

EXHIBIT 1

**UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY**

ESTATE OF JOANNE BARROWS, SUSAN
HAGOOD, SHARON MERKLEY,
LORRAINE KOHL, and DOLLY BALANI,
individually and on behalf of all others
similarly situated,

Plaintiffs,

v.

HUMANA, INC., and NAVIHEALTH, INC.,

Defendants.

Civil File No. 3:23-cv-00654 (RGJ/CHL)

CLASS ACTION COMPLAINT

DEMAND FOR JURY TRIAL

PLAINTIFFS' SECOND AMENDED CLASS ACTION COMPLAINT

Plaintiffs, Estate of JoAnne Barrows, Susan Hagood, Sharon Merkley, Lorraine Kohl, and Dolly Balani (“Plaintiffs”), individually and on behalf of all others similarly situated (the “Class” or “Classes”), by and through their attorneys, bring this class action against Defendant Humana, Inc. (“Humana”), and Defendant naviHealth, Inc. (“naviHealth”) (collectively, “Defendants”), and allege as follows:

INTRODUCTION

1. This putative class action arises from Humana’s illegal and undisclosed deployment of artificial intelligence (AI) in place of real doctors, and from naviHealth’s creation, design, and purposeful sale of that AI technology to Humana for exactly that use. Humana employs this process to summarily deny elderly patients care owed to them under Medicare Advantage Plans on false pretenses. The AI Model, known as nH Predict, is used to override real treating physicians’ determinations as to medically necessary care patients require. Humana knows that the nH Predict AI Model predictions are highly inaccurate and are not based on patients’ medical needs but

continues to use this system, and naviHealth—which built nH Predict, owns all proprietary rights in it, and is [REDACTED]—knows the same thing and continues to sell and support it for that purpose.

2. naviHealth created and designed the nH Predict AI Model as its own proprietary AI tool to use in the adjudication of post-acute care claims. naviHealth then sold its services as a third-party claims administrator, including the use of its nH Predict AI Model, to Humana and other health insurers. In doing so, naviHealth and Humana ensured that the nH Predict AI Model was used to adjudicate critical post-acute care claims, rather than adjudicating claims through meaningful individual review by licensed physicians. naviHealth did not merely operate a tool at Humana’s direction; it conceived of, engineered, marketed, and profited from nH Predict as a product built precisely for the use to which Humana put it.

3. By this action, Plaintiffs challenge the process employed by Humana and naviHealth to make claim determinations—i.e., Humana enlisting naviHealth’s services, including the design, sale, and use of the nH Predict AI Model—and not the denial of any individual claim.

4. Despite the high rate of wrongful denials, Humana continues to employ naviHealth to systemically use this flawed AI Model to deny claims, and naviHealth continues to sell, operate, and profit from it, because they know that only a tiny minority of policyholders (roughly 0.2%)¹ will appeal denied claims, and the vast majority will either pay out-of-pocket costs or forgo the remainder of their prescribed post-acute care. Humana banks on the patients’ impaired conditions, lack of knowledge, and lack of resources to appeal the wrongful AI-powered decisions.

5. The fraudulent scheme affords Humana a clear financial windfall in the form of

¹ Karen Pollitz, et al., *Claims Denials and Appeals in ACA Marketplace Plans in 2021*, KFF (Feb. 9, 2023), <https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans/> (last visited Nov. 13, 2023).

policy premiums without having to pay for promised care, while the elderly are prematurely kicked out of care facilities nationwide, forced to deplete family savings to continue receiving necessary medical care, or forced to forgo care altogether, all because an AI Model “disagrees” with their real live doctors’ determinations. The scheme affords naviHealth its own, separate financial windfall: [REDACTED]

[REDACTED]. naviHealth builds and operates the very tool that produces those results.

6. Defendant Humana, Inc. is one of the nation’s largest insurance companies. Humana provides Medicare Advantage health insurance plans for 5.1 million eligible Americans.²

7. Humana masquerades as an insurer that brings “the human side of healthcare,” claiming, “Our approach is simple—offer personalized care from people who care.”³ Humana’s CEO Bruce Broussard claims Humana is “continuously working to remove barriers to health and to provide quality care.”⁴ In reality, Humana systematically deploys the nH Predict AI Model to prematurely and in bad faith discontinue payment for healthcare services for elderly individuals with serious diseases and injuries. These elderly patients are left either with overwhelming medical debt, or without the medical care that they require.

8. The nH Predict AI Model determines Medicare Advantage patients’ coverage criteria in post-acute care settings with rigid and unrealistic predictions for recovery.⁵ Relying on the nH Predict AI Model, Humana purports to predict how much care an elderly patient “should” require but overrides real doctors’ determinations as to the amount of care a patient in fact requires

² *For Each Person*, HUMANA, [humana.com/about/impact/individual](https://www.humana.com/about/impact/individual) (last visited Nov. 30, 2023).

³ *About Humana*, Humana, <https://www.humana.com/about> (last updated Nov. 9, 2023).

⁴ *Letter From Humana’s President and Chief Executive Officer*, HUMANA, <https://www.humana.com/about/ceo-message> (last updated Nov. 9, 2023).

⁵ Casey Ross and Bob Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need*, STAT (Mar. 13, 2023), <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/>.

to recover. As such, Humana makes coverage determinations not based on individual patient's needs but based on the outputs of the nH Predict AI Model, thus maximizing the likelihood of inappropriate denial of necessary care prescribed by the patients' doctors. Humana's implementation of the nH Predict AI Model resulted in a significant increase in the number of post-acute care coverage denials.

9. Through this faulty process, Humana intentionally limits its employees' discretion to deviate from the nH Predict AI Model predictions by collaborating with naviHealth to set targets to keep stays at post-acute care facilities within 1% of the days projected by the AI Model.⁶ Employees who deviate from the nH Predict AI Model projections are disciplined and terminated, regardless of whether a patient requires more care.⁷ naviHealth is an affirmative actor in this arrangement: naviHealth designed the 1%-of-projected-days target methodology and applies it as part of the utilization-management services it sells to Humana under the parties' Post-Acute Care Management Services Agreement, described further below.

10. The nH Predict AI Model saves Humana money by allowing them to deny claims they are obligated to pay and otherwise would have paid by eliminating the labor costs associated with paying doctors and other medical professionals for the time needed to conduct an individualized, manual review of each of its insured's claims. The nH Predict AI Model likewise saves naviHealth money and generates revenue for naviHealth: naviHealth is [REDACTED]

[REDACTED]
[REDACTED]—meaning naviHealth profits directly and

⁶ Casey Ross and Bob Herman, *UnitedHealth Pushed Employees to Follow an Algorithm to Cut Off Medicare Patients' Rehab Care*, STAT (Nov. 14, 2023), <https://www.statnews.com/2023/11/14/unitedhealth-algorithm-medicare-advantage-investigation/#:~:text=The%20nation's%20largest%20health> (Humana uses the same nH Predict model as UnitedHealth).

⁷ *Id.*

specifically from the very denials at issue in this action.

11. Humana also utilizes the nH Predict AI Model to aggressively deny coverage because they know they will not be held accountable for wrongful denials.

12. In many instances, Humana purposefully shifts the financial responsibilities of funding post-acute care of its insureds to American taxpayers. In its coverage denial letters, Humana informs patients who qualify for Medicare that their coverage is being denied solely due to their Medicare eligibility. Humana directs these patients to enroll in the government-subsidized Medicare program despite knowing that its use of the nH Predict AI Model will result in wrongful denials of coverage.

13. Plaintiffs and Class members had their post-acute care coverage determined by the nH Predict AI Model. Humana failed to use reasonable standards in evaluating the individual claims of Plaintiffs and Class members and instead allowed their coverage needs to be wholly determined by AI.

14. By engaging in this misconduct, Humana breached its fiduciary duties, including the duties of good faith and fair dealing, because its conduct serves Humana's own economic self-interest and elevates Humana's interests above the interests of the insureds. naviHealth designed, built, and sold Humana the very instrument of that misconduct—for naviHealth's own profit—with full knowledge of how claims determinations for Humana members were being made and Humana's obligation to provide individualized, doctor-led review that nH Predict was deployed to displace.

15. By bringing this action, Plaintiffs seek to remedy Humana's and naviHealth's past improper and unlawful conduct by recovering damages to which Plaintiffs and the Class are rightfully entitled and enjoin Humana and naviHealth from continuing to perpetrate their scheme

against Humana's Medicare Advantage insureds.

JURISDICTION AND VENUE

16. This Court 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 Plaintiff 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.

17. In addition, under 28 U.S.C. §1367, this Court may exercise supplemental jurisdiction over the state law and common law claims against Humana and naviHealth alike because all claims are derived from a common nucleus of operative facts and are such that Plaintiffs would ordinarily expect to try them in one judicial proceeding.

18. This Court has personal jurisdiction over Humana, Inc. because Humana, Inc. is headquartered in Kentucky, has sufficient minimum contacts with Kentucky, and otherwise purposefully avail themselves of the benefits and protections of Kentucky law, so as to render the exercise of jurisdiction by this Court proper and consistent with traditional notion of fair play and substantial justice.

19. This Court also has personal jurisdiction over Defendant naviHealth, Inc. naviHealth purposefully directed its conduct at Kentucky and at this District by negotiating and entering into the Post-Acute Care Management Services Agreement ("PACSA") with a Kentucky-headquartered insurer, by designing, marketing, and operating the nH Predict AI Model specifically for use by that Kentucky-headquartered insurer in making coverage determinations for its members nationwide (including in this District), and by agreeing to Kentucky choice-of-law and Kentucky-situs dispute-resolution provisions in the PACSA itself. naviHealth thereby

availed itself of the benefits and protections of Kentucky law, and the exercise of personal jurisdiction over naviHealth in this Court comports with traditional notions of fair play and substantial justice.

20. Venue is proper in this Court pursuant to 28 U.S.C. § 1391. Humana, Inc. regularly conducts business in this District, and a substantial part of the events giving rise to the claims asserted herein occurred in this District. Humana, Inc. resides in this District, being headquartered at 500 West Main St., Louisville, KY 40202. Venue is likewise proper as to naviHealth because a substantial part of the events giving rise to the claims against naviHealth—including naviHealth’s sale of its services, including nH Predict, for use by a Kentucky-headquartered insurer, and naviHealth’s provision of coverage-determination services under the PACSA for members whose claims were adjudicated in and from this District—occurred in this District, and because naviHealth is subject to personal jurisdiction here.

THE PARTIES

21. Plaintiff JoAnne Barrows. JoAnne Barrows was at all times relevant to this action a citizen of Minnesota, residing in Hennepin County. At all relevant times mentioned herein, Ms. Barrows was covered by a Medicare Advantage Plan policy provided by Humana.

22. Plaintiff Susan Hagood. Susan Hagood was at all times relevant to this action a citizen of North Carolina, residing in Buncombe County. At all relevant times mentioned herein, Ms. Hagood was covered by a Medicare Advantage Plan policy provided by Humana.

23. Plaintiff Sharon Merkley. Plaintiff Sharon Merkley was at all times relevant to this action a citizen of Kentucky, residing in Daviess County. At all relevant times mentioned herein, Mrs. Merkley was covered by a Medicare Advantage Plan policy provided by Humana.

24. Plaintiff Lorraine Kohl. Plaintiff Lorraine Kohl was at all times relevant to this

action a citizen of Wisconsin, residing in Outagamie County. At all relevant times mentioned herein, Mrs. Kohl was covered by a Medicare Advantage Plan policy provided by Humana.

25. Plaintiff Dolly Balani. Plaintiff Dolly Balani was at all times relevant to this action a citizen of Texas, residing in Cameron County. At all relevant times mentioned herein, Mrs. Balani was covered by a Medicare Advantage Plan policy provided by Humana.

26. Defendant Humana, Inc. Humana, Inc. is a Delaware corporation, headquartered at 500 West Main St., Louisville, KY 40202. Humana, Inc. conducts insurance operations throughout the country, representing to consumers that it “mak[es] healthcare more equitable and accessible,” and that it “make[s] it easier for people to achieve their best health.”⁸ Humana, Inc. has a license to use the federally registered service mark “HUMANA,” markets and issues health insurance and insures, issues, administers, and makes coverage and benefit determinations related to the health care policies nationally through its controlled agents and undisclosed principals and agents. Defendant Humana, Inc. is licensed and registered to conduct business in all 50 states, and does conduct business in all 50 states, and is thereby subject to the laws and regulations of all 50 states.

27. Defendant naviHealth, Inc. naviHealth, Inc. is a Delaware corporation with its principal place of business in Brentwood, Tennessee. naviHealth is a technology and care-management company that created, designed, owns, and operates the nH Predict AI Model. naviHealth licenses and sells nH Predict, and related utilization-management services, to health insurers throughout the country—including Humana—pursuant to services agreements such as the PACSA between naviHealth and Humana Insurance Company, effective August 1, 2017. Under the PACSA, naviHealth is [REDACTED]

[REDACTED]

⁸ *Humana’s Impact*, HUMANA, <https://www.humana.com/about/impact> (last updated Nov. 9, 2023).

