WILLIAMS & CONNOLLY LLP
Steven M. Cady (*pro hac vice*)
scady@wc.com
Dylan C. McDevitt (*pro hac vice*)
dmcdevitt@wc.com
680 Maine Avenue, SW
Washington, DC 20024
Telephone: (202) 434-5000
Facsimile: (202) 434-5029

STEVENS BECKER P.C.
Lily Becker (CA Bar No. 251145)
lily@stevensbecker.com
345 West Portal Avenue, Suite 110
San Francisco, CA 94127
Telephone: (415) 237-3830

Counsel for the Magellan Defendants

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

JENNIFFER ROIZ et al.,

Plaintiffs,

v.

CALIFORNIA PHYSICIANS' SERVICE DBA BLUE SHIELD OF CALIFORNIA, MAGELLAN HEALTH, INC., MAGELLAN HEALTHCARE, INC., and HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA,

Defendants.

Case No. 3:25-cv-09978-WHO

MAGELLAN'S NOTICE OF MOTION AND MOTION TO DISMISS THE COMPLAINT AGAINST MAGELLAN; MEMORANDUM OF POINTS & AUTHORITIES

Date: April 29, 2026
Time: 2:00 p.m.
Location: Courtroom 2; 17th Floor
Judge: William H. Orrick

TO THE COURT, ALL PARTIES, AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that on April 29, 2026, at 2:00 p.m., or as soon thereafter as this matter may be heard before the Honorable William H. Orrick, Courtroom 2 on the 17th Floor of the United States Courthouse located at 450 Golden Gate Avenue, San Francisco, California 94102, Defendants Magellan Health, Inc., Magellan Healthcare, Inc., and Human Affairs International of California, Inc. (collectively, "Magellan" or the "Magellan Defendants") will and hereby do move the Court for an order dismissing Plaintiffs' Complaint pursuant to Rules 8(a), 9(b), and 12(b)(6) of the Federal Rules of Civil Procedure. The Magellan Defendants respectfully request an order dismissing with prejudice all of Plaintiffs' claims against them.

This Motion is based upon this Notice of Motion and Motion to Dismiss; the attached Memorandum of Points and Authorities; the pleadings and filings in this action; and such other matters Defendants may present at or before the hearing.

Dated: February 24, 2026

Respectfully submitted,

By: */s/ Steven M. Cady*
Steven M. Cady (*pro hac vice*)
Dylan C. McDevitt (*pro hac vice*)

By: */s/ Lily Becker*
Lily Becker (CA Bar No. 251145)

Counsel for Magellan Defendants

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MEMORANDUM OF POINTS AND AUTHORITIES

I. Introduction

This suit tries to parlay generalized, well-known, industry-wide, and heavily regulated issues with health insurance provider directories into a vacuous twelve-count class action. But Plaintiffs' complaint proceeds more on vibes than it does on well-pleaded facts. The 60-page, 291-plus paragraph complaint fails across the board to meet several basic pleading requirements. For one, it violates Rule 8 by asserting a litany of claims against multiple defendants without specifying which acts or omissions *Magellan* committed. As the Ninth Circuit has admonished, that sort of "shotgun pleading" is impermissible. *See Gibson v. City of Portland*, 165 F.4th 1265, 1288–89 (9th Cir. 2026). The complaint also flunks Rule 9(b) because it alleges fraud without bothering to explain the who, what, when, where, and how of Magellan's supposed misrepresentations. Those shortcomings are particularly problematic here given the distinct roles of Blue Shield and Magellan. As the complaint briefly acknowledges, Blue Shield is the health insurer, and Magellan is a contracted services provider. Yet, Plaintiffs proceed as if each entity is interchangeable and plead only generalized and nondescript acts and omissions by "Defendants." The Federal Rules require more.

Infected by these global deficiencies, the complaint's attempts to plead each individual count against Magellan fail for several additional reasons. *First*, the ERISA claims against Magellan are insufficiently pleaded. The complaint does not establish what plan benefits were denied and by whom, nor do Plaintiffs adequately plead Magellan's status as a plan fiduciary with respect to any particular function. The ERISA claim for false statements is nonactionable and, in any event, not pleaded with particularity as Rule 9 requires. And Plaintiffs' Parity Act claim lacks sufficient detail about how Magellan treated their mental health benefits more strictly than their medical benefits.

