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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SUZANNE KISTING-LEUNG, SAMANTHA DABABNEH, RANDALL RENTSCH, CRISTINA THORNHILL, AMANDA BREDLOW, AND ABDULHUSSEIN ABBAS, 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-CSK

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

Date: December 3, 2024
Time: 1:30 p.m.
Judge: Hon. Dale A. Drozd
Courtroom: 4, 15th Floor
Third Am. Compl. Filed: June 15, 2024

PLEASE TAKE NOTICE that on December 3, 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 order dismissing the Third Amended Complaint of Plaintiffs Suzanne Kisting-Leung, Samantha Dababneh, Randall Rentsch, Cristina Thornhill, Amanda Bredlow, and Abdulhussein Abbas, pursuant to Federal Rules of Civil Procedure 8, 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.

MEET AND CONFER CERTIFICATION

Pursuant to the Court's Civil Standing Order I.C., counsel for Defendants initiated a meet and confer with counsel for Plaintiffs by telephone on August 19, 2024 concerning the subject matter of this motion. Counsel for Defendants advised of their intent to move to dismiss all claims and stated the specific grounds for the motion. Despite their good-faith efforts at informal resolution, the parties were unable to avoid the need for this motion.

Dated: August 23, 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' Claims. 4

ARGUMENT 7

I. Plaintiffs Kisting-Leung, Thornhill, and Bredlow Lack Article III Standing...............7

II. Plaintiff Rentsch's Claims Are Time-Barred. 8

III. Plaintiffs' ERISA Claims (First and Second Causes of Action) Should Be Dismissed. 9

A. Plaintiffs' Claim to Enforce Plan Rights Under Section 502(a)(1)(B) (Count I) Should Be Dismissed. 9

1. Plaintiffs Have Not Identified Any Plan Provisions Purportedly Breached. 10

2. Two Plaintiffs Have Not Exhausted Their Administrative Remedies. 12

B. Plaintiffs' 502(a)(3) Claim For Equitable Relief (Count II) Should Be Dismissed. 14

1. Plaintiffs Have Not Alleged a Breach of Fiduciary Duty. 15

2. Plaintiffs Have Not Properly Stated A Claim For Equitable Relief. 16

3. Plaintiffs' 502(a)(3) Claim Duplicates Their 502(a)(1)(B) Claim. 16

IV. Plaintiffs' California UCL Claim (Third Cause of Action) Should Be Dismissed. 17

A. Plaintiffs Fail To Plead Count III With Particularity Under Rule 9(b)...........17

B. Plaintiffs Fail To Plausibly Plead a UCL Claim Under Rule 8. 19

C. ERISA Preempts Plaintiffs' UCL Claim. 22

CONCLUSION 24

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

Adan v. Kaiser Found. Health Plan, Inc.,
2018 WL 1174559 (N.D. Cal. Mar. 6, 2018)....................13

Aetna Health Inc. v. Davila,
542 U.S. 200 (2004)....................22, 23

Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.,
99 F. Supp. 3d 1110 (C.D. Cal. 2015)....................10, 12, 13, 14

Ashcroft v. Iqbal,
556 U.S. 662 (2009)....................22

Beaver v. Tarsadia Hotels,
816 F.3d 1170 (9th Cir. 2016)....................9

Bunce v. Ocwen Loan Servicing, LLC,
2013 WL 3773950 (E.D. Cal. July 17, 2013)....................21

Chambers v. Mont. Contractors Ass'n Health Care Tr.,
797 F. Supp. 2d 1050 (D. Mont. 2009)....................8

Chiappa v. Cumulus Media, Inc.,
2020 WL 7401745 (N.D. Ga. Dec. 17, 2020)....................8

Cleghorn v. Blue Shield of Cal.,
408 F.3d 1222 (9th Cir. 2005)....................23

Egelhoff v. Egelhoff ex rel. Breiner,
532 U.S. 141 (2001)....................23

Fortier v. Anthem, Inc.,
2020 WL 13304004 (C.D. Cal. Oct. 26, 2020)....................17

Gabriel v. Alaska Elec. Pension Fund,
773 F.3d 945 (9th Cir. 2014)....................15, 16

Gobeille v. Liberty Mut. Ins. Co.,
577 U.S. 312 (2016)....................22, 23

Great Pac. Sec. v. Barclays Cap., Inc.,
743 F. App'x 780 (9th Cir. 2018)....................19

Grenell v. UPS Health & Welfare Package,
390 F. Supp. 2d 932 (C.D. Cal. 2005)....................14

Grp. 1 Auto., Inc. v. Aetna Life Ins. Co.,
2020 WL 8299592 (S.D. Tex. Nov. 9, 2020) 8

Hadley v. Kellogg Sales Co.,
243 F. Supp. 3d 1074 (N.D. Cal. 2017) 22

Hasten v. Prudential Ins. Co. of Am.,
470 F. Supp. 3d 1076 (N.D. Cal. 2020) 13

Height St. Skilled Care, LLC v. Liberty Mut. Ins. Co.,
2022 WL 1665220 (E.D. Cal. May 25, 2022) 20

Heimeshoff v. Hartford Life & Accident Ins. Co.,
571 U.S. 99 (2013) 8

Hewitt v. W. & S. Fin. Grp. Flexible Benefits Plan,
2018 WL 3064564 (6th Cir. Apr. 18, 2018) 8, 9

IJKG Opco LLC v. Gen. Trading Co.,
2018 WL 3019885 (D.N.J. June 18, 2018) 8

Joseph v. Am. Gen. Life Ins. Co.,
495 F. Supp. 3d 953 (S.D. Cal. 2020), *aff'd*, 2021 WL 3754613 (9th Cir. Aug. 25, 2021) 9

Kazda v. Aetna Life Ins. Co.,
2019 WL 11769104 (N.D. Cal. Sept. 11, 2019) 10, 17

Kearns v. Ford Motor Co.,
567 F.3d 1120 (9th Cir. 2009) 18, 19

Lopez v. Stages of Beauty, LLC,
307 F. Supp. 3d 1058 (S.D. Cal. 2018) 1, 12

Marroquin v. Loya Cas. Ins. Co.,
2023 WL 9743710 (C.D. Cal. Sept. 18, 2023) 20

Miller v. Taryle,
2013 WL 12205851 (C.D. Cal. Sept. 10, 2013) 19

Paulsen v. CNF Inc.,
559 F.3d 1061 (9th Cir. 2009) 15

Physicians Surgery Ctr. of Chandler v. Cigna Healthcare Inc.,
550 F. Supp. 3d 799 (D. Ariz. 2021) 16

Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41 (1987) 23, 24

Reiten v. Blue Cross of Cal.,
2020 WL 1032371 (C.D. Cal. Jan. 23, 2020) 10

McDermott Will & Emery LLP
Attorneys At Law
Los Angeles

Rutledge v. Pharm. Care Mgmt. Ass'n,
592 U.S. 80 (2020) 23

Saloojas, Inc. v. Cigna Healthcare of Cal., Inc.,
2022 WL 5265141 (N.D. Cal. Oct. 6, 2022) 18