[REDACTED]. naviHealth is registered and/or otherwise authorized to, and does, conduct business in Kentucky and throughout the United States, and is thereby subject to the laws and regulations of Kentucky and the other states in which the Class and Subclasses reside.

FACTUAL ALLEGATIONS

A. Background

28. Humana offered and sold Medicare Advantage health insurance plans to consumers, including Plaintiffs and Class members.

29. A Medicare Advantage plan is a type of health plan offered by private companies that contract with Medicare. Medicare Advantage is a taxpayer-funded alternative to traditional Medicare that covers 30.8 million people.⁹ Medicare Advantage accounts for more than half (51 percent) of the eligible Medicare population, and \$454 billion (or 54 percent) of total federal Medicare spending.¹⁰

30. Plaintiffs and Class members enrolled with Humana to receive Medicare Advantage health insurance coverage. Humana provided Plaintiffs and members of the Class with written terms explaining the plan coverage Humana offered to them. According to these terms, Humana is obligated to provide benefits for covered health services and must pay all reasonable and medically necessary expenses incurred by a covered member.

31. From at least December 12, 2019, to the present (the “Relevant Period”), Plaintiffs and Class members were referred to and received “post-acute care”—medically necessary care for patients recovering from serious illnesses and injuries. Post-acute care is covered by the terms of

⁹ Nancy Ochieng, et al., *Medicare Advantage in 2023: Enrollment Update and Key Trends*, KFF (Aug. 9, 2023), <https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/> (last visited Nov. 13, 2023).

¹⁰ *Id.*

their insurance agreements provided by Humana.

32. Post-acute care encompasses skilled care, therapy, and other services provided by home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), acute inpatient rehab facilities (AIRs), acute rehab units (ARUs), and long-term care hospitals (LTCHs), collectively known as post-acute care (PAC) providers because they typically furnish care after an inpatient hospital stay.

33. Medicare Advantage providers use a prospective payment system for each type of PAC provider. Under this system, insurers pay PAC providers an upfront fee that is based on estimates of the national average cost of providing covered care for a specified period of time.

34. Due to the nature of the prospective payment system, insurers' coverage decisions occur before or during a patient's post-acute care. When the insurer decides to end coverage before the doctor's requested discharge date for the patient, the patients are left with an impossible choice: to either forgo their post-acute care despite not being well enough to function without it or pay out-of-pocket to continue receiving care they were wrongfully denied—if they can afford it.

35. Other patients are denied coverage before they receive any post-acute care. When patients are referred to post-acute care facilities by their doctors, Defendants use the nH Predict AI Model to deny prior authorization requests, regardless of the patients' actual conditions or doctors' recommendations.

36. Humana created and instituted a process designed to override and circumvent doctors from determining individual coverage for post-acute care in a thorough, fair, and objective manner, instead using the nH Predict AI Model to supplant real doctors' recommendations and patients' medical needs. naviHealth, in turn, created and designed the nH Predict AI Model, and purposefully sold its services to Humana precisely so that Humana could benefit from the process

described in this paragraph. Humana’s use of the nH Predict AI Model, which directs Humana’s medical review employees to prematurely stop covering care without considering an individual patient’s needs, is systematic, illegal, malicious, and oppressive.¹¹

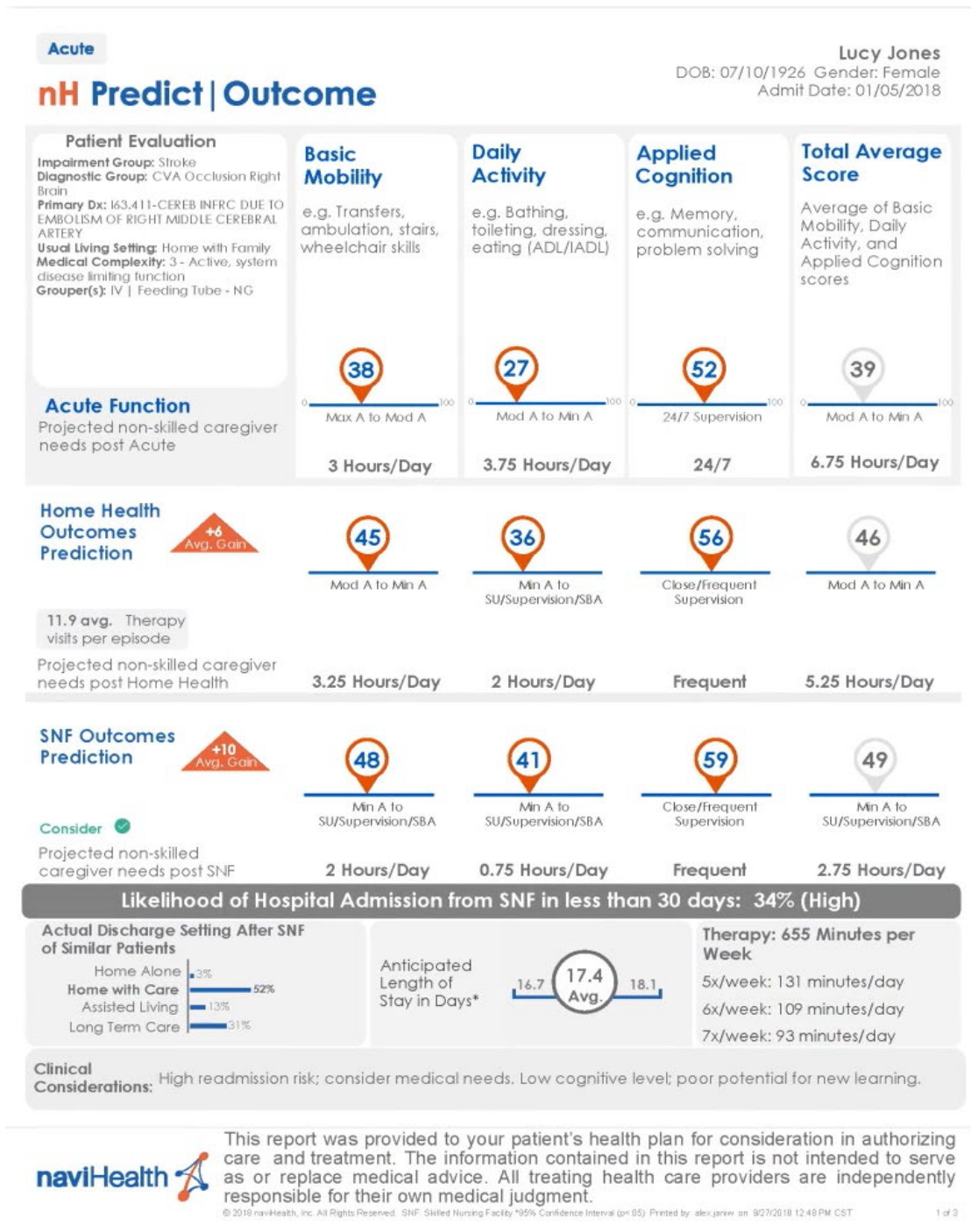
37. The nH Predict AI Model attempts to predict the amount of post-acute care a patient “should” require, pinpointing the precise moment when Humana will cut off payment for a patient’s treatment. If the nH Predict AI Model determines the patient shouldn’t require any post-acute care, it recommends denial of prior authorization. The nH Predict AI Model compares a patient’s diagnosis, age, living situation, and physical function to similar patients in a database of six million patients it compiled over the years of working with providers to predict patients’ medical needs, estimated length of stay, and target discharge date.¹²

38. The following is a true and correct representation of a sample nH Predict Outcome sheet, taken from a naviHealth presentation.¹³ The Outcome sheet bears naviHealth’s own branding and is generated by naviHealth’s proprietary software, underscoring that nH Predict—and the methodology it applies—is naviHealth’s product, not Humana’s.

¹¹ Casey Ross and Bob Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need*, STAT (Mar. 13, 2023), <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/> (last visited Nov. 13, 2023).

¹² *Id.*

¹³ *NaviHealth Guiding the Way – Animated Explainer*, ECG PRODUCTIONS, <https://www.ecgprod.com/navihealth-guiding-the-way-animated-explainer/> (last visited Nov. 13, 2023).



39. Humana wrongfully delegates its obligation to evaluate and investigate claims to the nH Predict AI Model. naviHealth wrongfully accepted that delegation and profits from it. The nH Predict AI Model spits out generic recommendations based on incomplete and inadequate medical records and fails to adjust for a patient's individual circumstances and conflicts with basic

rules on what Medicare Advantage plans must cover.

40. Upon information and belief, the nH Predict AI Model applies rigid criteria from which Humana's employees are instructed not to deviate. The employees who deviate from the nH Predict AI Model prediction are disciplined and terminated, regardless of whether the additional care for a patient is justified.

41. Under Medicare Advantage Plans, patients who have a three-day hospital stay are typically entitled to up to 100 days in a nursing home. With the use of the nH Predict AI Model, Humana cuts off payment in a fraction of that time. Patients rarely stay in a nursing home more than 14 days before they start receiving payment denials.¹⁴

42. Upon information and belief, the outcome reports generated by nH Predict are rarely, if ever, communicated with patients or their doctors. When patients and doctors request their nH Predict reports, naviHealth's employees deny their requests and tell them that the information is proprietary. As alleged in greater detail below, that "proprietary" designation refers to naviHealth's own nH Predict methodology, which naviHealth refuses to disclose to patients or providers to protect naviHealth's commercial interests and to conceal its misconduct.

43. Denials issued by Humana are appealable to Quality Improvement Organizations ("QIOs"), independent third-party organizations established to review claims determinations, per the Medicare Act. These QIOs can overturn denials and reinstate benefits in individual cases. There is, therefore, no way for any individual patient to understand the actual basis for Humana's refusal to pay and there is no way for any individual patient to challenge the systematic process that leads to that refusal.

¹⁴ Casey Ross and Bob Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need*, STAT (Mar. 13, 2023), <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/> (last visited Nov. 13, 2023).

44. Upon information and belief, over 90 percent of patient claim denials are reversed through either an internal appeal process or through federal Administrative Law Judge (ALJ) proceedings. Additionally, over 80 percent of prior authorization request denials are reversed on appeal.¹⁵ This demonstrates the blatant inaccuracy of the nH Predict AI Model, and the lack of human review involved in the coverage denial process. The problem with this process is systemic. It is inherently unfair for Humana to employ a coverage determination process that it knows will result in improper denials while ignoring the recommendations of doctors. It is likewise inherently unfair for naviHealth to have designed, and to continue to sell and operate, a coverage determination process that it knows will result in improper denials at this rate.

45. Plaintiffs' and the Class's use of this appeals system is generally futile. Under the Medicare Act, the decisionmakers on appeal only have the authority to reinstate benefits—they lack the authority to enjoin Humana from abusing the nH Predict AI Model to make coverage determinations, which is a part of the relief sought by Plaintiffs.

46. Additionally, upon information and belief, even if Plaintiffs or the Class succeed on any individual appeal, Humana and its contractor naviHealth request updated medical records, issue another denial, and force patients to restart the appeals process with the goal of depriving patients of the opportunity to receive additional care.

47. Upon information and belief, naviHealth employees are given a length of stay “budget,” and if the cases they oversee come in under that budget, they receive bonus compensation. This bonus structure is not limited to individual employee incentives: naviHealth itself, as a company, is [REDACTED]

¹⁵ *Examining Health Care Denials and Delays in Medicare Advantage Before the Permanent Subcommittee on Investigations*, 118th Cong. (2023) (statement of Sen. Richard Blumenthal, Chairman, Permanent Subcommittee on Investigations).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] naviHealth thus has a direct and continuing financial stake in the outcomes produced by the very nH Predict AI Model it designed and operates.

48. If Plaintiffs were required to exhaust their administrative remedies before bringing this action in court, they would suffer irreparable harm. To reach the highest level of appeal before the Medicare Appeals Council often takes years.¹⁶ While waiting for a decision, Plaintiffs, like all patients, would be left with two options: (1) to stay in post-acute care facility and risk being responsible for months' or years' worth of medical bills if their appeals are denied; or (2) to forgo care while they wait for a decision to be made on their appeals. Plaintiffs are elderly and/or ill patients who have suffered serious medical traumas. If they opt to forgo care while waiting for a decision on appeal, they risk further serious injury.

49. If Plaintiffs were required to exhaust their appeals before bringing this action in court, Humana's misconduct would be capable of repetition while evading review. Humana knows that if patients are required to exhaust their remedies, they need only pay the relatively small claims appealed before they reach the highest level of appeal, and their systemic misconduct would never be reviewable in court.