Second, the contract claims against Magellan fail because Plaintiffs do not adequately allege the specifics of the at-issue contracts and engage in impermissible shotgun pleading, incorporating by reference dozens of federal statutes and collectively alleging vague breaches by "Defendants."

Third, the UCL claim fails because Plaintiffs fail to plead fraud with particularity as required by Rule 9(b) and don't adequately allege a non-fraud unlawful business practice.

Fourth, the misrepresentation claims fail for lack of particularity under Rule 9.

Fifth, the unjust enrichment claim fails because Plaintiffs do not plead that Magellan retained a benefit at their expense and they separately rely on the existence of express contracts.

In sum, the complaint fails to plausibly plead any claim against Magellan and thus must be dismissed as to Magellan.

II. Statement of the Issues to Be Decided

1. Whether to dismiss Plaintiffs' denial of benefits claim under 29 U.S.C. § 1132(a)(1)(B) against Magellan because the complaint does not identify a specific plan term with which Magellan failed to comply.

2. Whether to dismiss Plaintiffs' breach of fiduciary duty claim under 29 U.S.C. § 1132(a)(3) against Magellan because the complaint does not properly allege Magellan's fiduciary status or a plan-wide injury.

3. Whether to dismiss Plaintiffs' false statements claim under 29 U.S.C. § 1149 because the statute provides no private right of action and because the claim is not pleaded with the particularity required by Rule 9(b).

4. Whether to dismiss Plaintiffs' Parity Act claim because the complaint fails to plead sufficient facts showing that Magellan applied more strict criteria to mental health benefits than were applied to medical and surgical benefits.

5. Whether to dismiss Plaintiffs' contract-based causes of action against Magellan because the complaint does not plausibly allege the existence or terms of a contract that Magellan breached.

6. Whether to dismiss Plaintiffs' claim under the California Unfair Competition Law against Magellan because the complaint does not plead fraud by Magellan with particularity as required by Rule 9(b) and because Plaintiffs fail to allege any non-fraud unlawful business practice.

7. Whether to dismiss Plaintiffs' claims for intentional and negligent

misrepresentations against Magellan because they are not pleaded with particularity as required by Rule 9(b).

8. Whether to dismiss Plaintiffs' claim for unjust enrichment or restitution against Magellan because Plaintiffs do not identify the benefit conferred on Magellan at Plaintiffs' expense and because Plaintiffs separately plead the existence of a governing contract.

III. Background[1]

Plaintiffs are four policyholders who purchased health insurance through Blue Shield of California. According to Plaintiffs, their Blue Shield plans' online directories for mental health providers were inaccurate, indeed fraudulent, because the directories included providers who did not return their phone calls, were not conveniently located, were not accepting new patients, were not actually in-network, or were otherwise inaccessible. Compl. ¶¶ 1–3, 53, 67, 79, 88, 121. Based on these allegations, Plaintiffs assert a bevy of ERISA, contract, fraud, and unjust enrichment claims.

In addition to suing their insurer Blue Shield, the health insurance corporation that "administers the Blue Shield of California health insurance plans," Compl. ¶ 16, Plaintiffs also name three different Magellan entities as defendants. Magellan is not affiliated with Blue Shield, nor is it an insurer. Instead, Magellan subcontracts with Blue Shield to "administer[] the mental health benefits for many of Blue Shield's insurance plans." Compl. ¶¶ 17–19. That is, Magellan serves as the plan's "Mental Health Service Administrator" (MHSA), which Blue Shield's plan documents describe as an entity that will "administer" or "underwrite and deliver" mental health services "through a unique network of MHSA Participating Providers." Compl. ¶ 95.

