plans if such language existed.

Without Plaintiffs identifying plan language to show the scope and extent of Cigna's obligations, there is no way for this Court to determine whether Cigna's use of PxDx would have actually breached those obligations. As courts routinely hold, the lack of such specifics mandates dismissal. *See, e.g.*, *Rutter*, 2022 WL 1443336, at *7 (dismissing where plaintiffs "failed to identify a provision in the iCloud Terms and Conditions" to support their breach of contract claim); *In re Ambry Genetics Data Breach Litig.*, 567 F. Supp. 3d 1130, 1143-44 (C.D. Cal. 2021) (dismissing for failure to "allege the specific provisions in the contract creating the obligation"); *Satvati*, 634 F. Supp. 3d at 797 (dismissing where "Plaintiffs fail[ed] to identify a Policy provision that Defendant breached").

III. Plaintiffs' California UCL Claim (Second Cause of Action) Should Be Dismissed.

The gist of Plaintiffs' UCL claim is the same as the other counts—Plaintiffs allege that as a result of Cigna's use of PxDx, they did not receive the benefits to which they are entitled under their benefit plans, which Plaintiffs allege was "unfair," "unlawful," and/or "fraudulent" under California Business & Professions Code Section 17200. (SAC ¶ 122 (as relief for the Section 17200 claim, seeking an order "enjoining Defendants from ***denying benefits*** owed to Cigna insureds through its scheme involving the PXDX processing system").) This Count fails under both Rules 9(b) and 8.

A. Plaintiffs Fail To Plead Count II With Particularity Under Rule 9(b).

Section 17200 claims grounded in fraud are subject to Rule 9(b). *See Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1124-25 (9th Cir. 2009). This is true even "where fraud is not an essential element of a claim," but a plaintiff "choose[s] nonetheless to allege in the complaint that the defendant has engaged in fraudulent conduct" and "rel[ies] entirely on that course of conduct as the basis of [the] claim." *Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1103-05 (9th Cir. 2003); *United Food & Com. Workers Cent. Pa. & Regional Health & Welfare Fund v. Amgen, Inc.*, 400 F. App'x 255, 257 (9th Cir. 2010) ("Because the complaint sounded in fraud, all of its allegations are subject to Rule 9(b)'s pleading requirements. [. . .] Consequently, the district court properly dismissed the complaint in its entirety, including its UCL 'unlawful' and 'unfair' claims.").

Plaintiffs' complaint undoubtedly sounds in fraud because its premise is that Cigna used PxDx as a secret and fraudulent scheme to deny members their covered benefits. (*See, e.g.*, SAC ¶ 27 ("The Cigna Defendants fraudulently misled California insureds into believing that their health plan would individually assess their claims and pay for medically necessary procedures"); *id.* ¶ 8 ("Cigna also made deceptive and misleading representations to Plaintiffs and Class members regarding the efficiency of their services").) Because Plaintiffs' complaint sounds in fraud, all three prongs of their UCL claim are subject to Rule 9(b). *See Kearns*, 567 F.3d at 1127 (no error in district court applying Rule 9(b) to the entire UCL claim where the complaint "alleges a unified course of fraudulent conduct"); *Saloojas, Inc. v. Cigna Healthcare of Cal., Inc.*, 2022 WL 5265141, at *9 (N.D. Cal. Oct. 6, 2022) (noting that provider-plaintiff's UCL "claim invokes each prong of unfair competition" and

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applying Rule 9(b) to the entire UCL claim because "Saloojas's complaint undoubtedly sounds in fraud").

Rule 9(b) requires Plaintiffs to "state with particularity the circumstances constituting fraud[.]" In the Ninth Circuit, that means that Plaintiffs must "articulate the who, what, when, where, and how of the misconduct alleged." *Kearns*, 567 F.3d at 1126; *see also In re Toyota Motor Corp. Unintended Acceleration Mktg., Sales Pracs., & Prod. Liab. Litig.*, 754 F. Supp. 2d 1145, 1170 (C.D. Cal. 2010) (requiring plaintiff to "allege particular facts explaining the circumstances of the fraud, including time, place, persons, statements made[,] and an explanation of how or why such statements are false or misleading."). Despite three tries, Plaintiffs have not pled any such specifics. Plaintiffs identify only two alleged misrepresentations: (1) "Cigna's policies falsely claim that determinations related to medical necessity of health care services would be made by a medical director, when in reality the medical directors are not involved in reviewing patients' claims"; and (2) "Cigna'[s] website falsely states 'we've got you covered,' leading Plaintiff and Class members to believe that Cigna would conduct a thorough, fair, and objective review of their claims." (SAC ¶ 8.)

These assertions are not "particular facts explaining the circumstances of the fraud." As to the first theory, Plaintiffs do not identify what terms in their benefit plan support it. As to the second theory, Plaintiffs cannot seriously contend that an isolated phrase from www.cigna.com—which, in full context, states "Your health care needs change over the course of your lifetime. When they do, we've got you covered"— amounts to a legally-actionable promise by Cigna to review their claims in any particular way, or not to use a claims review process like PxDx. At any rate, that same Cigna website also has a disclaimer at the bottom which states "All insurance policies and group benefit plans contain exclusions and limitations." (Ex. A at 12.) A snippet from Cigna's website plainly cannot override plan benefit limitations.

Next, "plaintiffs alleging claims under the . . . UCL are required to plead and prove actual reliance on the misrepresentations or omissions at issue." *Great Pac. Sec. v. Barclays Cap., Inc.*, 743 F. App'x 780, 783 (9th Cir. July 30, 2018) (citing *Kwikset Corp. v. Super. Ct.*, 51 Cal. 4th 310, 326-27 (2011)). Plaintiffs here make the boilerplate assertion that they supposedly "relied on the Cigna Defendants' misrepresentations" (SAC ¶¶ 43, 68, 78)—but not one of them alleges that they even saw

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the "we've got you covered" phrase on Cigna's website or any alleged representations in the Cigna benefit plans before they decided to buy their health insurance. (*See id.* ¶ 8.) The UCL claim thus fails for this reason as well.

Finally, "in the context of a fraud suit involving multiple defendants, a plaintiff must, at a minimum, identify the role of each defendant in the alleged fraudulent scheme." *Swartz v. KPMG LLP*, 476 F.3d 756, 765 (9th Cir. 2007). Plaintiffs do not meet this requirement either. They allege that "Cigna" (collectively) had allegedly "made deceptive and misleading representations" (SAC ¶ 8), but they do not identify the alleged role that Cigna Corporation versus Cigna Health and Life Insurance Company had played in the alleged fraud. Dismissal is appropriate for this reason as well. *See Swartz*, 476 F.3d at 765 ("general allegations that the 'defendants' engaged in fraudulent conduct" are insufficient); *Miller v. Taryle*, 2013 WL 12205851, at *5-6 (C.D. Cal. Sept. 10, 2013) (dismissing where plaintiff "has not differentiated the allegations to put each Defendant on notice of its alleged participation in the fraud").

B. Plaintiffs Fail To Plausibly Plead a UCL Claim Under Rule 8.

Even if Rule 9(b) did not apply, Plaintiffs have not plausibly alleged their Section 17200 claim under Rule 8. In arguing that Cigna's conduct was "unlawful," Plaintiffs cite alleged violations of California Insurance Code § 790.03(h), California Code of Regulations title 10, § 2695.7, and California Health & Safety Code §1367.01(e) and (h(4). (SAC ¶¶ 109-114.) The first two cannot form the basis for a UCL claim because they are part of the Unfair Insurance Practices Act (UIPA), which "contemplate[s] only administrative enforcement by the Insurance Commission." *Zhang v. Super. Ct.*, 57 Cal. 4th 364, 384 (2013). Thus, "private UIPA actions are absolutely barred" and "a litigant may not rely on the proscriptions of section 790.03 as the basis for a UCL claim." *Id.* Likewise, "the regulations set forth in 10 C.C.R. section 2695.1 cannot be used as a predicate offense for an UCL claim of unlawfulness because those regulations are promulgated under the auspices of Insurance Code section 790.03(h).").[6] *Height St. Skilled Care, LLC v. Liberty Mut. Ins. Co.*, 2022 WL 1665220, at *5 (E.D. Cal. May 25, 2022).

[6] 10 C.C.R. § 2695.1 is the preamble to these UIPA regulations, which also include Section 2695.7. *See Aerojet Rocketdyne, Inc. v. Glob. Aerospace, Inc.*, 2020 WL 3893395, at *7 (E.D. Cal. July 10,

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Plaintiffs' allegations that Cigna's use of PxDx to review claims violated California Health & Safety Code § 1367.01(e) and (h)(4) (*see* SAC ¶ 113) fare no better. Section 1367.01(e) states:

> No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

This regulation prohibits persons who are not competent health care professionals from denying or modifying services for medical necessity reasons. As Plaintiffs acknowledge, the PxDx process allows Cigna's medical directors—doctors—to review claims and either approve or deny them. (*See* SAC ¶ 1 (alleging that Cigna uses PxDx to allow its "***doctors*** to automatically deny payments in batches of hundreds or thousands at a time.").) Plaintiffs do not allege that any individual other than a doctor or licensed health care professional reviewed their claims, which means they have not alleged a violation of this section.

Plaintiffs also try to support the "unlawful" prong with their allegation that Cigna's use of PxDx violated California Health & Safety Code Section 1367.01(h)(4)—by allegedly "fail[ing] to communicate to Plaintiffs and Class members in writing their decision to deny Plaintiffs' and Class members' claims and provide a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity, including the information as to how Plaintiffs and Class members may file a grievance with the plan[.]" (*Id.* ¶ 114.) Plaintiffs have not plausibly pled a violation of this regulation either because they acknowledge that in denying their claims, Cigna sent them letters that explained why the procedure was not covered. (*See id.* ¶ 34 (Kisting-Leung); *id.* ¶ 47 (Dababneh); *id.* ¶ 56 (Rentsch); *id.* ¶ 73 (Thornhill).)

Finally, Plaintiffs' attempts to rely on the "unfair" prong fail for two reasons. First, Plaintiffs do not plead any distinct "unfairness" UCL theory separate and apart from their "unlawful" or "fraudulent" UCL theories. (*See id.* ¶ 115.) For the reasons above, Plaintiffs have not pled either of

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2020) (finding that plaintiffs could not allege a violation of the unlawful prong based on 10 C.C.R. § 2695.7 because "neither Insurance Code section 790.03, nor its enabling regulation, 10 C.C.R. section 2695.1, can serve as the predicate offense for an 'unlawfulness' claim under the UCL.").

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those two prongs. Where "the unfair business practices alleged under the unfair prong of the UCL overlap entirely with the business practices addressed in the fraudulent and unlawful prongs of the UCL, the unfair prong of the UCL cannot survive if the claims under the other two prongs of the UCL do not survive." *Hadley v. Kellogg Sales Co.*, 243 F. Supp. 3d 1074, 1104-05 (N.D. Cal. 2017).

Second, Plaintiffs do not offer any well-pled facts to support their "unfair" prong, even under ordinary Rule 8 pleading standards. They assert that Cigna's use of PxDx "offend[s] established public policy and cause[s] harm to consumers that greatly outweighs any benefit associated with those practices" (SAC ¶ 115), but these are nothing more than "threadbare recitals of the elements of a cause of action" that do not satisfy Rule 8. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Finally, Plaintiffs also allege that Cigna's use of PxDx is unfair because it "constitute[s] a systematic breach of consumer contracts" (SAC ¶ 115)—but as explained *supra* at 11, Plaintiffs have not plausibly alleged any actual breach of contract here.

IV. ERISA Preempts Plaintiffs' State-Law Claims.

As the benefit plans of all four Plaintiffs show, all of them are subject to ERISA. (*See* Exs. B-F.)[7] Plaintiffs allege that Cigna's use of PxDx amounted to improper processing of their claims, as a result of which they allegedly did not receive their covered benefits under their plans. (*See, e.g.*, SAC ¶ 44 (alleging that Cigna "evade[d] the legally required process for reviewing [Plaintiffs'] claims"); *id.* ¶ 1 (alleging that Cigna's use of PxDx was a "scheme" to "ultimately, [deny] the payments for necessary medical procedures owed to them under Cigna's health insurance policies").) Plaintiffs, in effect, complain that they did not receive the benefits they were due under their ERISA-governed plans. ERISA—which "provide[s] a uniform regulatory regime over employee benefit plans," *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004)—provides the exclusive framework for Plaintiffs to challenge such denials.