Sargent v. S. Cal. Edison 401(k) Sav. Plan,
2020 WL 6060411 (S.D. Cal. Oct. 14, 2020) 8

Sarkisyan v. CIGNA Healthcare of Cal., Inc.,
613 F. Supp. 2d 1199 (C.D. Cal. 2009) 23, 24

Shin v. Wash. Mut. Bank, F.A.,
2018 WL 4491185 (N.D. Cal. Sept. 19, 2018) 9

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

Star Dialysis, LLC v. WinCo Foods Emp. Benefit Plan,
401 F. Supp. 3d 1113 (D. Idaho 2019) 10

Swartz v. KPMG LLP,
476 F.3d 756 (9th Cir. 2007) 19

United Food & Com. Workers Cent. Pa. & Reg'l Health & Welfare Fund v. Amgen, Inc.,
400 F. App'x 255 (9th Cir. 2010) 18

Vang v. Geil Enters. Inc.,
2023 WL 3168513 (E.D. Cal. Apr. 28, 2023) 24

Varity Corp. v. Howe,
516 U.S. 489 (1996) 15, 17

Vaught v. Scottsdale Healthcare Corp. Health Plan,
546 F.3d 620 (9th Cir. 2008) 13, 16

Vess v. Ciba-Geigy Corp. USA,
317 F.3d 1097 (9th Cir. 2003) 18

Way v. JP Morgan Chase Bank, N.A.,
2018 WL 2117630 (E.D. Cal. May 8, 2018) 21

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

Wise v. Verizon Commc'ns, Inc.,
600 F.3d 1180 (9th Cir. 2010) 23

Zhang v. Super. Ct.,
57 Cal. 4th 364 (2013) 20

1
2
3
4
5
6
7
8
9
10
11
12
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24
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26
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Statutes

Cal. Bus. & Pro. Code § 17200 .... *passim*

Cal. Health & Safety Code § 1367.01(e) 20

Cal. Health & Safety Code § 1367.01(h)(4) 20

Cal. Ins. Code § 790.03(h) 20

ERISA § 413 8

ERISA § 502(a) 8

ERISA § 502(a)(1)(B) .... *passim*

ERISA § 502(a)(3) .... *passim*

ERISA § 503 15

Other Authorities

10 C.C.R. § 2695.1 20

10 C.C.R. § 2695.7 20

29 C.F.R. § 2560.503-1 .... 11, 15, 16

Fed. R. Civ. P. 8 .... *passim*

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

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

Fed. R. Civ. P. 12(b)(6) 1

Defendants The Cigna Group (f/k/a Cigna Corporation) and Cigna Health and Life Insurance Company ("CHLIC" and together with The Cigna Group, "Cigna") respectfully submit this memorandum of points and authorities in support of their motion, pursuant to Federal Rules of Civil Procedure 8, (9)(b), 12(b)(1), and 12(b)(6), to dismiss the Third Amended Complaint ("TAC").

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 spoke with Plaintiffs' counsel about its various deficiencies, after which Plaintiffs filed three amended complaints. But despite having now had ***four*** opportunities to plead their claims, Plaintiffs still have not stated one. The problems start with Plaintiffs' assumption that PxDx is an "illegal scheme" (TAC ¶ 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 article from which Plaintiffs borrow most of their factual allegations 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, 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-5QL3.) Thus, rather than being some unlawful scheme to fill Cigna's pockets, PxDx checks whether certain specific treatments that providers order are actually covered by the member's benefit plan. And as

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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 TAC cites to and relies on this article (*see, e.g.*, TAC ¶¶ 3 n.3, 73), the ProPublica article is "incorporated by reference" into the complaint. *See Lopez v. Stages of Beauty, LLC*, 307 F. Supp. 3d 1058, 1064 (S.D. Cal. 2018).

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Dr. Muney also described, other payors have similar systems: "[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 given this background, Plaintiffs have not plausibly alleged any of their claims. To start, the claims that three Plaintiffs—Kisting-Leung, Thornhill, and Bredlow—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* TAC ¶ 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).) These three Plaintiffs' claims should therefore be dismissed for lack of standing. And Plaintiff Rentsch's claims should be dismissed for the separate reason that they are time-barred.

Even setting that aside, Plaintiffs have not pled key elements of any of their claims. Count I (claim for benefits under 29 U.S.C. § 1132(a)(1)(B)) should be dismissed because Plaintiffs have not alleged a violation of Plaintiffs' plan terms and because they have not shown that Plaintiffs exhausted their administrative remedies. Count II (claim for equitable relief under 29 U.S.C. § 1132(a)(3)) should be dismissed because Plaintiffs have not alleged a breach of fiduciary duty or a claim for equitable relief. Count III (a claim under California's Unfair Competition Law ("UCL")) should be dismissed for multiple reasons, including because this Count sounds in fraud, yet Plaintiffs fail to meet the pleading requirements of Rule 8, let alone the heightened requirements of Rule 9(b). Plaintiffs' UCL claim is also preempted by ERISA. This claim is premised on Cigna allegedly using PxDx to deny Plaintiffs their covered benefits, and it hinges on whether the services that Plaintiffs obtained were actually covered by their benefit plans. Because their plans are necessary to establish liability for their UCL claim, this claim is preempted.

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

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[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, Thornhill's, and Bredlow's standing.

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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 ***and, ultimately, the payments*** for necessary medical procedures owed to them under Cigna's health insurance policies." (TAC ¶ 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.* ¶ 9.) 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," which Plaintiffs say 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 medical necessity review. And that Cigna website includes a disclaimer that "[a]ll insurance policies and group benefit plans contain exclusions and limitations." (Ex. A at 12.)

Four of the named Plaintiffs—Suzanne Kisting-Leung, Samantha Dababneh, Randall Rentsch, and Cristina Thornhill—are California citizens. (TAC ¶¶ 16-19.) Plaintiff Amanda Bredlow is a citizen of Washington (*id.* ¶ 20), and Plaintiff Abdulhussein Abbas is a citizen of Texas (*id.* ¶ 21). All six Plaintiffs bring two ERISA claims, and they purport to represent a class of "[a]ll persons who are or were participants in, or beneficiaries of, health insurance plans governed by ERISA for which Defendants serve as the claims administrator with respect to medical benefits and who sought and were denied coverage for benefits, in whole or in part, based on Defendants' use of the PXDX algorithm[.]" (*Id.* ¶ 104.) The California Plaintiffs also bring a state-law claim under the California Unfair Competition Law, and claim to represent a class of "[a]ll persons who are or were participants

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in, or beneficiaries of, health insurance plans for which Defendants serve as the claims administrator with respect to medical benefits and who sought and were denied coverage for benefits, in whole or in part, based on Defendants' use of the PXDX algorithm as alleged herein, within the State of California during the period of four years prior to the filing of the complaint[.]" (*Id.* ¶ 106.)