50. Roughly 0.2% of consumers appeal their health insurance claim denials. Far fewer pursue their appeal to the third level, before an administrative law judge. Upon information and

¹⁶ Casey Ross and Bob Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need*, STAT (Mar. 13, 2023), <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/> (quoting Chris Comfort, COO of Calvary Hospital, as stating that the appeals process lasts up to 2.5 years, often leading to appeals that “outlast[] the beneficiary”).

belief, when a patient appeals to an ALJ, Humana selectively does not contest the appeal after scrutinizing the assessment of the nH Predict AI Model—Humana instead agrees to pay the claims. Upon information and belief, in doing so, Humana pays the claims of less than 0.2% of consumers and ensures that no claims make it to the Medicare Appeals Council, and thus nobody exhausts their administrative remedies. In this way, Humana ensures that if patients are required to exhaust their administrative remedies, they will be able to fraudulently review and deny over 99% of claims without their misconduct being reviewable in court.

51. Humana fraudulently misled its insureds into believing that their health plans would individually assess their claims and pay for medically necessary care.

52. Had Plaintiffs and Class members known that Humana would evade the legally required process for reviewing patient claims and instead delegate that process to its nH Predict AI Model to review and deny claims, they would not have enrolled with Humana and/or would not have paid for their plan the amount they had to pay to be enrolled.

53. Humana's use of the nH Predict AI Model to deny its insureds' claims undermines the principles of fairness and meaningful claim evaluation, which insureds expect from their insurers.

B. naviHealth's Creation, Design, and Deployment of the nH Predict AI Model

54. naviHealth created and designed the nH Predict AI Model. naviHealth built nH Predict's predictive algorithm, assembled and maintains the underlying database of patient records against which nH Predict compares each Medicare Advantage member, and authored the software that generates the "outcome sheets," such as the one reproduced above, that naviHealth uses to make coverage determinations.

55. When naviHealth sells its services to an insurer such as Humana, naviHealth is

selling access to the nH Predict tool and the savings it provides insurers by denying claims.

56. naviHealth and Humana entered into the PACSA, effective August 1, 2017, under which naviHealth agreed to provide, and Humana agreed to pay for, utilization-management services built around the nH Predict AI Model. The PACSA and its accompanying Statement(s) of Work set the terms on which naviHealth designed, deployed, and continues to operate nH Predict for Humana's Medicare Advantage line of business.

57. Article II(e) of the PACSA provides that [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] naviHealth thus [REDACTED]
[REDACTED]
[REDACTED]—confirming that nH Predict is naviHealth's own product, marketed and sold to Humana via naviHealth's services, rather than a tool Humana itself created or controls.

58. Article IV of the PACSA, titled [REDACTED] provides that [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Article IV further provides that [REDACTED]
[REDACTED]
[REDACTED]

59. naviHealth knew, at all times relevant to this action, of Humana's contractual obligations to the Medicare Advantage members whose post-acute care claims naviHealth

administered. Under the PACSA, Humana was required to provide naviHealth the Benefit Plan designs applicable to the members naviHealth would service, including CMS-approved changes to those designs, and naviHealth accepted delegated responsibility for utilization management functions addressing benefit coverage and medical necessity. Consistent with that arrangement, in November 2023 a naviHealth National Accounts director expressly acknowledged to Humana that

[REDACTED]

[REDACTED] naviHealth therefore knew that the post-acute care determinations it made and/or administered were required to conform to Humana members' plan terms, including contractual obligations alleged herein governing individualized, doctor-informed review.

60. In addition to creating and designing nH Predict, naviHealth exercised delegated responsibility over the post-acute coverage review process. In 2018, Humana described naviHealth as having [REDACTED] and stated that naviHealth used its proprietary predictive model [REDACTED]. Humana's description confirms that naviHealth's role extended beyond supplying software: naviHealth was delegated utilization management responsibility and used its own predictive methodology in making the level-of-care and length-of-stay determinations at issue here,

61. nH Predict functioned as part of the decision-making process, rather than merely as an informational or predictive tool. In a June 2023 presentation, Humana expressly categorized nH Predict as a [REDACTED] and identified its [REDACTED] as including [REDACTED]. The same presentation depicted nH Predict [REDACTED]

[REDACTED] Thus,

naviHealth and its proprietary nH Predict model were incorporated directly into the process for making the post-acute care coverage determinations at issue here.

62. naviHealth's own utilization-management employees, applying nH Predict, directly communicated coverage determinations to Plaintiffs, without disclosing that those determinations were generated by a population-based algorithm rather than an individualized clinical assessment, as alleged further below with respect to Plaintiffs Merkley and Kohl.

63. naviHealth sells the utilization-management services described herein, including access to nH Predict, to insurers other than Humana. naviHealth's commercial interest in nH Predict is thus independent of, and broader than, any single insurer's business, including Humana's; naviHealth acts to advance its own, separate commercial enterprise—selling an algorithmic coverage determination product to the health insurance industry generally—and not merely to protect or advance Humana's interest in performing Humana's own contracts with its members.

C. Plaintiff JoAnne Barrows

64. Plaintiff JoAnne Barrows is enrolled in the Medicare Advantage Plan provided by Humana.

65. In November of 2021, 86-year-old JoAnne Barrows fell at home and fractured her leg. On or around November 23, 2021, Ms. Barrows was admitted to Methodist Hospital in St. Louis Park, Minnesota, where she was placed in a cast and put on a non-weight-bearing order for six weeks.

66. On or around November 26, 2021, Ms. Barrows was discharged from Methodist Hospital and admitted to the Good Samaritan Society Ambassador rehabilitation facility in Robbinsdale, Minnesota.

67. On or around December 9, 2021, Humana informed Ms. Barrows that they were terminating her coverage in two days, on December 11, after only approximately two weeks of care.

68. Ms. Barrows and her doctor were bewildered by Humana's premature termination of coverage because Ms. Barrows was still under a non-weight-bearing order for four more weeks. Ms. Barrows's doctor recommended that she continue rehabilitation treatment, but Humana refused to cover additional treatment.

69. Ms. Barrows and her family vigorously appealed Humana's denial, but their efforts were unsuccessful. The appeals were denied, and Humana deemed Ms. Barrows ready to return home despite being bedridden and using a catheter.

70. Because Ms. Barrows was not yet fit to return home, her family had no choice but to pay for her stay at the Good Samaritan Society Ambassador rehabilitation facility out of pocket.

71. Due to the high cost of the Good Samaritan Society Ambassador rehabilitation facility, Ms. Barrows's family made the difficult decision to transfer her to an assisted living facility, which was less expensive.

72. Unfortunately, the care provided at the assisted living facility was substandard, resulting in the deterioration of Ms. Barrows's condition.

73. As a result, Ms. Barrows's family had to make another difficult decision and end her care due to the poor quality of care she was receiving. On or around December 22, 2021, Ms. Barrows returned home, but she was not in a physical state to be there safely. She was unable to use her injured leg, could not go to the restroom without assistance, and still had a catheter in.

74. Due to Humana's wrongful denial of coverage, Ms. Barrows health was significantly impacted as she could not afford to receive the care she needed and was entitled to.

Ms. Barrows also suffered significant economic losses in the form of out-of-pocket payments for treatment that should have been otherwise covered by her plan.

D. Plaintiff Susan Hagood

75. Plaintiff Susan Hagood is enrolled in the Medicare Advantage plan provided by Humana.

76. On or around September 10, 2022, Ms. Hagood was admitted to Mission Hospital in Asheville, North Carolina, with a urinary tract infection, sepsis, and a spinal infection.

77. On or around October 26, 2022, Ms. Hagood was discharged from Mission Hospital with eleven discharging diagnoses, including sepsis, acute kidney failure, kidney stones, nausea and vomiting, a urinary tract infection, osteomyelitis of lumbar spine, and an L3 phlegmon.

78. She was admitted to a skilled nursing facility, The Oaks at Brevard, the same day. During her time at the skilled nursing facility, Ms. Hagood was on a maximum allowable dose of oxycodone and constantly endured exceptionally high pain levels.

79. Additionally, Ms. Hagood suffered from low oxygenation, which developed into pneumonia.

80. After a telehealth conference with her infectious disease specialist on or around November 15, 2022, Ms. Hagood scheduled an appointment at Mission Hospital for November 28, 2022.

81. Upon return to Mission Hospital on November 28, 2022, she experienced a rapid spike in blood pressure and was taken to the emergency room, where it was discovered that Ms. Hagood's condition had worsened considerably. She was diagnosed with a multi-level disc edema with discitis osteomyelitis, consolidative phlegmon within her epidural spaces, a large staghorn calculus in each kidney, and pneumonia.

82. On or around November 27, 2022, Humana denied Ms. Hagood's claim for the treatment she received at The Oaks at Brevard between November 14 and November 28, refusing to pay for half of her month-long stay. Despite Ms. Hagood's critical condition, Humana denied her coverage, explaining that Ms. Hagood did not require the level of care a skilled nursing facility provided and should be discharged home.

83. Ms. Hagood and her family have incurred over \$24,000 in out-of-pocket medical expenses for treatment that Humana should have covered.

84. To date, Ms. Hagood remains in a skilled nursing facility and requires ongoing medical care due to her health condition.

E. Plaintiff Sharon Merkley

85. Plaintiff Sharon Merkley is enrolled in a Medicare Advantage plan with Humana. She pays a monthly premium of \$46.00 for that plan.

86. Mrs. Merkley suffers from Parkinson's Disease, HTN, atrial fibrillation, and arthritis.

87. On or around November 4, 2023, Mrs. Merkley was admitted to Vanderbilt University Medical Center in Nashville, Tennessee, after experiencing severe hives, high blood pressure, and an inability to walk. Mrs. Merkley was diagnosed with an autoimmune disease called bullous pemphigoid.

88. Mrs. Merkley was treated at Vanderbilt until November 16, 2023, when she was discharged and transferred to a skilled nursing facility, Signature Healthcare in Hartford, Kentucky.

89. On or around November 16, 2023, Humana approved prior authorization for the skilled nursing care, sending Mrs. Merkley a letter confirming the approval. However, Humana

did not specify a length of stay (denoted by “Unit(s) Approved”) in the letter.

90. On or around November 17, 2023, naviHealth sent Mrs. Merkley a letter noting the prior authorization, indicating that Mrs. Merkley’s coverage determinations would be processed by naviHealth and the nH Predict AI Model. Unlike Humana’s letter, naviHealth limited Mrs. Merkley’s length of stay to “3” Unit(s) Approved. This letter was naviHealth’s own direct communication with Mrs. Merkley, sent on naviHealth’s own letterhead and applying naviHealth’s own nH Predict AI Model; it did not disclose that the “3” Unit(s) Approved figure was generated by comparing Mrs. Merkley to a population-based dataset rather than by an individualized assessment of her actual condition.

91. On or around December 6, 2023, Humana issued a Notice of Medicare Non-Coverage, terminating Mrs. Merkley’s coverage, effective December 8, 2023.

92. Mrs. Merkley appealed this denial to Kepro, a QIO. On or around December 7, 2023, Kepro granted Mrs. Merkley’s appeal, reinstating coverage. Kepro determined that the skilled nursing services were medically necessary, because Mrs. Merkley “[could] not walk and require[d] maximum assistance with two-person assistance for bed mobility,” could only “stand for 25 seconds,” required “moderate assistance with upper body dressing and toileting and maximum assistance with upper and lower body bathing and lower body dressing,” and she had “an open wound to [her] sacrum.” Kepro determined that Mrs. Merkley required 24-hour care.

93. Despite Mrs. Merkley’s condition, Humana issued another denial just four days later, on or around December 11, 2023. Coverage was to be terminated on December 13, 2023. On information and belief, naviHealth’s [REDACTED] under the PACSA rewarded naviHealth for exactly this pattern—repeated, rapid re-issuance of length-of-stay-limiting determinations regardless of Kepro’s intervening reversals—giving naviHealth its own financial incentive,

separate from Humana's, to limit Mrs. Merkley's care.

94. Mrs. Merkley again appealed the denial to Kepro, and on or around December 13, 2023, Kepro determined that skilled nursing care was still medically necessary, reinstating coverage.

95. Humana issued another denial the very next day, on or around December 14, 2023, terminating coverage effective December 16, 2023. Mrs. Merkley appealed, and Kepro once again overturned the denial.

96. Humana issued a fourth denial on or around December 20, 2023, terminating coverage effective December 22, 2023. Mrs. Merkley appealed, and Kepro once again overturned the denial.

97. Humana issued a fifth denial the very same day, on or around December 22, 2023, terminating coverage on Christmas Eve, December 24, 2023. Mrs. Merkley appealed, and Kepro once again overturned the denial.

98. Humana issued a sixth denial on or around December 28, 2023, terminating coverage effective December 30, 2023. Mrs. Merkley appealed, and Kepro once again overturned the denial.

99. Humana issued a seventh denial on or around January 5, 2024, terminating coverage effective January 7, 2024. Mrs. Merkley appealed, but this time Humana received the break it had been fishing for—Kepro denied the appeal. Mrs. Merkley elevated to a second-level appeal, which Kepro again denied on or around January 10, 2024. After her appeals were resolved, on January 18, 2024, Mrs. Merkley returned home. She was not medically fit to return home—she was unable to walk, she had active sores requiring wound care, and she still required 24-hour care to function. On information and belief, the individualized clinical facts that repeatedly persuaded

Kepro to reverse Humana's and naviHealth's denials—Mrs. Merkley's inability to walk, her wound care needs, and her need for 24-hour care—were facts naviHealth's own nH Predict AI Model never adequately accounted for.