[7] Plaintiffs reference these plans (or "health insurance policies") repeatedly throughout the complaint (*see, e.g.*, SAC ¶ 1), and they all allege that they were "covered by a health insurance policy provided by the Cigna Defendants." (*Id.* ¶¶ 13-16.) These plans are thus incorporated by reference into the SAC. *See Lopez*, 307 F. Supp. 3d at 1064.

To assess conflict (or defensive) preemption, courts disregard the "label affixed" to a state-law claim, and instead focus on its substance to determine if it is a disguised claim for ERISA benefits. *Id.* at 214. A state-law claim "relate[s] to" an employee benefit plan if it "has a reference to" or "an impermissible connection with ERISA plans." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319-20 (2016). This impermissible connection can be shown "where the existence of an ERISA plan is a critical factor in establishing liability under a state cause of action," in which case "the state law claim is preempted." *Wise*, 600 F.3d at 1190. State-law claims are also preempted when they "govern[] . . . a central matter of plan administration or interfere[] with nationally uniform plan administration," *Gobeille*, 577 U.S. at 319-20—and "payment of benefits" is, of course, "a central matter of plan administration." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001); *accord Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86-87 (2020) (ERISA is "primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, ***such as by requiring payment of specific benefits***").

The uniform regulatory regime that ERISA envisions would collapse if plaintiffs could "obtain remedies under state law that Congress rejected in ERISA." *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). That is why "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Davila*, 542 U.S. at 209; *Sarkisyan v. CIGNA Healthcare of Cal., Inc.*, 613 F. Supp. 2d 1199, 1208 (C.D. Cal. 2009) ("to the extent that Plaintiffs' claims are intended to rectify a wrongful denial of benefits promised under an ERISA-regulated plan, and not to remedy a violation of a legal duty independent of ERISA, the claims are preempted."); *Gonzaba v. Bd. of Trs. of S. Cal. Const. Laborers*, 2013 WL 1694602, at *1 (S.D. Cal. Apr. 18, 2013) ("common law claims seek[ing] to recover such benefits purportedly due" under an ERISA plan are preempted).

There is no doubt that recovery of plan benefits is what Plaintiffs are seeking here. The premise of their lawsuit is that Cigna allegedly used PxDx to deny them "payments for necessary medical procedures owed to them ***under Cigna's health insurance policies***" (SAC ¶ 1)—*i.e.*, payments allegedly owed under ERISA-governed benefit plans. And it doesn't make a difference whether

Plaintiffs try to recover their plan benefits through a breach of contract claim, or on an unjust enrichment theory, or through the UCL—because the broad scope of ERISA preemption cannot be avoided that easily. *See, e.g.*, *Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225-26 (9th Cir. 2005) (finding UCL claim preempted where "[plaintiff] sought benefits under the plan and did not receive them" because "these are precisely the kind of claims that the Supreme Court in *Davila* held to be pre-empted"); *Sarkisyan*, 613 F. Supp. 2d at 1205 (finding various state-law claims, including UCL, preempted because "ERISA plainly preempts Plaintiffs' claims to the extent that Plaintiffs seek redress for what they claim to be CIGNA's wrongful denial of benefits to their daughter").

Finally, to the extent Plaintiffs may argue that they are also disputing the way that Cigna processed their claims—*i.e.*, by allegedly using PxDx, and by Cigna's medical directors allegedly not reviewing the claims in enough detail (*see* SAC ¶ 24)—that theory would also be preempted because ERISA is the "exclusive vehicle" for challenges based on "improper processing of a claim for benefits." *See Dedeaux*, 481 U.S. at 51-52; *Sarkisyan*, 613 F. Supp. 2d at 1206 (finding Section 17200 claim "based on Cigna's alleged 'improper claims handling practices'" preempted); *Vang v. Geil Enters. Inc.*, 2023 WL 3168513, at *5 (E.D. Cal. Apr. 28, 2023) (finding claim based on "alleged improper withholding of benefits and the back dating [of] a notice required by law to be provided to [plaintiff]" preempted, "because these allegations are directly related to the administration of the [plan]").

CONCLUSION

Cigna respectfully requests that the Court dismiss the complaint in its entirety.

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Dated: February 1, 2024

Respectfully submitted,

By: */s/ Dmitriy Tishyevich*
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CERTIFICATE OF SERVICE

I hereby certify that on February 1, 2024, I electronically filed a true and correct copy of the foregoing document with the Clerk of the Court using the Court's CM/ECF system, which will send notice of the filing to counsel of record.

/s/ Dmitriy Tishyevich
Dmitriy Tishyevich

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SUZANNE KISTING-LEUNG, SAMANTHA DABABNEH, RANDALL RENTSCH, and CHRISTINA THORNHILL, individually and on behalf of all other similarly situated,

Plaintiffs,

v.

CIGNA CORPORATION, CIGNA HEALTH AND LIFE INSURANCE COMPANY, and DOES 1 through 50, inclusive,

Defendants.

Case No. 2:23-cv-01477-DAD-KJN

DECLARATION OF DMITRIY TISHYEVICH IN SUPPORT OF CIGNA'S MOTION TO DISMISS THE SECOND AMENDED COMPLAINT

Date: June 4, 2024
Time: 1:30 P.M.
Judge Hon. Dale A. Drozd
Courtroom: 4, 15th floor
Sec. Am. Complaint Filed: December 18, 2023

McDermott Will & Emery LLP
Attorneys At Law
Los Angeles

I, Dmitriy Tishyevich, hereby declare:

1. I am a partner of the firm McDermott Will & Emery LLP, attorneys for Defendants The Cigna Group and Cigna Health and Life Insurance Company (collectively, "Cigna"). I have personal knowledge of the facts stated herein, and if called as a witness, could and would testify competently thereto. I submit this Declaration in support of Cigna's Motion to Dismiss.

2. Attached hereto as Exhibit A is a true and correct copy of the Cigna website, available at www.cigna.com, accessed on January 31, 2024.

3. Attached hereto as Exhibit B is a true and correct copy of excerpts from the AMDOCS, Inc. health benefit plan applicable to the claims at issue for Plaintiff Suzanne Kisting-Leung.

4. Attached hereto as Exhibit C is a true and correct copy of excerpts from the Sunrun, Inc. health benefit plan applicable to the claim at issue for Plaintiff Samantha Dababneh.

5. Attached hereto as Exhibit D and Exhibit E are true and correct copies of excerpts from the Lennar Corporation health benefit plans applicable to the claims at issue for Plaintiff Randall Rentsch.

6. Attached hereto as Exhibit F is a true and correct copy of excerpts from the Becton Dickinson health benefit plan applicable to the claim at issue for Plaintiff Cristina Thornhill.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: February 1, 2024

/s/ Dmitriy Tishyevich
Dmitriy Tishyevich

EXHIBIT A

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Hey, Rookie

Case 2:23-cv-01477-DAD-KJN Document 28-2 Filed 02/01/24 Page 3 of 13

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Your health care needs change over the course of your lifetime. When they do, we've got you covered.

Feedback

Case 2:23-cv-01477-DAD-KJN Document 28-2 Filed 02/01/24 Page 4 of 13

Planning for the Unexpected

Supplemental insurance policies offer additional coverage and cash benefits when you need it most.

- Coverage for cancer, hospitalization, stroke and heart attack, accidents, and life insurance
- Cash benefits to use however you'd like[2]
- Typically come with budget-friendly monthly premiums
- Buy anytime, 24/7/365

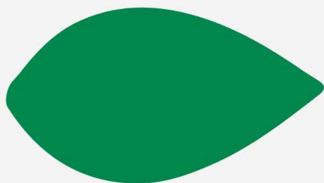
Feedback

Turning 65?

We can help you navigate your new world of Medicare.

- Flexible coverage options
- Plenty of no-cost perks
- 24/7 member support

Explore and shop our Medicare plans



Dental Care, *Covered*

Oral health affects **all** your health, both physical and mental.

- Dental coverage to fit a range of needs
- Plan options that bundle vision and hearing, too
- Coverage costs pennies a day
- Shop online anytime, 24/7/365

Shop and compare our Dental plans

Feedback

Feedback

Buying Medical Coverage On Your Own?

Cigna Healthcare offers quality plan options, personalized support, and low costs.

- Plans offer virtual care starting at $0[3] and come with $0 preventive care[4]
- Financial assistance available, if you qualify
- Additional coverage for diabetes and asthma/COPD, if needed
- Available for shopping during Open Enrollment (Nov 1-Dec 15, in most states)

See what Cigna Healthcare offers

Feedback

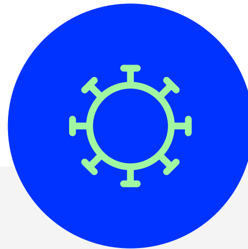
Getting Coverage Through Work?

If your employer is offering you Cigna Healthcare coverage, we can help you make an informed decision.

- Highlights of our plans and coverages
- Perks of all Cigna Healthcare medical plans
- Tools to look up in-network doctors and covered prescription drugs
- Additional coverage you can buy on your own

commitment

Feedback



Coronavirus (COVID-19) Resource Center

Find the latest information about vaccinations, testing, coverage, and more.

Visit the COVID-19 Resource Center

Also Popular

Insurance 101

Search Rx List

Member Guide

COVID Resources

Important Pharmacy Benefits Update

If you are a Cigna Healthcare customer with Pharmacy benefits, you may be able to get an emergency refill on your medication(s) if it was lost or damaged due to a recent natural disaster.

Learn more about Pharmacy updates in your area

Feedback

***Offered by Cigna Health and Life Insurance Company**

[1]Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.

[2]View Supplemental State Policy Disclosures, Exclusions, Limitations, and Reductions.

[3]$0 virtual care (no cost share) for eligible preventive care and Dedicated Virtual Urgent Care for minor acute medical conditions. Not available for all plans. HSA plans and non-minor acute medical care may apply a copay, coinsurance or deductible. Cigna Healthcare provides access to Dedicated Virtual Care through a national telehealth provider, MDLive located on myCigna, as part of your health plan. Providers are solely responsible for any treatment provided to their patients.

[4]Availability of $0 preventive care (no cost share) by plan may vary. Includes eligible in-network preventive care services. Some preventive care services may not be covered, including most immunizations for travel. Reference plan documents for a list of covered and non-covered preventive care services.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group℠, including Cigna Health and Life Insurance Company (Bloomfield, CT.) (CHLIC), Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc., Express Scripts, Inc., or their affiliates, and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of South Carolina, Inc., and Cigna HealthCare of Texas, Inc., Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries. In Utah, all products and services are provided by Cigna Health and Life Insurance Company (Bloomfield, CT). Policy forms: OK – HP-APP-1 et al., OR – HP-POL38 02-13, TN – HP-POL43/HC-CERIV1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

THESE POLICIES PAY LIMITED BENEFITS ONLY. THEY ARE NOT COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DO NOT COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE “MINIMIUM ESSENTIAL COVERAGE” OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT

(ACA). THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group insurance policies may contain exclusions, limitations, reduction in benefits, and terms under which the policy may be continued in force or discontinued. For costs and details of coverage, contact your Cigna Healthcare representative.

Accidental Injury, Critical Illness, and Hospital Care plans or insurance policies are distributed exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT). The Cigna Healthcare names, logos, and marks are owned by Cigna Intellectual Property, Inc.

This is a solicitation for insurance. An insurance agent/producer may contact you. Product availability varies by state. These policies contain exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. For cost and complete details of coverage, contact your insurance agent/producer or the company.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Loyal American Life Insurance Company. (Cleveland, OH)

This page is not intended for use in NM and WA.

Feedback

I want to...