B. Cigna's PxDx Claims Review Process and Plaintiffs' Claims.

Cigna administers "benefits for covered health services" for its clients' health benefit plans. (*See id.* ¶ 25.) Cigna does so by following plan terms: as Plaintiffs recognize, Cigna members have benefit plans that set the terms and limits of their healthcare coverage. (*See, e.g., id.* ("Defendants provided Plaintiffs and Class members with ***plan documents*** explaining the plan coverage available under their employer-sponsored plans"); *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.* ¶ 25 (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.* ¶¶ 54–55 (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 "[t]he denial letter indicated that the PXDX algorithm reviewed her claim"); *id.* ¶¶ 63, 66, 70, 72 (same allegations for Rentsch).)

Plaintiffs allege 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 Plaintiff has shown that their claim denials were contrary to plan terms.

<u>Dababneh</u> 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.* ¶¶ 54–55.) Dababneh does not identify any plan terms to show that this denial was contrary to plan terms or that anything in her benefit plan would preclude Cigna from using a claims review process like PxDx. (*See id.* ¶¶ 52–58.)

Rentsch alleges that Cigna denied coverage of four transforaminal epidurals, which he received between June 2016 and February 2017 as treatment for a pinched nerve, as "not medically necessary." (*Id.* ¶¶ 62–63, 65–66, 69–70, 71–72.) Rentsch likewise 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.* ¶¶ 59–75.)

Abbas alleges that he received monitoring services following surgery for a microdiscectomy in February 2023, as well as an epidural in April 2023, and that Cigna denied coverage for these services as "not medically necessary." (*Id.* ¶ 95–96.) He alleges "[u]pon information and belief" that Cigna "failed to have [its] doctors conduct a thorough, fair, and objective investigation into each of Mr. Abbas's claims and instead denied them based on the automated PXDX process." (*Id.* ¶ 100.) Like the other named Plaintiffs, Abbas 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.* ¶¶ 94–103.)

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

Kisting-Leung alleges that she had two transvaginal ultrasounds, on August 19 and November 30, 2022, and that Cigna denied these services as "not medically necessary." (*Id.* ¶¶ 40–41, 44–45.) Kisting-Leung alleges—only "[u]pon information and belief"—that Cigna "Defendants used the PXDX system to 'review' and deny [her] claims." (*Id.* ¶ 48.) But that is not true. Rather than being denied through PxDx, the Explanation of Benefit ("EOB") forms for these claims indicate that they were denied because Kisting-Leung's benefit plan did not cover them, with a code stating that "[t]he submitted code is denied because it's related to a service that your plan doesn't cover." (*See* Kessel

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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 ultrasounds 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." (TAC ¶¶ 77, 79–80.) Thornhill 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 "[u]pon information and belief" only—that her claim was denied through PxDx. (*Id.* ¶¶ 82–83.) Here, again, that was not the case. In fact, Cigna's review indicates that Ms. Thornhill's claim was denied after Cigna issued an EOB 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.

Bredlow alleges that she received IVF treatment between August 2 and 23, 2022, and that Cigna denied coverage for these services because "the submitted code for the procedure was 'missing or invalid.'" (TAC ¶ 87.) Bredlow also does not identify any plan terms to show that this treatment should have been covered with the submitted claim code or any plan terms that would preclude Cigna from using PxDx. (*Id.* ¶¶ 86–93.) And while Bredlow alleges "[u]pon information and belief" that her claim was processed and denied through PxDx, (*id.* ¶ 90), Cigna's records indicate that Bredlow's IVF treatment was not subject to PxDx either. (Kessel Decl. ¶¶ 22–23; *see also* Kessel Exs. 7–13.)

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[4] The TAC 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, Thornhill, and Bredlow Lack Article III Standing.

Plaintiffs allege that they were injured because Cigna denied their claims using PxDx for services that allegedly should have been covered under the terms of their benefit plans. (*See* TAC ¶ 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 and, ultimately, ***the payments*** for necessary medical procedures owed to them under Cigna's ***health insurance policies***.").) And all Plaintiffs—including Kisting-Leung, Thornhill and Bredlow—tie their alleged injuries to these PxDx denials, alleging that they "had their claims automatically rejected by Cigna using the PXDX system[.]" (*Id.* ¶ 6.)

But this injury theory does not square with the claims that Kisting-Leung, Thornhill, and Bredlow allege in the TAC that Cigna 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, 15, 22–23.) Because Kisting-Leung, Thornhill, and Bredlow have not alleged 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 and Bredlow (but not Thornhill) allege that if they had "known that the Defendants would evade the legally required process for reviewing [their] claims and delegate that process to its PXDX algorithm to review and deny claims, [they] would not have enrolled with Cigna or at most would only have paid less for [their plans]." (TAC ¶¶ 51, 93.) But neither Kisting-Leung nor Bredlow supports this speculative statement with any alleged facts. Moreover, this theory would still turn on whether Cigna had in fact denied their claims using PxDx—otherwise Kisting-Leung and Bredlow would have felt no impact from their plan's use of PxDx, because they personally would have received the exact coverage they expected. Because Kisting-Leung and Bredlow do not identify any claims under their plan that were subject to PxDx, they cannot make that showing.

With no standing, Kisting-Leung's, Thornhill's, and Bredlow's claims should be dismissed.

II. Plaintiff Rentsch's Claims Are Time-Barred.

Rentsch's claims fail because they are time-barred. As the Supreme Court has found, an ERISA benefits plan may set a time limit on when a member may file a claim. *See Hewitt v. W. & S. Fin. Grp. Flexible Benefits Plan*, 2018 WL 3064564, at *2 (6th Cir. Apr. 18, 2018) ("Although ERISA specifies a three- or six-year limitations period for claims of breach of fiduciary duty under 29 U.S.C. § 1113, a contractual provision in a plan may specify a shorter limitations period as long as there is no controlling statute to the contrary and the limitations period is reasonable").[5] Rentsch's ERISA plan set that limit at "3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services." (Ex. B at 46, Ex. C at 48, Ex. D at 49 (Lennar Plans).) Here, Rentsch's claim for benefits was denied on February 27, 2018 (TAC ¶ 72),[6] more than five years before his co-plaintiffs filed their original complaint on July 24, 2023. (Dkt. 1.)[7] So Rentsch's claim is untimely by the terms of his plan. *See Heimeshoff*, 571 U.S. at 110; *see also Chambers v. Mont. Contractors Ass'n Health Care Tr.*, 797 F. Supp. 2d 1050, 1057 (D. Mont. 2009) ("because Chambers filed this lawsuit beyond the limitations period imposed by the Plan, his