100. At home, Mrs. Merkley's rehab care was limited to twice-weekly home-healthcare visits.

101. On or around January 30, 2024, Mrs. Merkley contacted the skilled nursing facility to schedule her Dupixent injection, for which she was a week past due. The facility informed her that Humana refused to pay for the injection. Mrs. Merkley was unable to receive her injection and suffered from a renewed breakout of hives caused by her bullous pemphigoid.

102. On or around February 1, 2024, Mrs. Merkley was admitted to Owensboro Health Regional Hospital in Owensboro, Kentucky, because of the consequences of not receiving her injection and a urinary tract infection. On or around February 6, 2024, Humana refused to cover any further inpatient care in Owensboro Health Regional Hospital. Upon discharge on or around February 6, 2024, she was transferred to another skilled nursing facility, Chautauqua Health and Rehabilitation of Owensboro.

103. On or around February 14, 2024, Humana issued a Notice of Medicare Non-Coverage, terminating coverage effective February 16, 2024. Mrs. Merkley appealed, and Kepro overturned the denial, reinstating coverage.

104. Three days later, on or around February 19, 2024, Humana issued another denial, terminating coverage effective February 21, 2024. Mrs. Merkley appealed, and Kepro once again overturned the denial.

105. On or around February 26, 2024, Humana issued a third denial, terminating coverage effective February 28, 2024. Mrs. Merkley appealed, and Kepro once again overturned

the denial.

106. On or around March 5, 2024, Humana issued a fourth denial, terminating coverage effective March 7, 2024. Mrs. Merkley appealed, and Kepro once again overturned the denial.

107. On or around March 11, 2024, Humana issued a fifth denial, terminating coverage effective March 13, 2024. Mrs. Merkley appealed, but this time Kepro denied her appeal. Mrs. Merkley elevated the appeal to a second-level appeal, which Kepro also denied. Mrs. Merkley was informed over the phone that her appeal had been denied, and she was not informed that she could appeal the decision further.

108. Starting on March 14, 2024, Mrs. Merkley has paid out-of-pocket for her skilled nursing care. To date, she has paid \$10,000, and has another outstanding bill for \$15,000. She remains in the skilled nursing facility, working towards her recovery.

F. Plaintiff Lorraine Kohl

109. Plaintiff Lorraine Kohl is enrolled in a Medicare Advantage plan with Humana. She pays a monthly premium of \$224.00 for that plan.

110. On or around December 15, 2022, Mrs. Kohl fell and fractured her right hip. She was admitted to St. Elizabeth Hospital in Appleton, Wisconsin, where she underwent surgery to treat the fracture on or around December 17, 2022. On or around December 20, 2022, Mrs. Kohl was transferred to Oakridge Gardens Nursing Center, a skilled nursing facility in Menasha, Wisconsin.

111. On or around January 4, 2023, just shy of three weeks after fracturing her hip, Humana issued a denial, refusing to cover Mrs. Kohl's rehabilitation care effective January 6, 2023. The same day, Mrs. Kohl received a separate letter from naviHealth, explaining that coverage was denied and claiming she needed "little" help to move around and perform self-care

skills. At the time of the denial, Mrs. Kohl was unable to walk, as she could not lift her right leg unassisted. As with the letter naviHealth sent to Mrs. Merkley, naviHealth's letter to Mrs. Kohl was naviHealth's own direct communication, applying naviHealth's own Model, and did not disclose that the "little" help determination rested on a population-based comparison rather than an individualized examination of Mrs. Kohl's actual, un rebutted inability to walk.

112. On or around January 4, 2023, Mrs. Kohl appealed the denial to Livanta. On January 6, 2023, Livanta denied her appeal, claiming the care was no longer medically necessary.

113. Rather than elevating to a second-level appeal before Livanta, Mrs. Kohl's family opted to write a letter on or around January 6, 2023, and appeal the decision through Humana directly. On or around January 7, 2023, Mrs. Kohl was informed that Humana denied her appeal.

114. On or around January 28, 2023, Mrs. Kohl suffered another fall while at Oakridge Gardens, fracturing her left hip. She was transported by ambulance to St. Elizabeth Hospital, where she remained and received care until February 1, 2023. On or around February 1, 2023, Mrs. Kohl and her doctor sought prior authorization from Humana to receive further skilled nursing care, but Humana denied prior authorization, stating that she did not meet the criteria for skilled nursing services.

115. Despite this denial, Mrs. Kohl was then transferred back to Oakridge Gardens for more skilled nursing care—her doctor was adamant that she needed skilled nursing care to recover, so Mrs. Kohl decided to appeal the prior authorization and, if all else failed, pay out-of-pocket to get the care she needed.

116. On or around February 14, 2023, Mrs. Kohl visited her doctor, who provided a written recommendation that she continue receiving skilled nursing care. Her doctor stated that skilled nursing care was "very medically necessary considering her injuries, subsequent surgeries,

and need for additional physical therapy and conditioning. She has demonstrated adequate progression and will need to continue these therapies at Oak Ridge in order to improve her overall mobility and to maintain her safety.”

117. On or around February 21, 2023, Mrs. Kohl appealed her prior authorization denial to Humana directly. On or around February 27, 2023, Humana granted her appeal and paid for her care for the month of February.

118. On or around March 1, 2023, Humana issued a denial letter, terminating Mrs. Kohl’s coverage as of March 3, 2023. That same day, Mrs. Kohl appealed the denial to Livanta.

119. On or around March 3, 2023, Livanta denied Mrs. Kohl’s appeal. Livanta noted that Mrs. Kohl “currently requires maximal help to total dependence for self-care activities, such as dressing, bathing, and toileting.”

120. Mrs. Kohl was billed out-of-pocket from March 4, 2023, to April 4, 2023, when she left Oakridge Gardens and returned home. She has an outstanding balance of \$22,806.70.

G. Plaintiff Dolly Balani

121. Plaintiff Dolly Balani is enrolled in a Medicare Advantage plan with Humana. She pays a monthly premium of \$137.40 for that plan. Starting December 1, 2023, Mrs. Balani's monthly premium was increased to \$262.10.

122. Mrs. Balani suffers from Parkinson’s Disease and arthritis, causing her to be at-risk of falls. On or around November 28, 2023, Mrs. Balani suffered a fall, fracturing her hip. She was admitted to Valley Baptist Medical Center in Brownsville, Texas.

123. Mrs. Balani’s doctor recommended she be transferred to an inpatient rehab facility for two weeks. During preadmission screening, Mrs. Balani required substantial to maximal assistance with bed mobility, transfers, and ambulation. She was also deemed a fall risk.

124. On December 1, 2023, Humana denied prior authorization for Mrs. Balani's inpatient rehab care, claiming inpatient rehab was not medically necessary.

125. On December 11, Mrs. Balani was discharged from Valley Baptist Medical Center and was transferred to South Texas Rehabilitation Hospital, in inpatient rehabilitation facility. Because of Humana's denial, she paid out-of-pocket for one week of care. Mrs. Balani paid \$8,724 for her week in South Texas Rehabilitation Hospital.

126. Mrs. Balani made significant progress towards her recovery during her week in South Texas Rehabilitation Hospital. Unfortunately, Mrs. Balani was unable to pay for a second week of care out of pocket, so she did not receive the full two weeks of care recommended by her doctor.

127. Mrs. Balani appealed the decision to Maximus, a QIO. On December 14, 2023, Maximus denied the appeal, upholding the finding that the care was not medically necessary.

128. Mrs. Balani submitted a second-level appeal, seeking reconsideration from Maximus. Maximus denied the appeal.

129. On December 19, Mrs. Balani was discharged from South Texas Rehabilitation Hospital, and returned home. She still required physical therapy, occupational therapy, and wound care. Mrs. Balani received weekly in-home therapy and wound care until April of 2024. She now receives weekly home-health visits.

130. On December 26, 2023, Mrs. Balani again elevated her appeal, seeking review by an administrative law judge. On February 15, 2024, the ALJ held a hearing on the matter. On February 29, 2024, the ALJ upheld the denial, finding that inpatient rehab services were not medically necessary.

131. Mrs. Balani has appealed the ALJ's decision to the Medicare Appeals Council. A

hearing is yet to be calendared.

132. On January 1, 2024, Mrs. Balani did not renew her Humana Medicare Advantage plan, instead opting to enroll in traditional Medicare.

CLASS ALLEGATIONS

133. 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 purchased Medicare Advantage Plan health insurance from Defendant in the United States within the Class Period.”

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

134. The North Carolina Subclass which Plaintiffs seek to represent comprises:

“All persons who purchased Medicare Advantage Plan health insurance from Defendant in the state of North Carolina within the Class Period.”

135. The Minnesota Subclass which Plaintiffs seek to represent comprises:

“All persons who purchased Medicare Advantage Plan health insurance from Defendant in the state of Minnesota within the Class Period.”

136. The Kentucky Subclass which Plaintiffs seek to represent comprises:

“All persons who purchased Medicare Advantage Plan health insurance from Defendant in the state of Kentucky within the Class Period.”

137. The Wisconsin Subclass which Plaintiffs seek to represent comprises:

“All persons who purchased Medicare Advantage Plan health insurance from Defendant in the state of Wisconsin within the Class Period.”

138. The Texas Subclass which Plaintiffs seek to represent comprises:

“All persons who purchased Medicare Advantage Plan health insurance from Defendant in the state of Texas within the Class Period.”

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

139. The Class Period accords with the relevant statutes of limitations, curtailed by the date on which Humana first partnered with naviHealth to adjudicate post-acute care claims (August 1, 2017), as follows:

Class Period Start Date	State(s) in which Humana Policy Issued
August 1, 2017 (10-year statute of limitations)	Illinois, Iowa, Kentucky, Louisiana, Missouri, Rhode Island, West Virginia, Wyoming
December 12, 2017 (6-year statute of limitations)	Alabama, Arizona, Connecticut, Georgia, Hawaii, Indiana, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, South Dakota, Tennessee, Utah, Vermont, Washington, Wisconsin
December 12, 2018 (5-year statute of limitations)	Arkansas, Florida, Idaho, Kansas, Nebraska, Oklahoma, Virginia
December 12, 2019 (4-year statute of limitations)	California, Pennsylvania, Texas
December 12, 2020 (3-year statute of limitations)	Alaska, Colorado, Delaware, District of Columbia, Maryland, Mississippi, New Hampshire, North Carolina, South Carolina

140. Plaintiffs bring the claims asserted against naviHealth (unjust enrichment and tortious interference with contract) on behalf of the Class and Subclasses as defined above, all of whose members’ post-acute care coverage were, on information and belief, determined using the nH Predict AI Model that naviHealth designed and operated.

141. The Class is so numerous that their individual joinder herein is impracticable. On information and belief, members of the Class number in the thousands to millions throughout the United States and the named states. 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 Humana and third-party retailers and vendors.

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

- a. Whether Humana's delegation of coverage determinations to an automated procedure resulted in a failure to diligently conduct a thorough, fair, and objective investigation into determinations of claims for medical expenses submitted by insureds and/or healthcare providers;
- b. Whether Humana automatically denied coverage for claims submitted by insureds and/or healthcare providers;
- c. Whether Humana's denials of coverage are based on its use of nH Predict AI Model to determine a patients' care needs based on Humana's or naviHealth's internally-generated criteria;
- d. Whether Humana failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies; and
- e. Whether Humana has a practice of relying on the nH Predict AI Model to make coverage denials instead of engaging in good-faith individual coverage determinations.;
- f. Whether naviHealth created and designed the nH Predict AI Model and purposefully sold naviHealth's services to Humana for the specific purpose of deciding post-acute care coverage claims;

- g. Whether naviHealth had knowledge of the Humana–Member plan contracts’ promise of individualized, doctor-led review, and intended that Humana use nH Predict to depart from that promise;
- h. Whether naviHealth’s conduct in designing, selling, and operating nH Predict tortiously interfered with the Humana–Member plan contracts, and whether any privilege or justification excuses that conduct; and
- i. Whether naviHealth was unjustly enriched by retaining services fees and length-of-stay-based bonus compensation for designing, selling, and operating nH Predict.

143. Plaintiffs’ claims are typical of the claims of the Class and arise from the same common practice and scheme used by Humana and naviHealth to deny coverage for the members of the Class. In each instance, Humana used the nH Predict AI Model to review, process, and reduce coverage without adhering to the coverage determination standards set by Medicare. 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.

144. Plaintiffs and the Class have suffered injury in fact and have lost money as a result of Humana’s misconduct and naviHealth’s misconduct. Plaintiffs and the Class had their coverage automatically and illegally denied by Humana’s use of the nH Predict AI Model without individualized evaluation of their medical records by Humana’s medical directors. naviHealth, for its part, was [REDACTED] for designing, selling, and operating the nH Predict AI Model that produced that result.

145. 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.

146. The trial and litigation of Plaintiffs' claims are manageable. Individual litigation of the legal and factual issues raised by Humana's and naviHealth's 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.