Get an ID card

File a claim

View my claims and EOBs

Check coverage under my plan

See prescription drug list

Find an in-network doctor, dentist, or facility

Find a form

Find 1095-B tax form information

View the Cigna Healthcare Glossary

Contact Cigna Healthcare

Audiences

Individuals and Families

Medicare

Employers

Brokers

Providers

Secure Member Sites

myCigna member portal

Health Care Provider portal

Cigna for Employers

Client Resource Portal

Cigna for Brokers

The Cigna Group Information

About Cigna Healthcare

The Cigna Group

Careers

Newsroom

Investors

Suppliers

Third Party Administrators

International

Evernorth Health Services

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Privacy

Legal

Product Disclosures

Company Names

Customer Rights

Accessibility

Non-Discrimination Notice

Language Assistance [PDF]

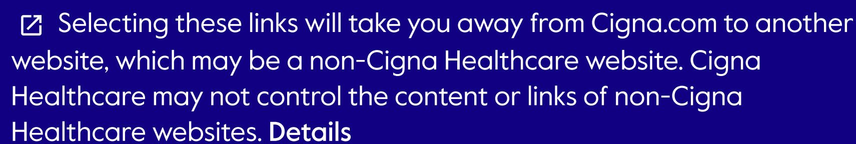
Report Fraud

Sitemap

Disclaimer

Individual and family medical and dental insurance plans are insured by Cigna Health and Life Insurance Company (CHLIC), Cigna HealthCare of Arizona, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of South Carolina, Inc., and Cigna HealthCare of Texas, Inc. Group health insurance and health benefit plans are insured or administered by CHLIC, Connecticut General Life Insurance Company (CGLIC), or their affiliates (see **a listing of the legal entities** that insure or administer group HMO, dental HMO, and other products or services in your state). Accidental Injury, Critical Illness, and Hospital Care plans or insurance policies are distributed exclusively by or through operating subsidiaries of The Cigna Group Corporation, are administered by Cigna Health and Life Insurance Company, and are insured by either (i) Cigna Health and Life Insurance Company (Bloomfield, CT); (ii) Life Insurance Company of North America ("LINA") (Philadelphia, PA); or (iii) New York Life Group Insurance Company of NY ("NYLGICNY") (New York, NY), formerly known as Cigna Life Insurance Company of New York. The Cigna Healthcare name, logo, and other Cigna Healthcare marks are owned by The Cigna Group Intellectual Property, Inc. LINA and NYLGICNY are not affiliates of The Cigna Group.

All insurance policies and group benefit plans contain exclusions and limitations. For availability, costs and complete details of coverage, contact a licensed agent or Cigna Healthcare sales representative. This website is not intended for residents of New Mexico.



Selecting these links will take you away from Cigna.com to another website, which may be a non-Cigna Healthcare website. Cigna Healthcare may not control the content or links of non-Cigna Healthcare websites. **Details**

Feedback

EXHIBIT B

Amdocs, Inc.

OPEN ACCESS PLUS MEDICAL
BENEFITS

Premier Plan

EFFECTIVE DATE: January 1, 2022

ASO107A

3209216; 2501522; 2501340; 2501339; 2501251; 2501106; 2500773; 2500658; 2500532; 2500372; 2499338; 2464158; 2464154

This document printed in May, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information 5
Special Plan Provisions 7
Important Notices 8
How To File Your Claim 10
Eligibility - Effective Date 11
- Employee Insurance 11
- Waiting Period 11
- Dependent Insurance 11

Important Information About Your Medical Plan 12
Open Access Plus Medical Benefits 13
- The Schedule 13
- Certification Requirements - Out-of-Network 33
- Prior Authorization/Pre-Authorized 33
- Covered Expenses 34

Prescription Drug Benefits 45
- The Schedule 45
- Covered Expenses 49
- Limitations 49
- Your Payments 51
- Exclusions 51
- Reimbursement/Filing a Claim 52

Exclusions, Expenses Not Covered and General Limitations 52
Coordination of Benefits 55
Expenses For Which A Third Party May Be Responsible 58
Payment of Benefits 59
Termination of Insurance 60
- Employees 60
- Dependents 60
- Rescissions 60

Medical Benefits Extension During Hospital Confinement 60
Federal Requirements 61
- Notice of Provider Directory/Networks 61
- Qualified Medical Child Support Order (QMCSO) 61
- Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 62
- Effect of Section 125 Tax Regulations on This Plan 63
- Eligibility for Coverage for Adopted Children 64
- Coverage for Maternity Hospital Stay 64
- Women's Health and Cancer Rights Act (WHCRA) 64

Group Plan Coverage Instead of Medicaid 64
Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA) 64
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 65
Claim Determination Procedures under ERISA 65
Appointment of Authorized Representative 67
Medical - When You Have a Complaint or an Appeal 67
COBRA Continuation Rights Under Federal Law 69
ERISA Required Information 72
Definitions 74

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY AMDOCS, INC. WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89

(e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

Amdocs, Inc. Medical Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Amdocs, Inc.
625 Maryville Center, #200
St. Louis, MO 63141
314-212-7000

Employer Identification Number (EIN):	Plan Number:
431339487	502

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it.

Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this

statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 05-15

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095 12-17

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

HC-DFS1480 01-21

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

HC-DFS1553 01-21

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840 10-16

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841 10-16

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

HC-DFS842 10-16

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly

EXHIBIT C

Sunrun, Inc.

OPEN ACCESS PLUS MEDICAL
BENEFITS

EFFECTIVE DATE: January 1, 2022

ASO21
3338372

This document printed in July, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information **4**

Special Plan Provisions **6**

Important Notices **7**

How To File Your Claim **9**

Eligibility - Effective Date **10**

Employee Insurance 10
Waiting Period 10
Dependent Insurance 10

Important Information About Your Medical Plan **11**

Open Access Plus Medical Benefits **12**

The Schedule 12
Certification Requirements - Out-of-Network 32
Prior Authorization/Pre-Authorized 32
Covered Expenses 33

Exclusions, Expenses Not Covered and General Limitations **43**

Coordination of Benefits **45**

Expenses For Which A Third Party May Be Responsible **48**

Payment of Benefits **50**

Termination of Insurance **50**

Employees 50
Dependents 51
Rescissions 51

Federal Requirements **51**

Notice of Provider Directory/Networks 51
Qualified Medical Child Support Order (QMCSO) 51
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 52
Effect of Section 125 Tax Regulations on This Plan 53
Eligibility for Coverage for Adopted Children 54
Coverage for Maternity Hospital Stay 54
Women's Health and Cancer Rights Act (WHCRA) 54
Group Plan Coverage Instead of Medicaid 54
Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA) 55
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 55
Claim Determination Procedures under ERISA 55
Appointment of Authorized Representative 57
Medical - When You Have a Complaint or an Appeal 57
COBRA Continuation Rights Under Federal Law 59
ERISA Required Information 62

Definitions **64**

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY SUNRUN, INC. WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89

coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

Sunrun Group Health Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Sunrun Inc.
225 Bush, Suite 1400
San Francisco, CA 94104
805-540-7643

Employer Identification Number (EIN):	Plan Number:
262841711	501

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

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If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 05-15

EXHIBIT D

LENNAR CORPORATION

OPEN ACCESS PLUS MEDICAL
BENEFITS

Health Reimbursement Arrangement

Premier Plan

EFFECTIVE DATE: January 1, 2016

ASO26a
3210080

This document printed in June, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information 5
Special Plan Provisions 7
Important Notices 8
How To File Your Claim 9
Eligibility - Effective Date 10
- Employee Insurance 10
- Waiting Period 10
- Dependent Insurance 10

Important Information About Your Medical Plan 11
Open Access Plus Medical Benefits 12
- The Schedule 12
- Certification Requirements - Out-of-Network 23
- Prior Authorization/Pre-Authorized 23
- Covered Expenses 24

Exclusions, Expenses Not Covered and General Limitations 32
Coordination of Benefits 34
Expenses For Which A Third Party May Be Responsible 37
Payment of Benefits 38
Termination of Insurance 39
- Employees 39
- Dependents 39
- Rescissions 39

Federal Requirements 39
- Notice of Provider Directory/Networks 39
- Qualified Medical Child Support Order (QMCSO) 39
- Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 40
- Effect of Section 125 Tax Regulations on This Plan 41
- Eligibility for Coverage for Adopted Children 42
- Coverage for Maternity Hospital Stay 42
- Women's Health and Cancer Rights Act (WHCRA) 43
- Group Plan Coverage Instead of Medicaid 43
- Requirements of Medical Leave Act of 1993 (as amended) (FMLA) 43
- Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 43
- Claim Determination Procedures under ERISA 44
- Medical - When You Have a Complaint or an Appeal 45
- COBRA Continuation Rights Under Federal Law 46
- ERISA Required Information 49

Definitions 51

What You Should Know About Cigna Choice Fund® – Health Reimbursement Account 59

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HC-NOT1

payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

LENNAR CORPORATION WELFARE BENEFIT PLAN

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

LENNAR CORPORATION
27240 Turnberry Lane

Suite 200
Valencia, CA 91355
661-600-0194

Employer Identification Number (EIN):	Plan Number:
954337490	502

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
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and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 05-15

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10 V1

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS2 04-10 V2

EXHIBIT E

Lennar Corporation

OPEN ACCESS PLUS MEDICAL BENEFITS

Health Reimbusement Account

EFFECTIVE DATE: January 1, 2017

ASO28

3210080

This document printed in January, 2018 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information 5
Special Plan Provisions 7
Important Notices 8
Important Information 8
How To File Your Claim 10
Eligibility - Effective Date 10
- Employee Insurance 10
- Waiting Period 11
- Dependent Insurance 11

Important Information About Your Medical Plan 11
Open Access Plus Medical Benefits 12
- The Schedule 12
- Certification Requirements - Out-of-Network 24
- Prior Authorization/Pre-Authorized 24
- Covered Expenses 25

Exclusions, Expenses Not Covered and General Limitations 33
Coordination of Benefits 36
Expenses For Which A Third Party May Be Responsible 39
Payment of Benefits 40
Termination of Insurance 40
- Employees 40
- Dependents 41
- Rescissions 41

Federal Requirements 41
- Notice of Provider Directory/Networks 41
- Qualified Medical Child Support Order (QMCSO) 41
- Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 42
- Effect of Section 125 Tax Regulations on This Plan 43
- Eligibility for Coverage for Adopted Children 44
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- Group Plan Coverage Instead of Medicaid 44
- Requirements of Medical Leave Act of 1993 (as amended) (FMLA) 45
- Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 45
- Claim Determination Procedures under ERISA 45
- Appointment of Authorized Representative 47
- Medical - When You Have a Complaint or an Appeal 47
- COBRA Continuation Rights Under Federal Law 48
- ERISA Required Information 52

Definitions..53

What You Should Know About Cigna Choice Fund® – Health Reimbursement Account 63

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HC-NOT89

ERISA Required Information

The name of the Plan is:

Lennar Corporation Welfare Benefit Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Lennar Corporation
27240 Turnberry Lane, Suite 200
Valencia, CA 91355
661-600-0194

Employer Identification Number (EIN):	Plan Number:
954337490	502

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

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The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

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HC-FED72 05-15

Definitions

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HC-DFS1 04-10
V1

EXHIBIT F

Becton Dickinson

OPEN ACCESS PLUS MEDICAL
BENEFITS

OAP

EFFECTIVE DATE: January 1, 2022

ASO36
3332071

This document printed in August, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information 4

Special Plan Provisions 6

Important Notices 7

How To File Your Claim 9

Eligibility - Effective Date 10

Employee Insurance 10
Waiting Period..10
Dependent Insurance 10

Important Information About Your Medical Plan 11

Open Access Plus Medical Benefits 12

The Schedule 12
Certification Requirements - Out-of-Network..36
Prior Authorization/Pre-Authorized 36
Covered Expenses 37

Exclusions, Expenses Not Covered and General Limitations 47

Coordination of Benefits..50

Expenses For Which A Third Party May Be Responsible 52

Payment of Benefits 53

Termination of Insurance..54

Employees 54
Dependents 54
Rescissions 54

Federal Requirements 54

Notice of Provider Directory/Networks..54
Qualified Medical Child Support Order (QMCSO) 54
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 55
Effect of Section 125 Tax Regulations on This Plan..56
Eligibility for Coverage for Adopted Children..57
Coverage for Maternity Hospital Stay..57
Women's Health and Cancer Rights Act (WHCRA) 58
Group Plan Coverage Instead of Medicaid..58
Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA) 58
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)..58
Claim Determination Procedures under ERISA 59
Appointment of Authorized Representative 60
Medical - When You Have a Complaint or an Appeal..60
COBRA Continuation Rights Under Federal Law 62
ERISA Required Information..66

Definitions..67

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY BECTON DICKINSON WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT89

coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66M 07-14

ERISA Required Information

The name of the Plan is:

Becton, Dickinson and Company Group Life and Health Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Becton, Dickinson and Company
1 Becton Drive
Franklin Lakes, NJ 07417-1815
201-847-6800

Employer Identification Number (EIN):	Plan Number:
220760120	501

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan’s decision or lack thereof concerning a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 M 05-15

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095 12-17

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Attorneys for Defendants
The Cigna Group (f/k/a Cigna Corporation) and
Cigna Health and Life Insurance Company

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SUZANNE KISTING-LEUNG, SAMANTHA DABABNEH, RANDALL RENTSCH, and CHRISTINA THORNHILL, individually and on behalf of all other similarly situated,

Plaintiffs,

v.