After Plaintiff Jenniffer Roiz enrolled in an ERISA-governed plan through her employer in August 2024, she "learn[ed]" that her existing therapist was not in network and searched for an in-network therapist using Blue Shield's website, which redirected her to the Magellan directory. Compl. ¶¶ 51, 53. The Magellan directory "listed hundreds of providers matching her search criteria, including accepting new patients," of which Roiz called ten, but none of the providers she

[1] The facts alleged in the complaint are assumed true for the purposes of this motion only.

called answered, and just two returned her call to tell her they were not accepting new patients. Compl. ¶ 53. Roiz continued seeing her out-of-network therapist at $150 per session, which Blue Shield agreed to cover at the in-network rate for three months, after which Roiz was required to pay out-of-network coinsurance. Compl. ¶¶ 55–56. Roiz alleges that she stopped therapy due to cost, Compl. ¶¶ 56, but she does not claim that Magellan ever made any coverage determination for her.

The three remaining Plaintiffs, Claudine Castillo, Candyce Marto, and Kevin Maedel, each enrolled in "non-ERISA" HMO plans designed for public employees of California. Compl. ¶¶ 14–15, 101, 105. In August 2025, Castillo sought urgent mental health care for her minor son. Compl. ¶ 65. Blue Shield referred her to Magellan, which provided a list of four providers. Compl. ¶ 66. Two were not accepting new patients, and two did not return her calls. *Id.* Magellan broadened the search radius to 25 miles and provided six additional providers, but apparently none of those providers were located in areas that Castillo "would be practically able to travel to on a regular basis." Compl. ¶ 67. The complaint does not allege that Magellan made any benefit determination regarding care for Castillo's son.

Marto and Maedel enrolled in a Blue Shield HMO plan through Maedel's employer. Compl. ¶ 75. Marto alleges that in 2022 she searched the Magellan directory and found hundreds of listed providers, but after contacting approximately 15, none were "available to provide care." Compl. ¶¶ 78–79. She alleges she went without therapy for three years because her plan does not cover out-of-network care. Compl. ¶ 80. Maedel alleges he has repeatedly called providers listed in Blue Shield and Magellan directories seeking therapy and psychiatric care but that most providers did not return calls, were not accepting new patients, or were not in-network. Compl. ¶¶ 87–88. He also alleges he contacted more than 20 psychiatric providers without success and has been unable to obtain in-network care. Compl. ¶¶ 91–92. The complaint does not allege that Magellan made any benefit determination for Marto or Maedel.

Plaintiffs also allege that their counsel and unnamed "experienced and qualified researchers" conducted a "secret shopper" study in July 2025. Compl. ¶ 117. The survey purported to test 100 provider listings from the Magellan directory for behavioral health therapy

within 25 miles of Santa Ana, California. Compl. ¶¶ 118, 121. The complaint alleges that 47 providers were unreachable because "they never returned the calls or the phone number was incorrect or out of service." Compl. ¶ 121. Of the 53 providers reached, "40 did not accept the insurance plan, were not accepting new patients, did not provide the necessary services, had no appointments available within one month, and/or were not practicing at the listed location," but the complaint does not specify how many providers fell into each of those distinct camps. *Id.*

IV. Legal Standard

In deciding a motion to dismiss, the court accepts as true all material allegations in the complaint and views them in the light most favorable to the plaintiff. *Dent v. NFL*, 968 F.3d 1126, 1130 (9th Cir. 2020). To survive the motion, a complaint must contain sufficient factual allegations to support a plausible claim for relief. *Id.* When a complaint alleges fraud, the heightened pleading standard of Rule 9(b) applies, which requires a plaintiff alleging fraud to do so "with particularity," including the "who, what, when, where, and how of the misconduct charged." *Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1106 (9th Cir. 2003) (internal quotation marks omitted).

V. Plaintiff Roiz's ERISA Claims Against Magellan Must Be Dismissed.[2]

Roiz asserts four claims under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001–1003 against "Defendants," without distinguishing between Blue Shield and Magellan: (1) improper denial of benefits pursuant to § 1132(a)(1)(B); (2) breach of fiduciary duty under §§ 1132(a)(1)(B) and (a)(3); (3) false statements and representations under §§ 1132(a)(1)(B), (a)(3), and 1149; and (4) lack of parity in mental health benefits as required by ERISA and the Mental Health Parity and Addiction Equity Act (the "Parity Act"), §§ 1132(a)(1)(B), (a)(3), and 1185a. *See* Compl. ¶¶ 176–98. Each claim fails.