147. Humana and naviHealth 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 Humana and naviHealth.

148. Absent a class action, Humana and naviHealth 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 Humana and naviHealth will be allowed to continue their respective violations of law and to retain the proceeds of their ill-gotten gains.

FIRST CAUSE OF ACTION
BREACH OF CONTRACT—NATIONWIDE
(On Behalf of Plaintiffs and the Nationwide Class, Against Defendant Humana, Inc.)

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

150. Humana formed an agreement and entered into a contract of insurance ("insurance

agreement”) with Plaintiffs and Class members including offer, acceptance, and consideration.

151. Pursuant to that insurance agreement, Plaintiffs and the Class paid money to Humana in exchange for Humana providing a health insurance policy to Plaintiffs and the Class. Humana received premiums in exchange for the issuance of a policy of health insurance.

152. Each insurance agreement included, without limitation, Defendant's duty to exercise its fiduciary duties to policyholders, abide by applicable state laws, and adequately review and inform policyholders prior to a claim denial.

153. Each insurance agreement included a provision stating: “At Humana, a process called Utilization Management (UM) is used to determine whether a service or treatment is covered and appropriate for payment under your benefit plan. Humana does not reward or provide financial incentives to doctors, other individuals or Humana employees for denying coverage or encouraging under use of services. In fact, Humana works with your doctors and other providers to help you get the most appropriate care for your medical condition.”

154. Each insurance agreement included a provision stating: “If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.”

155. Plaintiffs and the Class performed their obligations under the contract by timely paying the amounts due under the contract.

156. Humana breached each insurance agreement by, without limitation, failing to keep its promise to fulfill its fiduciary duties to policyholders, abide by applicable state laws, provide a thorough, fair, and objective investigation of each submitted claim prior to a claim denial, and provide written statements to Plaintiffs and the Class, accurately listing all bases for Humana's denial of claims and the factual and legal bases for each reason given for such denial.

157. Humana breached each insurance agreement by making coverage determinations

based upon the prediction of the nH Predict AI Model, rather than “work[ing] with your doctors and other providers to help you get the most appropriate care for your medical condition.”

158. Humana breached each insurance agreement by failing to disclose that the nH Predict AI Model prediction was the basis for coverage determinations and for providing false pretextual reasons for the determinations, rather than providing an accurate “written statement that explains why we said no.”

159. By using the nH Predict AI Model to resolve Plaintiffs' and Class members' claims without an adequate individualized investigation, Humana breached the insurance agreement.

160. As a direct and proximate result of Humana's breach of contract, Plaintiffs and the Class have suffered damages in an amount to be proven at trial.

SECOND CAUSE OF ACTION
BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR
DEALING—NATIONWIDE
(On Behalf of Plaintiffs and the Nationwide Class, Against Defendant Humana, Inc.)

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

162. Plaintiffs and Class members entered into written insurance agreements with Humana that provided for coverage for medical services administered by healthcare providers.

163. Pursuant to the contracts, Humana implied and covenanted that they would act in good faith and follow the law and the contracts with respect to the prompt and fair payment of Plaintiffs' and Class members' claims.

164. Humana has breached its duty of good faith and fair dealing by, among other things:

- a. Improperly delegating its claims review function to the nH Predict AI Model system which uses an automated process to summarily deny claims;
- b. Failing to require its agents to conduct a thorough, fair, and objective

investigation of each submitted claim, such as examining patient records, reviewing coverage policies, and using their expertise to decide whether to approve or deny claims to avoid unfair denials.

165. Humana's practices as described herein violated its duties to Plaintiffs and Class members under the insurance contracts.

166. Humana's practices as described herein failed to provide Plaintiffs and Class members a thorough, fair, individualized, and objective investigation of each of their claims in breach of the implied covenant of good faith and fair dealing arising from Humana's insurance agreements.

167. Humana's breach of Plaintiffs' and Class members' right to a thorough, fair, and objective investigation damaged Plaintiffs and Class members.

168. As a direct and proximate result of Humana's breaches, Plaintiffs and Class members have suffered and will continue to suffer in the future, economic losses and other general, incidental, and consequential damages in amounts according to proof at trial. Plaintiffs and Class members are also entitled to recover statutory and nominal damages, and prejudgment interest, against Humana.

169. Humana's misconduct was committed intentionally, in a malicious, fraudulent, despicable, and oppressive manner, entitling Plaintiffs and Class members to punitive damages against Defendant.

THIRD CAUSE OF ACTION
UNJUST ENRICHMENT

(On Behalf of Plaintiffs and the Nationwide Class and, alternatively, the North Carolina, Minnesota, Kentucky, Wisconsin, and Texas Subclasses, Against All Defendants)

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

A. Defendant Humana

171. By delegating the claims review process to the nH Predict system, Humana knowingly charged Plaintiffs and Class members insurance premiums for a service that Humana failed to deliver; this was done in a manner that was unfair, unconscionable, and oppressive.

172. Humana knowingly received and retained wrongful benefits and funds from Plaintiffs and Class members. In so doing, Humana acted with conscious disregard for the rights of Plaintiffs and Class members.

173. As a result of Humana's wrongful conduct as alleged herein, Humana has been unjustly enriched at the expense of, and to the detriment of, Plaintiffs and members of the Class.

174. Humana's unjust enrichment is traceable to, and resulted directly and proximately from, the conduct alleged herein.

175. Under the common law doctrine of unjust enrichment, it is inequitable for Humana to be permitted to retain the benefits they received from Plaintiffs and the Class because Humana delegated its claims process to the nH Predict AI Model in an unfair, unconscionable, and oppressive manner. Humana's retention of such funds is inequitable and constitutes unjust enrichment.

176. The financial benefits derived by Humana rightfully belong to Plaintiffs and Class members. Humana should be compelled to return in a common fund for the benefit of Plaintiffs and members of the Class all wrongful or inequitable proceeds received by Humana.

176. Plaintiffs and members of the Class have no adequate remedy at law. Plaintiffs plead this count in the alternative and in addition to their breach of contract claim. Under this alternative theory, Plaintiffs allege that the contract between the parties is unenforceable or void,

or that the terms are materially disputed so as to prevent a meeting of the minds.

B. Defendant naviHealth

178. Plaintiffs and the Class paid Humana premiums for the promise of individualized review. Humana, in turn, paid naviHealth services fees under PACSA Article III(a) and budget-linked bonus compensation, for creating, designing, and operating the very tool built to decide those members' post-acute care claims. naviHealth was paid specifically for building and running the mechanism used to decide Plaintiffs' own claims.

179. naviHealth designed nH Predict specifically to be sold to insurers like Humana to replace individualized, doctor-led review of post-acute care claims, and was paid fees and bonus compensation for exactly that purpose. naviHealth was aware of, and benefited from, the compensation it received for a product it built and marketed for this use.

180. naviHealth built and sold access to, for profit, the very tool that supplanted the individualized review Humana had promised its members, and was paid—including through [REDACTED] [REDACTED] — for delivering exactly the substitution the insurance agreements did not authorize. Retaining that compensation while Plaintiffs paid premiums for a different, promised process is inequitable.

181. Plaintiffs and the Class have no adequate remedy at law against naviHealth. naviHealth is not a party to the Humana–Member plan contracts, and no contract between Plaintiffs and naviHealth exists or could exist. Nor does any legal remedy against Humana reach naviHealth's separately retained [REDACTED] under the PACSA, which are an entirely separate category from the premium payments recoverable in connection with the breach of contract claim asserted against Humana.

182. As a direct result of naviHealth's unjust enrichment, Plaintiffs and the Class have sustained damages in an amount to be determined at trial, and naviHealth should be compelled to disgorge, for the benefit of Plaintiffs and the Class, all wrongful or inequitable proceeds it has received in connection with the conduct alleged herein.

FOURTH CAUSE OF ACTION
COMMON LAW FRAUD

(On Behalf of Plaintiffs, the North Carolina, Minnesota, Kentucky, Wisconsin, and Texas Subclasses, Against Defendant Humana, Inc.)

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

184. As alleged more fully above, Defendant made material omissions of fact to Plaintiff and Class members. Specifically, prior to Plaintiffs and the Class purchasing and renewing their insurance policies with Defendant, Defendant failed to disclose (1) its coverage determinations would be made by an algorithm under a process designed to deny claims on sham pretenses, and (2) the algorithm would not conduct an individualized objective investigation.

185. Defendant knew that its material omissions were false and misleading when made.

186. Defendant intended that Plaintiffs and Class members rely on these material omissions when purchasing and renewing insurance policies with Defendant. Plaintiffs and the Class reasonably relied on these omissions. Had Defendant conspicuously disclosed the truth in its contract of insurance or pre-sale marketing, Plaintiffs would have been aware of it.

187. Defendant's material omissions were a substantial factor and proximate cause in causing damages and losses to Plaintiffs and Class members.

188. Defendant engaged in this fraud to Plaintiffs' and the Class's detriment to increase Defendant's own sales and profits.

189. Plaintiffs and Class members were injured as a direct and proximate result of

Defendant's conduct because they would not have purchased medical coverage from Defendant had they known the truth; or at minimum, they would have paid less for insurance coverage from Defendant.

190. Plaintiffs seek damages according to proof at trial. By reason of the conduct of Defendant as alleged herein, Plaintiffs are also entitled to punitive damages.

FIFTH CAUSE OF ACTION
TORTIOUS INTERFERENCE WITH CONTRACT
(On Behalf of Plaintiffs and the Nationwide Class, Against Defendant naviHealth, Inc.)

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

192. As alleged above, Humana formed an agreement and entered into a contract of insurance ("insurance agreement") with Plaintiffs and Class members including offer, acceptance, and consideration.

193. naviHealth created and designed the nH Predict AI Model and purposefully sold and operated it on behalf of Humana specifically for use in deciding post-acute care coverage under Medicare Advantage plans, including the plan contracts described herein. naviHealth built and sold the tool for the specific purpose of deciding post-acute care coverage under agreements like the ones at issue here, and thereby knew of those agreements and knew what they promised.

194. naviHealth designed nH Predict—a population-based predictive algorithm—for the specific purpose of having Humana use it to decide coverage. Thus, naviHealth intended that Humana would decide coverage by algorithm rather than by the individualized physician review the insurance agreements promised. naviHealth purposefully sold a tool built to replace the promised process with a different one, which is intentional conduct directed at exactly the substitution that constitutes the breach.

195. Humana's actual use of nH Predict—the very product naviHealth designed and sold to it for this purpose—to make the coverage determinations underlying Plaintiffs' and the Class's denials caused Humana's breach of the insurance agreements alleged in the First Cause of Action above.

196. naviHealth built nH Predict for its own commercial purposes and sells it to multiple insurers, as alleged above. naviHealth thereby acted to advance its own independent commercial interest—not solely to protect Humana's interest in performing Humana's own contract.

197. naviHealth is a fee-for-service independent contractor, not an owner, officer, director, shareholder, secured creditor, or joint venturer with an equity- or profit-sharing-type stake in Humana's business.

198. naviHealth had a duty to disclose the true, population-based nature of the nH Predict methodology to Plaintiffs and their treating physicians. Indeed, as the Model's designer and operator, naviHealth alone knew that its methodology compares patients to a population-based dataset rather than individually assessing them, a fact unavailable to Plaintiffs or their physicians by any other means. naviHealth partially disclosed material facts in a manner that created a false impression of full disclosure, including in its denial letters, without disclosing that a population-based algorithm designed and sold by naviHealth, not a treating-physician review, generated the actual result.

199. naviHealth failed to disclose the nH Predict methodology despite this duty. When patients and physicians directly requested nH Predict reports, they were affirmatively refused and told the information was “proprietary” — active concealment in response to a specific inquiry, not passive silence about an observable fact. On information and belief, that “proprietary” designation refers to naviHealth's own trade secret in the algorithm, protected as naviHealth's exclusive

property under PACSA Article II(e) and defined as [REDACTED] under PACSA Article VI(a), and naviHealth required or directed that Humana withhold that information in order to protect naviHealth's own commercial interest in a product it licenses to other insurers as well.

200. naviHealth's own direct communications with Plaintiffs Merkley and Kohl, described above, were naviHealth's own omissions, not omissions merely imputed to it through Humana: naviHealth itself sent those letters, on its own behalf, applying its own Model, without disclosing the Model's actual methodology.

201. naviHealth's financial incentive to keep the methodology concealed was independent of Humana's: because naviHealth's bonus compensation was tied to keeping patients' length-of-stay under the Model's projected targets, naviHealth had its own stake, separate from Humana's, in preventing physicians from learning of and successfully challenging the population-based methodology, since disclosure would predictably increase the successful appeals of the kind described above with respect to Plaintiff Merkley.

202. As a direct and proximate result of naviHealth's tortious interference with the Humana–Member plan contracts, Plaintiffs and the Class have suffered damages in an amount to be proven at trial.

