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6 **UNITED STATES DISTRICT COURT**
7 **EASTERN DISTRICT OF CALIFORNIA**
8

9 SAMANTHA DABABNEH and RANDALL
10 RENTSCH, individually and on behalf of all
others similarly situated,

11 Plaintiffs,

12 vs.

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

16 Defendants.
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Case No. 2:23-cv-01477-DAD-CSK

**STIPULATED MOTION TO AMEND THE
COMPLAINT TO ADD PROPOSED
PLAINTIFF AND CLASS
REPRESENTATIVE MICHAEL
MAHSHIGIAN AND [PROPOSED] ORDER
TO EXTEND DEADLINES AND TO
ALLOW AMENDMENT**

Pursuant to Federal Rules of Civil Procedure 15(a), 16(b), and 21, and Local Rule 220, Plaintiffs Samantha Dababneh and Randall Rentsch (“Plaintiffs”) hereby seek this Court’s leave to file a Fourth Amended Complaint for the limited purpose of adding Michael Mahshigian (“Proposed Plaintiff”) as a named plaintiff and class representative for the ERISA class and California Unfair Competition Law (“UCL”) subclass, and provide Defendants an opportunity for discovery associated with the Proposed Plaintiff. The amendment is necessary because the sole current representative of the UCL subclass, Samantha Dababneh, was unavailable to continue prosecuting the action for an indefinite period or be deposed by the current discovery deadline as a result of personal extenuating circumstances that arose after the scheduling conference. Accordingly, the UCL subclass claims—which remain live and were properly pleaded at the outset—are at risk because of the uncertainty around Plaintiff Dababneh’s participation, even though this case is still in its pre-certification stage.

Cigna Corporation and Cigna Health and Life Insurance Company (collectively, “Cigna” or “Defendants”) consent to the filing of this motion and proposed order, and to entry of the Proposed Fourth Amended Complaint to join Proposed Plaintiff to this lawsuit, provided that Plaintiff Dababneh is dismissed as a class representative, or, if she intends to participate in the lawsuit, is available for deposition by the amended deadline herein.¹ If Plaintiffs’ motion is granted, this Court’s class certification briefing schedule will be largely undisturbed, with only minor modifications to the schedule relating to discovery about the Proposed Plaintiff and the deposition of Plaintiff Dababneh, if she resumes participating in this lawsuit and is not dismissed as a class representative, as set forth in the appended proposed order to extend deadlines. The class certification briefing schedule will not change.

I. INTRODUCTION

Plaintiffs seek to add for good cause shown the Proposed Plaintiff to ensure continuing representation of the UCL subclass. Plaintiffs have prosecuted this case diligently for more than three years, working cooperatively with Defendants through three prior stipulated amendments. The current need to add a class representative arises from a circumstance the parties could not have foreseen: In

¹ In addition to adding Mr. Mahshigian, the Proposed Fourth Amended Complaint contains minor changes to the Parties and claims to reflect this Court’s orders of March 31, 2025 and August 13, 2026. *See* Ex. C (Comparison of Third Amended Complaint and Proposed Fourth Amended Complaint). In consenting to the filing of this motion and to the proposed order, Defendants do not admit the allegations of the Proposed Fourth Amended Complaint.

August 2026, the sole remaining representative of the UCL subclass became unavailable to continue for an indefinite period due to personal circumstances beyond her or Plaintiffs' counsel's control. Plaintiffs responded by identifying a co-representative of the UCL subclass. The Parties propose only minor modifications to the Court's Scheduling Order to permit Defendants an opportunity for any third-party discovery necessitated by the addition of a new Plaintiff and to set an extended deadline for Plaintiff Dababneh's deposition, if she resumes participation in the lawsuit and is not dismissed as a class representative. Rule 16's diligence standard is satisfied. If this Court agrees, leave to amend the complaint by stipulation should be granted. Accordingly, Plaintiffs respectfully move this Court to grant the Plaintiffs leave to file the Proposed Fourth Amended Complaint ("PFAC") and to enter the stipulated proposed order to extend deadlines.

II. LEGAL STANDARD

In considering whether to allow an amendment after a pretrial scheduling order has, as here, been entered, *Johnson v. Mammoth Recreations, Inc.*, 975 F.2d 604, 607–08 (9th Cir. 1992), the moving party must demonstrate good cause, Fed. R. Civ. P. 16(b)(4); *Johnson*, 975 F.2d at 609; *see also Jackson v. Laureate, Inc.*, 186 F.R.D. 605, 606–08, 609 & n.6 (E.D. Cal. 1999) (noting good-cause requirement mandatory and not overcome by stipulation alone). The focus of this first inquiry is the moving party's diligence, and in particular its assistance in creating a workable scheduling order under Rule 16; its inability to foresee the events necessitating the amendment; and its diligence in seeking the amendment itself. *Pizana v. SanMedica Int'l LLC*, 345 F.R.D. 469, 478 (E.D. Cal. 2022) (quoting *Wake Forest Acquisitions, L.P. v. Vanderbilt Com. Lending, Inc.*, 2018 WL 1586362, at *3 (E.D. Cal. Apr. 2, 2018)).

Next, this Court considers in its discretion whether the amendment is proper under Fed. R. Civ. P. 15(a), with a presumption in favor of granting leave to amend. *Foman v. Davis*, 371 U.S. 178, 182 (1962); *Eminence Cap., LLC v. Aspeon, Inc.*, 316 F. 3d 1048, 1052 (9th Cir. 2003). Where the parties consent, this Court should grant such leave. Fed. R. Civ. P. 15(a)(2). Leave is also warranted under Rules 15(a)(2) and 21 given the liberal amendment policy, the absence of undue delay or prejudice, and the narrow adjustments requested below that will not disturb the key class certification briefing deadlines in this case.

**III. ON DISCOVERY OF THE REPRESENTATIVE'S UNAVAILABILITY,
PLAINTIFFS ACTED DILIGENTLY IN SEEKING AMENDMENT**

Good cause exists to grant Plaintiffs' motion. Plaintiffs have diligently participated in this case, including in assisting the Court in creating the Rule 16 order. They could not have foreseen the class representative's recent unavailability due to personal circumstances. Once they understood Ms. Dababneh unavailable for deposition within the parties' fact discovery deadline, Plaintiffs' counsel moved quickly to secure a co-representative and to offer that Proposed Plaintiff to Defendants for discovery. Under the Rule 16 framework, these facts, taken together, establish good cause for this Court to consider Plaintiffs' amendment.

A. Plaintiffs were diligent in creating the Rule 16 order

Plaintiffs did not lack diligence in formulating the scheduling order. The first factor of the Rule 16 good-cause inquiry asks whether the moving party assisted the Court in creating a workable schedule. *Pizana*, 345 F.R.D. at 478 (collecting cases). Plaintiffs' counsel in this case timely filed joint scheduling reports and have worked collaboratively and in good faith with opposing counsel to craft an appropriate discovery schedule.

The parties timely submitted their joint scheduling report on May 23, 2025. Dkt. 58. Plaintiffs thereafter honored the resulting schedule, and when modifications became necessary, they were accomplished cooperatively and by joint motion: The parties jointly moved to modify the schedule on April 28, 2026 (granted May 1, 2026), and again on August 24, 2026 based on the parties' negotiations. This record of timely reporting and cooperative scheduling reflects the diligence the first factor is meant to reward. Plaintiffs' assistance in creating the Court's Rule 16 order weighs in favor of finding good cause for amendment. *Pizana*, 345 F.R.D. at 478.

Separately, the previous amendments to the Complaint were all entered by stipulation. Dkt. 22, Dkt. 25, Dkt. 34. Each was filed before this Court issued an opinion and order on Cigna's motion to dismiss and before the Plaintiffs filed their notice of intent not to amend the case to add further claims. Dkt. 55, 56. This, too, reflects the Plaintiffs' diligence. *Cf. Pizana*, 345 F.R.D. at 483 ("Plaintiff's proposed amendments are unrelated to plaintiff's two previous amendments, and there has been no history of repeated failures to cure pleading deficiencies in this case.").

B. Plaintiffs could not have foreseen the class representative's unavailability

Plaintiffs' counsel could not have foreseen the events necessitating this amendment. Good cause turns in part on the moving party's ability to foresee the events that make amendment necessary. *Pizana*, 345 F.R.D. at 478. When the schedule was originally set, Ms. Dababneh was an active, willing class representative. Her subsequent unavailability and inability to presently participate in the lawsuit stems from extenuating personal circumstances unrelated to this case—circumstances that were first brought to counsel in July 2026 and only became resolvable through the requested amendment by late August 2026. Dec. of Larkin Turner (Ex. A).

C. Plaintiffs acted diligently in seeking amendment once the class representative's unavailability became apparent

Plaintiffs did not delay this amendment. After determining that Ms. Dababneh was unavailable for deposition within the fact discovery period and locating a co-representative, Plaintiffs' counsel contacted Defendants' counsel on August 31, 2026 with the name of the proposed representative, and the parties agreed to seek amendment. Dec. of Larkin Turner (Ex. A). This process occurred over weeks, not months. *Cf. Kamal v. Eden Creamery, LLC*, 88 F. 4th 1268, 1277-78 (9th Cir. 2023) (finding plaintiffs not diligent where they waited eight months to move to amend). The final factor asks whether the moving party was diligent in seeking amendment once the need arose. *Pizana*, 345 F.R.D. at 478. Dababneh first signaled that she might be unavailable for deposition due to extenuating personal circumstances unrelated to this case in early July. Turner Dec. She then indicated that she would sit for deposition. *Id.* Understanding that Ms. Dababneh's deposition availability was in flux, counsel began searching for a co-representative to protect the subclass in the event she could not continue. *Id.* That search led counsel to the Proposed Plaintiff, who had approached Plaintiffs' counsel seeking representation in this matter in 2023. *Id.* Mr. Mahshigian signed a retainer on August 28, 2026. *Id.* The next business day, August 31, 2026, Plaintiffs offered Mr. Mahshigian to Defendants for written discovery and deposition, on a timeline requiring no change to the class-certification schedule. *Id.* Defendants later stated they would agree to the addition of the Proposed Plaintiff with the understanding that Plaintiff Dababneh would be dismissed as a class representative if she was not available to be deposed or participate in the lawsuit so long as minor changes could be made to the schedule permitting

related discovery into the Proposed Plaintiff, to which Plaintiffs agreed. *Id.* On these facts, Plaintiffs were diligent. Because Plaintiffs assisted in creating a workable schedule, could not have foreseen the representative's unavailability, and acted diligently—within weeks, not months—once these circumstances arose, this Court should find good cause for amendment under Rule 16(b).

IV. BECAUSE CIGNA CONSENTS, THIS COURT SHOULD PERMIT PLAINTIFFS' AMENDMENT AND GRANT LEAVE TO EXTEND THE SCHEDULE

The Plaintiffs and Defendants have stipulated to the Fourth Amended Complaint; provided that the Plaintiffs demonstrate good cause, this Court should permit amendment. Fed. R. Civ. P. 15(a)(2). And because Defendants seek discovery related to the Proposed Plaintiff and a deadline for Plaintiff Dababneh's dismissal as a class representative or, if she is able to participate in the lawsuit again, her deposition, the Parties respectfully request that this Court extend the schedule relating to this discovery as set forth below.

A. Leave to Amend the Complaint

If this Court agrees that Plaintiffs were diligent in seeking amendment, it should grant the Plaintiffs leave to amend the complaint because the other party consents. Fed. R. Civ. P. 15(a)(2); *Foman*, 371 U.S. at 182. Prejudice is ordinarily the "touchstone" affecting whether to grant leave to amend the complaint, *Eminence*, 316 F.3d at 1052, with the opposing party bearing the burden to establish it, *DCD Programs, Ltd. v. Leighton*, 833 F.2d 183, 186–87 (9th Cir. 1987). It follows that where Defendants consent, amendment is heavily favored. The amendment is also in the interests of justice, which are not outweighed by undue delay, bad faith, repeated failure to cure, or futility. Here, "[t]he threshold procedural issue of class certification has not yet been addressed." *Pizana*, 345 F.R.D. at 484. Courts routinely allow counsel to identify a new representative pre-certification. *Cf. id.* (citing, e.g., *Woods v. Google LLC*, 2018 WL 4030570, at *10 (N.D. Cal. Aug. 23, 2018) (granting leave to amend to add a class representative where another representative was deemed inadequate to represent the class)).