CIGNA CORPORATION, CIGNA HEALTH AND LIFE INSURANCE COMPANY, and DOES 1 through 50, inclusive,

Defendants.

Case No. 2:23-cv-01477-DAD-KJN

DECLARATION OF DR. JULIE B. KESSEL IN SUPPORT OF CIGNA'S MOTION TO DISMISS THE SECOND AMENDED COMPLAINT

Date: June 4, 2024
Time: 1:30 P.M.
Judge Hon. Dale A. Drozd
Courtroom: 4, 15th floor
Sec. Am. Complaint Filed: December 18, 2023

McDermott Will & Emery LLP
Attorneys At Law
Los Angeles

I, Julie B. Kessel, MD, hereby declare as follows.

1. I am employed by Cigna as a Medical Officer in the Clinical Performance and Quality department.

2. I am over 18 years of age and have personal knowledge of the matters set forth herein based on my experience and review of documents relevant to this case. If called upon, I could testify competently and truthfully to the matters discussed below.

3. As a Medical Officer at Cigna, I have had responsibility over Cigna's clinical coverage and review policies, including policies related to the clinical review process known as "procedure to diagnosis" review, or "PxDx." In the course of my work, I am generally familiar with Cigna's medical director review processes for claims that Cigna administers. During my time working at Cigna, I have become familiar with the kinds of claims documents and medical records that are typically reviewed in the course of reviewing, processing, and adjudicating a claim. As relevant to this case, and as explained in more detail below, I have reviewed various claims documents relating to claims from Plaintiff Kisting-Leung and Plaintiff Thornhill as referenced in the Second Amended Complaint ("SAC").

4. I submit this declaration in support of Cigna's Motion to Dismiss the Second Amended Complaint, and to respond to the allegation that (1) Plaintiff Kisting-Leung's claims from 2022 for two transvaginal ultrasounds (the "Kisting-Leung Claims") and (2) Plaintiff Thornhill's 2022 claim for gene expression profiling ("Thornhill Claim," and together with the Kisting-Leung Claims, the "Claims") were denied through Cigna's PxDx review process. (*See* SAC ¶¶ 32-44, 69-78.)

5. As I explain below, my investigation, including my review of Ms. Kisting-Leung's and Ms. Thornhill's claims documents, shows that their Claims were not denied through Cigna's PxDx review process.

I. CIGNA'S PXDX REVIEW PROCESS

6. The following is a brief overview of Cigna's business and how and when Cigna applies its PxDx review process, which will help explain and provide additional context for my conclusion that this process was not applied to the Claims.

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Attorneys At Law
Los Angeles

7. Cigna is a healthcare insurance and benefits company that administers claims, including for employer-sponsored health benefit plans. The health benefit plans for which Cigna administers claims have various coverage limitations. When Cigna adjudicates claims for these plans, Cigna reviews claims to make sure that, among other things, the service at issue is covered under the patient's health benefit plan, including that the claim is for a medically necessary service.

8. PxDx is one of the review processes that Cigna uses to determine whether the service at issue is covered by the member's plan, including the medical appropriateness of that service. Cigna's PxDx process is applied to review claims only after a patient has already received the service.

9. If a claim was denied through Cigna's PxDx review process, both the patient and the provider will receive an "Explanation of Benefits" ("EOB") or "Explanation of Payments" ("EOP") document that generally includes a denial reason based on medical necessity (or in some instances, explaining that the service was considered experimental, investigational, or unproven under Cigna's clinical coverage policies). Additionally, both the patient and the provider will also receive a letter that outlines the specific service billed, the non-approved diagnosis code submitted, and the applicable coverage policy supporting the coverage denial.

II. CIGNA'S PXDX REVIEW PROCESS WAS NOT USED TO DENY KISTING-LEUNG'S AND THORNHILL'S CLAIMS.

10. I have reviewed the EOBs associated with the Claims. With respect to Ms. Kisting-Leung, neither of the EOBs for her two transvaginal ultrasounds, with dates of service on August 19, 2022 and November 30, 2022, show that those claims were denied through Cigna's PxDx review process. Similarly, the EOBs for Ms. Thornhill's claim on September 19, 2022 show that her claim was not denied through PxDx review.

11. EOBs are claim documents that the administrator of the patient's healthcare claims will send to the patient after the claim has been adjudicated. Like the name Explanation of Benefits suggests, EOBs typically show (among other things) the services billed on a particular claim; the date of those services; the amounts billed by the provider; any applicable in-network provider discounts from those billed charges; the amounts covered under the patient's benefit plan (*i.e.*, the "allowed amount"); any amounts not covered under the terms of the benefit plan; the applicable patient

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

responsibility (*i.e.*, the amounts that the patient owes for the plan's out-of-pocket deductible, copay, or coinsurance amounts); and the amounts paid by the plan.

A. The Kisting-Leung Claims Were Not Denied Through PxDx Review.

12. I have reviewed the EOBs associated with the August 19 and November 30, 2022 transvaginal ultrasound services discussed in the Complaint, which are attached as **Exhibit 1** and **Exhibit 2** to this Declaration. The remark code associated with Ms. Kisting-Leung's denials stated that "[t]he submitted code is denied because it's related to a service that your plan doesn't cover. Please refer to your plan booklet." This remark code is not the kind of medical necessity denial remark code that is typically used for claims that are reviewed and denied using the PxDx process, and is instead the kind of remark code used to indicate lack of coverage for the service at issue under the member's benefit plan.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
MATTHEW M TREINEN DO, Claim # 4652226997952											
08/19/22	RADIOLOGIST	99.00	0.00	99.00	0.00	0.00	0.00	0.00	0	0.00	A0
08/19/22	RADIOLOGIST	99.00	0.00	99.00	0.00	0.00	0.00	0.00	0	0.00	A0
Total		**$198.00**	**$0.00**	**$198.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**	

IF YOU ARE COVERED BY MORE THAN ONE HEALTH BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN.

Notes

A0 - THE SUBMITTED CODE IS DENIED BECAUSE IT'S RELATED TO A SERVICE THAT YOUR PLAN DOESN'T COVER. PLEASE REFER TO YOUR PLAN BOOKLET.

(Ex. 1 at 3; *see also* Ex. 2 at 5 (same).)

13. Moreover, as explained above, if a claim was denied based on PxDx review, both the patient and healthcare provider will receive a separate letter detailing the services billed, the diagnosis codes billed, and the applicable Cigna clinical coverage policy used in adjudicating that PxDx denial. However, there were no such PxDx denial letters associated with Ms. Kisting-Leung's transvaginal ultrasound Claims.

14. Accordingly, my review of Ms. Kisting-Leung's Claims records confirms that neither of the transvaginal ultrasound Claims referenced in the SAC were denied as a result of PxDx review.

B. The Thornhill Claim Was Not Denied Through PxDx Review.

15. I also reviewed the EOBs associated with the September 19, 2022 claim for Ms. Thornhill (attached as **Exhibit 3** and **Exhibit 4** to this Declaration), which are EOBs processed

on September 29 and November 25, 2022, respectively. The remark codes on these EOBs show that Ms. Thornhill's claim was not denied as a result of PxDx review.

16. Specifically, on the September 29 EOB (**Exhibit 3**), the remark code on Ms. Thornhill's claim stated that Cigna "need[s] more information about this claim to determine if the services received were medically necessary," and that if Cigna does not "receive the information[,] we'll have to close the claim." This remark code does not indicate that the claim was denied for lack of medical necessity, but rather that Cigna needed more information—including any applicable "facility records, office notes, history & physical, diagnostic reports [and] operative/anesthesia records"—before it could determine whether the services were medically necessary. This kind of remark code is not the kind of denial remark code that is typically used for claims that are reviewed and denied using Cigna's PxDx process, and is instead used to describe claims that are put on hold from processing due to lack of information.

Claim detail

CIGNA received this claim on September 23, 2022 and processed it on September 29, 2022.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
DERMTECH INC, Claim # 4652226692976											
09/19/22	LABORATORY	1,300.00	0.00	1,300.00	0.00	0.00	0.00	0.00	0	0.00	A0
Total		**$1,300.00**	**$0.00**	**$1,300.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**	

Notes

A0 - WE NEED MORE INFORMATION ABOUT THIS CLAIM TO DETERMINE IF THE SERVICES RECEIVED WERE MEDICALLY NECESSARY. THE HEALTH CARE PROVIDER WILL PROVIDE CIGNA THE INFORMATION WE NEED TO PROCESS THIS CLAIM (FACILITY RECORDS, OFFICE NOTES, HISTORY & PHYSICAL, DIAGNOSTIC REPORTS OPERATIVE/ANESTHESIA RECORDS, AND/OR PHOTOS FOR POTENTIAL COSMETIC PROCEDURES). IF WE DON'T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM.

(Ex. 3 at 3.)

17. This same request for medical records was also submitted to Ms. Thornhill's medical provider, Dermtech Inc., through an EOP (explanation of payment)—which is an analogous document memorializing the same information as that provided in the EOB, but sent to medical providers rather than patients. (*See* **Exhibit 5** at 3.)

MCDERMOTT WILL & EMERY LLP
ATTORNEYS AT LAW
LOS ANGELES

18. Two months later, Cigna issued another EOB on November 25 (**Exhibit 4**). The remark code on this EOB stated: "We need medical records to process this claim. We have requested but not yet received it. We've closed the claim." As reflected here, Cigna had requested additional medical records in the September 29 EOB and EOP to evaluate whether the services Ms. Thornhill received were medically necessary, did not receive those records, and closed the claim two months later as a result.

Claim detail

CIGNA received this claim on September 23, 2022 and processed it on November 25, 2022.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
DERMTECH INC, Claim # 4652226692976											
09/19/22	LABORATORY	1,300.00	0.00	1,300.00	0.00	0.00	0.00	0.00	0	0.00	A0
Total		$1,300.00	$0.00	$1,300.00	$0.00	$0.00	$0.00	$0.00		$0.00	

Notes

A0 - WE NEED MEDICAL RECORDS TO PROCESS THIS CLAIM. WE HAVE REQUESTED BUT NOT YET RECEIVED IT. WE'VE CLOSED THE CLAIM.

(Ex. 4 at 3.[1])

19. Given that this claim was denied for lack of information necessary to assess the medical necessity of the procedure billed, it was not denied through PxDx review. There was also no PxDx denial letter associated with Ms. Thornhill's claim.

20. Accordingly, my review of Ms. Thornhill's Claims records confirms that the gene expression profiling test referenced in the SAC was not denied as a result of PxDx review.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed this 1st day of February, 2024.