203. naviHealth's conduct was committed intentionally, in a malicious, fraudulent, wanton, and oppressive manner, entitling Plaintiffs and the Class to punitive damages against naviHealth. As alleged above, naviHealth designed nH Predict and the accompanying 1%-of-projected-days utilization target with knowledge that doing so would produce widespread erroneous denials of medically necessary post-acute care, and did so because naviHealth's own

[REDACTED]

[REDACTED]. This was conduct undertaken for naviHealth's own

pecuniary gain, not mere carelessness or mistake. naviHealth compounded that conduct through affirmative concealment, i.e., failing to disclose the nH Predict methodology to patients and physicians. And even as Kepro reversed naviHealth's denials of Plaintiff Merkley's coverage six times in a row over the course of a month, naviHealth continued to apply the same population-based methodology to issue new denials of her care rather than reassess its approach, a pattern reflecting a conscious and continuing disregard for Plaintiffs' and the Class's rights, not an isolated lapse in judgment.

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, consequential damages, statutory damages, nominal damages, exemplary/punitive damages, costs and attorneys' fees;
- b. Awarding damages for emotional distress;
- c. Awarding disgorgement and/or restitution, including of the services fees and bonus compensation naviHealth received under the PACSA
- d. Awarding pre-judgment interest to the extent permitted by law;
- e. Appropriate declaratory and injunctive relief enjoining Humana from continuing its improper and unlawful claim handling practices as set forth herein, and enjoining naviHealth from continuing to design, sell or operate nH Predict, or any successor algorithmic tool, for use by Humana or other insurers in a manner that violates the law;
- f. 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 29, 2026

Respectfully submitted,

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EXHIBIT 2

**UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY**

ESTATE OF JOANNE BARROWS, SUSAN
HAGOOD, SHARON MERKLEY,
LORRAINE KOHL, and DOLLY BALANI,
individually and on behalf of all others
similarly situated,

Plaintiffs,

v.

HUMANA, INC.,

Defendant.

Case No. 3:23-cv-00654 (RGJ/CHL)

**PLAINTIFFS' FIRST SET OF REQUESTS FOR
PRODUCTION OF DOCUMENTS TO DEFENDANT**

Pursuant to Federal Rules of Civil Procedure 26 and 34, Plaintiffs The Estate of Joanne Barrows, Susan Hagood, Sharon Merkley, Lorraine Kohl, and Dolly Balani (collectively “Plaintiffs”), on behalf of themselves and all others similarly situated, and by and through their counsel, hereby request that Defendant Humana, Inc., (“Defendant” or “Humana”) produce and permit Plaintiffs, by their attorneys, to inspect and copy the Documents listed in this First Set of Requests for Production of Documents (“Requests”) described below. Plaintiffs request that Defendant respond to these Requests within 30 days of service and produce the requested documents via secure file transfer. Plaintiffs request that such production be made in accordance with the “DEFINITIONS,” “INSTRUCTIONS,” and “RELEVANT TIME PERIOD” set forth below.

DEFINITIONS

Unless otherwise indicated, the following definitions shall be applicable to these Requests without regard to capitalization.

1. General Definitions:

- a. The masculine, feminine, or neutral pronouns do not exclude any other genders.
- b. “Including” means “including but not limited to.”
- c. The present tense shall be construed to include the past tense and vice versa.
- d. “And” and “or” shall be construed either disjunctively or conjunctively, whichever is appropriate to have the broadest reach.
- e. “Any” means one or more, “Each” means each and every, and “All” means all and any.
- f. “Concerning” means relating to, referring to, describing, evidencing or constituting.
- g. “Including” means including but not limited to and including without limitation.
- h. “Relate” or “related” or “relating” means, without limitation, refer to, discuss, describe, memorialize, reflect, consider, pertain to, analyze, evaluate, constitute, study, survey, record, summarize, criticize, comment, or otherwise involve, in whole or in part.
- i. References to employees, officers, directors, or agents include both current and former employees, officers, directors, or agents.

2. “Action” or “Actions” refers to the above-captioned action, which is pending in the United States District Court for the Western District of Kentucky.

3. “Communication” means the transmission, sending, or receipt of information of any kind (in the form of facts, ideas, thoughts, symbols, opinions, data, inquiries, or otherwise) by one or more persons and/or between two or more persons by or through any means and includes, without limitation, oral and written communications of any kind, such as correspondence, memoranda, letters, notes, reports, presentations, comments, face-to-face, conversations, telephone conversations, text messages, instant messages, voice messages, negotiations, agreements, inquiries, understandings, meetings, letters, notes, telegrams, mail, email, and

postings of any type, including on social media. Communication includes instances where one party addresses the other party, but the other party does not necessarily respond.

4. “Defendant,” “Humana,” “You,” or “Your” refers to the entire corporate family to which these Requests are sent and includes Humana, Inc. and their current or former predecessors, successors, parents, subsidiaries, divisions, affiliates, directors, officers, agents, managing agents, current and former employees, and all other persons acting on behalf of, or at the direction of, such entities.

5. “Document” is synonymous in meaning and equal in scope to the usage of the term in Federal Rule of Civil Procedure 34(a)(1)(A) and shall have the broadest possible meaning and interpretation ascribed to the term “documents” under the Federal Rules of Civil Procedure. “Document” is defined to include, without limitation, any document and electronically-stored data or information stored in any medium, including electronic or computerized data compilations, electronic chats, instant messaging, email communications, other ESI from personal computers, audio and video recordings, photographs, and hard copy documents. Drafts and non-identical duplicates constitute separate documents. Attachments, exhibits, appendices, schedules, and enclosures to documents are considered part of the same document.

6. “Electronically Stored Information” or “ESI” means information that is stored electronically, regardless of media or whether it is in the original format in which it was created.

7. “Employee” means, without limitation, any Person who worked for You as an independent contractor or who You employ or employed during the Relevant Time Period, including, without limitation, any current or former officer, director, executive, manager, secretary, assistant, staff member, messenger, consultant, contractor, sales personnel, or agent, or any other person paid directly or indirectly by an entity for any reason. “Employee” and “personnel,” as used herein, shall have the same meaning and scope.

8. “Identity,” “Identify” or “identifying” means, depending on whether the Request seeks to identify persons, documents, or transactions or occurrences:

a. When referring to a person, these terms mean to provide the full name, last

known residence address, home telephone number, email address, and, with respect to Your employees, the last known job title or position, job title or position when working in the relevant position, tenure of employment with Defendant(s) (if applicable), business address(es), business telephone number(s) and business email address(es) during the relevant time period, and a detailed description of the area of responsibility while in the relevant position.

- b. When referring to Documents, these terms mean to state the type of document, its title, author, recipients, date, and Bates-stamp numbers (if any), the location of the document, and to identify the custodian of the Document.
- c. When referring to a transaction or occurrence, these terms mean to provide the date of the transaction or occurrence and identify each person who was a party to the transaction or occurrence.

9. “Insureds” means plan members, patients, insureds, participants, and beneficiaries that are members of any proposed class in this Action.

10. “Medical Claims” means insurance claims submitted by patients or providers to cover medical expenses, including those submitted for coverage of routine care, emergency care, medical goods, services, tests, treatments, procedures, and/or prescription drugs.

11. “Medical Directors” means physician medical professionals reviewing insurance claims for naviHealth.

12. “Person” means, without limitation, any natural person, entity, individual, or group of individuals, or any business, partnership, joint venture, unincorporated association, corporation, firm, estate, legal or governmental entity, or association.

13. “Post-Acute Care” means the medical treatment that follows an acute healthcare condition received in (1) a skilled nursing facility (SNF); (2) an inpatient rehabilitation facility (IRF); or (3) a long-term rehabilitation facility.

14. “nH Predict” means naviHealth’s software program, tool, or AI algorithm developed and used by You in making coverage determinations.

15. “SICCs” means Your Skilled Inpatient Care Coordinators employed by naviHealth.

16. “Source Code” means the version of a computer program in which the programmer’s original programming statements are expressed in a source language (e.g., C++, C#, Visual Basic, Java, etc.) which may be compiled, assembled, or scripted and linked into equivalent machine-executable object code, thereby resulting in an executable software program.

INSTRUCTIONS

1. You are requested to produce all documents in your possession, custody, or control that are described below.

2. As the term “possession” relates to emails, the term includes without limitation: (a) “deleted” or “archived” emails which have not been permanently deleted, including all subdirectories irrespective of the title of such subdirectories; (b) “sent” emails, including all subdirectories irrespective of the title of such subdirectories; (c) “received” emails, including all subdirectories irrespective of the title of such subdirectories; and (d) draft emails, even if unsent.

3. Unless otherwise indicated, the Documents to be produced include all Documents prepared, sent, dated, or received, or those that otherwise existed, during the Relevant Time Period.

4. In producing Documents, you are requested to produce each original Document together with all non-identical copies and drafts of that Document.

5. All documents shall be produced as they are kept in the usual course of business, organized, and labeled to correspond with each Request. Documents produced in response to one Request need not be produced again in subsequent Requests, provided they are clearly designated as being responsive to the subsequent Request.

6. A Document with handwritten, typewritten, or other recorded notes, editing marks, etc., is not and shall not be deemed to be identical to one without such modifications, additions, or deletions.

7. All electronically stored information must be produced in a form consistent with any court-ordered ESI Protocol in this case.

8. Documents not otherwise responsive to a Request shall be produced if such

Documents refer to or explain the Documents that are called for by the Request, or if such Documents are attached to (or the parent document of) Documents called for by the Request.

9. If any Document sought by the Requests is known to have existed but no longer exists, has been destroyed, or is otherwise unavailable, you must identify the Document, the reason for its loss, destruction or unavailability, the name of each person known or reasonably believed by you to have present possession, custody, or control of the original and any copy thereof (if applicable).

10. If You object to any Request or to any portion of any Request, state the grounds for the objection with specificity, as required by Fed. R. Civ. P. 34(b)(2)(B), so that Plaintiffs can understand how the objection relates to their request, and respond to the remainder.

11. If You assert an objection to any request, You must nonetheless respond and produce any responsive Documents that are not subject to the stated objection. If you object to any Request or to any portion of any Request, state whether any responsive materials are being withheld on the basis of the objection, as required by Fed. R. Civ. P. 34(b)(2)(C). In particular, state clearly—for each Request—what categories of Documents are being produced, and what categories of Documents (if any) are being withheld based on the objection(s). If no Document or ESI responsive to a Request exists, please state that no responsive Document or ESI exists. This will allow Plaintiffs to understand your responses and streamline the meet and confer process.

12. This Request for Production is continuing in nature. In accordance with Fed. R. Civ. P. 26(e), supplemental responses and production should be promptly provided as additional Documents are found or become available during the litigation. If a Document described by a Request is not in existence or in your possession, custody, or control at the time of the first response to the Request, but later comes into existence or into your possession, custody, or control, you must immediately produce that Document. Plaintiffs reserve the right to propound additional document requests.

13. If You assert a claim of privilege as to one or more Documents or portions of Documents sought in this Request for Production, you should submit a privilege log that lists, for

each such Document for which privilege is claimed: (i) the number and particular part of the Document request to which the supposed privileged information is responsive; (ii) the Bates range, file name, or Document ID number as applicable; (iii) the Document title, or in the case of emails, subject line, (iv) the type of Document (e.g., letter, memorandum, account statement, etc.); (v) the Document's date and the date of any meeting, conversation, or event reflected or referred to in the Document; (vi) the signatory or signatories, author(s), addressee(s), and/ or each other person who sent or received a copy of the Document or to whom the contents of the allegedly privileged communication contained in the Document have been disclosed, either orally or in writing; (vii) a description of the subject matter of the Document; (viii) the Document's location and custodian; and (ix) the basis for the claim of privilege. Such information should be supplied in sufficient detail to permit Plaintiffs to assess the applicability of the privilege claimed. To the extent the parties enter into a stipulation concerning a privilege log and/or its format (or the Court orders one), and/or any related requirements, You shall produce a privilege log in accordance with those requirements.

14. When a Document contains both privileged and non-privileged material, the non-privileged material must be disclosed to the fullest extent possible. If a privilege is asserted with regard to part of the material contained in a Document, you should clearly indicate the portions as to which the privilege is claimed. When a Document has been redacted in any fashion, you should identify as to each Document, the reason for the redaction using the procedures set forth in the paragraph above. Any redaction should be clearly visible on the redacted Document.

15. Unless otherwise ordered by the Court or provided in a protocol entered into by the Parties, if one or more members of a Document family are wholly withheld as privileged, the entire family shall be produced with the wholly withheld privileged document(s) identified with a Bates stamped slipsheet placeholder TIFF.

16. If You claim ambiguity in interpreting a request (or definition or instruction), Your claim shall not be utilized as a basis for refusal to respond to the request, and You shall set out in Your response the language deemed ambiguous and the interpretation used in responding to that request.

RELEVANT TIME PERIOD

Unless otherwise specifically indicated, the relevant time period for each document request is December 12, 2017, through the present (the “Relevant Time Period”), and shall include all Documents and information that relate to such period, even if prepared or published outside of it. If a Document prepared before this period is necessary for a correct or complete understanding of any Document covered by a Request, you must produce the earlier Document as well. If any Document is undated and the date of its preparation cannot be determined, the Document shall be produced if otherwise responsive to the Request.