B. Leave to Extend this Court's Schedule

This Court should grant leave to extend the schedule for the limited purpose of permitting discovery related to the Proposed Plaintiff and for Defendants to depose Plaintiff Dababneh if she resumes

participating in the lawsuit and is not dismissed as a class representative, which will not require changes to the class certification briefing deadlines. The parties' proposal confines adjustments to discrete discovery tasks related to the Proposed Plaintiff; leaves the class-certification briefing schedule unchanged; and specifies dates for discovery responses, third-party subpoenas, and the deposition of the Proposed Plaintiff. The Parties separately request that the Court modify the schedule to allow the deposition of Cherri Reddick to occur on October 13, 2026, after the current September 30, 2026, fact deposition deadline in this case. As a result of coordination with the *Snyder* action and conflicts with counsel's schedules, the Parties believe good cause exists and have mutually agreed to proceed with Ms. Reddick's deposition on October 13, 2026. These proposed changes are outlined below:

Revised Deadline	Event
September 30, 2026	Parties complete fact discovery and fact depositions other than deposition of Cigna's remaining 30(b)(6) witness, dismissal or deposition of Plaintiff Dababneh, and discovery related to the Proposed Plaintiff; Cigna to serve third-party subpoenas related to the Proposed Plaintiff by this date
October 13, 2026	Parties complete the duly noticed Rule 30(b)(1) deposition of Cherri Reddick
October 16, 2026	Plaintiffs provide responses to Cigna's discovery requests to the Proposed Plaintiff
November 4, 2026	Deadline for Plaintiffs to inform Cigna if Ms. Dababneh intends to resume participating in the lawsuit.
November 11, 2026	Deadline for production of documents by the parties related to the Proposed Plaintiff's claims, excluding documents received from third parties
November 25, 2026	Plaintiff Dababneh to be deposed or dismissed as a class representative on or before this date

Revised Deadline	Event
December 18, 2026	The Proposed Plaintiff will be deposed on or before this date
January 4, 2027	Parties complete discovery into the Proposed Plaintiff's claims

V. CONCLUSION

Because good cause exists to permit amendment under Rule 16(b), and because Defendants will not be prejudiced by Plaintiffs' amendment under Rule 15(a), Plaintiffs respectfully request that this Court enter the proposed order and permit the filing of the Proposed Fourth Amended Complaint attached hereto as Exhibit B.

DATED: September 30, 2026

CLARKSON LAW FIRM, P.C.

By: /s/ Glenn A. Danas

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Emma Ritter Gordon

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on September 30, 2026, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

/s/ Glenn A. Danas

Glenn A. Danas

EXHIBIT A

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1 UNITED STATES DISTRICT COURT
2 EASTERN DISTRICT OF CALIFORNIA

3 SAMANTHA DABABNEH and RANDALL
4 RENTSCH, individually and on behalf of all
5 others similarly situated,

6 Plaintiffs,

7 vs.

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

11 Defendants.

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

**DECLARATION OF ATTORNEY
LARKIN TURNER IN SUPPORT OF
PLAINTIFFS' STIPULATED
MOTION TO AMEND**

I, Larkin Turner, state as follows:

1. I am an attorney with Clarkson Law Firm, P.C., counsel for Plaintiffs. I make this declaration based on personal knowledge and case records maintained in the ordinary course of business.
2. Following the Court's order setting the Initial Scheduling Conference for June 9, 2025, the parties timely submitted a joint scheduling report on May 23, 2025.
3. When schedule modifications became necessary, the parties proceeded collaboratively by joint motion: on April 28, 2026, and again on August 24, 2026.
4. In early July 2026, Plaintiff Samantha Dababneh first informed Plaintiffs' counsel that she was potentially unable to appear for deposition due to extenuating personal circumstances unrelated to this case.
5. Approximately one week later, Ms. Dababneh stated that she *would* be available for deposition.
6. At that time, in the event that Ms. Dababneh became unavailable for deposition, I began to search for a co-representative.
7. On July 22, 2026, I informed counsel for Cigna that Ms. Dababneh was having difficulty finding a workable date for deposition.
8. By mid-August 2026, when Ms. Dababneh had not been able to commit to a deposition date, I concluded that she was not likely to be available for deposition prior to the close of fact discovery in this case.
9. On August 19, 2026, I informed counsel for Cigna that Ms. Dababneh was still having difficulty finding a workable date for deposition.
10. On August 24, 2026, I contacted Proposed Plaintiff Michael Mahshigian, who had contacted Clarkson Law Firm about this case in 2023 but did not sign an engagement agreement. Mr. Mahshigian indicated that he was still interested in the case, was immediately available for deposition, and was willing to be a corepresentative of the UCL subclass.
11. Mr. Mahshigian signed a retainer with Clarkson Law Firm on Friday, August 28, 2026.

12. On Monday, August 31, 2026, Plaintiffs informed Defendants that Ms. Dababneh was unavailable for deposition, offered Mr. Mahshigian to Defendants for written discovery and deposition, and requested their position on a motion to amend the complaint.

13. The parties met and conferred regarding this issue on September 3, 2026. On September 11, 2026, the parties reached an agreement to file a stipulated motion to amend the complaint provided the motion contain a request and proposed order to amend the schedule to permit Cigna to conduct third-party discovery relating to the Proposed Plaintiff.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on September 30, 2026.

Larkin Turner

Larkin Turner

EXHIBIT B

CLARKSON LAW FIRM, P.C.

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6 **UNITED STATES DISTRICT COURT FOR THE**
7 **EASTERN DISTRICT OF CALIFORNIA**
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9 SAMANTHA DABABNEH, MICHAEL
10 MAHSHIGIAN, and RANDALL RENTSCH,
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12 vs.

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

**FOURTH AMENDED CLASS ACTION
COMPLAINT**

1. CLAIM FOR APPROPRIATE
EQUITABLE RELIEF UNDER 29 U.S.C.
§ 1132(A)(3)
2. VIOLATION OF CALIFORNIA UNFAIR
COMPETITION LAW, BUSINESS &
PROFESSIONS CODE SECTION 17200, *et*
seq.

DEMAND FOR JURY TRIAL

1 Plaintiffs Samantha Dababneh, Michael Mahshigian, and Randall Rentsch (collectively
 2 “**Plaintiffs**”), individually and on behalf of all others similarly situated (the “**Class**”), by and
 3 through their attorneys, brings this class action against Defendants Cigna Corporation and Cigna
 4 Health and Life Insurance Company, and Does 1-50, inclusive (collectively, “**Defendants**” or
 5 “**Cigna**”) and allege as follows:

6 **I. INTRODUCTION**

7 1. This action arises from Cigna’s illegal scheme to systematically, wrongfully, and
 8 automatically deny its insureds the thorough, individualized physician review of claims guaranteed
 9 to them and, ultimately, the payments for necessary medical procedures owed to them under Cigna’s
 10 health insurance policies.

11 2. Cigna is a major medical insurance company in the United States, with approximately
 12 18 million members nationwide and 2.1 million members in California.¹ Cigna pledges that the
 13 company is “committed to improving the health and vitality” of its members.² In reality, Cigna
 14 developed an algorithm known as PXDX that it relies on to enable its doctors to automatically deny
 15 payments in batches of hundreds or thousands at a time for treatments that do not match certain pre-
 16 set criteria, thereby evading the legally-required individual physician review process.

17 3. Relying on the PXDX system, Cigna’s doctors instantly reject claims on medical
 18 grounds without ever opening patient files, leaving thousands of patients effectively without
 19 coverage and with unexpected bills. The scope of this problem is massive. For example, over a
 20 period of two months in 2022, Cigna doctors denied over 300,000 requests for payments using this
 21 method, spending an average of just *1.2 seconds* “reviewing” each request.³

22
 23
 24 ¹ Based on Cigna’s 18 million members nationwide,
 25 <https://www.statista.com/statistics/985102/medical-customers-of-cigna/>; California Health Care
 26 Almanac, <https://www.chcf.org/wp-content/uploads/2022/06/HealthInsurersAlmanac2022.pdf>
 (last accessed on July 24, 2023).

27 ² The Cigna Group Company Profile, <https://www.cigna.com/about-us/company-profile/> (last
 accessed on July 24, 2023).

28 ³ Patrick Rucker, et al., How Cigna Saves Millions by Having Its Doctors Reject Claims Without
 Reading Them, ProPublica, Mar. 25, 2023, [https://www.propublica.org/article/cigna-pxdx-medical-
 health-insurance-rejection-claims](https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims) (last accessed on July 20, 2023).

1 4. The PXDX system saves Cigna money by allowing it to deny claims it previously
2 paid and by eliminating the labor costs associated with paying doctors and other employees for the
3 time needed to conduct individualized, manual review for each Cigna insured.

4 5. Cigna also utilizes the PXDX system because it knows it will not be held accountable
5 for wrongful denials. For instance, Cigna knows that only a tiny minority of policyholders (roughly
6 0.2%)⁴ will appeal denied claims, and the vast majority will either pay out-of-pocket costs or forgo
7 the at-issue procedure.

8 6. Plaintiffs and members of the alleged Class had their claims automatically rejected by
9 Cigna using the PXDX system without any individualized consideration. Cigna failed to use
10 reasonable standards in evaluating the individual claims of Plaintiffs and Class members and instead
11 allowed its doctors to sign off on the denials in batches.

12 7. Cigna failed to disclose to Plaintiffs and Class members that their claims would be
13 reviewed and denied by the PXDX algorithm without any real doctor involvement.

14 8. Cigna intentionally omitted any reference to the PXDX algorithm in the policies
15 provided to Plaintiffs and Class members.

16 9. Cigna also made deceptive and misleading representations to Plaintiffs and Class
17 members regarding the efficiency of their services. For example, Cigna's policies falsely claim that
18 determinations related to medical necessity of health care services would be made by a medical
19 director, when in reality the medical directors are not involved in reviewing patients' claims.
20 Additionally, Cigna's website falsely states, "we've got you covered," leading Plaintiff and Class
21 members to believe that Cigna would conduct a thorough, fair, and objective review of their claims.

22 10. Plaintiffs bring these class claims against Cigna under the Employee Retirement
23 Income Security Act, 29 U.S.C. § 1132(a), also known as "ERISA § 502(a)," to recover benefits
24 wrongfully denied, to enjoin Cigna from utilizing illegal policies and practices going forward, and
25 to obtain other appropriate equitable relief to redress Cigna's violations.

26 11. By engaging in this misconduct, Cigna breached its fiduciary duties, including its duty

27 ⁴ See, e.g., Claims Denials and Appeals in ACA Marketplace Plans in 2021,
28 <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/> (last accessed on July 20, 2023).

1 of good faith and fair dealing, because its conduct serves Cigna’s own economic self-interest and
2 elevates Cigna’s interests above the interests of its insureds.

3 12. By bringing this action, Plaintiffs seek to remedy Cigna’s past improper and unlawful
4 conduct by recovering damages to which Plaintiffs and the Class are rightfully entitled and enjoin
5 Cigna from continuing to perpetrate its scheme against its nationwide and California insureds.

6 **II. JURISDICTION AND VENUE**

7 13. This Court has subject matter jurisdiction over Plaintiffs’ claims pursuant to 28 U.S.C.
8 § 1331 because Plaintiffs’ action arises under a law of the United States, specifically the Employee
9 Retirement Income Security Act of 1974 (“ERISA”).

10 14. This Court also has subject matter jurisdiction over Plaintiffs’ claims pursuant to 28
11 U.S.C. § 1332(d)(2). This is a class action in which there is a diversity of citizenship between at
12 least one Plaintiffs Class member and one Defendant; the proposed Classes each exceed one
13 hundred members; and the matter in controversy exceeds the sum of \$5,000,000.00, exclusive of
14 interest and costs.

15 15. Venue is proper in this Court pursuant to 28 U.S.C. § 1391. Defendants regularly
16 conduct business in this District, and a substantial part of the events giving rise to the claims asserted
17 herein occurred in this District. Plaintiff Kisting-Leung is a citizen of California who resides in this
18 District.