Dated: February 1, 2024

JB Kessel MD

Dr. Julie B. Kessel

[1] Cigna also sent an EOP to Ms. Thornhill's provider Dermtech Inc., memorializing the same lack of information reason for the denial of this claim. (*See* **Exhibit 6** at 3.)

EXHIBIT 1

Cigna Health and Life Insurance Company
BOURBONNAIS CLAIM OFFICE
P. O. BOX 182223
CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company AS AGENT FOR VINDICIA, INC.

To see the latest claims and plan information on myCigna, scan the code.

MICHAEL H LEUNG
16918 SW RICHEN PARK CIRCLE
SHERWOOD OR 97140

Service date
August 19, 2022

Claim # / ID
4652226997952 / U28274935

Provider Network Status:
IN NETWORK

Account name / Account #
VINDICIA, INC. / 2500372

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Explanation of benefits

for a claim received for SUZANNE N KISTING, Claim # 4652226997952

Patient's relationship to Subscriber: DEPENDENT

Subscriber Name: MICHAEL H LEUNG

Summary of a claim for services on August 19, 2022

for services provided by MATTHEW M TREINEN DO

Amount Billed	$198.00	This was the amount that was billed for your visit on 08/19/2022.
Discount	$0.00	CIGNA negotiates discounts with health care professionals and facilities to help you save money. Using an in-network option is one way you can save. Visit myCIGNA.com or call Customer Service to learn more.
Amount not covered	$198.00	This is the portion of your bill that's not covered by your plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information. The total amount of what is not allowed and/ or not covered is $198.00 of which you owe $198.00 .
What your plan paid	$0.00	Your plan paid $0.00.
What I owe	**$198.00**	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.

PLEASE SEE CLAIM DETAILS ON PAGE 3.

Glossary

% Paid: The part of the Amount Billed that your health plan paid
Allowed Amount: The amount that Cigna determines is reasonable reimbursement for covered services provided to you. This may be established in accordance with an agreement between a health care provider and Cigna.
Amount Billed: The amount a health care provider can bill for covered services
Amount Not Covered: The part of the Amount Billed that is not covered by, or eligible for payment under, your plan
Coinsurance: A shared cost between you and your health plan that equals the Allowed Amount for a covered service. This shared cost starts once you have met your deductible.
Copay: A dollar amount you pay for an eligible health care or related service, typically due at the time the service is provided. When present, a copay is usually applied on a per occurrence, per admission, per day, or annual basis.
Deductible: A set amount you pay out of pocket in one plan or contract year for covered services before your health plan will start covering part of the cost
Discount: The amount you save by using a network health care provider. Cigna negotiates lower rates with network health care providers to help you save money. Using out-of-network providers will cost you more. If you go out-of-network for services, Cigna may be able to get you discounts through third-party vendor contracts.
In-Network: A group of health care providers that have a contract with Cigna to provide you with health care coverage. Using in-network providers will save you money.
Out-of-Network: Any health care provider that does not have a contract with Cigna to provide you with health care coverage. Using out-of-network providers will cost you more money.
Out-of-Pocket Maximum: The total dollar amount a customer will pay toward the coverage of a health plan's benefits/services within a calendar or contract year.
What My Plan Paid: The part of the Amount Billed that your health plan paid
What I Owe: The part of the Amount Billed you are responsible for. This amount might include your deductible, coinsurance, any amount over the maximum reimbursable charge, or products or services not covered by your plan.

Federal Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you're not satisfied with this decision, you can start the Appeal process by sending a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time frame is provided by applicable state law or permitted by your plan).
Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name 2) Account number from the front of this form 3) ID number from the front of this form 4) Name of the patient and relationship and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. Your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.
- If, after all required reviews of your claim have been completed, all or part of your claim is denied, you have the right to file a civil action under section 502(a) of the Employee Retirement Income Security Act. Any civil action must be brought in the United States District Court for the Western District of Tennessee within one (1) year after the final plan decision on your claim.

Need Help?

Login or register for myCigna.com to view claim details or chat with a representative. You can call us at (800) 244-6224 (1.800.CIGNA24) or the number on the back of your ID Card. Please have your claim number ready.

Claim received for SUZANNE N KISTING
Claim # 4652226997952
ID U28274935

THIS IS NOT A BILL

Claim detail

CIGNA received this claim on September 3, 2022 and processed it on October 13, 2022.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
MATTHEW M TREINEN DO, Claim # 4652226997952											
08/19/22	RADIOLOGIST	99.00	0.00	99.00	0.00	0.00	0.00	0.00	0	0.00	A0
08/19/22	RADIOLOGIST	99.00	0.00	99.00	0.00	0.00	0.00	0.00	0	0.00	A0
Total		**$198.00**	**$0.00**	**$198.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**	

** After you have met your deductible, the costs of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.*

Other important information that I need to know

IF YOU ARE COVERED BY MORE THAN ONE HEALTH BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN.

Notes

A0 - THE SUBMITTED CODE IS DENIED BECAUSE IT'S RELATED TO A SERVICE THAT YOUR PLAN DOESN'T COVER. PLEASE REFER TO YOUR PLAN BOOKLET.

Claim received for SUZANNE N KISTING
Claim # 4652226997952
ID U28274935

THIS IS NOT A BILL

Additional information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, You can contact your provider directly or you can print and fill out the request form and send it back to Cigna. Go to Cigna.com and click "Find a Form" at the bottom of the page. Choose "Privacy Forms," then "Cigna Health Care Privacy Forms." Print the **Request for Diagnosis and Treatment Code Information form**. If you have difficulty accessing the form, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

If you don't agree with our final internal review of your claim, you may be able to ask for an independent external review. Your plan and any state or federal requirements determine whether your claim is eligible for external review. For questions about your appeal rights or for assistance, call the Employee Benefits Security Administration at 1-866-444-EBSA(3272) or go online to www.askebsa.dol.gov

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

If you have difficulty reading English, we offer language assistance. For help please call the Customer Service number on your ID card.

Si tiene problemas para leer el texto en inglés, le ofrecemos asistencia de idiomas. Para obtener ayuda, por favor, llame al número de Servicio al cliente que figura en su tarjeta de identificación.

Si vous avez des difficultés à lire l'anglais, nous offrons une assistance linguistique. Pour toute aide, veuillez composer le numéro du Service à la clientèle qui se trouve sur votre carte d'identification.

Für den Fall, dass Sie den englischen Text nicht verstehen, bieten wir mehrsprachige Unterstützung an. Rufen Sie in diesem Fall bitte die auf Ihrer Versicherungskarte angegebene Kundenservice-Nummer an.

Kung nahihirapan ka sa pagbabasa ng wikang Ingles, nag-aalok kami ng tulong sa wika. Para sa tulong pakitawagan ang numero ng Serbisyo ng Customer sa iyong ID card.

如果對您來說閱讀英文會有困難，我們可以提供您語言協助。欲取得協助，請撥打會員卡上的客戶服務電話號碼。

Bilagáana Bizaad wólta' níł nanitł'ahgo, saad bee niká'a'doowołígíí hóló. Áká'a'áyeed biniiyé t'áá shǫǫdi áká'anídaalwo'go dabinaanishígíí bich'į' hodíílnih éí naaltsoos bee nee hózinígíí bikáa'gi bibéésh bee hane'é yisdzoh.

EXHIBIT 2

Cigna Health and Life Insurance Company
BOURBONNAIS CLAIM OFFICE
P. O. BOX 182223
CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company AS AGENT FOR VINDICIA, INC.

Customer service
Call the number on the back of your ID card or
(800) 244-6224 (1.800.CIGNA24)
www.myCIGNA.com
If you have any questions about this document, please call Customer Service at the number above. Please have your claim number ready.

MICHAEL H LEUNG
2057 UPPER BANK WAY
ROSEVILLE CA 95747-4566

Service date
November 30, 2022

Claim # / ID
4652234003714 / U28274935

Provider Network Status:
IN NETWORK

Account name / Account #
VINDICIA, INC. / 2500372

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Explanation of benefits

for a claim received for SUZANNE N KISTING, Claim # 4652234003714

Patient's relationship to Subscriber: DEPENDENT

Subscriber Name: MICHAEL H LEUNG

Summary of a claim for services on November 30, 2022

for services provided by ALBERT BRANDT SCHRANER MD

Amount Billed	$825.00	This was the amount that was billed for your visit on 11/30/2022.
Discount	$0.00	CIGNA negotiates discounts with health care professionals and facilities to help you save money. Using an in-network option is one way you can save. Visit myCIGNA.com or call Customer Service to learn more.
Amount not covered	$825.00	This is the portion of your bill that's not covered by your plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information. The total amount of what is not allowed and/ or not covered is $825.00 of which you owe $825.00 .
What your plan paid	$0.00	Your plan paid $0.00.
What I owe	**$825.00**	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.

PLEASE SEE CLAIM DETAILS ON PAGE 3.

Glossary

% Paid: The part of the Amount Billed that your health plan paid
Allowed Amount: The amount that Cigna determines is reasonable reimbursement for covered services provided to you. This may be established in accordance with an agreement between a health care provider and Cigna.
Amount Billed: The amount a health care provider can bill for covered services
Amount Not Covered: The part of the Amount Billed that is not covered by, or eligible for payment under, your plan
Coinsurance: A shared cost between you and your health plan that equals the Allowed Amount for a covered service. This shared cost starts once you have met your deductible.
Copay: A dollar amount you pay for an eligible health care or related service, typically due at the time the service is provided. When present, a copay is usually applied on a per occurrence, per admission, per day, or annual basis.
Deductible: A set amount you pay out of pocket in one plan or contract year for covered services before your health plan will start covering part of the cost
Discount: The amount you save by using a network health care provider. Cigna negotiates lower rates with network health care providers to help you save money. Using out-of-network providers will cost you more. If you go out-of-network for services, Cigna may be able to get you discounts through third-party vendor contracts.
In-Network: A group of health care providers that have a contract with Cigna to provide you with health care coverage. Using in-network providers will save you money.
Out-of-Network: Any health care provider that does not have a contract with Cigna to provide you with health care coverage. Using out-of-network providers will cost you more money.
Out-of-Pocket Maximum: The total dollar amount a customer will pay toward the coverage of a health plan's benefits/services within a calendar or contract year.
What My Plan Paid: The part of the Amount Billed that your health plan paid
What I Owe: The part of the Amount Billed you are responsible for. This amount might include your deductible, coinsurance, any amount over the maximum reimbursable charge, or products or services not covered by your plan.

Federal Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you're not satisfied with this decision, you can start the Appeal process by sending a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time frame is provided by applicable state law or permitted by your plan).
Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name 2) Account number from the front of this form 3) ID number from the front of this form 4) Name of the patient and relationship and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.

Claim received for SUZANNE N KISTING
Claim # 4652234003714
ID U28274935

THIS IS NOT A BILL

Claim detail

CIGNA received this claim on December 6, 2022 and processed it on January 24, 2023.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
ALBERT BRANDT SCHRANER MD, Claim # 4652234003714											
11/30/22	DIAG SERVICE	525.00	0.00	525.00	0.00	0.00	0.00	0.00	0	0.00	A0
11/30/22	DIAG SERVICE	300.00	0.00	300.00	0.00	0.00	0.00	0.00	0	0.00	A0
Total		**$825.00**	**$0.00**	**$825.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**	

** After you have met your deductible, the costs of covered expenses are shared by you and your health plan.*
The percentage of covered expenses you are responsible for is called coinsurance.

Other important information that I need to know

IF YOU ARE COVERED BY MORE THAN ONE HEALTH BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN.

Notes

A0 - THE SUBMITTED CODE IS DENIED BECAUSE IT'S RELATED TO A SERVICE THAT YOUR PLAN DOESN'T COVER. PLEASE REFER TO YOUR PLAN BOOKLET.