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[5] Cigna recognizes that courts are divided over whether contractual time limitations may apply to ERISA breach-of-fiduciary-duty claims. *Compare*, *e.g.*, *Hewitt*, 2018 WL 3064564, at *2; *Chiappa v. Cumulus Media, Inc.*, 2020 WL 7401745, at *3 (N.D. Ga. Dec. 17, 2020) (similar); *IJKG Opco LLC v. Gen. Trading Co.*, 2018 WL 3019885, at *6–7 (D.N.J. June 18, 2018) (contractual limitation should apply because "the plan, in short, is at the center of ERISA and employers are given leeway under ERISA to design plans as they see fit"), *with Sargent v. S. Cal. Edison 401(k) Sav. Plan*, 2020 WL 6060411, at *8 (S.D. Cal. Oct. 14, 2020) ("the Court finds that § 1113 controls Plaintiff's fiduciary claim, and the Plan's 180-day limitations period does not bar Plaintiff's claim."); *Grp. 1 Auto., Inc. v. Aetna Life Ins. Co.*, 2020 WL 8299592, at *7–8 (S.D. Tex. Nov. 9, 2020) (interpreting Fifth Circuit precedent to ban contractual limitations on time limits in 502(a)(3) claims). But the ERISA statute does not forbid parties from contracting for a shorter period, *see Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 107 (2013) ("If parties are permitted to contract around a default statute of limitations, it follows that the same rule applies where the statute creating the cause of action is silent regarding a limitations period."), and Rentsch's plan limit applies to all Section 502(a) claims (Ex. B at 46, Ex. C at 48, Ex. D at 48–49 (Lennar Plans) ("you have the right to bring a civil action under section 502(a) of ERISA . . . however, no action will be brought at all unless brought within 3 years after a claim is submitted[.]")), so the Court should apply Rentsch's plan limitation to both ERISA counts.

[6] Plaintiffs state that the claim was denied on February 27, 2017 (TAC ¶ 72), but from the context of the complaint, it appears that they meant February 27, 2018, given it is the last in a series of treatment and the third round of treatment occurred in December 2017 (*id.* ¶ 69).

[7] Cigna takes no position at this time on whether Rentsch can claim relation back to the original complaint or whether the time limitations of Rentsch's plan apply to his UCL claims but reserves the right to raise these issues at a later date.

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action is time-barred."); *Hewitt*, 2018 WL 3064564 at *2 (finding defendant's "breach-of-fiduciary-duty claim is time-barred" under the terms of the plan).

Rentsch's claim under the California Unfair Competition Law is also untimely. "The statute of limitation for a UCL violation is four years." *Joseph v. Am. Gen. Life Ins. Co.*, 495 F. Supp. 3d 953, 962 (S.D. Cal. 2020) (citing Cal. Bus. & Prof. Code § 17208), *aff'd*, 2021 WL 3754613 (9th Cir. Aug. 25, 2021). "[T]he UCL statute of limitations is governed by common law accrual rules." *Beaver v. Tarsadia Hotels*, 816 F.3d 1170, 1178 (9th Cir. 2016). And "under the UCL's statute of limitations, the cause of action accrued when the harm was completed." *Id.*; *see also Shin v. Wash. Mut. Bank, F.A.,* 2018 WL 4491185, at *9 (N.D. Cal. Sept. 19, 2018). In this case, Rentsch's alleged harm occurred when his claim was denied on February 27, 2018, so Rentsch had until February 27, 2022 to file his claim. (*See* Dkt 1.) Because even his co-plaintiffs did not file their complaint until more than a year after that, Rentsch's UCL claim is also clearly time-barred.

III. Plaintiffs' ERISA Claims (First and Second Causes of Action) Should Be Dismissed.

For the first time in their third amended complaint, Plaintiffs bring two ERISA claims: a claim to enforce rights under ERISA § 502(a)(1)(B) (Count I) and a claim for equitable relief under ERISA § 502(a)(3) (Count II). These new claims suffer from serious deficiencies—namely, that (1) Plaintiffs have not identified anything in their benefit plans or in the ERISA statute that would preclude Cigna from using a system like PxDx to process claims and review them for coverage limitations; and (2) they have failed to show that any of Cigna's claim denials were contrary to plan terms. For these and other reasons below, the Court should dismiss these ERISA claims.

A. Plaintiffs' Claim to Enforce Plan Rights Under Section 502(a)(1)(B) (Count I) Should Be Dismissed.

When Plaintiffs brought a series of state-law claims in their first three complaints, Cigna pointed out that these claims were preempted by ERISA. (Dkt. 28, Cigna's Motion to Dismiss Sec. Am. Compl. at 16–18.) Recognizing this fatal flaw, Plaintiffs have replaced all but one of their state-law causes of action with ERISA claims. Yet these claims fare no better than the original state-law claims. Plaintiffs' claim to enforce plan rights under Section 502(a)(1)(B) fails for the fundamental reasons that the Plaintiffs have not alleged any plan provisions that were breached and do not show

exhaustion of their administrative remedies.

1. Plaintiffs Have Not Identified Any Plan Provisions Purportedly Breached.

Plaintiffs have not—and cannot—identify any terms of their benefits plans that Cigna plausibly breached. ERISA § 502(a)(1)(B) allows Plaintiffs to "recover benefits due to [them] under the terms of [the] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights to future benefits under the terms of the plan." To make such a claim, Plaintiffs "must allege facts that establish [1] the existence of an ERISA plan as well as [2] the provisions of the plan that entitle [them] to benefits." *Reiten v. Blue Cross of Cal.*, 2020 WL 1032371, at *2 (C.D. Cal. Jan. 23, 2020). This means that "a plaintiff who brings a claim for benefits under ERISA must identify a specific plan term that confers the benefit in question." *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015).

The crux of Plaintiffs' theory is that Cigna allegedly engaged in an "illegal scheme to systematically, wrongfully, and automatically deny" insured individuals "thorough, individualized physician review of claims guaranteed to them" and "payments for ***necessary medical procedures*** owed to them under Cigna's health insurance policies." (TAC ¶ 1.) But the TAC does not identify a single plan provision mandating coverage for Plaintiffs' claims, which means that Plaintiffs have not alleged that Cigna's denials violated any plan terms. Without this basic predicate, Plaintiffs have not stated an ERISA benefits claim. *See Kazda v. Aetna Life Ins. Co.*, 2019 WL 11769104, at *4 (N.D. Cal. Sept. 11, 2019) (Section 502(a)(1)(B) claims "are dismissed if there is a lack of any specific reference to plan provisions which affords the benefits."); *Star Dialysis, LLC v. WinCo Foods Emp. Benefit Plan*, 401 F. Supp. 3d 1113, 1139 (D. Idaho 2019) (dismissing where there were "insufficient factual allegations to support [plaintiff's] claim that [defendants'] payments violated the terms of the Plan" and "general allegation[s]" were "not sufficient to demonstrate that [Defendants] breached the Plan terms"); *Almont*, 99 F. Supp. 3d at 1158 (dismissing where plaintiffs "do not actually allege that the specific services they provided to the patients at issue were covered under the terms of the relevant plans or describe the plan terms that would support such coverage").

Unable to point to any plan provisions requiring Cigna to approve coverage for their claims, Plaintiffs attack Cigna's use of PxDx review in medical necessity determinations as a deficient claims

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procedure under the terms of their plans, regardless of whether it comes to the right outcome under the terms of those same plans. In support, Plaintiffs point to two alleged plan terms:

- That "Cigna's insurance policies state that its determinations of medical necessity are made 'by a Medical Director,' when in fact Cigna uses the automated PXDX algorithm to make medical necessity determinations." (TAC ¶ 30.)
- That "Cigna's insurance policies state that Cigna will provide written or electronic notice of adverse benefits determinations that include 'the specific reason or reasons for the adverse determination,' but Cigna routinely fails to disclose that the PXDX algorithm was the reason for many adverse benefits determinations." (*Id.* ¶ 31.)