19 **III. THE PARTIES**

20 16. Plaintiff Samantha Dababneh is, and at all times relevant to this action has been, a
21 citizen of California. At all relevant times mentioned herein, Plaintiff Dababneh was a beneficiary
22 of a plan sponsored by SunRun, Inc., which is subject to ERISA. Cigna was at all times an ERISA
23 fiduciary under SunRun, Inc.’s ERISA plan because Cigna is the named claims administrator with
24 discretion to make benefits determinations under that plan.

25 17. Plaintiff Michael Mahshigian is, and at all times relevant to this action has been, a
26 citizen of California. At all relevant times mentioned herein, Plaintiff Mahshigian was a beneficiary
27 of a plan sponsored by Howard University and Howard University Hospital, which is subject to
28 ERISA. Cigna was at all times an ERISA fiduciary under Howard University and Howard

1 University Hospital's ERISA plan because Cigna is the named claims administrator with direction
2 to make benefits determinations under that plan.

3 18. Plaintiff Randall Rentsch is, and at all times relevant to this action has been, a citizen
4 of California. At all relevant times mentioned herein, Plaintiff Rentsch was a beneficiary of a plan
5 sponsored by Lennar Homes, LLC, which is subject to ERISA. Cigna was at all times an ERISA
6 fiduciary under Lennar Homes, LLC's ERISA plan because Cigna is the named claims administrator
7 with discretion to make benefits determinations under that plan.

8 19. Defendant Cigna Corporation is a Connecticut corporation headquartered at 900
9 Cottage Grove Road, Bloomfield, Connecticut 06002. Defendant Cigna Corporation conducts
10 insurance operations throughout the nation, including in California, representing to consumers that
11 Cigna and its subsidiaries are a global health service organization. Defendant Cigna Corporation
12 has a license to use the federally registered service mark "Cigna," markets and issues health
13 insurance and insures, issues, administers, and makes coverage and benefit determinations related
14 to the health care policies nationally through its various wholly owned and controlled subsidiaries,
15 controlled agents and undisclosed principals and agents, including Defendant Cigna Health and Life
16 Insurance Company. Defendant Cigna Corporation is licensed and regulated by the California
17 Department of Insurance ("CDI") and the California Department of Managed Health Care
18 ("CDMHC") to transact the business of insurance in the State of California, is in fact, transacting
19 the business of insurance in the State of California, and is thereby subject to the laws and regulations
20 of the State of California.

21 20. Defendant Cigna Health and Life Insurance Company, incorporated in Connecticut,
22 is a wholly owned subsidiary of Defendant Cigna Corporation, with its principal place of business
23 at 900 Cottage Grove Road, Bloomfield, Connecticut 06002. Defendant Cigna Health and Life
24 Insurance Company markets and issues health insurance and insures, issues, administers, and
25 renders coverage and benefit determinations related to the health care policies. Defendant Cigna
26 Health and Life Insurance Company is licensed and regulated by the CDI and the CDMHC to
27 transact the business of insurance in the State of California, is in fact, transacting the business of
28

1 insurance in the State of California, and is thereby subject to the laws and regulations of the State
2 of California.

3 **IV. FACTUAL ALLEGATIONS**

4 **A. Background**

5 21. Defendants offered and sold health coverage to nationwide and California consumers,
6 including the employer sponsors of Plans in which Plaintiffs are participants and beneficiaries.

7 22. Defendants provided Plaintiffs and Class members with plan documents explaining
8 the plan coverage available under their employer-sponsored plans. According to these terms, Cigna
9 must provide benefits for covered health services and pay all reasonable and medically necessary
10 expenses incurred by a covered member. Nowhere in these written terms did Cigna disclose that its
11 insurance coverage decisions would be automated or made by computers rather than human doctors.

12 23. From at least July 24, 2019, to the present, thousands or millions of Cigna insureds,
13 through healthcare providers, submitted bills to Cigna for reasonable and medically necessary
14 expenses covered by their plan terms.

15 24. To determine whether a submitted claim is medically necessary, Defendants are
16 required to conduct and diligently pursue a “thorough, fair, and objective” investigation into each
17 bill for medical expenses submitted, per California Insurance Regulations, Cal. Code Regs. tit. 10,
18 § 2695.7 (d). This means Cigna’s medical directors must examine patient records, review coverage
19 policies, and use their expertise to decide whether to approve or deny claims to avoid unfair denials.

20 25. Defendants have deliberately failed to fulfill their statutory obligation to review
21 individual claims in a “thorough,” “fair,” and “objective” manner, instead denying the claims for
22 medical expenses of its California insureds without conducting *any* investigation, let alone a
23 thorough, fair, or objective investigation.

24 26. Defendants utilize the PXDX system, which employs an algorithm to identify
25 discrepancies between diagnoses and what Defendants consider acceptable tests and procedures for
26 those ailments and automatically deny claims on those bases. After the PXDX system denies claims,
27 Cigna doctors then sign off on the denials in batches without opening each patient’s files to conduct
28 a more detailed review of, for example, the treatment/procedure at issue and related injuries, the

1 patient's prior medical or surgical history, the chronology of medical events, or any ambiguities and
2 complications.

3 27. Cigna's insurance policies state that its determinations of medical necessity are made
4 "by a Medical Director," when in fact Cigna uses the automated PXDX algorithm to make medical
5 necessity determinations.

6 28. Cigna's insurance policies state that Cigna will provide written or electronic notice of
7 adverse benefits determinations that include "the specific reason or reasons for the adverse
8 determination," but Cigna routinely fails to disclose that the PXDX algorithm was the reason for
9 many adverse benefits determinations.

10 29. In violation of California law, Defendants wrongfully delegated their obligation to
11 evaluate and investigate claims to the PXDX system, including determining whether medical
12 expenses are reasonable and medically necessary.

13 30. In violation of Cal. Code Regs. tit. 10, § 2695.7 (b)(1), Defendants failed to inform
14 their insureds in writing of the decision to deny their claims and failed to provide statements listing
15 all bases for such denial, including factual and legal bases for each reason given for such denial.

16 31. Defendants fraudulently misled California insureds into believing that their health
17 plan would individually assess their claims and pay for medically necessary procedures. Cigna
18 omitted the explanation of its PXDX from its written policies.

19 32. While its policies neatly avoided disclosure and explanation of PXDX, Cigna
20 communicated to customers and potential customers that it provides a careful, individual review of
21 all coverage decisions. For instance, Cigna's website falsely states, "we've got you covered," leading
22 Plaintiff and Class members to believe that Cigna would conduct a thorough, fair and objective
23 review of their claims.

24 33. Defendants use of the PXDX system to make coverage determinations violates both
25 ERISA and California law.

26 34. Defendants knowingly committed unfair and deceptive acts or practices with a
27 frequency indicating a general practice in violation of California Insurance Code, § 790.03.
28

35. Defendants' review system of California insureds' claims undermines the principles of fairness and meaningful claim evaluation, which insureds expect from their insurers.

B. Plaintiff Samantha Dababneh

36. Plaintiff Samantha Dababneh has been enrolled with Cigna since around July 2023.

37. On or around September 2022, Ms. Dababneh's doctor determined that it was medically necessary to check her Vitamin D levels to confirm she had no Vitamin D deficiency. Accordingly, Ms. Dababneh's doctor ordered such a test, which was administered on September 9, 2023.

38. On or around September 24, 2023, Ms. Dababneh received a denial letter from Cigna stating that Cigna was denying her claim because it was "not medically necessary."

39. The denial letter indicated that the PXDX algorithm reviewed her claim.

40. The denial letter was also not signed by an actual doctor, but by "Cigna Healthcare," indicating that the real doctor was not involved in the denial of Ms. Dababneh's claim.

41. Defendants failed to have a doctor diligently pursue a thorough, fair, and objective investigation into Ms. Dababneh's claim.

42. Defendants failed to disclose the PXDX process and its implications to Ms. Dababneh. Defendants further made misrepresentations to Ms. Dababneh that a doctor would conduct a thorough, fair, and objective investigation into her claims, knowing about the falsity of such representation. Ms. Dababneh reasonably relied on Defendants' misrepresentation and suffered damages as a result.

C. Plaintiff Michael Mahshigian

43. Plaintiff Michael Mahshigian was enrolled with Cigna from July 23, 2018, until December 31, 2022.

44. Due to a prior injury to his spine, in 2022 Mr. Mahshigian was suffering severe chronic pain and was unable to perform everyday activities.

45. To treat his pain, Mr. Mahshigian's doctors recommended and routinely provided routine radiofrequency ablation (RFA) while he awaited recommended cervical fusion surgery, which Cigna would not and did not authorize.

1 46. On October 20, 2022, Mr. Mahshigian underwent RFA. Without having a doctor
2 review the claim, Cigna denied Mr. Mahshigian's claim for anesthesia associated with this service
3 as not medically necessary using PXDX.

4 47. Mr. Mahshigian's anesthesiologist resubmitted the claim. Without having a doctor
5 review the claim, Cigna again denied it as not medically necessary using PXDX.

6 48. Upon information and belief, Defendants failed to have their doctors conduct a
7 thorough, fair, and objective investigation into Mr. Mahshigian's claim and instead denied it based
8 on the automated PXDX process. Cigna's automatic process affixed a doctor's signature to the claim
9 denial letter and stated that if appealed, it would be reviewed by a doctor who "wasn't involved in
10 making the first decision"—someone who didn't "work for or report to the doctor who made this
11 first decision." At least one of Mr. Mahshigian's denial letters was signed by a medical doctor.

12 49. However, when Cigna's PXDX algorithm denied Mr. Mahshigian's claim, no doctor
13 had actually reviewed it.

14 50. Defendants failed to disclose the PXDX process and its implications to Mr.
15 Mahshigian.

16 51. Mr. Mahshigian reasonably relied on Defendants' misrepresentations and suffered
17 damages as a result.

18 52. Defendants failed to have a doctor diligently pursue a thorough, fair, and objective
19 investigation into Mr. Mahshigian's claim.

20 53. Defendants failed to disclose the PXDX process and its implications to Mr.
21 Mahshigian. Defendants further made misrepresentations to Mr. Mahshigian that a doctor would
22 conduct a thorough, fair, and objective investigation into his claims, knowing about the falsity of
23 such representation. Mr. Mahshigian reasonably relied on Defendants' misrepresentation and
24 suffered damages as a result.

25 **D. Plaintiff Randall Rentsch**

26 54. Plaintiff Randall Rentsch was enrolled with Cigna from around 2015 until around
27 2018.
28

1 55. In or around 2016, Mr. Rentsch was diagnosed with a herniated disk in his neck, which
2 pinched a nerve and caused severe pain.

3 56. To help reduce inflammation in Mr. Rentsch's neck, his treating physician prescribed
4 a series of transforaminal epidurals.

5 57. On or around June 6, 2026, Mr. Rentsch received his first transforaminal epidural.

6 58. On or around June 13, 2016, Cigna informed Mr. Rentsch in writing that his claim
7 was denied because the treatment was "not medically necessary." The denial letter indicated that
8 the PXDX algorithm reviewed his claim.

9 59. Mr. Rentsch continued to experience severe pain and required additional injections.
10 As such, Mr. Rentsch had no choice but to continue his treatment despite Cigna's denial of his
11 claims.

12 60. On or around August 26, 2016, Mr. Randall received his second transforaminal
13 epidural.

14 61. On or around October 10, 2016, Cigna informed Mr. Rentsch in writing that they were
15 again denying his claim because the treatment was "not medically necessary." At that point, the
16 charges accrued for the two rounds of the epidural injections totaled \$5,014.80.

17 62. Upon information and belief, Cigna used the PXDX algorithm to "review" and deny
18 Mr. Rentsch's claims.

19 63. Mr. Rentsch continued to endure severe pain and required additional injections. As a
20 result, his treating physician prescribed more epidural injections.

21 64. On or around December 6, 2017, Mr. Rentsch received his third round of
22 transforaminal epidural.

23 65. On or around December 11, 2017, Cigna again denied his claim, stating the procedure
24 was "not medically necessary." Cigna continued to use the PXDX algorithm to wrongfully deny
25 Mr. Rentsch's claims.