Claim received for SUZANNE N KISTING
Claim # 4652234003714
ID U28274935

THIS IS NOT A BILL

Additional information related to the Patient Protection and Affordable Care Act of 2010

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No Cost Language Services for customers who live in California and customers who live outside of California who are covered under a policy issued in California. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-244-6224 for Cigna medical/dental or 1-866-421-8629 for mental health/substance use. For more help, call either the HMO Help Center at 1-888-466-2219 or for Non-HMO plans (e.g. PPO) call the CA Dept. of Insurance at 1-800-927-4357. **English**

Servicios de idioma sin costo para asegurados que viven en California y para asegurados que viven fuera de California y que están cubiertos por una póliza emitida en California. Puede obtener un intérprete. Puede hacer que le lean los documentos en español y que le envíen algunos de ellos en ese idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-244-6224 para servicios médicos/dentales de Cigna o al 1-866-421-8629 para la salud mental/consumo de sustancias. Para obtener ayuda adicional, llame al Centro de ayuda HMO al 1-888-466-2219 o para los planes que no sean HMO (p. ej. PPO) llame al Departamento de Seguros de CA al 1-800-927-4357. **Spanish**

居住在加州境內的被保人和居住在加州境外但受到加州境內核發保單承保的被保人可取得**免費語言服務**。您可取得口譯員服務。我們可以用中文將文件讀給您聽，並將部分備有中文版的文件寄送給您。欲取得協助，請撥打您會員卡上所列示的電話號碼，或致電 1-800-244-6224 與 Cigna 醫療 / 牙科聯絡，或撥打 1-866-421-8629 聯繫 行為健康服務的精神健康 / 物質使用部門。欲取得其他協助，請致電 1-888-466-2219 與 HMO 協助中心聯絡，或非 HMO 計畫 (例如：PPO) 請致電 1-800-927-4357 與加州保險部聯絡。**Chinese**

خدمات لغوية بدون تكلفة للعملاء المقيمين في ولاية كاليفورنيا والعملاء المقيمين خارج ولاية كاليفورنيا الذين تشملهم سياسة تأمين صادرة في ولاية كاليفورنيا. يُمكنك الاستعانة بمترجم. يمكنك طلب قراءة الوثائق لك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-244-6244 لخدمات Cigna الطبية / صحة الأسنان أو على الرقم 1-866-421-8629 للصحة النفسية / تعاطي المواد المخدرة. للحصول على المزيد من المساعدة، اتصل إما بمركز HMO للمساعدة على الرقم 1-888-466-2219 أو للبرامج الأخرى غير HMO (مثل PPO)، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. **Arabic**

캘리포니아 거주 고객 및 캘리포니아에서 발행된 보험으로 보장을 받는 캘리포니아 이외 지역 거주 고객님들을 위한 **무료 언어 지원 서비스**. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스를 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 기재된 안내번호 혹은 Cigna 의료/치과 안내번호(1-800-244-6224번), 혹은 정신 건강/약물 사용에 대해서는 안내번호(1-866-421-8629번)로 연락해주십시오. 더 많은 도움이 필요하신 분은 HMO 헬프 센터(HMO Help Center), 안내번호 1-888-466-2219번으로 문의하시거나 비-HMO 플랜(예: PPO)에 해당하시는 분은 캘리포니아주 보험국(CA Dept. of Insurance) 안내번호 1-800-927-4357번으로 연락해주십시오. **Korean**

Walang Gastos na Mga Serbisyo sa Wika para sa mga customer na nakatira sa California at mga customer na nakatira sa labas ng California na sakop ng isang polisiyang inisyu sa California. Makakakuha ka ng interpreter. Maaari mong ipabasa para sa iyo ang mga dokumento at maaaring ipadala sa iyo ang ilan sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-244-6224 para sa medikal/dental ng Cigna o sa 1-866-421-8629 para sa mga kalusugang pangkaisipan/paggamit ng droga. Para sa karagdagang tulong, tumawag sa HMO Help Center sa 1-888-466-2219 o para sa mga planong Hindi HMO (hal. PPO) tawagan ang CA Dept. of Insurance sa 1-800-927-4357. **Tagalog**

Dịch vụ trợ giúp ngôn ngữ miễn phí cho khách hàng sinh sống trong tiểu bang California và khách hàng sống ngoài California được đài thọ qua một hợp đồng bảo hiểm y tế ký kết tại California. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được có người đọc văn bản cho quý vị hoặc được nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên (ID) của quý vị hoặc gọi chương bảo hiểm y tế/nha khoa Cigna theo số 1-800-244-6224, hoặc gọi số 1-866-421-8629 để biết thông tin về chương trình chăm sóc sức khỏe tâm thần/sử dụng chất gây nghiện. Để được giúp đỡ thêm, vui lòng gọi Trung tâm Trợ giúp HMO tại 1-888-466-2219 hoặc gọi Bộ Bảo hiểm California tại số 1-800-927-4357 cho các vấn đề thuộc các chương trình bảo hiểm không thuộc loại HMO (như các chương trình PPO). **Vietnamese**

សេវាបកប្រែភាសាដោយឥតអស់ថ្លៃ សម្រាប់អតិថិជនដែលរស់នៅក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា និងអតិថិជនដែលរស់នៅក្រៅរដ្ឋកាលីហ្វ័រនីញ៉ា ដែលបានរ៉ាប់រង នៅក្រោមច្បាប់សន្យា បានចេញឱ្យក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឱ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះ ទៅឱ្យអ្នក ជាភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬលេខ 1-800-244-6224 សម្រាប់ខាងសុខភាព/ធ្មេញ Cigna ឬ 1-866-421-8629 សម្រាប់ខាងឥរិយាបថសុខភាពអារម្មណ៍/ការរំលោភសារធាតុញៀន Cigna។ សម្រាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយ HMO តាមលេខ 1-888-466-2219 ឬសម្រាប់គម្រោងមែនមែនជា HMO (ដូចជា PPO) ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។**Khmer**

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਹਨ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਵਿੱਚ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਤੋਂ ਬਾਹਰ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਕੈਲੀਫ਼ੋਰਨੀਆ ਵਿੱਚ ਜਾਰੀ ਕੀਤੀ ਗਈ ਪਾਲਿਸੀ ਦੇ ਅਧੀਨ ਕਵਰਡ ਹਨ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਸਾਨੂੰ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਉੱਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਤੇ ਜਾਂ Cigna ਮੈਡੀਕਲ/ਡੈਂਟਲ ਲਈ 1-800-244-6224 ਤੇ ਜਾਂ ਮਾਨਸਿਕ ਸਿਹਤ/ਪਦਾਰਥਾਂ ਦੇ ਉਪਯੋਗ ਲਈ 1-866-421-8629 ਤੇ ਫੋਨ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ, ਜਾਂ ਤਾਂ HMO ਮਦਦ ਕੇਂਦਰ ਨੂੰ 1-888-466-2219 ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਗੈਰ HMO ਯੋਜਨਾਵਾਂ (ਉਦਾਹਰਣ ਲਈ PPO) ਲਈ CA ਦੇ ਬੀਮਾ ਵਿਭਾਗ (CA Dept.of Insurance) ਨੂੰ 1-800-927-4357 ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

خدمات رایگان مربوط به زبان برای مشتریانی که در کالیفرنیا زندگی می‌کنند و مشتریانی که در خارج کالیفرنیا زندگی کرده و بر اساس بیمه نامه‌ای که در کالیفرنیا صادر شده تحت پوشش هستند. می‌توانید از خدمات یک مترجم شفاهی برخوردار شوید. می‌توانید بگوئید که مدارک به زبان شما برایتان خوانده شوند و برخی از آن‌ها به زبان شما برایتان ارسال شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید و یا با شماره 1-800-244-6224 برای طرح پزشکی/دندانپزشکی Cigna یا با شماره 1-866-421-8629 برای برنامه بهداشت روانی/مصرف مواد مخدر تماس بگیرید. برای دریافت کمک بیشتر، با مرکز کمک HMO به شماره 1-866-466-2219 و یا برای طرح‌های غیر HMO (برای مثال PPO) به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. **Persian**

無料の言語サービス。カリフォルニア州にお住まいのお客様、および、カリフォルニア州外にお住まいで、カリフォルニア州において発行された保険のお客様が対象。通訳がご利用でき、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカードに記載の電話番号、またはCigna医療・歯科サービス担当：1-800-244-6224、またはメンタルヘルス・薬物使用のための担当：1-866-421-8629までご連絡ください。その他のお問い合わせは、HMO Help Center：1-888-466-2219、またはNon-HMOプラン（例：PPO「優先医療給付機構」）については、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。**Japanese**

Бесплатные услуги перевода для клиентов, проживающих на территории штата Калифорния, а также для тех клиентов, которые проживают за его пределами и имеют страховой полис, выданный в штате Калифорния. Вы имеете право воспользоваться услугами устного переводчика. Вам могут прочесть ваши документы, а также выслать перевод некоторых из них на вашем языке. Чтобы получить помощь, позвоните нам по номеру, указанному в вашей идентификационной карте; по вопросам получения медицинских/стоматологических услуг, оказываемых Cigna, позвоните по номеру 1-800-244-6224, по вопросам психического здоровья/употребления наркотиков — 1-866-421-8629. Для получения дополнительной помощи обращайтесь либо в Центр поддержки HMO по телефону 1-888-466-2219 либо обращайтесь в Министерство страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357 для получения информации в отношении не HMO планов (например PPO). **Russian**

Անվճար Լեզվական Ծառայություններ անդամների համար, ովքեր բնակվում են Կալիֆորնիայում և անդամների համար, ովքեր բնակվում են Կալիֆորնիայից դուրս բայց ապահովագրված են Կալիֆորնիայում տրված ապահովագրությամբ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող եք փաստաթղթերը ձեր լեզվով ընթերցել տալ ձեզ համար և նրանց մի մասը ստանալ ձեր լեզվով: Օգնության համար, զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ՝ 1-800-244-6244, Cigna-ի բժշկական/ատամնաբուժական ծրագրի համար կամ՝ 1-866-421-8629 վարքային առողջապահական ծառայությունների համար՝ հոգեկան առողջության/թմրանյութերի օգտագործման դեպքում: Լրացուցիչ օգնության համար զանգահարեք կա՛մ HMO-ի Օգնության կենտրոն 1-888-466-2219 համարով կամ՝ Ոչ-HMO ծրագրերի համար (օրինակ՝ PPO) զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով: **Armenian**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi rau cov qhua uas nyob hauv xeev California thiab cov qhua uas nyob tawm Xeev California uas tau muaj kev pov fwm los ntawm California. Koj yeej muaj tau tus neeg txhais lus. Koj hais tau kom muab cov ntawv nyeem rau koj mloog thiab kom muab qee cov ntaub ntawv txhais ua koj hom lus xa rau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-244-6224 rau Cigna chaw pab them nqi kho mob/kho hniav los sis 1-866-421-8629 rau thov kev pab cuam kev noj qab haus huv fab kev coj cwj pwm los ntawm rau kev coj cwj pwm/kev siv yeeb tshuaj. Yog xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Muab Kev Pab ntawm tus xov tooj 1-888-466-2219 los sis rau cov chaw pab them nqi kho mob uas Tsis Koom HMO (piv txwv li yog PPO) hu rau CA Lub Tuam Tsev Tswj Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. **Hmong**

कैलिफ़ोर्निया और कैलिफ़ोर्निया के बाहर रहने वाले कैलिफ़ोर्निया में जारी पॉलिसी के तहत कवर किये गए ग्राहकों के लिए निःशुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप इन दस्तावेज़ों को किसी से पढ़वा सकते हैं और कुछ दस्तावेज़ों को अपनी भाषा में प्राप्त कर सकते हैं। Cigna स्वास्थ्य/दंत के लिए अपने ID कार्ड पर सूचीबद्ध नंबर 1-800-244-6224 पर या मानसिक स्वास्थ्य/नशे के उपयोग संबंधी सहायता के लिए 1-866-421-8629 पर कॉल करें। अधिक सहायता के लिए, HMO सहायता केंद्र पर 1-888-466-2219 पर कॉल करें या गैर-HMO योजनाओं (उदा. PPO) के लिए 1-800-927-4357 पर CA बीमा विभाग (CA Dept. of Insurance) को कॉल करें। **Hindi**

บริการภาษาโดยไม่เสียค่าใช้จ่าย สำหรับลูกค้าที่อาศัยอยู่ในรัฐแคลิฟอร์เนีย และที่อาศัยอยู่นอกรัฐแคลิฟอร์เนียที่ได้รับการคุ้มครองภายใต้กรมธรรม์ที่ออกในรัฐแคลิฟอร์เนีย คุณสามารถขอล่ามแปลภาษาได้ คุณสามารถขอให้อ่านเอกสารให้คุณฟัง และขอให้ส่งเอกสารบางส่วนถึงคุณเป็นภาษาของคุณ หากต้องการความช่วยเหลือ โปรดโทรศัพท์ถึงเราตามหมายเลขที่ระบุไว้บนบัตรประจำตัวของคุณ หรือหมายเลข 1-800-244-6224 สำหรับบริการของ Cigna ด้านการรักษาพยาบาล/ทันตกรรมของ Cigna หรือ 1-866-421-8629 สำหรับบริการของ ด้านสุขภาพจิต/การใช้สารที่มีผลต่อจิตประสาทในทางที่ผิด หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือสำหรับแผนการรักษาพยาบาลแบบ HMO ที่หมายเลข 1-888-466-2219 หรือสำหรับแผนการรักษาพยาบาลที่ไม่ใช่ HMO (เช่น PPO) โปรดโทรศัพท์ถึง Dept. of Insurance ของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 **Thai**

824713_d 05/21

EXHIBIT 3

Cigna Health and Life Insurance Company
BOURBONNAIS CLAIM OFFICE
P. O. BOX 182223
CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company AS AGENT FOR

SHAKA J THORNHILL
325 N BALDWIN AVE
APT D
SIERRA MADRE CA 91024-1275

To see the latest claims and plan information on myCigna, scan the code.