Neither argument supports Plaintiffs' challenges to PxDx.

First, with respect to Cigna's claims handling procedures, the TAC itself recognizes that each of these Plaintiffs received letters explaining the basis of their denials (*i.e.*, because of lack of medical necessity) for any claims reviewed through PxDx. (*See*, *e.g.*, *id.* ¶¶ 54, 66, 95.) And Plaintiffs acknowledge that the letters identify when claims were processed by PxDx. (*Id.* ¶ 55 (noting that Dababneh's "denial letter indicated that the PXDX algorithm reviewed her claim."); ¶ 63 (same for Rentsch's claim).)

Indeed, these Plaintiffs received letters that explained the service billed, the diagnosis, the denied amounts, and crucially, the clinical coverage policy Cigna used in reviewing and adjudicating these claims as not medically necessary. And Plaintiffs' letters noted that the coverage policies that Cigna used to review and deny their claims are all available online. (*See*, *e.g.*, Ex. J at 3 (Dababneh letter, dated Sept. 24, 2023); Ex. K at 4 (Abbas letter, dated Mar. 20, 2023); Ex. L at 3 (Rentsch letter, dated October 10, 2016).).

While Plaintiffs try to allege various statutory provisions under 29 C.F.R. § 2560.503-1 that Cigna purportedly violated through PxDx review—including that Cigna's claims procedures did not disclose the true reason for their adverse benefits determinations (29 CFR § 2560.503-1(g)); and that Cigna failed to afford full and fair review of its adverse benefits determinations (29 CFR § 2560.503-1(h) and (j))—none has merit. As noted above, Plaintiffs' EOBs and letters described the basis for Cigna's determinations, and Plaintiffs' plans and their letters lay out each step of the appeals

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procedure. (*See, e.g.,* Ex. E at 67–69 (Amdocs Plan); Ex. B at 45–46, Ex. C at 47–48, Ex. D. at 47–49 (Lennar Plan); Ex. F at 57–59 (Sunrun Plan); Ex. G at 60–62 (Becton Dickinson Plan); Ex. H at 83–85 (Volkswagen Plan); Ex. I at 42–44 (Anywhere Real Estate Plan);[8] Exs. J–L (Dababneh, Abbas, and Rentsch's letters at 2–4).)

Second, Cigna's PxDx review process is fully consistent with Plaintiffs' plan terms governing medical necessity review. Plaintiffs argue that PxDx does not constitute an adequate review of their claims, pointing to the fact that their plans' medical necessity definitions require medical necessity benefits determinations to be made "by a Medical Director." (TAC ¶ 30; *see also id.* ¶ 111 (alleging a class injury because Plaintiffs' and Class members' claims were denied "without individualized evaluation of their medical records by Cigna's medical directors.").) But that reads a requirement into the plan that does not exist. Plaintiffs' plans do not lay out any specific method by which medical necessity must be determined. Instead, they note that "procedures for determining Medical Necessity vary, according to the type of service or benefit requested[.]" (*See*, *e.g.*, Ex. E at 65 (Amdocs Plan); Exs. B, C, and D at 44–45 (Lennar Plans); Ex. F at 55 (Sunrun Plan); Ex. G at 59 (Becton Dickinson Plan); Ex. H at 81 (Volkswagen Plan); *see also* Ex. I at 51–52 (Anywhere Real Estate Plan) (laying out various factors that would be considered in determining necessity).) So each Plaintiff received exactly the review their plans delineated, and Plaintiffs cannot maintain an ERISA § 502(a)(1)(B) action to enforce rights that do not exist under their plans. *See Almont*, 99 F. Supp. 3d at 1158 (dismissing claims where Plaintiff providers merely alleged Defendants were not justified in refusing to pay claims but did "not actually allege that the specific services they provided to the patients at issue were covered under the terms of the relevant plans or describe the plan terms that would support such coverage").

2. Two Plaintiffs Have Not Exhausted Their Administrative Remedies.

Count I should be dismissed for an independent reason that Plaintiffs Dababneh and Rentsch

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[8] Plaintiffs reference these plans (or "health insurance policies") repeatedly throughout the complaint (*see*, *e.g.*, TAC ¶ 1), and they all allege that they were "beneficiar[ies] of a plan" for which "Cigna is the named claims administrator[.]" (*Id.* ¶¶ 16–21.) These plans are thus incorporated by reference into the TAC. *See Lopez*, 307 F. Supp. 3d at 1063–64.

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have not alleged that they exhausted their plans' administrative remedies.[9] Although exhaustion is not explicitly laid out in the ERISA statute, the Ninth Circuit has consistently held that a plaintiff "must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court." *Adan v. Kaiser Found. Health Plan, Inc.*, 2018 WL 1174559, at *5 (N.D. Cal. Mar. 6, 2018); *see also Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008) ("before bringing suit under § 502, an ERISA plaintiff claiming a denial of benefits 'must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court.'"). And where "a failure to exhaust is clear on the face of the complaint, the defense may be brought in a motion to dismiss." *Hasten v. Prudential Ins. Co. of Am.*, 470 F. Supp. 3d 1076, 1079 (N.D. Cal. 2020).

Here, Plaintiffs raise the issue of exhaustion when they assert that their claims are "deemed exhausted" because Cigna "made appealing the adverse benefits determinations futile[.]" (TAC ¶ 120). But while several Plaintiffs allege that they appealed their claims (*id.* ¶¶ 43, 81, 88, 98), at no point do Plaintiffs Dababneh or Rentsch allege that they did so. *See Adan*, 2018 WL 1174559, at *7 (finding Plaintiff's failure to exhaust was "evident from the face of the Complaint" where she made "no allegations that she engaged in Defendant's dispute resolution process"). It is therefore clear "on the face of the complaint" that at least these two Plaintiffs failed to exhaust. *Hasten*, 470 F. Supp. 3d at 1079 (finding that it was clear from the face of the complaint that Plaintiff had not exhausted where she alleged that she was "deemed to have exhausted the administrative remedies available under the plan" but excusing because the Defendant did not adhere to ERISA requirements).

These two Plaintiffs' failure to exhaust also should not be excused. Generally, a failure to exhaust will be excused in three limited circumstances—when "resort to administrative remedies would be futile," "when the remedy provided is inadequate," and when "a plan has failed to establish or follow claims procedures consistent with the requirements of ERISA." *Almont,* 99 F. Supp. 3d at 1178. Plaintiffs make no allegation that an inadequate remedy was provided. And as discussed, *supra*

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[9] *See*, *e.g.*, Exs. B–D at 45–49 (Lennar Plans); Ex. F at 57-59 (Sunrun Plan); Exs. J, L (Dababneh and Rentsch letters at 2-4).

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12, they have not shown any violations of ERISA requirements.