26 66. On or around February 23, 2017, Mr. Rentsch received his fourth round of
27 transforaminal epidural.
28

1 67. On or around February 27, 2017, Cigna again denied his claim, falsely claiming that
2 the procedure was “not medically necessary.” Cigna continued to deploy the PXDX algorithm to
3 “review” and deny Mr. Rentsch’s claims.

4 68. On or around March 25, 2023, Mr. Rentsch discovered through an article published
5 by ProPublica that Defendants had been using the PXDX algorithm to review patients’ claims. Prior
6 to that, Mr. Rentsch had no knowledge of this illegal practice by Defendants. Additionally, Mr.
7 Rentsch had no way of knowing that Defendants had been using the PXDX algorithm to wrongfully
8 deny his claims.

9 69. Defendants failed to have a doctor diligently pursue a thorough, fair, and objective
10 investigation into Mr. Rentsch’s claim.

11 70. Defendants failed to disclose the PXDX process and its implications to Mr. Rentsch.
12 Defendants further made misrepresentations to Mr. Rentsch that a doctor would conduct a thorough,
13 fair, and objective investigation into his claims, knowing about the falsity of such representation.
14 Mr. Rentsch reasonably relied on Defendants’ misrepresentation and suffered damages as a result.

15 **V. CLASS ALLEGATIONS**

16 71. Plaintiffs bring this action on their own behalf and on behalf of all other persons
17 similarly situated pursuant to Rule 23 of the Federal Rules of Civil Procedure. The Class which
18 Plaintiffs seek to represent comprises:

19 All persons who are or were participants in, or beneficiaries of, health
20 insurance plans governed by ERISA for which Defendants serve as the
21 claims administrator with respect to medical benefits and who sought
22 and were denied coverage for benefits, in whole or in part, based on
Defendants’ use of the PXDX algorithm as alleged herein, within the
applicable statute of limitations.

23 72. The class definition may be further defined or amended by additional pleadings,
24 evidentiary hearings, a class certification hearing, and orders of this Court.

25 73. The California Class Plaintiffs seek to represent comprises:

26 All persons who are or were participants in, or beneficiaries of, health
27 insurance plans for which Defendants serve as the claims administrator
28 with respect to medical benefits and who sought and were denied
coverage for benefits, in whole or in part, based on Defendants’ use of

1 the PXDX algorithm as alleged herein, within the State of California
2 during the period of four years prior to the filing of the complaint
through the present.

3 74. The subclass definition may be further defined or amended by additional pleadings,
4 evidentiary hearings, a class certification hearing, and orders of this Court.

5 75. The Class is so numerous that their individual joinder herein is impracticable. Upon
6 information and belief, members of the Class number in the millions across the country. Upon
7 information and belief, members of the California Subclass number in the hundreds of thousands or
8 millions throughout California. The precise number of Class members and their identities are
9 unknown to Plaintiffs at this time but may be determined through discovery. Class members may
10 be notified of the pendency of this action by mail and/or publication through the distribution records
11 of Defendants and third-party retailers and vendors.

12 76. Common questions of fact and law predominate over questions that may affect
13 individual class members, including the following:

- 14 a. Whether Defendants automatically denied payment for claims submitted by
15 insureds and/or healthcare providers without having a medical director examine
16 patient records, review coverage policies and use their expertise to decide whether
17 to approve or deny claims?
- 18 b. Whether Defendants' denials of claims are based on its use of the PXDX system,
19 which employs an algorithm to identify discrepancies between diagnoses and what
20 Defendants consider acceptable tests and procedures for those ailments and
21 automatically deny claims on those bases?
- 22 c. Whether Defendants failed to adopt and implement reasonable standards for the
23 prompt investigation and processing of claims arising under insurance policies?
- 24 d. Whether Defendants have a practice of relying on the PXDX system to review and
25 deny certain claims instead of having medical directors use their expertise to decide
26 whether to approve or deny those claims?
- 27 e. Whether Defendants provided false or pretextual reasons for issuing denials of
28 coverage, failed to provide accurate statements stating the reason for denial, and

purposefully concealed their use of the PXDX system to make coverage determinations?

f. Whether Defendants' use and application of the PXDX system violates Defendants' fiduciary duties under ERISA?

g. What remedies are available under ERISA for Defendants' failure to provide individual analysis or claims determinations?

77. Plaintiffs' claims are typical of the claims of the Class and arise from the same common practice and scheme used by Defendants to deny the claims of the members of the Class. In each instance, Defendants used the PXDX system to review, process, and deny insured claims without the medical director's review. Plaintiffs will fairly and adequately represent and protect the interests of the Class. Plaintiffs have retained competent and experienced counsel in class action and other complex litigation.

78. Plaintiffs and the Class members have suffered injury, in fact, and have lost money as a result of Defendants' misconduct. Plaintiffs and the Class had their claims automatically rejected by Cigna using the PXDX system without individualized evaluation of their medical records by Cigna's medical directors.

79. A class action is superior to other available methods for fair and efficient adjudication of this controversy. The expense and burden of individual litigation would make it impracticable or impossible for the Class to prosecute their claims individually.

80. The trial and litigation of Plaintiffs' claims are manageable. Individual litigation of the legal and factual issues raised by Defendants' conduct would increase delay and expense to all parties and the court system. The class action device presents far fewer management difficulties and provides the benefits of a single, uniform adjudication, economics of scale, and comprehensive supervision by a single court.

81. Defendants have acted on grounds generally applicable to the entire Class, thereby making final injunctive relief and/or corresponding declaratory relief appropriate with respect to the Class as a whole. The prosecution of separate actions by individual Class members would create the risk of inconsistent or varying adjudications with respect to individual Class members that would

1 establish incompatible standards of conduct for Defendants.

2 82. Absent a class action, Defendants will likely retain the benefits of their wrongdoing.
3 Because of the small size of the individual Class members' claims, few, if any, Class members could
4 afford to seek legal redress for the wrongs complained of herein. Absent a representative action, the
5 Class will continue to suffer losses and Defendants will be allowed to continue these violations of
6 law and to retain the proceeds of its ill-gotten gains.

7 **FIRST CAUSE OF ACTION**

8 **Claim for Appropriate Equitable Relief under 29 U.S.C. § 1132(a)(3)**

9 **Against All Defendants**

10 **(On Behalf of all Plaintiffs and the Class)**

11 83. Plaintiffs reallege and incorporate by reference all preceding allegations as though
12 fully set forth herein.

13 84. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a particular beneficiary to
14 bring a civil action to: "(A) enjoin any act or practice which violates any provision of this title or
15 the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations
16 or (ii) to enforce any provisions of this title or the terms of the plan."

17 85. Defendants are ERISA fiduciaries because Defendants function as the "claims
18 administrator" and/or "plan administrator" within the meaning of such term under ERISA for
19 Plaintiffs and the Class.

20 86. As ERISA fiduciaries, Defendants owe Plaintiffs and the Class a variety of fiduciary
21 duties, including the duties to make decisions in accordance with insurance plan terms and ERISA.

22 87. Defendants also must provide Plaintiffs and the Class receive a "full and fair review"
23 of all claims reviewed and denied by Defendants.

24 88. Notwithstanding these fiduciary obligations, these defendants developed and relied
25 upon internal practices and policies that improperly restricted coverage in contravention of
26 Plaintiffs' health insurance plans and ERISA. Due to the fiduciary breaches perpetrated by
27 Defendants, including without limitation, the issuance of misleading or false denial letters, Plaintiffs
28 and the Class are entitled to other equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

1 89. Although Defendants were obligated to do so, they failed to provide a “full and fair
2 review” of denied claims pursuant to ERISA § 503, 29 U.S.C. § 1133 for Plaintiffs and the Class,
3 by using the PXDX algorithm to make coverage determinations without sufficient review, and for
4 failing to disclose the true “specific reasons” for the denials.

5 90. The law and implementing regulations set forth minimum standards for claim
6 procedures, appeals, notice to insureds, and the like. In engaging in the conduct described herein,
7 including systematic reimbursement reductions without disclosure or contractual authorization,
8 Defendants failed to comply with the law, federal regulations, and federal common law.

9 91. The consequences of Defendants’ violations of the law and regulations is that
10 Defendants failed to provide a “full and fair review,” failed to provide reasonable claims procedures,
11 and failed to make required disclosures.

12 92. Plaintiffs and the members of the Class have been harmed by Defendants’ breaches
13 of fiduciary duty because their claims have been subjected to restrictions not imposed by their health
14 insurance plans and which are illegal under ERISA

15 93. Plaintiffs and Class members seek this Court’s order that they are entitled to
16 appropriate equitable relief under 29 U.S.C. § 1132(a)(3).

17 **SECOND CAUSE OF ACTION**

18 **Violation of California Unfair Competition Law,**

19 **Business & Professions Code Section 17200, *et. seq.***

20 **Against all Defendants**

21 **(On Behalf of Plaintiffs Dababneh, Mahshigian, and the California Subclass)**

22 94. Plaintiffs reallege and incorporate by reference all preceding allegations as though
23 fully set forth herein.

24 95. Plaintiffs bring this cause of action pursuant to Business and Professions Code Section
25 17500, *et seq.*, on her own behalf and on behalf of all other persons similarly situated.

26 96. California’s Unfair Competition Law (“UCL”) prohibits “any unlawful, unfair... or
27 fraudulent business act or practice.” Cal. Bus & Prof. Code section 17200, *et. seq.*

1 97. Under the California Insurance Code, § 790.03(h), the following are classified as
2 unfair methods of competition and unfair and deceptive acts or practices in the business of insurance
3 when they are knowingly committed or performed with such frequency as to indicate a general
4 practice:

- 5 a. “Failing to adopt and implement reasonable standards for the prompt investigation
6 and processing of claims arising under insurance policies.”
7 b. “Not attempting in good faith to effectuate prompt, fair, and equitable settlements of
8 claims in which liability has become reasonably clear.”
9 c. “Failing to provide promptly a reasonable explanation of the basis relied on in the
10 insurance policy, in relation to the facts or applicable law, for the denial of a claim or
11 for the offer of a compromise settlement.”

12 98. **Unlawful Prong:** Defendants’ conduct violates the unlawful prong of § 17200
13 because they violate California’s express statutory and regulatory requirements regarding insurance
14 claims handling pursuant to Cal. Health & Saf. Code §1367.01, and because they violate the implied
15 covenant of good faith and fair dealing.

16 99. Defendants violated the unlawful prong of § 17200 when they allowed the PDX
17 system to review and deny Plaintiffs and Class members’ claims instead of having a licensed
18 physician who is competent to evaluate the specific clinical issues involved in the health care
19 services requested by the provider to deny or modify requests for authorization of health care
20 services for an enrollee for reasons of medical necessity as required by Cal. Health & Saf. Code
21 §1367.01(e).

22 100. Defendants violated the unlawful prong of § 17200 when they failed to communicate
23 to Plaintiffs and Class members in writing their decision to deny Plaintiffs’ and Class members’
24 claims and provide a clear and concise explanation of the reasons for the plan’s decision, a
25 description of the criteria or guidelines used, and the clinical reasons for the decisions regarding
26 medical necessity, including the information as to how Plaintiffs and Class members may file a
27 grievance with the plan, as required by Cal. Health & Saf. Code §1367.01(h)(4).
28

1 101. Defendants violated the unlawful prong of § 17200 when they utilized the PXDX
2 system to review and deny Plaintiffs and Class members' claims rather than conducting a fair and
3 full review, acting in bad faith to deny Plaintiffs and Class members of benefits they were due under
4 the insurance agreements, violating the implied covenant of good faith and fair dealing.

5 102. **Unfair Prong:** Defendants' actions violated the unfair prong of § 17200 because the
6 acts and practices set forth above, including Defendants' use of the PXDX system to process and
7 deny claims, rejection of claims in batches without a thorough, fair, and objective investigation
8 offend established public policy and cause harm to consumers that greatly outweighs any benefit
9 associated with those practices. Defendants' actions also violate the unfair prong because they
10 constitute a systematic breach of consumer contracts.