Service date
September 19, 2022

Claim # / ID
4652226692976 / U84437713

Provider Network Status:
OUT OF NETWORK

Account name / Account #
/ 3332071

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Explanation of benefits

for a claim received for CRISTINA THORNHILL, Claim # 4652226692976

Patient's relationship to Subscriber: DEPENDENT

Subscriber Name: SHAKA J THORNHILL

Summary of a claim for services on September 19, 2022

for services provided by DERMTECH INC

Amount Billed	$1,300.00	This was the amount that was billed for your visit on 09/19/2022.
Discount	$0.00	CIGNA negotiates discounts with health care professionals and facilities to help you save money. Using an in-network option is one way you can save. Visit myCIGNA.com or call Customer Service to learn more.
Amount not covered	$1,300.00	This is the portion of your bill that's not covered by your plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information. The total amount of what is not allowed and/ or not covered is $1,300.00 of which you owe $0.00 .
What your plan paid	$0.00	Your plan paid $0.00.
What I owe	**$0.00**	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.

PLEASE SEE CLAIM DETAILS ON PAGE 3.

Glossary

% Paid: The part of the Amount Billed that your health plan paid
Allowed Amount: The amount that Cigna determines is reasonable reimbursement for covered services provided to you. This may be established in accordance with an agreement between a health care provider and Cigna.
Amount Billed: The amount a health care provider can bill for covered services
Amount Not Covered: The part of the Amount Billed that is not covered by, or eligible for payment under, your plan
Coinsurance: A shared cost between you and your health plan that equals the Allowed Amount for a covered service. This shared cost starts once you have met your deductible.
Copay: A dollar amount you pay for an eligible health care or related service, typically due at the time the service is provided. When present, a copay is usually applied on a per occurrence, per admission, per day, or annual basis.
Deductible: A set amount you pay out of pocket in one plan or contract year for covered services before your health plan will start covering part of the cost
Discount: The amount you save by using a network health care provider. Cigna negotiates lower rates with network health care providers to help you save money. Using out-of-network providers will cost you more. If you go out-of-network for services, Cigna may be able to get you discounts through third-party vendor contracts.
In-Network: A group of health care providers that have a contract with Cigna to provide you with health care coverage. Using in-network providers will save you money.
Out-of-Network: Any health care provider that does not have a contract with Cigna to provide you with health care coverage. Using out-of-network providers will cost you more money.
Out-of-Pocket Maximum: The total dollar amount a customer will pay toward the coverage of a health plan's benefits/services within a calendar or contract year.
What My Plan Paid: The part of the Amount Billed that your health plan paid
What I Owe: The part of the Amount Billed you are responsible for. This amount might include your deductible, coinsurance, any amount over the maximum reimbursable charge, or products or services not covered by your plan.

Federal Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you're not satisfied with this decision, you can start the Appeal process by sending a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time frame is provided by applicable state law or permitted by your plan).
Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name 2) Account number from the front of this form 3) ID number from the front of this form 4) Name of the patient and relationship and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. Your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.
- If, after all required reviews of your claim have been completed, all or part of your claim is denied, you have the right to file a civil action under section 502(a) of the Employee Retirement Income Security Act. Any civil action must be brought in the United States District Court for the Western District of Tennessee within one (1) year after the final plan decision on your claim.

Need Help?

Login or register for myCigna.com to view claim details or call us at the number on the back of your ID Card.

Claim received for CRISTINA THORNHILL
Claim # 4652226692976
ID U84437713

THIS IS NOT A BILL

Claim detail

CIGNA received this claim on September 23, 2022 and processed it on September 29, 2022.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
DERMTECH INC, Claim # 4652226692976											
09/19/22	LABORATORY	1,300.00	0.00	1,300.00	0.00	0.00	0.00	0.00	0	0.00	A0
Total		**$1,300.00**	**$0.00**	**$1,300.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**	

** After you have met your deductible, the costs of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.*

Other important information that I need to know

*HEALTH CARE PROFESSIONAL: WE NEED THE ADDITIONAL INFORMATION MENTIONED BELOW TO PROCESS THIS CLAIM. PLEASE USE THIS FORM TO REPLY. IF YOU USE ANOTHER FORM, PLEASE INCLUDE THE REFERENCE NUMBER SHOWN ABOVE IN YOUR REPLY. ** IF YOU ARE COVERED BY MORE THAN ONE HEALTH BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN.*

Notes

A0 - WE NEED MORE INFORMATION ABOUT THIS CLAIM TO DETERMINE IF THE SERVICES RECEIVED WERE MEDICALLY NECESSARY. THE HEALTH CARE PROVIDER WILL PROVIDE CIGNA THE INFORMATION WE NEED TO PROCESS THIS CLAIM (FACILITY RECORDS, OFFICE NOTES, HISTORY & PHYSICAL, DIAGNOSTIC REPORTS OPERATIVE/ANESTHESIA RECORDS, AND/OR PHOTOS FOR POTENTIAL COSMETIC PROCEDURES). IF WE DON'T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM.

Claim received for CRISTINA THORNHILL
Claim # 4652226692976
ID U84437713

THIS IS NOT A BILL

Additional information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, You can contact your provider directly or you can print and fill out the request form and send it back to Cigna. Go to Cigna.com and click "Find a Form" at the bottom of the page. Choose "Privacy Forms," then "Cigna Health Care Privacy Forms." Print the **Request for Diagnosis and Treatment Code Information form** . If you have difficulty accessing the form, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

If you don't agree with our final internal review of your claim, you may be able to ask for an independent external review. Your plan and any state or federal requirements determine whether your claim is eligible for external review. For questions about your appeal rights or for assistance, call the Employee Benefits Security Administration at 1-866-444-EBSA(3272) or go online to www.askebsa.dol.gov

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

If you have difficulty reading English, we offer language assistance. For help please call the Customer Service number on your ID card.

Si tiene problemas para leer el texto en inglés, le ofrecemos asistencia de idiomas. Para obtener ayuda, por favor, llame al número de Servicio al cliente que figura en su tarjeta de identificación.

Si vous avez des difficultés à lire l'anglais, nous offrons une assistance linguistique. Pour toute aide, veuillez composer le numéro du Service à la clientèle qui se trouve sur votre carte d'identification.

Für den Fall, dass Sie den englischen Text nicht verstehen, bieten wir mehrsprachige Unterstützung an. Rufen Sie in diesem Fall bitte die auf Ihrer Versicherungskarte angegebene Kundenservice-Nummer an.

Kung nahihirapan ka sa pagbabasa ng wikang Ingles, nag-aalok kami ng tulong sa wika. Para sa tulong pakitawagan ang numero ng Serbisyo ng Customer sa iyong ID card.

如果對您來說閱讀英文會有困難，我們可以提供您語言協助。欲取得協助，請撥打會員卡上的客戶服務電話號碼。

Bilagáana Bizaad wólta' nił nanitł'ahgo, saad bee niká'a'doowołígíí hóló. Áká'a'áyeed biniiyé t'áá shǫǫdi áká'anídaalwo'go dabinaanishígíí bich'į' hodíílnih éí naaltsoos bee nee hózinígíí bikáa'gi bibéésh bee hane'é yisdzoh.

EXHIBIT 4

Cigna Health and Life Insurance Company
BOURBONNAIS CLAIM OFFICE
P. O. BOX 182223
CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company AS AGENT FOR BECTON DICKINSON

To see the latest claims and plan information on myCigna, scan the code.

SHAKA J THORNHILL
325 N BALDWIN AVE
APT D
SIERRA MADRE CA 91024

Service date
September 19, 2022

Claim # / ID
4652226692976 / U84437713

Provider Network Status:
OUT OF NETWORK

Account name / Account #
BECTON DICKINSON / 3332071

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Explanation of benefits

for a claim received for CRISTINA THORNHILL, Claim # 4652226692976

Patient's relationship to Subscriber: DEPENDENT

Subscriber Name: SHAKA J THORNHILL

Summary of a claim for services on September 19, 2022

for services provided by DERMTECH INC

Amount Billed	$1,300.00	This was the amount that was billed for your visit on 09/19/2022.
Discount	$0.00	CIGNA negotiates discounts with health care professionals and facilities to help you save money. Using an in-network option is one way you can save. Visit myCIGNA.com or call Customer Service to learn more.
Amount not covered	$1,300.00	This is the portion of your bill that's not covered by your plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information. The total amount of what is not allowed and/ or not covered is $1,300.00 of which you owe $1,300.00 .
What your plan paid	$0.00	Your plan paid $0.00. This is a correction of a previously processed claim.
What I owe	**$1,300.00**	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.

PLEASE SEE CLAIM DETAILS ON PAGE 3.

Glossary

% Paid: The part of the Amount Billed that your health plan paid
Allowed Amount: The amount that Cigna determines is reasonable reimbursement for covered services provided to you. This may be established in accordance with an agreement between a health care provider and Cigna.
Amount Billed: The amount a health care provider can bill for covered services
Amount Not Covered: The part of the Amount Billed that is not covered by, or eligible for payment under, your plan
Coinsurance: A shared cost between you and your health plan that equals the Allowed Amount for a covered service. This shared cost starts once you have met your deductible.
Copay: A dollar amount you pay for an eligible health care or related service, typically due at the time the service is provided. When present, a copay is usually applied on a per occurrence, per admission, per day, or annual basis.
Deductible: A set amount you pay out of pocket in one plan or contract year for covered services before your health plan will start covering part of the cost
Discount: The amount you save by using a network health care provider. Cigna negotiates lower rates with network health care providers to help you save money. Using out-of-network providers will cost you more. If you go out-of-network for services, Cigna may be able to get you discounts through third-party vendor contracts.
In-Network: A group of health care providers that have a contract with Cigna to provide you with health care coverage. Using in-network providers will save you money.
Out-of-Network: Any health care provider that does not have a contract with Cigna to provide you with health care coverage. Using out-of-network providers will cost you more money.
Out-of-Pocket Maximum: The total dollar amount a customer will pay toward the coverage of a health plan's benefits/services within a calendar or contract year.
What My Plan Paid: The part of the Amount Billed that your health plan paid
What I Owe: The part of the Amount Billed you are responsible for. This amount might include your deductible, coinsurance, any amount over the maximum reimbursable charge, or products or services not covered by your plan.