[2] Magellan agrees with Blue Shield that the relevant statutes of limitations should be applied to dismiss Plaintiffs' claims to the extent they seek relief for conduct that occurred prior to November 19, 2021 (for Counts One through Nine) or November 19, 2022 (for counts Ten through Twelve). *See* ECF 41 at 22.

A. Roiz's claim for improper denial of benefits against Magellan fails (Count One).

To state a claim for denial of benefits under § 1132(a)(1)(B), a plaintiff must identify the specific plan terms that entitle her to benefits that the defendant was required to provide but did not. Roiz pleads neither a specific plan term that entitled her to benefits from *Magellan* nor any denial of benefits by *Magellan*. Those omissions are fatal.

In plain terms, "[t]he issue in a claim for benefits under [§ 1132(a)(1)(B)] is whether the terms of the plan provide coverage" for the benefit that the plaintiff alleges she was denied. *See Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1159 (C.D. Cal. 2015). To meet that standard, a plaintiff needs to allege that "the specific services . . . at issue were covered under the terms of the relevant plans or describe the plan terms that would support such coverage." *See id.* at 1158.

Roiz has not satisfied any of these requirements. Her allegations amount to the following chain of events. She enrolled in her Blue Shield plan because she subjectively thought it offered "the 'best' coverage." Compl. ¶ 51. But nowhere in the complaint does she explain the basis for that belief, and she also says she chose her plan because it had the lowest copayment for in-network mental health services. *Id.* At the time she enrolled in her health plan, she was already seeing her therapist weekly. *Id.* It wasn't until after enrolling that Roiz apparently "learn[ed] that her existing therapist was not in-network" with Blue Shield, but she makes no allegation that Blue Shield, Magellan, or anyone else ever told her otherwise. Compl. ¶ 53. Still, Roiz complained to Blue Shield, and Blue Shield "agreed to cover three months of services with her current therapist at the in-network rate" but declined to "extend this three-month allowance when Roiz was unable to find an in-network provider." Compl. ¶ 56. As a consequence, Roiz "was required to pay the out-of-network coinsurance for each visit with her therapist."[3] *Id.* Roiz stopped seeing her therapist shortly thereafter because she could not afford the high cost of the plan's out-of-network

[3] The fact that Roiz was required to pay out-of-network coinsurance for her therapist cannot give rise to a claim for denial of benefits, because she admits that her therapist was in fact out of network and does not allege anyone ever told her otherwise. Obviously, it does not violate the plan terms to require a beneficiary to pay out-of-network coinsurance for an out-of-network provider.

coinsurance. *Id.* The complaint is devoid of any facts detailing Roiz's attempts to locate an in-network provider from that point forward, or any attempts to engage with Blue Shield or Magellan to locate a suitable in-network provider.

These allegations do not reference a single specific plan term, let alone one that "specif[ies] benefits" that Magellan was "obligated to pay but failed to pay." *Glendale Outpatient Surgery Ctr. v. United Healthcare Servs., Inc.*, 805 F. App'x 530, 531 (9th Cir. 2020). To begin, Roiz does not allege that Magellan "made" any "claim determination," so Magellan cannot be a "proper defendant" for her denial of benefits claim. *Echague v. Metro. Life Ins. Co.*, 43 F. Supp. 3d 994, 1008 (N.D. Cal. 2014) (Orrick, J.). What's more, although Roiz references generalized issues with finding available providers when she was new to her Blue Shield plan, she points to no specific plan term that entitled her to something more from *Magellan* than what she received. That too dooms her claim. *See Almont*, 99 F. Supp. 3d at 1158 (dismissing denial of benefits claim where plaintiff failed to allege that "the specific services" at issue "were covered under the terms of the relevant plans"). Accordingly, Roiz fails to plead a claim for denial of benefits under ERISA against Magellan.