11 103. **Fraudulent Prong:** Defendants have violated the fraudulent business practices prong
12 of § 17200 because their omissions and misrepresentations regarding the Cigna insurance policies
13 and Plaintiffs' and Class Members' rights under their policies, including by using an algorithm to
14 make coverage determinations and the denying claims on sham pretenses, were likely to deceive a
15 reasonable consumer, and this information would be material to a reasonable consumer.

16 104. Defendants fraudulently misled Plaintiffs and Class members into believing that their
17 health plans would ensure thorough, fair, and objective investigations by medical professionals into
18 each submitted claim and provide coverage for reasonable and medically necessary procedures by
19 failing to disclose the PXDX system, and by making affirmative statements suggesting human-made
20 claims determinations.

21 105. Plaintiffs and Class members would not have enrolled with Defendants had they
22 known Defendants failed to diligently pursue submitted claims using a thorough, fair, and objective
23 investigation.

24 106. As a direct and proximate result of Defendants' violation of § 17200, Plaintiffs and
25 Class members have been injured in fact and suffered lost money in that Defendants failed to provide
26 benefits owed to their insureds under the insurance policies Defendants issued, and Defendants
27 overcharged for the policies themselves given that the policies' value was less than Plaintiffs paid.
28

107. In perpetrating their fraudulent conduct, Defendants acted in concert and participated in exactly the same fraudulent conduct, as described herein.

108. To date, Defendants continue to violate the Unfair Competition law by breaching their insurance contracts.

109. To date, some Plaintiffs and Class members are still insured by Defendants.

110. Pursuant to Business and Professions Code section 17203, Plaintiffs and Class members seek an order of this Court enjoining Defendants from denying benefits owed to Cigna insureds through its scheme involving the PXDX processing system. Without such an order, there is a continuing threat to Plaintiffs and Class members, as well as to members of the general public, that Defendants will continue to systematically deny and reduce benefits to California consumers through its use of the PXDX system.

111. Pursuant to Business and Professions Code section 17203, Plaintiffs and Class members seek an order of this Court awarding Plaintiffs and Class members restitution of the money wrongfully acquired by Defendants by means of responsibility attached to Defendants' failure to disclose the existence and significance of said misrepresentations in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, individually and on behalf of all others similarly situated, request that this Court enter an order granting the following relief against Defendants:

- a. Awarding actual damages, statutory damages, exemplary/punitive damages, costs and attorneys' fees;
- b. Awarding disgorgement and/or restitution;
- c. Awarding pre-judgment interest to the extent permitted by law;
- d. Appropriate declaratory and public injunctive relief enjoining Cigna from continuing its improper and unlawful claim handling practices as set forth herein;
- e. Such other and further relief as the Court may deem just and proper.

JURY TRIAL DEMANDED

Plaintiffs demand a jury trial on all triable issues.

DATED: September 30, 2026

CLARKSON LAW FIRM, P.C.

By: /s/ Glenn A. Danas

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EXHIBIT C

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1 UNITED STATES DISTRICT COURT FOR THE
2 EASTERN DISTRICT OF CALIFORNIA
3

4 ~~SUZANNE KISTING-LEUNG~~, SAMANTHA
DABABNEH, MICHAEL MAHSHIGIAN, and
5 RANDALL RENTSCH, ~~CRISTINA~~
~~THORNHILL~~, ~~AMANDA BREDLOW~~, and
6 ~~ABDULHUSSEIN ABBAS~~, individually and on
behalf of all other similarly situated,

7 Plaintiffs,

8 vs.

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

11 Defendants.
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– Case No.: 2:23-cv-0147-CSK

**THIRDFOURTH AMENDED CLASS
ACTION COMPLAINT**

~~1. CLAIM FOR BENEFITS UNDER 29~~
~~U.S.C. § 1132(a)(1)(B)~~
2.1 CLAIM FOR APPROPRIATE
EQUITABLE RELIEF UNDER 29 U.S.C.
§ 1132(A)(3)
3.2 VIOLATION OF CALIFORNIA UNFAIR
COMPETITION LAW, BUSINESS &
PROFESSIONS CODE SECTION 17200, *et*
seq.

DEMAND FOR JURY TRIAL

Plaintiffs ~~Suzanne Kisting-Leung~~, Samantha Dababneh, Michael Mahshigian, and Randall Rentsch, ~~Cristina Thornhill, Amanda Bredlow, and Abdulhussein Abbas~~ (collectively “**Plaintiffs**”), individually and on behalf of all others similarly situated (the “**Class**”), by and through their attorneys, brings this class action against Defendants Cigna Corporation and Cigna Health and Life Insurance Company, and Does 1-50, inclusive (collectively, “**Defendants**” or “**Cigna**”) and allege as follows:

I. INTRODUCTION

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.

2. Cigna is a major medical insurance company in the United States, with approximately 18 million members nationwide and 2.1 million members in California.¹ Cigna pledges that the company is “committed to improving the health and vitality” of its members.² In reality, Cigna developed an algorithm known as PXDX that it relies on to enable its doctors to automatically deny payments in batches of hundreds or thousands at a time for treatments that do not match certain pre-set criteria, thereby evading the legally-required individual physician review process.

3. Relying on the PXDX system, Cigna’s doctors instantly reject claims on medical grounds without ever opening patient files, leaving thousands of patients effectively without coverage and with unexpected bills. The scope of this problem is massive. For example, over a period of two months in 2022, Cigna doctors denied over 300,000 requests for payments using this method, spending an average of just *1.2 seconds* “reviewing” each request.³

¹ Based on Cigna’s 18 million members nationwide, <https://www.statista.com/statistics/985102/medical-customers-of-cigna/>; California Health Care Almanac, <https://www.chcf.org/wp-content/uploads/2022/06/HealthInsurersAlmanac2022.pdf> (last accessed on July 24, 2023).

² The Cigna Group Company Profile, <https://www.cigna.com/about-us/company-profile/> (last accessed on July 24, 2023).

³ Patrick Rucker, et al., How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them, ProPublica, Mar. 25, 2023, <https://www.propublica.org/article/cigna-px-dx-medical-health-insurance-rejection-claims> (last accessed on July 20, 2023).

4. The PXDX system saves Cigna money by allowing it to deny claims it previously paid and by eliminating the labor costs associated with paying doctors and other employees for the time needed to conduct individualized, manual review for each Cigna insured.

5. Cigna also utilizes the PXDX system because it knows it will not be held accountable for wrongful denials. For instance, Cigna knows that only a tiny minority of policyholders (roughly 0.2%)⁴ will appeal denied claims, and the vast majority will either pay out-of-pocket costs or forgo the at-issue procedure.

6. Plaintiffs and members of the alleged Class had their claims automatically rejected by Cigna using the PXDX system without any individualized consideration. Cigna failed to use reasonable standards in evaluating the individual claims of Plaintiffs and Class members and instead allowed its doctors to sign off on the denials in batches.

7. Cigna failed to disclose to Plaintiffs and Class members that their claims would be reviewed and denied by the PXDX algorithm without any real doctor involvement.

8. Cigna intentionally omitted any reference to the PXDX algorithm in the policies provided to Plaintiffs and Class members.

9. Cigna also made deceptive and misleading representations to Plaintiffs and Class members regarding the efficiency of their services. For example, 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. Additionally, 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.

10. Plaintiffs bring these class claims against Cigna under the Employee Retirement Income Security Act, 29 U.S.C. § 1132(a), also known as "ERISA § 502(a)," to recover benefits wrongfully denied, to enjoin Cigna from utilizing illegal policies and practices going forward, and to obtain other appropriate equitable relief to redress Cigna's violations.

11. By engaging in this misconduct, Cigna breached its fiduciary duties, including its duty

⁴ See, e.g., Claims Denials and Appeals in ACA Marketplace Plans in 2021, <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/> (last accessed on July 20, 2023).

of good faith and fair dealing, because its conduct serves Cigna's own economic self-interest and elevates Cigna's interests above the interests of its insureds.

12. By bringing this action, Plaintiffs seek to remedy Cigna's past improper and unlawful conduct by recovering damages to which Plaintiffs and the Class are rightfully entitled and enjoin Cigna from continuing to perpetrate its scheme against its nationwide and California insureds.

II. JURISDICTION AND VENUE

13. This Court has subject matter jurisdiction over Plaintiffs' claims pursuant to 28 U.S.C. § 1331 because Plaintiffs' action arises under a law of the United States, specifically the Employee Retirement Income Security Act of 1974 ("ERISA").

14. This Court also has subject matter jurisdiction over Plaintiffs' claims pursuant to 28 U.S.C. § 1332(d)(2). This is a class action in which there is a diversity of citizenship between at least one Plaintiffs Class member and one Defendant; the proposed Classes each exceed one hundred members; and the matter in controversy exceeds the sum of \$5,000,000.00, exclusive of interest and costs.

15. Venue is proper in this Court pursuant to 28 U.S.C. § 1391. Defendants regularly conduct business in this District, and a substantial part of the events giving rise to the claims asserted herein occurred in this District. Plaintiff Kisting-Leung is a citizen of California who resides in this District.

III. THE PARTIES

~~16. Plaintiff Suzanne Kisting-Leung is, and at all times relevant to this action has been, a citizen of California, residing in Placer County. At all relevant times mentioned herein, Plaintiff Kisting-Leung was a beneficiary of a plan sponsored by Amdocs, Inc., which is subject to ERISA. Cigna was at all times an ERISA fiduciary under Amdocs, Inc.'s ERISA plan because Cigna is the named claims administrator with discretion to make benefits determinations under that plan. Cigna has a financial conflict of interest in deciding claims under this plan because it both funds the plan and administers plan benefits.~~

~~17.~~16. Plaintiff Samantha Dababneh is, and at all times relevant to this action has been, a citizen of California. At all relevant times mentioned herein, Plaintiff Dababneh was a beneficiary

of a plan sponsored by SunRun, Inc., which is subject to ERISA. Cigna was at all times an ERISA fiduciary under SunRun, Inc.'s ERISA plan because Cigna is the named claims administrator with discretion to make benefits determinations under that plan. ~~Cigna has a financial conflict of interest in deciding claims under this plan because it both funds the plan and administers plan benefits.~~

17. Plaintiff Michael Mahshigian is, and at all times relevant to this action has been, a citizen of California. At all relevant times mentioned herein, Plaintiff Mahshigian was a beneficiary of a plan sponsored by Howard University and Howard University Hospital, which is subject to ERISA. Cigna was at all times an ERISA fiduciary under Howard University and Howard University Hospital's ERISA plan because Cigna is the named claims administrator with direction to make benefits determinations under that plan.

18. Plaintiff Randall Rentsch is, and at all times relevant to this action has been, a citizen of California. At all relevant times mentioned herein, Plaintiff Rentsch was a beneficiary of a plan sponsored by Lennar Homes, LLC, which is subject to ERISA. Cigna was at all times an ERISA fiduciary under Lennar Homes, LLC's ERISA plan because Cigna is the named claims administrator with discretion to make benefits determinations under that plan. ~~Cigna has a financial conflict of interest in deciding claims under this plan because it both funds the plan and administers plan benefits.~~

19. ~~Plaintiff Cristina Thornhill is, and at all times relevant to this action has been, a citizen of California. At all relevant times mentioned herein, Plaintiff Thornhill was a beneficiary of a plan sponsored by Becton, Dickinson, and Company, which is subject to ERISA. Cigna was at all times an ERISA fiduciary under Becton, Dickinson, and Company's ERISA plan because Cigna is the named claims administrator with discretion to make benefits determinations under that plan.~~

20. ~~Plaintiff Amanda Bredlow is, and at all times relevant to this action has been, a citizen of Washington. At all relevant times mentioned herein, Plaintiff Bredlow was a beneficiary of a plan sponsored by Volkswagen Group of America, Inc., which is subject to ERISA. Cigna was at all times an ERISA fiduciary under Volkswagen Group of America, Inc.'s ERISA plan because Cigna is the named claims administrator with discretion to make benefits determinations under that~~

~~plan. Cigna has a financial conflict of interest in deciding claims under this plan because it both funds the plan and administers plan benefits.~~

~~21. Plaintiff Abdulhussein Abbas is, and at all times relevant to this action has been, a citizen of Texas. At all relevant times mentioned herein, Plaintiff Abbas was a beneficiary of a plan sponsored by Anywhere Real Estate Group, LLC, which is subject to ERISA. Cigna was at all times an ERISA fiduciary under Anywhere Real Estate Group, LLC's ERISA plan because Cigna is the named claims administrator with discretion to make benefits determinations under that plan. Cigna has a financial conflict of interest in deciding claims under this plan because it both funds the plan and administers plan benefits.~~

22.19. Defendant Cigna Corporation is a Connecticut corporation headquartered at 900 Cottage Grove Road, Bloomfield, Connecticut 06002. Defendant Cigna Corporation conducts insurance operations throughout the nation, including in California, representing to consumers that Cigna and its subsidiaries are a global health service organization. Defendant Cigna Corporation has a license to use the federally registered service mark "Cigna," markets and issues health insurance and insures, issues, administers, and makes coverage and benefit determinations related to the health care policies nationally through its various wholly owned and controlled subsidiaries, controlled agents and undisclosed principals and agents, including Defendant Cigna Health and Life Insurance Company. Defendant Cigna Corporation is licensed and regulated by the California Department of Insurance ("CDI") and the California Department of Managed Health Care ("CDMHC") to transact the business of insurance in the State of California, is in fact, transacting the business of insurance in the State of California, and is thereby subject to the laws and regulations of the State of California.