Instead, they assert that their claims should be "deemed exhausted" since "Defendants made appealing the adverse benefits determinations futile because Defendants failed to disclose the true reason for its adverse benefits determinations." (TAC ¶ 120.) But even if Plaintiffs' assertion is true—and it is not—it is irrelevant. Plaintiffs knew they had an adverse benefits determination that their claims were not medically necessary, a denial which they knew they were entitled to appeal. They were informed of the means to do so and did not. (*See* Exs. B-D at 45-49 (Lennar Plans); Ex. F at 57-59 (Sunrun Plan); Exs. J, L (Dababneh and Rentsch letters at 2-4).) They also have not alleged any facts that would suggest that Cigna's use of PxDx in any way affects the outcome of appeals, since they admit they had all of the information necessary to show, in their view, that their claims were medically necessary. (*See* TAC ¶¶ 53, 61, 64, 68 (describing how Dababneh's and Rentsch's doctors prescribed their treatments).) So they have not alleged that appealing was futile. *See Almont*, 99 F. Supp. 3d at 1179 ("[t]he futility exception is narrow—the plan participant must show that it is certain that her claim will be denied on appeal, not merely that she doubts that an appeal will result in a different decision.").

In fact, Plaintiffs' real gripe is that they do not think most people take advantage of an insurer's appeal procedures, but in doing so, they acknowledge that Cigna offers an appeal system when claim benefits are denied. (TAC ¶ 5 ("Cigna knows that only a tiny minority of policyholders (roughly 0.2%) will appeal denied claims[.]"); *see also id*. n.4 (citing a report about appeals of denials for insureds covered by non-ERISA policies offered on the Affordable Care Act insurance exchange).) Nor could Plaintiffs possibly do otherwise, given that their denial letters clearly informed them of their right to appeal and the process for doing so. (*See* Exs. J, L (Dababneh and Rentsch letters).) Plaintiffs' unsupported conclusion that appeals would have been futile is thus insufficient. *See Grenell v. UPS Health & Welfare Package*, 390 F. Supp. 2d 932, 935 (C.D. Cal. 2005) ("Such unsupported allegations of futility will not sustain the futility exception to the exhaustion requirement.").

B. Plaintiffs' 502(a)(3) Claim For Equitable Relief (Count II) Should Be Dismissed.

Plaintiffs' Section 502(a)(3) claim fares no better than their Section 502(a)(1)(B) claim. ERISA provides a "catchall" provision that allows Plaintiffs to seek "***appropriate*** equitable relief"

where no other provision provides them with adequate relief. *Varity Corp. v. Howe*, 516 U.S. 489, 512, 515 (1996). But even under that provision, Plaintiffs must meet certain pleading standards. Plaintiffs' claim here fails for three reasons: First, Plaintiffs have not alleged a breach of fiduciary duty. Second, Plaintiffs have not properly stated a claim for equitable relief. And third, Plaintiffs' Section 502(a)(3) claim is entirely duplicative of their 502(a)(1)(B) claim.

1. Plaintiffs Have Not Alleged a Breach of Fiduciary Duty.

"[T]o establish an action for equitable relief under [ERISA Section 502(a)(3)], the defendant must be an ERISA fiduciary acting in its fiduciary capacity[,] and must violate ERISA-imposed fiduciary obligations." *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1075 (9th Cir. 2009). Plaintiffs acknowledge that Cigna owes them a duty to "make decisions in accordance with insurance plan terms and ERISA." (TAC ¶ 130.) They assert that Cigna violated its fiduciary duties by developing a claims review process that "improperly restricted coverage in contravention of Plaintiffs' health insurance plans, ERISA [sic][.]" (*Id.* at ¶ 132.) But nowhere do they point to any plan provision that prohibits the use of a claim matching system like PxDx to identify claims that Cigna has a right to deny. And nowhere do they point to any claim that was denied wrongfully by PxDx. Cigna cannot be held to have breached its fiduciary duty by properly denying claims for uncovered treatment. *See Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945, 954 (9th Cir. 2014) (under Section 502(a)(3), "a plaintiff who is a participant, beneficiary, or fiduciary must prove . . . that there is a remediable wrong, *i.e.,* that the plaintiff seeks relief to redress a violation of ERISA or the terms of a plan[.]").

Cigna's use of PxDx also didn't violate the ERISA statute. Plaintiffs assert that Cigna violated ERISA § 503 because PxDx "failed to provide a 'full and fair review' of denied claims." (TAC ¶ 133.) Plaintiffs misread ERISA § 503. ERISA's requirement of "a full and fair review of a claim and adverse benefit determination" only goes into effect ***after*** a claim has been denied. 29 C.F.R. § 2560.503-1(h). So the use of PxDx to identify the claims Cigna had a right to deny in the first place does not implicate Section 503's "full and fair review" requirement.

Plaintiffs also have not shown that Cigna failed to disclose the "specific reasons" for its denial and deprived them of "reasonable claim procedures." (TAC ¶¶ 133, 135.) The letters for claims reviewed through the PxDx review process are generated "to meet federal and state requirements"

(*see*, *e.g.*, Exs. J–K at 1–2) (Dababneh and Abbas's letters), and they provide the exact information that Plaintiffs say is missing—like "the specific reasons" for their adverse determinations (lack of coverage under the plan or improperly submitted procedure codes). (*See* TAC ¶ 54 (Dababneh), ¶¶ 63, 66, 70, 72 (Rentsch), ¶¶ 95–97 (Abbas); Exs. J–L (Dababneh, Abbas, and Rentsch's letters).) And, in line with federal regulation, they provide the "internal rule, guideline, protocol, or other similar criterion [that] was relied upon in making the adverse determination . . .," such as Cigna's clinical policies. 29 C.F.R. § 2560.503-1(g)(1)(v)(A). And Plaintiffs also have not shown any failure on Cigna's part to comply with ERISA's requirements for reasonable claims procedures (TAC ¶ 135), which in any event is a question of exhaustion, not fiduciary duty. *See Vaught*, 546 F.3d at 626–27. Because Cigna's use of PxDx to deny Plaintiffs' claims violated neither the terms of Plaintiffs' plans nor ERISA, Plaintiffs have not alleged a breach of fiduciary duty.

2. Plaintiffs Have Not Properly Stated A Claim For Equitable Relief.

Even if Plaintiffs had alleged a breach of fiduciary duty (they have not), they have not stated a proper claim for equitable relief. Because a plaintiff asserting a claim for breach of fiduciary duty under Section 502(a)(3) "must prove . . . that the relief sought is 'appropriate equitable relief,'" *Gabriel*, 773 F.3d at 954, a plaintiff must identify "what specific relief" they seek. *Physicians Surgery Ctr. of Chandler v. Cigna Healthcare Inc.*, 550 F. Supp. 3d 799, 812 (D. Ariz. 2021).