SPECIFIC DOCUMENT REQUESTS

REQUEST FOR PRODUCTION NO. 1 (Plaintiffs’ Documents and Data): All Documents, Communications, and data relating to Plaintiffs, including without limitation Documents and Communications concerning Evidence of Coverage contracts between each Plaintiff and Defendant, claims submitted by Plaintiffs, premium payments made by Plaintiffs, Plaintiffs’ nH Predict Outcome documents, Plaintiffs’ benefits, and Communications between Plaintiffs, or their agents or representatives, and Defendant, or its agents or representatives.

REQUEST FOR PRODUCTION NO. 2 (Defendant’s Defenses): All Documents or Communications supporting, qualifying, undermining, or otherwise concerning each defense You have asserted or plan to assert, including in opposition to any motion for class certification, in support of or opposition to any motion for summary judgment, or at trial.

REQUEST FOR PRODUCTION NO. 3 (Defendant’s Organizational Structure): Documents, including organizational charts, sufficient to show, on an annual basis, Your organizational structure and hierarchy, including Your parent companies, subsidiaries, affiliates, departments, units, and divisions and sufficient to Identify and reflect the roles, responsibilities, and hierarchy, on an annual basis of all employees (including agents and third-party consultants) responsible for or involved with assessment and adjudication of post-acute care medical claims for Insureds or the use of algorithms or AI in processing Insured’s Post-Acute Care claims.

REQUEST FOR PRODUCTION NO. 4 (Defendant's Policies and Procedures): Documents and Communications sufficient to show Your policies, operating procedures, protocols, methods, practices, memoranda, and reports concerning the manner You, Your agents, or any entity acting on Your behalf assess and adjudicate Medicare Advantage Post-Acute Care claims during the Relevant Period, including Documents and Communications sufficient to show any changes thereto. This Request includes, without limitation, Documents and Communications reflecting Humana's or its agents' policies and procedures for handling denied claims that are appealed, as well as the use of any medical management techniques (*e.g.*, prior authorization, step protocols, utilization review) to assess and adjudicate Medicare Advantage post-acute care claims.

REQUEST FOR PRODUCTION NO. 5 (Defendant's Relationship with naviHealth): All Documents and Communications relating to Defendant's relationship with naviHealth, including but not limited to any contracts or agreements between Defendant and naviHealth and any information relating to the reasons why You chose to engage naviHealth for Post-Acute Care claim review services, naviHealth's impact on Humana's business, the expected and actual financial consequences of hiring naviHealth, the risks of outsourcing claims review to naviHealth, and naviHealth's or nH Predict's compliance with or adherence to generally accepted standards of medical practice and Defendant's Medicare Advantage Evidence of Coverage documents.

REQUEST FOR PRODUCTION NO. 6 (naviHealth Marketing): All Documents and Communications that reflect information Humana considered or relied upon in purchasing or continuing to purchase naviHealth's services. This request includes, but is not limited to, any information presented by UnitedHealth Group, Inc., UnitedHealthcare, Inc., Optum, Inc., naviHealth, Inc. or any related entity to Humana to market, sell, or advertise naviHealth's services or to induce Humana to purchase or continue purchasing naviHealth's services.

REQUEST FOR PRODUCTION NO. 7 (AI Oversight): All Documents and Communications concerning Your policies, procedures, and processes used to oversee AI tools used by Humana, including naviHealth and nH Predict, including to ensure compliance with Evidence of Coverage contracts, to ensure legal compliance, and to measure performance, efficacy, and financial impact.

REQUEST FOR PRODUCTION NO. 8 (Insured Complaints): All Documents and Communications concerning any complaints or grievances, including those made by Medicare Advantage Insureds, concerning naviHealth, nH Predict, and denials of post-acute care claims, including any responses by Defendant to said complaints and any internal evaluations, reports, analyses, or meeting minutes and communications related to said complaints or grievances.

REQUEST FOR PRODUCTION NO. 9 (Volume of Claims Processed via nH Predict): Documents, Communications, and data sufficient to identify the number of Medicare Advantage claims submitted by Humana Insureds that were processed using nH Predict during the Relevant Time Period.

REQUEST FOR PRODUCTION NO. 10 (Volume of Medical Necessity Denials): Documents, Communications, and data sufficient to identify the number of Notices of Medicare Non-Coverage (“NOMNCs”) naviHealth or Humana issued to Humana Insureds for post-acute care claims on the basis of medical necessity during the Relevant Time Period, including prior authorization and concurrent denials.

REQUEST FOR PRODUCTION NO. 11 (Post-Acute Care Claim Denial Volume): Documents, Communications, and data sufficient to identify the number of Post-Acute Care Medicare Advantage claim denials on the basis of medical necessity, for claims submitted by Humana Insureds, that naviHealth or Humana processes annually during the Relevant Time Period, including separately by year.

REQUEST FOR PRODUCTION NO. 12 (Expected vs. Actual Rates of Post-Acute Care Claim Denials): Documents, Communications, and data sufficient to identify Your expected rate of Medicare Advantage Post-Acute Care claim denials each month from two years prior to the implementation of naviHealth to the present, as well as the actual rate of Post-Acute Care claim denials each month from two years prior to the implementation of naviHealth to the present.

REQUEST FOR PRODUCTION NO. 13 (Earnings, Revenue and Valuation): Documents, Communications, and data sufficient to identify Defendant’s valuation, value, revenue, profits, and profitability annually from the date Humana began utilizing naviHealth’s services to the present,

including but not limited to any analysis related to Humana's use of naviHealth's services.

REQUEST FOR PRODUCTION NO. 14 (Internal and Governmental Investigations): All Documents and Communications concerning internal (whether undertaken by You or on Your behalf) or governmental agency investigations into Defendant's policies, practices, or operations, relating to Defendant's use of naviHealth and nH Predict or any other algorithms or AI tools used to assess or adjudicate Post-Acute Care claims, including but not limited to any disclosures made by You regarding Your Medicare Advantage contracts to the Centers for Medicare & Medicaid Services ("CMS"), any disclosures made by You to the United States Senate Permanent Subcommittee on Investigations, any disclosures made by You concerning Office of Inspector General Audit OEI-09-18-00260, and any responses by You to any request for information, subpoena, or civil investigative demand issued by any government office or agency.

REQUEST FOR PRODUCTION NO. 15 (Governmental Investigations): All Documents and Communications produced by You to any local, state, or federal governmental agency or any legislative or regulatory body concerning Your assessment and adjudication of Medicare Advantage Post-Acute Care claims.

REQUEST FOR PRODUCTION NO. 16 (Evidence of Coverage Documents): Documents sufficient to identify the Evidence of Coverage documents, NOMNCs, and nH Predict Outcome documents applicable to Insureds in each of the 50 states, the District of Columbia, and Puerto Rico.

REQUEST FOR PRODUCTION NO. 17 (Employee Communications): All Documents and Communications shared between Lisa Stephens, Ang Sun, Greg Hayworth, or any individual listed in Humana's initial disclosures concerning the accuracy, risk, compliance, or efficacy of AI tools used by Humana, including naviHealth and nH Predict.

Dated: October 28, 2025

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CERTIFICATE OF SERVICE

I hereby certify that on October 28, 2025, a true and correct copy of the foregoing **Plaintiff's First Set of Requests for Production of Documents** was served on the following parties via email.

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Dated: October 28, 2025


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EXHIBIT 3



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August 26, 2026

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Re: *Barrows, et al. v. Humana Inc.*, Case No. 3:23-CV-00654-RGJ-CHL

Counsel:

I write on behalf of Plaintiffs in the captioned litigation to follow up on the matters discussed at our August 3, 2026, meeting and in response to Humana Inc.'s ("Humana") letter dated August 4, 2026, and to address deposition scheduling in advance of the deadline for Plaintiffs' motion for class certification.

I. Deposition Scheduling

Plaintiffs' deadline to file their motion for class certification is October 15, 2026. We therefore seek to depose Humana's corporate designees for Topic Nos. 3, 5–9, 13 and 14 in advance of that date. Please provide available dates for those witnesses so that the depositions can be completed sufficiently in advance of the October 15 deadline.

August 26, 2026

Page 2

II. Humana's Rule 30(b)(6) Objections and Responses.

a. **Time Period.** Humana objects to Plaintiffs' defined Relevant Time Period and states it will prepare its Rule 30(b)(6) witnesses to testify only for the period January 1, 2017 through June 30, 2025. *See* Defendant's Responses and Objections to Plaintiffs' Notice of Rule 30(b)(6) Deposition (June 22, 2026) ("O & Rs") at 9. Plaintiffs will not modify the Relevant Time Period for Topic Nos. 4-7 and 9-14; however, Plaintiffs do not object to Humana's modified time period for Topic Nos. 1-3, and 8. Please let us know whether this compromise is acceptable to Humana.

b. **Agreements.** Subject to resolution of the Relevant Time Period issue, and based on Humana's representations during the August 3 meet-and-confer and in their August 4 letter, Plaintiffs accept Humana's proposed offer of testimony for Topic Nos. 3, 4, 9, 11, 12, and 13.

c. **Further Discussion.** Separate from the Relevant Time Period issue, Topic Nos. 1, 2, 5, 6, and 8 require further clarification, as discussed below.

Topic No. 1: Humana offers to designate one or more corporate representatives to identify the employees principally responsible for Humana's retention of naviHealth and implementation of naviHealth's post-acute care utilization-management services. *See* O & Rs at 11. Plaintiffs do not object to the substantive offer of testimony. However, at the parties' August 3 meeting, Humana expressed concern about whether it still has corporate representatives who can testify about the entire noticed period. Plaintiffs note that the request is not for Humana to produce a representative who was present for the entire noticed period, but rather for Humana to produce a representative who, after receiving the necessary information and education from Humana's counsel, can answer questions about the noticed period. Plaintiffs request that Humana identify any portion of the modified January 1, 2017–June 30, 2025, period for which it claims it cannot prepare a witness. Plaintiffs reserve all rights.

Topic No. 2: Humana offers to designate one or more corporate representatives to testify regarding Humana's retention of naviHealth and implementation of the post-acute care utilization-management services naviHealth performs for Humana. *Id.* at 12. At the parties' August 3 meeting, Humana agreed that the offer of testimony would include why it elected to use naviHealth. Plaintiffs do not object to the substantive offer of testimony. However, Humana expressed concern about whether it still has corporate representatives who can testify about the entire noticed period. Again, Plaintiffs note that the request is not for Humana to produce a representative who was present for the entire noticed period, but rather for Humana to produce a representative who, after receiving the necessary information and education from Humana's counsel, can answer questions about the noticed period. Plaintiffs request Humana identify any portion of the modified January 1, 2017–June 30, 2025, period for which it claims it cannot prepare a witness. Plaintiffs reserve all rights.

Topic No. 5: Humana offers to designate one or more corporate representatives to testify regarding Humana's financial analyses of its delegation of post-acute care-related services to naviHealth. *Id.* at 16. At the parties' August 3 meeting, Humana agreed to clarify whether this offer of testimony includes analyses of forecasts or future projections, rather than testimony solely

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about retrospective analyses of Humana's delegation to naviHealth. Please confirm that Humana's offer encompasses the economic effects Humana attributed to the naviHealth delegation, the assumptions and metrics underlying those analyses, and whether Humana measured those effects on an aggregate or plan-level basis.

Topic No. 6: Humana offers to designate one or more corporate representatives to testify regarding Humana's understanding of the criteria naviHealth used to make post-acute care coverage determinations for Humana Medicare Advantage members. *See* O & Rs at 17–18. During the August 3 meeting, Plaintiffs explained that this offer is different from their original request, which seeks Humana's own understanding of the EOC requirements, the representations naviHealth made to Humana about compliance, and any nonprivileged analyses or conclusions Humana reached about whether the delegated process satisfied those requirements. Plaintiffs are not seeking a legal conclusion regarding the proper interpretation of any contract, statute, or regulation. Please confirm Humana's offer of testimony will include the information Plaintiffs seek.

Topic No. 7: Humana offers to designate one or more corporate representatives to testify regarding Humana's delegation and compliance functions as they relate to naviHealth. *See* O & Rs at 19. During the August 3 meeting, Humana confirmed that the offered testimony includes the results of compliance analyses, not just the compliance process, and represented that these documents have already been produced as delegation compliance audits. Based on Humana's confirmation and representation, Plaintiffs accept this offer of testimony.

Topic No. 8: Humana offers to designate one or more corporate representatives to testify regarding its produced data reflecting post-acute care coverage determinations delegated to naviHealth for Humana Medicare Advantage members. *Id.* at 20. Humana limits its offer of testimony to the period December 12, 2019, through June 30, 2025. *Id.* Plaintiffs understand that Humana's offer corresponds to the date range of the data produced in response to RFP Nos. 9 and 10. Humana has not, however, explained why that data begins on December 12, 2019. Please explain the basis for that limitation, including why HUM-BARR-0002448947 does not contain data for the earlier portion of the Relevant Time Period. Further, Plaintiffs are seeking testimony about how Humana tracks the relevant population and whether the underlying data can objectively identify class members. Please confirm that Humana's offer of testimony includes this information.