23.20. Defendant Cigna Health and Life Insurance Company, incorporated in Connecticut, is a wholly owned subsidiary of Defendant Cigna Corporation, with its principal place of business at 900 Cottage Grove Road, Bloomfield, Connecticut 06002. Defendant Cigna Health and Life Insurance Company markets and issues health insurance and insures, issues, administers, and renders coverage and benefit determinations related to the health care policies. Defendant Cigna Health and Life Insurance Company is licensed and regulated by the CDI and the CDMHC to

transact the business of insurance in the State of California, is in fact, transacting the business of insurance in the State of California, and is thereby subject to the laws and regulations of the State of California.

IV. FACTUAL ALLEGATIONS

A. Background

24-21. Defendants offered and sold health coverage to nationwide and California consumers, including the employer sponsors of Plans in which Plaintiffs are participants and beneficiaries.

25-22. Defendants provided Plaintiffs and Class members with plan documents explaining the plan coverage available under their employer-sponsored plans. According to these terms, Cigna must provide benefits for covered health services and pay all reasonable and medically necessary expenses incurred by a covered member. Nowhere in these written terms did Cigna disclose that its insurance coverage decisions would be automated or made by computers rather than human doctors.

26-23. From at least July 24, 2019, to the present, thousands or millions of Cigna insureds, through healthcare providers, submitted bills to Cigna for reasonable and medically necessary expenses covered by their plan terms.

27-24. To determine whether a submitted claim is medically necessary, Defendants are required to conduct and diligently pursue a “thorough, fair, and objective” investigation into each bill for medical expenses submitted, per California Insurance Regulations, Cal. Code Regs. tit. 10, § 2695.7 (d). This means Cigna’s medical directors must examine patient records, review coverage policies, and use their expertise to decide whether to approve or deny claims to avoid unfair denials.

28-25. Defendants have deliberately failed to fulfill their statutory obligation to review individual claims in a “thorough,” “fair,” and “objective” manner, instead denying the claims for medical expenses of its California insureds without conducting *any* investigation, let alone a thorough, fair, or objective investigation.

29-26. Defendants utilize the PXDX system, which employs an algorithm to identify discrepancies between diagnoses and what Defendants consider acceptable tests and procedures for those ailments and automatically deny claims on those bases. After the PXDX system denies claims, Cigna doctors then sign off on the denials in batches without opening each patient’s files to conduct

a more detailed review of, for example, the treatment/procedure at issue and related injuries, the patient's prior medical or surgical history, the chronology of medical events, or any ambiguities and complications.

30-27. 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.

31-28. 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.

32-29. In violation of California law, Defendants wrongfully delegated their obligation to evaluate and investigate claims to the PXDX system, including determining whether medical expenses are reasonable and medically necessary.

33-30. In violation of Cal. Code Regs. tit. 10, § 2695.7 (b)(1), Defendants failed to inform their insureds in writing of the decision to deny their claims and failed to provide statements listing all bases for such denial, including factual and legal bases for each reason given for such denial.

34-31. Defendants fraudulently misled California insureds into believing that their health plan would individually assess their claims and pay for medically necessary procedures. Cigna omitted the explanation of its PXDX from its written policies.

35-32. While its policies neatly avoided disclosure and explanation of PXDX, Cigna communicated to customers and potential customers that it provides a careful, individual review of all coverage decisions. For instance, 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.

36-33. Defendants use of the PXDX system to make coverage determinations violates both ERISA and California law.

37-34. Defendants knowingly committed unfair and deceptive acts or practices with a frequency indicating a general practice in violation of California Insurance Code, § 790.03.

~~38.35.~~ Defendants' review system of California insureds' claims undermines the principles of fairness and meaningful claim evaluation, which insureds expect from their insurers.

B. Plaintiff Suzanne Kisting-Leung

~~39.~~ Plaintiff Suzanne Kisting-Leung has been enrolled with Cigna since 2018.

~~40.~~ On August 19, 2022, Ms. Kisting-Leung underwent a transvaginal ultrasound after being referred by her doctor due to a suspected risk of ovarian cancer. The ultrasound results revealed that Ms. Kisting-Leung had a dermoid cyst on her left ovary.

~~41.~~ On or around October 17, 2022, Ms. Kisting-Leung received a letter from radiology informing her that Cigna denied her claim for the ultrasound procedure, stating that the procedure was not medically necessary. As a result, Ms. Kisting-Leung was left responsible for the \$198 bill.

~~42.~~ According to Cigna's Medical Coverage Policy, a transvaginal ultrasound is considered "medically necessary for the evaluation of suspected pelvic pathology or for screening or surveillance of a woman at increased risk for ovarian or endometrial cancer."⁵

~~43.~~ Ms. Kisting-Leung vigorously appealed Cigna's decision to deny coverage. To date, Cigna has not paid Ms. Kisting-Leung's claim.

~~44.~~ On November 30, 2022, Ms. Kisting-Leung was referred to and underwent another transvaginal ultrasound. Ms. Kisting-Leung's procedure was medically necessary as was confirmed by her referring doctor.

~~45.~~ Around December 2022, Ms. Kisting-Leung was informed by her medical provider that Cigna again denied coverage for her claim, stating that the procedure was not medically necessary.

~~46.~~ On May 18, 2023, Ms. Kisting-Leung received a \$525 bill from her medical provider for the second ultrasound.

~~47.~~ Ms. Kisting-Leung immediately appealed Cigna's decision to deny her claim. To date, Cigna has not paid for Ms. Kisting-Leung's second claim.

⁵ ~~Cigna Medical Coverage Policy, Transvaginal Ultrasound, Non-Obstetrical,~~ [https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/mm_0398_coveragepositioncrit](https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/mm_0398_coveragepositioncriteria_transvaginal_ultrasound.pdf)
~~eria_transvaginal_ultrasound.pdf~~ (last accessed on July 24, 2023).

~~48.— Upon information and belief, Defendants used the PXDX system to “review” and deny Ms. Kisting Leung’s claims.~~

~~49.— Upon information and belief, Defendants failed to have their doctors conduct a thorough, fair, and objective investigation into each of Ms. Kisting Leung’s claims and instead denied them based on the automated PXDX process.~~

~~50.— Defendants failed to disclose the PXDX process and its implications to Ms. Kisting Leung. Defendants further made misrepresentations to Ms. Kisting Leung that a doctor would conduct a thorough, fair, and objective investigation into her claims, knowing about the falsity of such representation. The PXDX process was material to Ms. Kisting Leung. Ms. Kisting Leung also reasonably relied on Defendants’ misrepresentations and suffered damages as a result.~~

~~51.— Had Ms. Kisting Leung known that 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.~~

C.B. Plaintiff Samantha Dababneh

~~52.36.~~ Plaintiff Samantha Dababneh has been enrolled with Cigna since around July 2023.

~~53.37.~~ On or around September 2022, Ms. Dababneh’s doctor determined that it was medically necessary to check her Vitamin D levels to confirm she had no Vitamin D deficiency. Accordingly, Ms. Dababneh’s doctor ordered such a test, which was administered on September 9, 2023.

~~54.38.~~ On or around September 24, 2023, Ms. Dababneh received a denial letter from Cigna stating that Cigna was denying her claim because it was “not medically necessary.”

~~55.39.~~ The denial letter indicated that the PXDX algorithm reviewed her claim.

~~56.40.~~ The denial letter was also not signed by an actual doctor, but by “Cigna Healthcare,” indicating that the real doctor was not involved in the denial of Ms. Dababneh’s claim.

~~57.41.~~ Defendants failed to have a doctor diligently pursue a thorough, fair, and objective investigation into Ms. Dababneh’s claim.

~~58.42.~~ Defendants failed to disclose the PXDX process and its implications to Ms. Dababneh. Defendants further made misrepresentations to Ms. Dababneh that a doctor would conduct a

thorough, fair, and objective investigation into her claims, knowing about the falsity of such representation. Ms. Dababneh reasonably relied on Defendants' misrepresentation and suffered damages as a result.

C. Plaintiff Michael Mahshigian

43. Plaintiff Michael Mahshigian was enrolled with Cigna from July 23, 2018, until December 31, 2022.

44. Due to a prior injury to his spine, in 2022 Mr. Mahshigian was suffering severe chronic pain and was unable to perform everyday activities.

45. To treat his pain, Mr. Mahshigian's doctors recommended and routinely provided routine radiofrequency ablation (RFA) while he awaited recommended cervical fusion surgery, which Cigna would not and did not authorize.

46. On October 20, 2022, Mr. Mahshigian underwent RFA. Without having a doctor review the claim, Cigna denied Mr. Mahshigian's claim for anesthesia associated with this service as not medically necessary using PXDX.

47. Mr. Mahshigian's anesthesiologist resubmitted the claim. Without having a doctor review the claim, Cigna again denied it as not medically necessary using PXDX.

48. Upon information and belief, Defendants failed to have their doctors conduct a thorough, fair, and objective investigation into Mr. Mahshigian's claim and instead denied it based on the automated PXDX process. Cigna's automatic process affixed a doctor's signature to the claim denial letter and stated that if appealed, it would be reviewed by a doctor who "wasn't involved in making the first decision"—someone who didn't "work for or report to the doctor who made this first decision." At least one of Mr. Mahshigian's denial letters was signed by a medical doctor.

49. However, when Cigna's PXDX algorithm denied Mr. Mahshigian's claim, no doctor had actually reviewed it.

50. Defendants failed to disclose the PXDX process and its implications to Mr. Mahshigian.

51. Mr. Mahshigian reasonably relied on Defendants' misrepresentations and suffered damages as a result.

1 52. Defendants failed to have a doctor diligently pursue a thorough, fair, and objective
2 investigation into Mr. Mahshigian's claim.

3 53. Defendants failed to disclose the PXDX process and its implications to Mr.
4 Mahshigian. Defendants further made misrepresentations to Mr. Mahshigian that a doctor would
5 conduct a thorough, fair, and objective investigation into his claims, knowing about the falsity of
6 such representation. Mr. Mahshigian reasonably relied on Defendants' misrepresentation and
7 suffered damages as a result.

8 **D. Plaintiff Randall Rentsch**

9 59.54. Plaintiff Randall Rentsch was enrolled with Cigna from around 2015 until around
10 2018.

11 60.55. In or around 2016, Mr. Rentsch was diagnosed with a herniated disk in his neck, which
12 pinched a nerve and caused severe pain.

13 61.56. To help reduce inflammation in Mr. Rentsch's neck, his treating physician prescribed
14 a series of transforaminal epidurals.

15 62.57. On or around June 6, 2026, Mr. Rentsch received his first transforaminal epidural.

16 63.58. On or around June 13, 2016, Cigna informed Mr. Rentsch in writing that his claim
17 was denied because the treatment was "not medically necessary." The denial letter indicated that
18 the PXDX algorithm reviewed his claim.

19 64.59. Mr. Rentsch continued to experience severe pain and required additional injections.
20 As such, Mr. Rentsch had no choice but to continue his treatment despite Cigna's denial of his
21 claims.