B. Roiz's claim for breach of fiduciary duty against Magellan fails (Count Two).

To maintain a claim for breach of fiduciary duty under ERISA, a plaintiff must allege that "(1) the defendant was a fiduciary; and (2) the defendant breached a fiduciary duty; and (3) the plaintiff suffered damages." *Bafford v. Northrup Grumman Corp.*, 994 F.3d 1020, 1026 (9th Cir. 2021). The plaintiff also is required to allege, separate from any individual injury, "that the fiduciary injured the benefit plan or otherwise jeopardized the entire plan or put at risk plan assets." *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1189 (9th Cir. 2010) (cleaned up). Roiz's claim does not meet these basic requirements. Once again failing to distinguish between Blue Shield and Magellan, she does not plausibly allege that *Magellan* was a fiduciary or that any breach by *Magellan* injured the plan as a whole, as opposed to merely Roiz herself.

1. Magellan was not acting as a fiduciary with respect to any action it is alleged to have taken against Roiz.

There are two kinds of ERISA fiduciaries: named fiduciaries, who are explicitly designated

in plan documents, and functional fiduciaries, who exercise discretionary control over an ERISA plan. *Bafford*, 994 F.3d at 1026. Roiz does not allege that Magellan is a named fiduciary and therefore proceeds against Magellan under a functional-fiduciary theory. *See* Compl. ¶ 185 (alleging "Defendants exercise discretionary authority"). So Roiz must allege that Magellan had sufficient discretionary control when "taking" the specific "action subject to complaint." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). She has not.

The complaint does not even make it to first base. It does not specify what act by *Magellan* allegedly breached a fiduciary duty, so it is impossible to assess whether Magellan was acting as a fiduciary when it took any particular action. *See Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 656 (9th Cir. 2019) ("Discretionary ability is insufficient to bestow fiduciary status if that discretion was not exercised." (cleaned up)). In place of these specifics, Roiz lobs collective allegations about "Defendants," impermissibly treating Blue Shield and Magellan as a single entity. That does not cut it. *Cf. Resh, Inc. v. Skimlite Mfg. Inc.*, 666 F. Supp. 3d 1054, 1059–60 (N.D. Cal. 2023) ("Plaintiff's failure to parse out which allegations are levied against which Defendants makes it exceedingly difficult, if not impossible, for individual Defendants to respond to Plaintiff's allegations." (cleaned up)).

The only interaction Roiz alleges she had with *Magellan* was searching for a provider in Magellan's directory. Compl. ¶ 53. But administering a provider directory to inform beneficiaries of available providers is plainly a ministerial function that lacks the kind of discretion necessary to make Magellan an ERISA fiduciary. *See Chaganti v. Ceridian Benefits Servs., Inc.*, 208 F. App'x 541, 547 (9th Cir. 2006) (recognizing that "communicating with beneficiaries" regarding their options under the plan is a ministerial, non-fiduciary function). The directory is simply a tool. It has none of the hallmarks of discretionary control: it does not adjudicate claims, approve or deny coverage, control payment, or render "ultimate decisions regarding benefits eligibility." *CSA 401(k) Plan v. Pension Pros., Inc.*, 195 F.3d 1135, 1140 (9th Cir. 1999). So the directory alone cannot support a claim that Magellan acted as a functional fiduciary.

Even if Roiz had pleaded facts to establish, generally, that Magellan had certain discretionary authority over her benefits, "the mere existence of a discretionary ability is

insufficient to bestow fiduciary status if that discretion was not 'exercise[d].'" *Depot*, 915 F.3d at 656 (quoting 29 U.S.C. § 1002(21)(A)(i)). So even if Roiz's allegation that "Defendants" were "responsible for making final and binding decisions about whether to approve coverage requested by plan members," Compl. ¶ 185, was somehow enough to transform *Magellan* into a fiduciary, Roiz's claim fails because she does not allege that Magellan "ever exercised that discretion, let alone 'when taking the action subject to complaint.'" *Depot*, 915 F.3d at 656 (quoting *Pegram*, 530 U.S. at 226). Indeed, Magellan is not alleged to have exercised any discretion at all.