Plaintiffs do not do that. They merely state, in conclusory fashion, that they "seek this Court's order that they are entitled to appropriate equitable relief under 29 U.S.C. § 1132(a)(3[)]." (TAC ¶ 137.) This is precisely the sort of claim that courts in this circuit have dismissed. *See Physicians Surgery Ctr. of Chandler*, 550 F. Supp. 3d at 812 (dismissing plaintiff's 502(a)(3) claim that "only allege[d] entitlement 'to damages and equitable, injunctive and declaratory relief'" because "[r]elying on these legal conclusions is improper at the pleading stage"). Because Plaintiffs offer little more than a legal conclusion, this complaint does not provide the basis for their claim for relief.

3. Plaintiffs' 502(a)(3) Claim Duplicates Their 502(a)(1)(B) Claim.

Plaintiffs' Section 502(a)(3) claim should be dismissed because it duplicates their Section 502(a)(1)(B) claim. Section 502(a)(3) is a "catchall" provision that only authorizes "appropriate equitable relief," so "where Congress elsewhere provided adequate relief for a beneficiary's injury,

there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate'" to maintain under Section 502(a)(3). *Varity*, 516 U.S. at 515.

The Ninth Circuit therefore allows plaintiffs to "bring simultaneous claims under Sections 1132(a)(1)(B) and 1132(a)(3) so long as they 'plead alternate theories of relief without obtaining double recoveries.'" *Kazda*, 2019 WL 11769104, at *5. But where there is "little functional daylight" between a plaintiff's theory of liability for 502(a)(1)(B) and (a)(3) claims, courts can dismiss the claim as duplicative. *Fortier v. Anthem, Inc.*, 2020 WL 13304004, at *4 (C.D. Cal. Oct. 26, 2020).

That is precisely the case here. Plaintiffs allege that Cigna violated Section 502(a)(1)(B) by "violat[ing] the terms of plan documents requiring payment of benefits to Class members by using the PXDX algorithm to make coverage determinations[.]" (TAC ¶ 117.) Plaintiffs allege the same thing when they claim that Cigna violated Section 502(a)(3) by "develop[ing] and rel[ying] upon internal practices and policies that improperly restricted coverage in contravention of Plaintiffs' health insurance plans," *i.e.*, the PxDx process. (*Id.* ¶ 132.) In other words, Plaintiffs' theory of liability under both provisions is that Cigna violated the terms of the plans by using PxDx, resulting in non-payment of benefits owed under their plans. These are identical theories of liability, with no "functional daylight" between them. *Fortier*, 2020 WL 13304004, at *4.[10]

IV. Plaintiffs' California UCL Claim (Third Cause of Action) Should Be Dismissed.

Plaintiffs' UCL claim alleges that Cigna's use of PxDx deprived them of their plan benefits, which Plaintiffs allege was "unfair," "unlawful," and/or "fraudulent" under California Business & Professions Code Section 17200. (TAC ¶ 154 (for the Section 17200 claim, seeking to "enjoin[] 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 III With Particularity Under Rule 9(b).

Section 17200 claims grounded in fraud are subject to Rule 9(b), requiring plaintiffs to "articulate the who, what, when, where, and how of the misconduct alleged." *Kearns v. Ford Motor*

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[10] Plaintiffs also fail to allege what equitable relief they actually seek, *supra* 17, making it impossible to ascertain whether Plaintiffs seek double recovery.

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Co., 567 F.3d 1120, 1124–26 (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. & Reg'l 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.").

The TAC sounds in fraud because its premise is that Cigna allegedly used PxDx as a secret and fraudulent scheme to deny members their covered benefits. (*See*, *e.g.*, TAC ¶ 34 (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.* ¶ 9 ("Cigna also made ***deceptive and misleading*** representations to Plaintiffs and Class members regarding the efficiency of their services.").) Because the entire TAC sounds in fraud, Rule 9(b) applies to all three prongs of Plaintiffs' UCL claim. *See Kearns*, 567 F.3d at 1127 (no error in district court applying Rule 9(b) to the entire UCL claim where 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 applying Rule 9(b) to the entire UCL claim because "Saloojas's complaint undoubtedly sounds in fraud").

Despite four tries, Plaintiffs have not pled the specifics that Rule 9(b) requires. 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." (TAC ¶ 9.)

These assertions are not particular facts explaining the circumstances of the fraud. *See Kearns*, 567 F.3d at 1124–26. As to the first theory, Plaintiffs do not identify what terms in their benefit plans support it, *supra* 11–13. 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 a particular way, let alone 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 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. 2018) (citing *Kwikset Corp. v. Super. Ct.*, 51 Cal. 4th 310, 326–27 (2011)). Plaintiffs make the boilerplate assertion that they supposedly "relied on Defendants' misrepresentations" (TAC ¶¶ 50, 92, 102), but none of them alleges that they saw the "we've got you covered" phrase on Cigna's website or any alleged misrepresentations in their benefit plans before they decided to buy their health insurance. (*See id.* ¶ 9.) The UCL claim fails for this reason too.

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 "made deceptive and misleading representations" (TAC ¶ 9) without identifying the alleged role that Cigna Corporation versus CHLIC 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 (it does), 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). (TAC ¶¶ 33, 141–144.) The first two cannot form the basis for a UCL claim because they are part of the Unfair Insurance Practices Act

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(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. § 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)."[11] *Height St. Skilled Care, LLC v. Liberty Mut. Ins. Co.*, 2022 WL 1665220, at *5 (E.D. Cal. May 25, 2022).

Plaintiffs' allegations that Cigna's use of PxDx violated California Health & Safety Code § 1367.01(e) and (h)(4) (*see* TAC ¶¶ 143–44) 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* TAC ¶ 2 (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

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[11] 10 C.C.R. § 2695.1 is the preamble to these UIPA regulations, which also include Section 2695.7, as both are "part of the regulatory scheme created by the California Insurance Commission pursuant to the UIPA and Insurance Code section 790.3(h)." *Marroquin v. Loya Cas. Ins. Co.*, 2023 WL 9743710, at *3 (C.D. Cal. Sept. 18, 2023) (finding that plaintiffs could not allege a violation of the unlawful prong based on 10 C.C.R. § 2695.7).

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medical necessity, including the information as to how Plaintiffs and Class members may file a grievance with the plan[.]" (*Id.* ¶ 144.) Plaintiffs have not plausibly pled a violation of this regulation either, because they acknowledge that Cigna sent them letters explaining why the procedure was not covered and how to appeal their decision. (*See*, *e.g.*, *id.* ¶ 54 (Dababneh); *id.* ¶ 66 (Rentsch); *id.* ¶ 95 (Abbas).)

Plaintiffs cannot meet the "unlawful" prong by alleging that Cigna "violate[d] the implied covenant of good faith and fair dealing." (TAC ¶ 142.) "[T]o state a claim for breach of the implied covenant of good faith and fair dealing, a plaintiff must identify the specific contractual provision that was frustrated." *Way v. JP Morgan Chase Bank, N.A.*, 2018 WL 2117630, at *3 (E.D. Cal. May 8, 2018). Moreover, Plaintiffs cannot use the implied covenant to establish obligations that were not in the express contract. *See Bunce v. Ocwen Loan Servicing, LLC*, 2013 WL 3773950, at *2 (E.D. Cal. July 17, 2013) (dismissing implied covenant claim and holding "an action alleging a breach of the implied covenant cannot be used by a plaintiff to try to extend existing, or to create new, obligations that were not contemplated by the parties when the contract was executed").