Topic No. 10: Humana offers to designate one or more corporate representatives to testify regarding documents it produced to government entities concerning its delegation of post-acute care utilization-management services to naviHealth or naviHealth's use of nH Predict, and changes to the scope of Humana's delegation to naviHealth over time. *Id.* at 23. During the August 3 meeting, Plaintiffs explained that they seek testimony about any connection between government investigations and changes in delegation to naviHealth. Humana represented that it is not aware of any change in behavior following a responsive investigation, and that its designated corporate representative would testify to that. Plaintiffs confirmed that they will seek responsive, non-privileged testimony from Humana on this Topic. Based on that representation, Plaintiffs accept the offer of testimony.

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Topic No. 14: Humana offers to designate one or more corporate representatives to testify regarding the general process for developing Medicare Advantage bids and related CMS submissions concerning post-acute care utilization or nH Predict, as well as the general methodology for calculating plan premiums. *Id.* at 29. During the August 3 meeting, Humana confirmed that its offer of general testimony from corporate representatives about this topic is not conditioned on the pre-identification of documents. Please confirm that Humana's offer of testimony covers the factual connection between PAC/naviHealth assumptions and the economics of the relevant plans. Subject that confirmation and to the resolution of the Relevant Time Period issue, Plaintiffs accept the offer of testimony.

III. Defendant's Document Production To-Date

Plaintiffs expressed concern that Humana's document production seemed low. Humana represented that, because relevant functions were delegated to naviHealth, there is a low number of documents in Humana's possession. Humana encouraged Plaintiffs to inquire about any purported production deficiencies in its production. Humana confirmed that the 3.2-terabyte hard-drive exclusively contains claims-related structured data.

Despite the large amount of claims-related structured data provided on the hard-drive, Plaintiffs still note deficiencies for Request Nos. 2, 3, 9, 10, 11, 12, and 17. For Request No. 2, Plaintiffs have identified no documents supporting Humana's defenses. As for Request No. 3, Plaintiffs have identified only one document providing data on Humana's organizational structure. As for Request Nos. 9, 10, 11, and 12, Plaintiffs are aware of the claims-related structured data on the hard-drive but have identified no documents that are "sufficient to identify the number of" claims, medical necessity denials, post-acute care denials, or expected versus actual post-acute care claim denials. Finally, as to Request No. 17, Plaintiffs have identified some communications with Lisa Stephens, but none with Ang Sun or Greg Hayworth.

Plaintiffs inquired about master/template coverage policies or Evidence of Coverage documents. Humana represented that it has produced all variants of the Evidence of Coverage documents.

IV. Anticipated naviHealth Witnesses

Plaintiffs intend to depose the following naviHealth witnesses: Dr. Thomas Edmonson, Dr. Leila Hosseini, Dr. Melissa Urrea, Dr. Jennifer Terrell, Susie-Welsh Gustafson. Please let us know if Humana intends to attend these Rule 45 depositions for the purpose of examining these witnesses.

V. Additional Items

Plaintiffs will address the other issues raised in Humana's August 4, 2026, letter remain for Plaintiffs in follow-up a follow up communication.

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Best,

LOCKRIDGE GRINDAL NAUEN PLLP

/s/ Simeon A. Morbey

Simeon A. Morbey

SAM/seg

cc: Plaintiffs' Counsel

EXHIBIT 4



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September 22, 2026

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**Re: Barrows, et al. v. Humana Inc., 3:23-cv-00654-RGJ-CHL (W.D. Ky.) – Plaintiffs’
Forthcoming Motion to File a Second Amended Complaint and Plaintiffs’
Forthcoming Motion to Extend the Class Certification Schedule**

Mr. Morbey:

On behalf of Defendant Humana Inc., I write in response to your email dated September 9, 2026, in which you requested Defendant’s position regarding your intent to amend the complaint to add naviHealth, Inc. as a named defendant; the Parties’ conferral call on Tuesday, September 15, during which we discussed this issue and also discussed Plaintiffs’ further intention to file a motion to extend the deadline to file their class certification motion and supporting expert reports; and your email of Saturday, September 19, in which you shared a copy of Plaintiffs’ contemplated second amended complaint. Please find below Humana’s positions on Plaintiffs’ two forthcoming motions.

Motion for Leave to Amend Complaint

After considering Plaintiffs’ proposed pleading amendment and its adverse implications on the progress of this case, Humana opposes Plaintiffs’ forthcoming motion to file a second amended complaint.

First, Plaintiffs' proposal to amend their complaint to add naviHealth as a defendant will derail the already-extended case management schedule, indefinitely delay a decision by the Court on important issues (such as class certification), and unduly prejudice Humana. Plaintiffs' class certification motion and accompanying expert reports and disclosures are presently due on October 15, 2026, and the deadline for discovery related to the named Plaintiffs and class certification is December 10, 2026. These deadlines were already extended once, at Plaintiffs' request, and Plaintiffs' attempt to extend those deadlines again (potentially indefinitely) while the Court resolves an untimely motion to amend the complaint after years of litigation would unduly prejudice Humana. See *Morse v. McWhorter*, 290 F.3d 795, 800 (6th Cir. 2002) (noting that "[d]enial may be appropriate . . . where there is undue delay, bad faith or dilatory motive on the part of the movant"). Plaintiffs' effort to amend the complaint also comes against the backdrop of Plaintiffs' decision not to proceed with depositions of witnesses that Humana had made available at mutually agreeable times, including as recently as this past Friday.

Second, the significant disruption and delay Plaintiffs' proposed new complaint will inflict on this litigation is not justified, especially when Plaintiffs have known about naviHealth since before this lawsuit's inception. Allegations regarding "the nH Predict AI Model" were a centerpiece of Plaintiffs' original complaint in this action, filed in December of 2023, including, *inter alia*, that Humana "collaborat[es] with naviHealth to set targets to keep stays at post-acute care facilities within 1% of the days projected by the [nH Predict] AI Model." ECF No. 1 ¶ 7. Further, the First Amended Complaint, filed in April of 2024, referred to naviHealth repeatedly, alleged that naviHealth was "Humana's contractor," ECF No. 37 ¶ 43, and that "naviHealth employees are given a length of stay 'budget,' and if the cases they oversee come in under that budget, they receive bonus compensation." *Id.* ¶ 44. The FAC also includes plaintiff-specific allegations about their interactions with naviHealth and distinguishes those interactions from those with Humana. See FAC ¶¶ 76-77. As discovery commenced, in their portion of the Rule 26(f) report (filed almost exactly a year ago), Plaintiffs reiterated their core theory in the case: that "Humana improperly delegates its health insurance claims review function for post-acute care to an AI tool called nH Predict," ECF No. 88 at 3, and the parties identified as one likely category of discovery "Humana's utilization, or the utilization of Humana's contractor naviHealth, of nH Predict," *id.* at 5. Plaintiffs have thus been on notice for years that naviHealth's actions, if any, are relevant to Plaintiff's claims.

Under these circumstances, Defendant expects to raise arguments in opposition to any motion for leave to amend that Plaintiffs' "undue delay in filing" justifies denial of leave of amend. See *Head v. Jellico Hous. Auth.*, 870 F.2d 1117, 1123 (6th Cir. 1989); see also *Whitlock v. FSL Mgmt., LLC*, No. 3:10-CV-562-M, 2010 WL 11526980, at *1 (W.D. Ky. Nov. 3, 2010) ("In making the determination whether to allow a requested amendment, the Court should take into consideration any undue delay in the moving party's request, along with the nature of the new claims and new parties to determine whether the proposed amendment would cause undue prejudice to the Defendants.").

Defendant reserves the right to make further arguments against amendment before the Court.



Class Certification Schedule

For similar reasons, Humana opposes Plaintiffs' proposed—potentially indefinite—extension of the discovery and class certification schedule, which has already been extended once. In the spirit of compromise, as set forth in my email of September 17, Humana previously offered a two-week extension of time for Plaintiffs to file their class certification motion and corresponding expert reports, with similar short extensions to the other dates set in the operative case management schedule, and Humana is prepared to stipulate to this modest extension. However, Humana cannot agree to further extensions, particularly where Plaintiffs' proposed extension would continue out the nearly-completed period for named Plaintiff and class certification discovery, and potentially delay by months or years a ruling on class certification in this case. This type of massive delay would impose significant costs and burdens on Humana, and deprive Humana of important opportunities to substantially narrow or resolve of this case through motion practice.

* * *

In accordance with the foregoing, Defendant expects and requests that Plaintiffs clearly indicate that Defendant opposes both their forthcoming motion to file a second amended complaint and their motion to extend the class certification schedule, so that it is clear to the Court that Defendant opposes the relief sought via both motions.

We are available to meet and confer on the items discussed in this letter at your convenience.

Sincerely,

/s/ Samuel Lehman

Samuel Lehman
Counsel
for O'MELVENY & MYERS LLP

cc (via email): Kevin D. Feder
 Jason Yan
 Bill Buffaloe
 Gillian Mak
 Michael Abate
 Chuck Stinson
 James Guilfoyle
 John C. Whitfield

EXHIBIT 5



RE: Barrows, et al v. Humana Inc., Case No. 3:23-CV-000654-RGJ-CHL - Motion for Limited Relief from Scheduling Order

From Theresa Burch <Theresa_Burch@kywd.uscourts.gov>

Date Tue 9/29/2026 10:15 AM

To Michael Boelter <mboelter@clarksonlawfirm.com>

Cc Feder, Kevin <kfeder@omm.com>; Lehman, Samuel <slehman@omm.com>; Buffaloe, William <wbuffaloe@omm.com>; Yan, Jason <jyan@omm.com>; Mak, Gillian <gmak@omm.com>; Michael P. Abate <mabate@kaplanjohnsonlaw.com>; Burt Anthony Stinson <cstinson@kaplanjohnsonlaw.com>; Asp, David W. <dwasp@locklaw.com>; Morbey, Simeon A. <samorbey@locklaw.com>; LaSalle, Kristie <kalasalle@locklaw.com>; Ritter Gordon, Emma <erittergordon@locklaw.com>; Grabau, Eve <megrabau@locklaw.com>; Glenn Danas <gdanas@clarksonlawfirm.com>; Adrian Barrio <abarrio@clarksonlawfirm.com>; Grace Chanin <gchanin@clarksonlawfirm.com>; Derek Brandt <dbrandt@clarksonlawfirm.com>; Larkin (Lark) Turner <lturner@clarksonlawfirm.com>; Jolen Medwid <jmedwid@clarksonlawfirm.com>

We do not need to schedule a telephonic conference. Please go ahead and file the motions.

Thank you.

Theresa L. Burch

Case Manager and Courtroom Deputy for
U.S. Magistrate Judge Colin H. Lindsay
U. S. District Court – Western District of Kentucky
601 W. Broadway
Louisville, Kentucky 40202
Phone: 502-625-3546

From: Michael Boelter <mboelter@clarksonlawfirm.com>

Sent: Wednesday, September 23, 2026 5:48 PM

To: Theresa Burch <Theresa_Burch@kywd.uscourts.gov>

Cc: Feder, Kevin <kfeder@omm.com>; Lehman, Samuel <slehman@omm.com>; Buffaloe, William <wbuffaloe@omm.com>; Yan, Jason <jyan@omm.com>; Mak, Gillian <gmak@omm.com>; Michael P. Abate <mabate@kaplanjohnsonlaw.com>; Burt Anthony Stinson <cstinson@kaplanjohnsonlaw.com>; Asp, David W. <dwasp@locklaw.com>; Morbey, Simeon A. <samorbey@locklaw.com>; LaSalle, Kristie <kalasalle@locklaw.com>; Ritter Gordon, Emma <erittergordon@locklaw.com>; Grabau, Eve <megrabau@locklaw.com>; Glenn Danas <gdanas@clarksonlawfirm.com>; Adrian Barrio <abarrio@clarksonlawfirm.com>; Grace Chanin <gchanin@clarksonlawfirm.com>; Derek Brandt <dbrandt@clarksonlawfirm.com>; Larkin (Lark) Turner <lturner@clarksonlawfirm.com>; Jolen Medwid <jmedwid@clarksonlawfirm.com>

Subject: Barrows, et al v. Humana Inc., Case No. 3:23-CV-000654-RGJ-CHL - Motion for Limited Relief from Scheduling Order

CAUTION - EXTERNAL:

Dear. Ms. Burch,

Counsel for Plaintiffs in the above captioned matter would like to discuss Plaintiffs' request for limited relief from the class certification deadlines in this case pending resolution of Plaintiffs' forthcoming motion to amend their complaint. Section 15 of the operative Scheduling Order (ECF No. 91) requires that the Parties must have a joint telephonic status conference with Judge Lindsay before Plaintiffs may file their motion.

Pursuant to Local Rule 37.1, the Parties have met and conferred about both the motion for limited relief from the schedule and the motion to amend the complaint. Humana has indicated that it will oppose both motions.

Best,

Michael Boelter

Associate Attorney

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