2. Roiz does not allege that Magellan caused injury to the plan as a whole.

Unlike denial-of-benefit claims under § 1132(a)(1)(B), individual injuries do not give rise to breach-of-fiduciary-duty claims under § 1132(a)(3). Rather, fiduciary claims are limited to circumstances where there is an injury "to the ERISA plan as a whole." *Wise*, 600 F.3d at 1189. For that reason, a defendant's mere "mishandling of an individual benefit claim does not violate any of the fiduciary duties defined in ERISA." *Amalgamated Clothing & Textiles Workers Union v. Murdock*, 861 F.2d 1406, 1414 (9th Cir. 1988). So a plaintiff alleging fiduciary breaches under ERISA must plead, distinct from any injury to herself, an injury to the entire benefit plan or the assets of the plan. *Wise*, 600 F.3d at 1189.

This plan-wide injury requirement independently bars Roiz's claim. The injuries she pleads are entirely individualized, and she pursues a denial-of-benefits claim to recover for those injuries. Because her claim for denial of benefits "will afford adequate relief," Roiz cannot bring a duplicative claim for breach of fiduciary duty. *Castillo v. Metro. Life Ins. Co.*, 970 F.3d 1224, 1229 (9th Cir. 2020).

C. Roiz's claim for false statements against Magellan fails (Count Three).

Yet again failing to differentiate between Blue Shield and Magellan, Roiz claims "Defendants" violated ERISA by making "false statements and false representations." Compl. ¶ 192. But there is no such cause of action, and, even if there was, she has not pleaded fraud with the specificity required by Rule 9(b).

Roiz's reliance on 29 U.S.C. § 1149, Compl. ¶ 191, is misplaced. That statute is a criminal statute enforced by the government, not a private civil right of action. *See* 29 U.S.C. § 1131(b)

("Any person that violates section 1149 of this title shall upon conviction be imprisoned not more than 10 years or fined under Title 18, or both."); *see also Soehnlen v. Fleet Owners Ins. Fund*, 844 F.3d 576, 585 (6th Cir. 2016) ("Neither litigant points to a single case construing § 1149 or produces concrete authority regarding whether § 1149 provides Plaintiffs with a cause of action."). Even assuming there was a freestanding "false statements" private cause of action under ERISA, Roiz has not come close to pleading "with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b); *see also Soehnlen*, 844 F.3d at 585–86 (assuming without deciding that § 1149 provides a cause of action and applying Rule 9(b) to uphold dismissal). The complaint contains none of these details, as Magellan shows in more detail below, *infra* Section V.B.1.

Nor can Roiz end-run § 1149's lack of a private right of action by recasting her "false statements" claim against Magellan as predicated on § 1132(a)(3). *See* Compl. ¶ 191. Framed as such, Roiz's claim is nothing more than a more specific version of her claim for breach of fiduciary duty. *Cf. Baker v. Save Mart Supermarkets*, 684 F. Supp. 3d 980, 987 (N.D. Cal. 2023) (Orrick, J.) (recognized ERISA breach of fiduciary duty by way of false statements). But Roiz has not plausibly pleaded a breach of fiduciary duty claim against Magellan for all the reasons discussed above, *see supra* Section IV.B, much less with the particularity required for a claim sounding in fraud, *see Concha v. London*, 62 F.3d 1493, 1502–03 (9th Cir. 1995) (recognizing the application of Rule 9(b) is appropriate when an ERISA plaintiff alleges fraud).

D. Roiz's Parity Act claim against Magellan fails (Count Four).

To bring a claim under the Parity Act, a plaintiff must allege that an ERISA-governed group health plan that offers both medical and mental health benefits imposes a more restrictive limitation on mental health treatment than it does on medical treatment. *Ryan S. v. UnitedHealth Grp., Inc.*, 98 F.4th 965, 971 (9th Cir. 2024). More specifically, the plaintiff is required to plausibly allege that the plan "assess[es]" mental health benefits claims in a way that is "more restrictive" than how it assesses medical claims "*under the same classification*."[4] *Id.* at 973

[4] The Parity Act and its implementing regulations set forth the "classifications" that apply to this comparison. *See id.* at 972 (citing 29 U.S.C. § 1185a(a)(8)(A)(iv) and 29 C.F.R. § 2590.712(c)(2)(ii)(A)). They are (1) "Inpatient, in-network," (2) "Inpatient, out-of-network,"

(emphasis added). It is insufficient for a plaintiff merely to assert that she had more trouble, in the abstract, with mental health benefits than medical benefits; instead, the plaintiff "must give reason to believe that some *analogous category* of claims is treated differently" by the health plan. *Id.* at 972 (emphasis added).