22 65.60. On or around August 26, 2016, Mr. Randall received his second transforaminal
23 epidural.

24 66.61. On or around October 10, 2016, Cigna informed Mr. Rentsch in writing that they were
25 again denying his claim because the treatment was "not medically necessary." At that point, the
26 charges accrued for the two rounds of the epidural injections totaled \$5,014.80.

27 67.62. Upon information and belief, Cigna used the PXDX algorithm to "review" and deny
28 Mr. Rentsch's claims.

1 ~~68.63.~~ Mr. Rentsch continued to endure severe pain and required additional injections. As a
 2 result, his treating physician prescribed more epidural injections.

3 ~~69.64.~~ On or around December 6, 2017, Mr. Rentsch received his third round of
 4 transforaminal epidural.

5 ~~70.65.~~ On or around December 11, 2017, Cigna again denied his claim, stating the procedure
 6 was “not medically necessary.” Cigna continued to use the PXDX algorithm to wrongfully deny
 7 Mr. Rentsch’s claims.

8 ~~71.66.~~ On or around February 23, 2017, Mr. Rentsch received his fourth round of
 9 transforaminal epidural.

10 ~~72.67.~~ On or around February 27, 2017, Cigna again denied his claim, falsely claiming that
 11 the procedure was “not medically necessary.” Cigna continued to deploy the PXDX algorithm to
 12 “review” and deny Mr. Rentsch’s claims.

13 ~~73.68.~~ On or around March 25, 2023, Mr. Rentsch discovered through an article published
 14 by ProPublica that Defendants had been using the PXDX algorithm to review patients’ claims. Prior
 15 to that, Mr. Rentsch had no knowledge of this illegal practice by Defendants. Additionally, Mr.
 16 Rentsch had no way of knowing that Defendants had been using the PXDX algorithm to wrongfully
 17 deny his claims.

18 ~~74.69.~~ Defendants failed to have a doctor diligently pursue a thorough, fair, and objective
 19 investigation into Mr. Rentsch’s claim.

20 ~~75.70.~~ Defendants failed to disclose the PXDX process and its implications to Mr. Rentsch.
 21 Defendants further made misrepresentations to Mr. Rentsch that a doctor would conduct a thorough,
 22 fair, and objective investigation into his claims, knowing about the falsity of such representation.
 23 Mr. Rentsch reasonably relied on Defendants’ misrepresentation and suffered damages as a result.

24 **E. — Plaintiff Cristina Thornhill**

25 ~~76. — Plaintiff Cristina Thornhill was enrolled with Cigna from around 2022.~~

26 ~~77. — In or around September 2022, Ms. Thornhill discovered an asymmetric mold on her~~
 27 ~~skin.~~

1 ~~78. Ms. Thornhill, concerned about mold growth due to family history of cancer,~~
2 ~~immediately consulted a dermatologist.~~

3 ~~79. On or around September 19, 2022, she was referred to and underwent an oncology~~
4 ~~and gene expression profiling—a procedure used to determine whether her mold contained~~
5 ~~cancerous cells.~~

6 ~~80. In or around December 2022, Cigna informed Ms. Thornhill in writing that her claim~~
7 ~~was denied because it was “not medically necessary.”~~

8 ~~81. Ms. Thornhill vigorously appealed Cigna’s decision to deny her claim but Cigna failed~~
9 ~~to reverse its wrongful decision and pay for the claim that it should have covered.~~

10 ~~82. Upon information and belief, Defendants failed to have a doctor diligently pursue a~~
11 ~~thorough, fair, and objective investigation into Ms. Thornhill’s claim.~~

12 ~~83. Instead, Defendants deployed the PXDX algorithm to “review” and deny Ms.~~
13 ~~Thornhill’s claims.~~

14 ~~84. Ms. Thornhill was forced to pay \$1,300 out of pocket for the procedure Defendants~~
15 ~~should have covered.~~

16 ~~85. Defendants failed to disclose the PXDX process and its implications to Ms. Thornhill.~~
17 ~~Defendants further made misrepresentations to Ms. Thornhill that a doctor would conduct a~~
18 ~~thorough, fair, and objective investigation into his claims, knowing about the falsity of such~~
19 ~~representation. Ms. Thornhill reasonably relied on Defendants’ misrepresentation and suffered~~
20 ~~damages as a result.~~

21 **F. Plaintiff Amanda Bredlow**

22 ~~86. Plaintiff Amanda Bredlow was enrolled with Cigna from 2020 to 2023.~~

23 ~~87. Between August 2, 2022, and August 23, 2022, Ms. Bredlow received IVF fertility~~
24 ~~services from Poma Fertility, LLC. Cigna refused to pay for her care, claiming that the submitted~~
25 ~~code for the procedure was “missing or invalid,” leaving Ms. Bredlow with a \$9,000 bill. Despite~~
26 ~~attempts to communicate with Defendants via their customer service line and provide the alleged~~
27 ~~missing information, Defendants refused to pay Ms. Bredlow’s claims.~~

28 ~~88. Ms. Bredlow appealed Cigna’s denial of her claims, but her appeals were denied.~~

1 89. ~~Upon information and belief, Defendants used the PXDX system to “review” and~~
2 ~~deny Ms. Bredlow’s claims.~~

3 90. ~~Upon information and belief, Defendants failed to have their doctors conduct a~~
4 ~~thorough, fair, and objective investigation into each of Ms. Bredlow’s claims and instead denied~~
5 ~~them based on the automated PXDX process.~~

6 91. ~~Defendants failed to disclose the PXDX process and its implications for Ms. Bredlow.~~
7 ~~Defendants further made misrepresentations to Ms. Bredlow that a doctor would conduct a~~
8 ~~thorough, fair, and objective investigation into her claims, while knowing the falsity of such~~
9 ~~representations. The claims review process was material to Ms. Bredlow.~~

10 92. ~~Ms. Bredlow reasonably relied on Defendants’ misrepresentations and suffered~~
11 ~~damages as a result.~~

12 93. ~~Had Ms. Bredlow known that Defendants would evade the legally required process~~
13 ~~for review of his claims and instead delegate that process to its PXDX algorithm to review and deny~~
14 ~~claims, she would not have enrolled with Cigna or at most would have paid less for her plan.~~

15 **G. Plaintiff Abdulhussein Abbas**

16 94. ~~Plaintiff Abdulhussein Abbas was enrolled with Cigna from 2021 to 2023.~~

17 95. ~~In or around February of 2023, Mr. Abbas was in an automobile collision, causing~~
18 ~~injuries to his back. On or around February 16, 2023, Mr. Abbas underwent surgery—his doctors~~
19 ~~performed a microdiscectomy, removing bulging nerves in his back to treat his pain. During this~~
20 ~~procedure, Mr. Abbas received monitoring services from DRF Monitoring PLLC. Defendants~~
21 ~~issued a denial, claiming the service was not medically necessary and refusing to pay for \$36,565~~
22 ~~of charges. Mr. Abbas’s doctors confirmed the treatment was medically necessary.~~

23 96. ~~On or around April 25, 2023, Mr. Abbas received pain management services in the~~
24 ~~form of an epidural from Dr. David Kleeland, as the surgery had not resolved his pain. Defendants~~
25 ~~once again denied care, claiming the treatment was not medically necessary. Mr. Abbas’s doctors~~
26 ~~confirmed the treatment was medically necessary.~~

27 97. ~~By May, Mr. Abbas’s pain had still not been resolved. Mr. Abbas’s doctors ordered a~~
28 ~~CT scan, to determine whether the first surgery had failed to resolve the issue and to determine~~

~~whether an additional surgery would be required. Despite Mr. Abbas's doctors' recommendations, Defendants again denied coverage, claiming the treatment was not medically necessary.~~

~~98. Mr. Abbas appealed Cigna's denial of his claims, but his appeals were denied.~~

~~99. Defendants used the PXDX system to "review" and deny Mr. Abbas's claims.~~

~~100. Upon information and belief, Defendants failed to have their 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.~~

~~101. Defendants failed to disclose the PXDX process and its implications for Mr. Abbas. Defendants further made misrepresentations to Mr. Abbas that a doctor would conduct a thorough, fair, and objective investigation into his claims, while knowing the falsity of such representations. The claims review process was material to Mr. Abbas.~~

~~102. Mr. Abbas reasonably relied on Defendants' misrepresentations and suffered damages as a result.~~

~~103. Had Mr. Abbas known that Defendants would evade the legally required process for review of his claims and instead delegate that process to its PXDX algorithm to review and deny claims, he would not have enrolled with Cigna or at most would have paid less for his plan.~~

V. CLASS ALLEGATIONS

~~104.71.~~ Plaintiffs bring this action on their own behalf and on behalf of all other persons similarly situated pursuant to Rule 23 of the Federal Rules of Civil Procedure. The Class which Plaintiffs seek to represent comprises:

All 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 as alleged herein, within the applicable statute of limitations.

~~105.72.~~ The class definition may be further defined or amended by additional pleadings, evidentiary hearings, a class certification hearing, and orders of this Court.

~~106.73.~~ The California Class Plaintiffs seek to represent comprises:

All persons who are or were participants 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 through the present.

107.74. The subclass definition may be further defined or amended by additional pleadings, evidentiary hearings, a class certification hearing, and orders of this Court.

108.75. The Class is so numerous that their individual joinder herein is impracticable. Upon information and belief, members of the Class number in the millions across the country. Upon information and belief, members of the California Subclass number in the hundreds of thousands or millions throughout California. The precise number of Class members and their identities are unknown to Plaintiffs at this time but may be determined through discovery. Class members may be notified of the pendency of this action by mail and/or publication through the distribution records of Defendants and third-party retailers and vendors.

109.76. Common questions of fact and law predominate over questions that may affect individual class members, including the following:

- a. Whether Defendants automatically denied payment for claims submitted by insureds and/or healthcare providers without having a medical director examine patient records, review coverage policies and use their expertise to decide whether to approve or deny claims?
- b. Whether Defendants' denials of claims are based on its use of the PXDX system, which employs an algorithm to identify discrepancies between diagnoses and what Defendants consider acceptable tests and procedures for those ailments and automatically deny claims on those bases?
- c. Whether Defendants failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies?
- d. Whether Defendants have a practice of relying on the PXDX system to review and deny certain claims instead of having medical directors use their expertise to decide whether to approve or deny those claims?

- e. Whether Defendants provided false or pretextual reasons for issuing denials of coverage, failed to provide accurate statements stating the reason for denial, and purposefully concealed their use of the PXDX system to make coverage determinations?
- f. Whether Defendants' use and application of the PXDX system violates Defendants' fiduciary duties under ERISA?
- g. What remedies are available under ERISA for Defendants' failure to provide individual analysis or claims determinations?

110.77. Plaintiffs' claims are typical of the claims of the Class and arise from the same common practice and scheme used by Defendants to deny the claims of the members of the Class. In each instance, Defendants used the PXDX system to review, process, and deny insured claims without the medical director's review. Plaintiffs will fairly and adequately represent and protect the interests of the Class. Plaintiffs have retained competent and experienced counsel in class action and other complex litigation.

111.78. Plaintiffs and the Class members have suffered injury, in fact, and have lost money as a result of Defendants' misconduct. Plaintiffs and the Class had their claims automatically rejected by Cigna using the PXDX system without individualized evaluation of their medical records by Cigna's medical directors.

112.79. A class action is superior to other available methods for fair and efficient adjudication of this controversy. The expense and burden of individual litigation would make it impracticable or impossible for the Class to prosecute their claims individually.

113.80. The trial and litigation of Plaintiffs' claims are manageable. Individual litigation of the legal and factual issues raised by Defendants' conduct would increase delay and expense to all parties and the court system. The class action device presents far fewer management difficulties and provides the benefits of a single, uniform adjudication, economics of scale, and comprehensive supervision by a single court.

114.81. Defendants have acted on grounds generally applicable to the entire Class, thereby making final injunctive relief and/or corresponding declaratory relief appropriate with

respect to the Class as a whole. The prosecution of separate actions by individual Class members would create the risk of inconsistent or varying adjudications with respect to individual Class members that would establish incompatible standards of conduct for Defendants.