Federal Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you're not satisfied with this decision, you can start the Appeal process by sending a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time frame is provided by applicable state law or permitted by your plan).
Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name 2) Account number from the front of this form 3) ID number from the front of this form 4) Name of the patient and relationship and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. Your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.
- If, after all required reviews of your claim have been completed, all or part of your claim is denied, you have the right to file a civil action under section 502(a) of the Employee Retirement Income Security Act. Any civil action must be brought in the United States District Court for the Western District of Tennessee within one (1) year after the final plan decision on your claim.

Need Help?

Login or register for myCigna.com to view claim details or chat with a representative. You can call us at (800) 997-1463 or the number on the back of your ID Card. Please have your claim number ready.

Claim received for CRISTINA THORNHILL
Claim # 4652226692976
ID U84437713

THIS IS NOT A BILL

Claim detail

CIGNA received this claim on September 23, 2022 and processed it on November 25, 2022.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Allowed amount	Copay	Deductible	What your plan paid	% paid	Coinsurance*	See notes
DERMTECH INC, Claim # 4652226692976											
09/19/22	LABORATORY	1,300.00	0.00	1,300.00	0.00	0.00	0.00	0.00	0	0.00	A0
Total		**$1,300.00**	**$0.00**	**$1,300.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**	

** After you have met your deductible, the costs of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.*

Other important information that I need to know

THIS IS A CORRECTION OF A PREVIOUSLY PROCESSED CLAIM. IF YOU ARE COVERED BY MORE THAN ONE HEALTH BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN.

Notes

A0 - WE NEED MEDICAL RECORDS TO PROCESS THIS CLAIM. WE HAVE REQUESTED BUT NOT YET RECEIVED IT. WE'VE CLOSED THE CLAIM.

Claim received for CRISTINA THORNHILL
Claim # 4652226692976
ID U84437713

THIS IS NOT A BILL

Additional information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, You can contact your provider directly or you can print and fill out the request form and send it back to Cigna. Go to Cigna.com and click "Find a Form" at the bottom of the page. Choose "Privacy Forms," then "Cigna Health Care Privacy Forms." Print the **Request for Diagnosis and Treatment Code Information form** . If you have difficulty accessing the form, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

If you don't agree with our final internal review of your claim, you may be able to ask for an independent external review. Your plan and any state or federal requirements determine whether your claim is eligible for external review. For questions about your appeal rights or for assistance, call the Employee Benefits Security Administration at 1-866-444-EBSA(3272) or go online to www.askebsa.dol.gov

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

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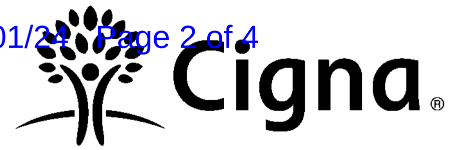
EXHIBIT 5

Case 2:23-cv-01477-DAD-KJN Document 28-13 Filed 02/01/24 Page 2 of 4

Cigna Health and Life Insurance Company
BOURBONNAIS CLAIM OFFICE
P. O. BOX 182223
CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company
AS AGENT FOR:



Provider Number:
330708997 0003

Date through which claims were processed:
SEPTEMBER 29, 2022

Remittance Tracking Number:
220930390344912

How to Contact Us
★ **Mail to the return address in upper left corner of this page**
➔ **http://www.cigna.com**
↑ **Phone:**

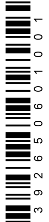
DERMTECH INC
PO BOX 74672
CHICAGO IL 60675-4672

Provider Explanation of Medical Benefits

Understanding this Benefits Statement

- This page provides a summary of the payments made this period.
- The accompanying pages give more detail on the claims we processed for this period. Please review both the front and back of each page to see how the benefit amounts shown in the Explanation of Medical Benefits Report were determined.

In the event a claim is denied......



Rights of Review and Appeal - For Physician or Health Care Provider

- If you have questions or disagree with the payment identified on this Explanation of Medical Benefits statement, you may ask to have it reviewed.
- If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.
If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan).
Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.
Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
You are entitled to receive free upon request access to , and copies of, all documents, records and other information relevant to your claim for benefits.
You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Provider Summary

No Payment was made with this statement

The charges submitted were negated or offset by the deductibles, coinsurance, etc., or the patient(s) may be incurring liability for payment. See the following provider detail page for an explanation of how the benefits were determined.

Definitions of terms used on the Provider Explanation of Medical Benefits Report section of this statement

Line:	Line item number.
Procedure Date:	Date you provided the service.
Procedure Code:	Code describing the service provided.
Adjusted Procedure Code:	Re-assigned procedure code (See Note).
Billed Amount:	Dollar amount you charged for service.
Adjusted Procedure Code Amount:	Dollar amount due to adjusted procedure code.
Allowed Amount:	Dollar amount covered by benefit plan.
Not Covered / Discount:	Part of "Billed Amount" Not Covered under the benefit plan **or** a Provider Discount.
Deduct / Copay Amount:	Portion of billed amount applied toward patient's deductible or copay (if any).
Coinsurance Amount:	The amount of the patient's coinsurance liability.
DRG / Per Diem / APC Type :	DRG (Diagnosis Related Group) / Per Diem / APC (Ambulatory Payment Classification) Category.
DRG / Per Diem / APC Number:	DRG (Diagnosis Related Group) /Per Diem / APC (Ambulatory Payment Classification) Code describing the service provided.
DRG / Per Diem Amount:	Dollar amount for DRG (Diagnosis Related Group) / Per Diem service provided.
DRG / Per Diem Benefit Amount:	Dollar amount payable by the benefit plan for DRG (Diagnosis Related Group) /Per Diem services.
Plan Benefit:	Dollar amount payable for services provided.
See Note:	If a portion or all of the charge is Not Covered, this is the written explanation of why it is Not Covered.
Other Insurance Paid:	The amount of another insurance carrier's payment.

000022

Provider Explanation of Medical Benefits Report

Cigna

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
330708997 0003	DERMTECH INC	09/29/2022		1

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
1	09192022 9192022	0089U		1300.00			1300.00					0.00	0.00	0.00	A0
	TOTAL			1300.00			1300.00							0.00	

Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.

PATIENT NAME: CRISTINA THORNHILL PATIENT#: 263083Z01 OPERATION LOCATION/GROUP# 50019-9-3332071 RECEIVE DATE: 09/23/2022 PROCESS DATE: 09/29
PATIENT'S RELATIONSHIP TO SUBSCRIBER: DEPENDENT PROVIDER NETWORK STATUS: OUT OF NETWORK
SUBSCRIBER NAME: SHAKA J THORNHILL SUBSCRIBER#: U84437713 REF#: 4652226692976

HEALTH CARE PROFESSIONAL: WE NEED THE ADDITIONAL INFORMATION MENTIONED BELOW TO PROCESS THIS CLAIM. PLEASE USE THIS FORM TO REPLY. IF YOU USE ANOTHER FORM, PLEASE INCLUDE THE REFERENCE NUMBER SHOWN ABOVE IN YOUR REPLY.

****

IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

CUP-FAF

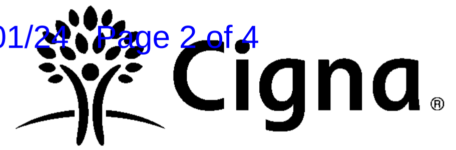
VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) WE NEED MORE INFORMATION ABOUT THIS CLAIM TO DETERMINE IF THE SERVICES RECEIVED WERE MEDICALLY NECESSARY. THE HEALTH CARE PROVIDER WILL PROVIDE CIGNA THE INFORMATION WE NEED TO PROCESS THIS CLAIM (FACILITY RECORDS, OFFICE NOTES, HISTORY & PHYSICAL, DIAGNOSTIC REPORTS OPERATIVE/ANESTHESIA RECORDS, AND/OR PHOTOS FOR POTENTIAL COSMETIC PROCEDURES). IF WE DON'T RECEIVE THE INFORMATION WE'LL HAVE TO CLOSE THE CLAIM.

EXHIBIT 6

Case 2:23-cv-01477-DAD-KJN Document 28-14 Filed 02/01/24 Page 2 of 4

Cigna Health and Life Insurance Company
BOURBONNAIS CLAIM OFFICE
P. O. BOX 182223
CHATTANOOGA TN 37422-7223



Cigna Health and Life Insurance Company
AS AGENT FOR:

BECTON DICKINSON

Provider Number:
330708997 0003

Date through which claims were processed:
NOVEMBER 25, 2022

Remittance Tracking Number:

DERMTECH INC
PO BOX 74672
CHICAGO IL 60675-4672

How to Contact Us

★ **Mail to the return address in upper left corner of this page**

➔ **http://www.cigna.com**

↑ **Phone: (800) 997-1463**

Provider Explanation of Medical Benefits

Understanding this Benefits Statement

- This page provides a summary of the payments made this period.
- The accompanying pages give more detail on the claims we processed for this period. Please review both the front and back of each page to see how the benefit amounts shown in the Explanation of Medical Benefits Report were determined.

In the event a claim is denied......

Rights of Review and Appeal - For Physician or Health Care Provider

- If you have questions or disagree with the payment identified on this Explanation of Medical Benefits statement, you may ask to have it reviewed.
- If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.
If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan).
Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.
Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
You are entitled to receive free upon request access to , and copies of, all documents, records and other information relevant to your claim for benefits.
You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Provider Summary

No Payment was made with this statement

The charges submitted were negated or offset by the deductibles, coinsurance, etc., or the patient(s) may be incurring liability for payment. See the following provider detail page for an explanation of how the benefits were determined.

Definitions of terms used on the Provider Explanation of Medical Benefits Report section of this statement

Line:	Line item number.
Procedure Date:	Date you provided the service.
Procedure Code:	Code describing the service provided.
Adjusted Procedure Code:	Re-assigned procedure code (See Note).
Billed Amount:	Dollar amount you charged for service.
Adjusted Procedure Code Amount:	Dollar amount due to adjusted procedure code.
Allowed Amount:	Dollar amount covered by benefit plan.
Not Covered / Discount:	Part of "Billed Amount" Not Covered under the benefit plan **or** a Provider Discount.
Deduct / Copay Amount:	Portion of billed amount applied toward patient's deductible or copay (if any).
Coinsurance Amount:	The amount of the patient's coinsurance liability.
DRG / Per Diem / APC Type :	DRG (Diagnosis Related Group) / Per Diem / APC (Ambulatory Payment Classification) Category.
DRG / Per Diem / APC Number:	DRG (Diagnosis Related Group) /Per Diem / APC (Ambulatory Payment Classification) Code describing the service provided.
DRG / Per Diem Amount:	Dollar amount for DRG (Diagnosis Related Group) / Per Diem service provided.
DRG / Per Diem Benefit Amount:	Dollar amount payable by the benefit plan for DRG (Diagnosis Related Group) /Per Diem services.
Plan Benefit:	Dollar amount payable for services provided.
See Note:	If a portion or all of the charge is Not Covered, this is the written explanation of why it is Not Covered.
Other Insurance Paid:	The amount of another insurance carrier's payment.

000644

Provider Explanation of Medical Benefits Report

Cigna

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL	Page
330708997 0003	DERMTECH INC	11/25/2022	Retain for Your Records	1

Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.

PATIENT NAME: CRISTINA THORNHILL PATIENT#: 263083Z01 OPERATION LOCATION/GROUP# 50019-9-3332071 RECEIVE DATE: 09/23/2022 PROCESS DATE: 11/25
PATIENT'S RELATIONSHIP TO SUBSCRIBER: DEPENDENT PROVIDER NETWORK STATUS: OUT OF NETWORK
SUBSCRIBER NAME: SHAKA J THORNHILL SUBSCRIBER#: U84437713 REF#: 4652226692976

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
1	09192022 9192022	0089U		1300.00			1300.00					0.00	0.00	0.00	A0
	TOTAL			1300.00			1300.00							0.00	

BALANCE.................. $1,300.00

** NOTES ON BENEFIT DETERMINATION:
THIS IS A CORRECTION OF A PREVIOUSLY PROCESSED CLAIM.
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

CUP-RVV

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) WE NEED MEDICAL RECORDS TO PROCESS THIS CLAIM. WE HAVE REQUESTED BUT NOT YET RECEIVED IT. WE'VE CLOSED THE CLAIM.