But Roiz does not allege that either Blue Shield or Magellan assesses or processes claims for mental health treatment differently, or that either entity denied a claim for her mental health benefits for a reason that it wouldn't apply to her medical benefits. Nor does she identify the applicable "category" at which she seeks to make the comparison. She does not allege, for example, that her health plan paid for outpatient, out-of-network medical care but didn't pay for outpatient, out-of-network mental health care, to take one example of the "classifications" from the regulations. *See* 29 C.F.R. § 2590.712(c)(2)(ii)(A)(4) (2025).

Even if Roiz could establish that *Magellan* managed a category of her plan's mental health benefits more strictly than *Blue Shield* managed an analogous category of her plan's medical and surgical benefits, it does not necessarily follow that *Magellan* has violated the Parity Act. Roiz does not allege—nor could she—that Magellan has any control whatsoever over any aspect of the plan design for her medical and surgical benefits. Blue Shield is the issuer of her plan and is the entity responsible for ensuring compliance with the Parity Act. *See* 29 U.S.C. § 1185a(a)(3)(A) (describing requirements as applying to "a group health plan . . . that provides both medical and surgical benefits and mental health or substance use disorder benefits"). Magellan does not provide medical and surgical benefits, so it cannot be held liable for Blue Shield's supposed failure to maintain consistent standards between medical and mental health benefits. As with many of its other claims, the complaint's decision to impermissibly treat Blue Shield and Magellan as a single entity is fatal to this one.

VI. Plaintiffs' State-Law Claims Against Magellan Must Be Dismissed.

A. Plaintiffs' contract claims fail (Counts Five through Eight).

(3) "Outpatient, in-network," (4) "Outpatient, out-of-network," (5) "Emergency care," and (6) "Prescription drugs." 29 C.F.R. § 2590.712(c)(2)(ii)(A).

Plaintiffs bring four contract-based causes of action. Counts Five and Eight assert claims for breach of contract and the implied covenant of good faith and fair dealing on behalf of a class of public employees who enrolled in non-ERISA Blue Shield plans. Compl. ¶¶ 199–212, 227–37. Counts Six and Seven assert the same claims on behalf of all plaintiffs and class members who enrolled in a non-ERISA plan. Compl. ¶¶ 213–26. These claims cannot survive for at least two reasons.

First, Plaintiffs do not plausibly allege the existence of their contracts with Magellan nor any specific term of those contracts. "To plead a claim for breach of contract, Plaintiff must at least allege the material terms of a specific contract . . . and state which obligations a defendant allegedly breached." *Langan v. United Servs. Auto. Ass'n*, 69 F. Supp. 3d 965, 980 (N.D. Cal. 2014). Plaintiffs have not done that here, and the lack of detail is striking. The complaint gestures at contracts generally but says nothing at all about what they contain. What do the contracts say? What promises are made by Blue Shield? By Magellan? There is nothing in the complaint that answers these questions. True, Plaintiffs state at a high level that the contracts generally require "Defendants" to provide them with mental health benefits and to follow federal law. *See* Compl. ¶¶ 201, 204. But without more detail, "there is no way for the Court to know even generally what the terms of the contract or contracts were, or even how many agreements are at issue." *Langan*, 69 F. Supp. 3d at 980. The vagueness with which Plaintiffs allege their contracts is on full display when one compares the allegations across the different contract-based claims. To support Counts Five and Eight, Plaintiffs make the bare, conclusory allegation that their public employers have contracts with Magellan, but in support of Counts Six and Seven they make the glaringly much less specific allegation that "Plaintiffs and Defendants have a direct contractual relationship." *Compare* Compl. ¶¶ 201, 229 *with* Compl. ¶¶ 214, 220. Plaintiffs supply no facts to explain the nature of this "relationship," and Magellan and the Court are left to guess what they mean.