~~115.82.~~ Absent a class action, Defendants will likely retain the benefits of their wrongdoing. Because of the small size of the individual Class members' claims, few, if any, Class members could afford to seek legal redress for the wrongs complained of herein. Absent a representative action, the Class will continue to suffer losses and Defendants will be allowed to continue these violations of law and to retain the proceeds of its ill-gotten gains.

FIRST CAUSE OF ACTION

~~Claim for Benefits under 29 U.S.C. § 1132(a)(1)(B)~~

~~Against all Defendants~~

~~(On Behalf of all Plaintiffs and the Class)~~

~~116.—Plaintiffs reallege and incorporate by reference all preceding allegations as though fully set forth herein.~~

~~117.—Defendants violated the terms of plan documents requiring payment of benefits to Class members by using the PXDX algorithm to make coverage determinations, instead of adopting reasonable standards for the prompt investigation and processing of claims. Defendants violated the plan terms—and guarantees of ERISA for a full and fair review of each claim for benefits—each time it used the PXDX system to make coverage determinations.~~

~~118.—Defendants' actions in denying coverage supposedly based on the pretextual reasons given in the denial letters when in fact the denial basis was the use of the PXDX algorithm, violates ERISA and the express terms of the ERISA governed insurance plan terms.~~

~~119.—Defendants violated the Secretary's ERISA claim regulations under 29 CFR § 2560.503-1(g) by choosing not to disclose the true reason for their adverse benefits determinations.~~

~~120.—Defendants made appealing the adverse benefits determinations futile because Defendants failed to disclose the true reason for its adverse benefits determinations. Thus, Plaintiffs' and Class members' claims are deemed exhausted.~~

~~121. Defendants violated the Secretary's ERISA claim regulations under 29 CFR § 2560.503-1(h) and (j) by failing to afford full and fair review of its adverse benefits determinations. Defendants violated the requirement to provide Plaintiffs and the Class with a full and fair review under Section 503 of ERISA, 29 U.S.C. § 1133(1) and (2) by failing to disclose the true reason for its adverse benefits determinations and affording a full and fair review of the decision.~~

~~122. Defendants' actions have harmed Plaintiffs and the Class because Defendants never afforded them a full and fair review under ERISA, opting instead to mislead them about their coverage denials and leave them with no chance for success on appeal.~~

~~123. As a result of Defendants' actions, Defendants have unlawfully denied coverage for Plaintiffs' and the Class's claims.~~

~~124. Defendants' actions constitute an unlawful denial of health insurance benefits under ERISA, as provided in 29 U.S.C. § 1132(a)(1)(B).~~

~~125. Plaintiffs and Class members are entitled to recover benefits denied by Defendants, interest, attorneys' fees, and other penalties as this court deems just, under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).~~

~~126. Plaintiffs and the Class are entitled to an order clarifying their rights to future benefits under the terms of their plan. Specifically, that Defendants must make claims determinations after providing a full and fair review and without using a claims determination process that violates the guarantees of ERISA.~~

SECOND CAUSE OF ACTION

Claim for Appropriate Equitable Relief under 29 U.S.C. § 1132(a)(3)

Against All Defendants

(On Behalf of all Plaintiffs and the Class)

~~127.83.~~ Plaintiffs reallege and incorporate by reference all preceding allegations as though fully set forth herein.

~~128.84.~~ ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes a particular beneficiary to bring a civil action to: "(A) enjoy any act or practice which violates any provision of this title or

the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.”

~~129.85.~~ Defendants are ERISA fiduciaries because Defendants function as the “claims administrator” and/or “plan administrator” within the meaning of such term under ERISA for Plaintiffs and the Class.

~~130.86.~~ As ERISA fiduciaries, Defendants owe Plaintiffs and the Class a variety of fiduciary duties, including the duties to make decisions in accordance with insurance plan terms and ERISA.

~~131.87.~~ Defendants also must provide Plaintiffs and the Class receive a “full and fair review” of all claims reviewed and denied by Defendants.

~~132.88.~~ Notwithstanding these fiduciary obligations, these defendants developed and relied upon internal practices and policies that improperly restricted coverage in contravention of Plaintiffs’ health insurance plans, and ERISA. Due ~~theto~~ the fiduciary breaches perpetrated by Defendants, including without limitation, the issuance of misleading or false denial letters, Plaintiffs and the Class are entitled to other equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3).

~~133.89.~~ Although Defendants were obligated to do so, they failed to provide a “full and fair review” of denied claims pursuant to ERISA § 503, 29 U.S.C. § 1133 for Plaintiffs and the Class, by using the PXDX algorithm to make coverage determinations without sufficient review, and for failing to disclose the true “specific reasons” for the denials.

~~134.90.~~ The law and implementing regulations set forth minimum standards for claim procedures, appeals, notice to insureds, and the like. In engaging in the conduct described herein, including systematic reimbursement reductions without disclosure or contractual authorization, Defendants failed to comply with the law, federal regulations, and federal common law.

~~135.91.~~ The consequences of Defendants’ violations of the law and regulations is that Defendants failed to provide a “full and fair review,” failed to provide reasonable claims procedures, and failed to make required disclosures.

~~136.92.~~ Plaintiffs and the members of the Class have been harmed by Defendants' breaches of fiduciary duty because their claims have been subjected to restrictions not imposed by their health insurance plans and which are illegal under ERISA

~~137.93.~~ Plaintiffs and Class members seek this Court's order that they are entitled to appropriate equitable relief under 29 U.S.C. § 1132(a)(3).

THIRD CAUSE OF ACTION

SECOND CAUSE OF ACTION

**Violation of California Unfair Competition Law,
Business & Professions Code Section 17200, *et. seq.***

Against all Defendants

**(On Behalf of Plaintiffs ~~Kisting-Leung, Rentsch, Thornhill,~~ Dababneh, Mahshigian, and the
California Subclass)**

~~138.94.~~ Plaintiffs reallege and incorporate by reference all preceding allegations as though fully set forth herein.

~~139.95.~~ Plaintiffs bring this cause of action pursuant to Business and Professions Code Section 17500, *et seq.*, on her own behalf and on behalf of all other persons similarly situated.

~~140.96.~~ California's Unfair Competition Law ("UCL") prohibits "any unlawful, unfair... or fraudulent business act or practice." Cal. Bus & Prof. Code section 17200, *et. seq.*

~~141.97.~~ Under the California Insurance Code, § 790.03(h), the following are classified as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance when they are knowingly committed or performed with such frequency as to indicate a general practice:

- a. "Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies."
- b. "Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear."

c. “Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.”

142.98. **Unlawful Prong:** Defendants’ conduct violates the unlawful prong of § 17200 because they violate California’s express statutory and regulatory requirements regarding insurance claims handling pursuant to Cal. Health & Saf. Code §1367.01, and because they violate the implied covenant of good faith and fair dealing.

143.99. Defendants violated the unlawful prong of § 17200 when they allowed the PXDX system to review and deny Plaintiffs and Class members’ claims instead of having a licensed physician who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider to deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity as required by Cal. Health & Saf. Code §1367.01(e).

144.100. Defendants violated the unlawful prong of § 17200 when they failed 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, as required by Cal. Health & Saf. Code §1367.01(h)(4).

145.101. Defendants 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, violating the implied covenant of good faith and fair dealing.

146.102. **Unfair Prong:** Defendants’ actions violated the unfair prong of § 17200 because the acts and practices set forth above, including Defendants’ use of the PXDX system to process and deny claims, rejection of claims in batches without a thorough, fair, and objective investigation offend established public policy and cause harm to consumers that greatly outweighs

any benefit associated with those practices. Defendants' actions also violate the unfair prong because they constitute a systematic breach of consumer contracts.

147.103. **Fraudulent Prong:** Defendants have violated the fraudulent business practices prong of § 17200 because their omissions and misrepresentations regarding the Cigna insurance policies and Plaintiffs' and Class Members' rights under their policies, including by using an algorithm to make coverage determinations and the denying claims on sham pretenses, were likely to deceive a reasonable consumer, and this information would be material to a reasonable consumer.

148.104. Defendants fraudulently misled Plaintiffs and Class members into believing that their health plans would ensure thorough, fair, and objective investigations by medical professionals into each submitted claim and provide coverage for reasonable and medically necessary procedures by failing to disclose the PXDX system, and by making affirmative statements suggesting human-made claims determinations.

149.105. Plaintiffs and Class members would not have enrolled with Defendants had they known Defendants failed to diligently pursue submitted claims using a thorough, fair, and objective investigation.

150.106. As a direct and proximate result of Defendants' violation of § 17200, Plaintiffs and Class members have been injured in fact and suffered lost money in that Defendants failed to provide benefits owed to their insureds under the insurance policies Defendants issued, and Defendants overcharged for the policies themselves given that the policies' value was less than Plaintiffs paid.

151.107. In perpetrating their fraudulent conduct, Defendants acted in concert and participated in exactly the same fraudulent conduct, as described herein.

152.108. To date, Defendants continue to violate the Unfair Competition law by breaching their insurance contracts.

153.109. To date, some Plaintiffs and Class members are still insured by Defendants.

154.110. Pursuant to Business and Professions Code section 17203, Plaintiffs and Class members seek an order of this Court enjoining Defendants from denying benefits owed to Cigna

insureds through its scheme involving the PXDX processing system. Without such an order, there is a continuing threat to Plaintiffs and Class members, as well as to members of the general public, that Defendants will continue to systematically deny and reduce benefits to California consumers through its use of the PXDX system.

~~155.111.~~ Pursuant to Business and Professions Code section 17203, Plaintiffs and Class members seek an order of this Court awarding Plaintiffs and Class members restitution of the money wrongfully acquired by Defendants by means of responsibility attached to Defendants' failure to disclose the existence and significance of said misrepresentations in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, individually and on behalf of all others similarly situated, request that this Court enter an order granting the following relief against Defendants:

- a. Awarding actual damages, statutory damages, exemplary/punitive damages, costs and attorneys' fees;
- b. Awarding disgorgement and/or restitution;
- c. Awarding pre-judgment interest to the extent permitted by law;
- d. Appropriate declaratory and public injunctive relief enjoining Cigna from continuing its improper and unlawful claim handling practices as set forth herein;
- e. Such other and further relief as the Court may deem just and proper.

JURY TRIAL DEMANDED

Plaintiffs demand a jury trial on all triable issues.

DATED: September 23, 2026

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8 **UNITED STATES DISTRICT COURT**
9 **EASTERN DISTRICT OF CALIFORNIA**

10 SAMANTHA DABABNEH and RANDALL
11 RENTSCH, individually and on behalf of all
others similarly situated,

12 Plaintiffs,

13 vs.

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

17 Defendants.

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

**[PROPOSED] ORDER TO EXTEND
DEADLINES AND TO ALLOW
AMENDMENT**

Having considered the parties' Stipulated Motion to Amend the Complaint to add Proposed Plaintiff and Class Representative Michael Mahshigian, and good cause appearing, the Court hereby GRANTS leave for Plaintiffs to amend the complaint to add the Proposed Plaintiff, and further ORDERS as follows:

Revised Deadline	Event
September 30, 2026	Parties complete fact discovery and fact depositions other than deposition of Cigna's remaining 30(b)(6) witness, dismissal or deposition of Plaintiff Dababneh, and discovery related to the Proposed Plaintiff; Cigna to serve third-party subpoenas related to the Proposed Plaintiff by this date
October 13, 2026	Parties complete the duly noticed Rule 30(b)(1) deposition of Cherri Reddick
October 16, 2026	Plaintiffs provide responses to Cigna's discovery requests to the Proposed Plaintiff
November 4, 2026	Deadline for Plaintiffs to inform Cigna if Ms. Dababneh intends to resume participating in the lawsuit.
November 11, 2026	Deadline for production of documents by the parties related to the Proposed Plaintiff's claims, excluding documents received from third parties
November 25, 2026	Plaintiff Dababneh to be deposed or dismissed as a class representative on or before this date
December 18, 2026	The Proposed Plaintiff will be deposed on or before this date
January 4, 2027	Parties complete discovery related to the Proposed Plaintiff's claims

PURSUANT TO STIPULATION, IT IS SO ORDERED.

Dated: _____, 2026

By: _____
Hon. Dale A. Drozd
United States District Judge