Plaintiffs run afoul of both requirements. Plaintiffs assert that Cigna "violated the unlawful prong of § 17200 when they utilized the PXDX system to review and deny Plaintiffs and Class members' claims rather than conducting a fair and full review, acting in bad faith to deny Plaintiffs and Class members of benefits they were due under the insurance agreements[.]" (TAC ¶ 145.) But as discussed, *supra* 10–13, Plaintiffs have never identified any provision of their plan that Cigna breached. And they do not point to any provision of the plan that Cigna frustrated through its use of PxDx. Instead, they seek to create a new obligation on Cigna to engage in manual review of every claim. Because this cannot form the basis for a breach of implied covenant claim, *see Bunce* 2013 WL 3773950, at *2, it also cannot form the basis for a claim under the "unlawful" prong of the UCL.

Finally, Plaintiffs' attempts to rely on the "unfair" prong fail for two reasons. <u>First</u>, Plaintiffs do not plead any distinct "unfair[ness]" UCL theory separate and apart from their "unlawful" or "fraudulent" UCL theories. (*See id.* ¶ 146.) For the reasons above, Plaintiffs have not pled either of 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

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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 plead facts to support their "unfair" prong allegations. 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" (TAC ¶ 146), 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). And while Plaintiffs allege that Cigna's use of PxDx "constitute[s] a systematic breach of consumer contracts" (TAC ¶ 146), as explained *supra* 10–13, Plaintiffs have not plausibly alleged any violation of the terms of the plans (the contracts at issue here).

C. ERISA Preempts Plaintiffs' UCL Claim.

As Plaintiffs acknowledge, all of their plans are subject to ERISA. (*See* TAC ¶¶ 16–21; Exs. B–I (Plaintiffs' plans).) 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.*, TAC ¶ 51 (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 [Plaintiffs] 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.

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 v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010). State-law claims are also preempted when they "govern[] . . . a central matter of plan administration or

1 interfere[] with nationally uniform plan administration," *Gobeille*, 577 U.S. at 319–20—and "payment
2 of benefits" is, of course, "a central matter of plan administration." *Egelhoff v. Egelhoff ex rel. Breiner*,
3 532 U.S. 141, 147–48 (2001); *accord Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86–87
4 (2020) (ERISA is "primarily concerned with pre-empting laws that require providers to structure
5 benefit plans in particular ways, ***such as by requiring payment of specific benefits***").

6 The uniform regulatory regime that ERISA envisions would collapse if plaintiffs could "obtain
7 remedies under state law that Congress rejected in ERISA." *See Pilot Life Ins. Co. v. Dedeaux*, 481
8 U.S. 41, 54 (1987). Therefore, "to the extent that Plaintiffs' claims are intended to rectify a wrongful
9 denial of benefits promised under an ERISA-regulated plan, and not to remedy a violation of a legal
10 duty independent of ERISA, the claims are preempted." *Sarkisyan v. CIGNA Healthcare of Cal., Inc.*,
11 613 F. Supp. 2d 1199, 1208 (C.D. Cal. 2009).

12 There is no doubt that Plaintiffs seek recovery of plan benefits. The premise of their lawsuit
13 is that Cigna allegedly used PxDx to deny "payments for necessary medical procedures owed to them
14 ***under Cigna's health insurance policies***" (TAC ¶ 1)—*i.e.*, payments allegedly owed under ERISA-
15 governed benefit plans. Plaintiffs cannot avoid ERISA preemption simply by pleading a violation of
16 the UCL. *See Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225–26 (9th Cir. 2005) (finding UCL
17 claim preempted where "[plaintiff] sought benefits under the plan and did not receive them" because
18 "these are precisely the kind of claims that the Supreme Court in *Davila* held to be pre-empted");
19 *Sarkisyan*, 613 F. Supp. 2d at 1205 (finding various state-law claims, including UCL, preempted
20 because "ERISA plainly preempts Plaintiffs' claims to the extent that Plaintiffs seek redress for what
21 they claim to be CIGNA's wrongful denial of benefits to their daughter").

22 Finally, to the extent Plaintiffs argue that they are also disputing the way that Cigna processed
23 their claims—*i.e.*, by allegedly using PxDx, and by Cigna's medical directors allegedly not reviewing
24 the claims in enough detail (*see* TAC ¶ 28)—ERISA also preempts that theory because ERISA is the
25 "exclusive vehicle" for challenges based on "improper processing of a claim for benefits." *See*
26 *Dedeaux*, 481 U.S. at 51–52; *Sarkisyan*, 613 F. Supp. 2d at 1206 (finding Section 17200 claim "based
27 on Cigna's alleged 'improper claims handling practices'" preempted); *Vang v. Geil Enters. Inc.*, 2023
28 WL 3168513, at *5 (E.D. Cal. Apr. 28, 2023) (finding claim based on "alleged improper withholding

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1 of benefits and the back dating [of] a notice required by law to be provided to [plaintiff]" preempted,
2 "because these allegations are directly related to the administration of the [plan]").

3 **CONCLUSION**

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

5

6 Dated: August 23, 2024 Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 23, 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
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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SUZANNE KISTING-LEUNG, SAMANTHA DABABNEH, RANDALL RENTSCH, CRISTINA THORNHILL, AMANDA BREDLOW, AND ABDULHUSSEIN ABBAS, 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-CSK

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

Date: December 3, 2024
Time: 1:30 P.M.
Judge Hon. Dale A. Drozd
Courtroom: 4, 15th floor
Third Am. Complaint Filed: June 15, 2024

McDermott Will & Emery LLP
Attorneys At Law
Los Angeles

1 I, Dmitriy Tishyevich, hereby declare:

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

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

8 3. Attached hereto as Exhibit B, Exhibit C, and Exhibit D are true and correct copies of
9 excerpts from the Lennar Corporation health benefit plans applicable to the claims at issue for
10 Plaintiff Randall Rentsch.

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

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

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

17 7. Attached hereto as Exhibit H is a true and correct copy of excerpts from the
18 Volkswagen Group of America, Inc. health benefit plan applicable to the claim at issue for Plaintiff
19 Amanda Bredlow.

20 8. Attached hereto as Exhibit I is a true and correct copy of excerpts from the Anywhere
21 Real Estate health benefit plan applicable to the claims at issue for Plaintiff Abdulhussein Abbas.

22 9. Attached hereto as Exhibit J is a true and correct copy of correspondence from Cigna
23 to Plaintiff Samantha Dababneh, dated September 24, 2023.

24 10. Attached hereto as Exhibit K is a true and correct copy of correspondence from Cigna
25 to Plaintiff Abdulhussein Abbas, dated March 20, 2023.

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27

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11. Attached hereto as Exhibit L is a true and correct copy of correspondence from Cigna to Plaintiff Randall Rentsch, dated October 16, 2016.

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

Dated: August 23, 2024

/s/ Dmitriy Tishyevich
Dmitriy Tishyevich

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