Plaintiffs' allegations concerning Magellan's purported breach are similarly bare. They cannot identify any specific contractual promise by Magellan at all. *Cf. infra* Section V.B.1. And they certainly don't describe how Magellan violated any contractual obligation. This defect forecloses the breach of implied covenant claims as well. *See Langan*, 69 F. Supp. 3d at 980

(dismissing claim for breach of implied covenant of good faith and fair dealing where plaintiff did "not allege with sufficient specificity the conduct that allegedly breached the implied covenant").5

Second, and relatedly, the contract claims are a particularly egregious example of impermissible shotgun pleading. Opting for vague allegations about a group of "Defendants," Magellan-specific allegations remain elusive. Without any details supporting the supposed existence of a contract, the material terms, and breaching acts by Magellan, Plaintiffs have failed to provide the notice that Rule 8 demands. *Gibson*, 165 F.4th at 1291 (upholding dismissal of "classic shotgun pleading" that was "conclusory and vague [and] assert[ed] multiple claims against multiple defendants without identifying who did what"). Moreover, even if the generally pleaded obligations and acts of "Defendants" could somehow be imputed to Magellan, the allegations are still woefully short. For instance, Plaintiffs imagine that "Defendants" are required, by an unidentified contract, to comply with federal law and breached that contractual promise by violating ***twenty-one*** different sections of three separate and sprawling federal statutes, all without bothering to parse these laws and how they were violated in breach of the contract. Compl. ¶ 204. That kitchen sink approach is improper. *See Gibson*, 165 F.4th at 1290 ("[P]ermitting parties to file pleadings that do not tie factual averments against specific parties to individual causes of action infringes Rule 8.").

B. Plaintiffs' claim under the California Unfair Competition Law fails (Count Nine).

The Unfair Competition Law (UCL) prohibits "unlawful, unfair or fraudulent" business practices. Cal. Bus. & Prof. Code § 17200. Because the statute is written disjunctively, California's courts have recognized essentially three different versions of the cause of action: an "unlawful" prong, an "unfair" prong, and a "fraudulent" prong. *Moran v. Prime Healthcare Mgmt.*, Inc., 208 Cal. Rptr. 3d 303, 309 (Ct. App. 2016). The unlawful prong of a UCL claim requires a plaintiff to plead the violation of some other law, *i.e.*, to establish the business practice

5 Plaintiffs' implied covenant claims separately fail because they are based on the same conduct and injuries as their breach of contract claims, rendering the implied covenant claims duplicative. *Green Crush LLC v. Paradise Splash I, Inc.*, 2018 WL 4940824, at *7 (C.D. Cal. Mar. 8, 2018).

at issue was "unlawful" in some way. *Id.* at 311. The "fraudulent" prong requires that the defendant's action is likely to deceive the public. *Schnall v. Hertz Corp.*, 93 Cal. Rptr. 2d 439, 457 (Ct. App. 2000). Plaintiffs assert both prongs here. Compl. ¶¶ 240, 253 [6]

Plaintiffs' UCL claim against Magellan fails for two reasons. First, Plaintiffs' UCL claims sound in fraud, which means they must meet the particularity requirements of Rule 9(b). *See Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1125–26 (9th Cir. 2009) (applying Rule 9(b) to UCL claims predicated on fraud). And Plaintiffs' allegations concerning Magellan do not come close to the degree of specificity that Rule 9(b) requires. Second, even if certain of the UCL "unlawful" predicates Plaintiffs allege do not depend on fraud, Plaintiffs have not sufficiently pleaded that Magellan violated these predicate provisions even under Rule 8.

1. Plaintiffs fail to plead fraud with the particularity required by Rule 9(b).

In bringing a UCL claim, a plaintiff "may allege a unified course of fraudulent conduct and rely entirely on that course of conduct as the basis of" her claim. *Kearns*, 567 F.3d at 1125. Such a claim "sound[s] in fraud," and the requirements of Rule 9(b) apply. *Id.* (citation omitted). That is precisely the situation here. Plaintiffs have expressly invoked the UCL's "fraudulent" prong. Compl. ¶ 253. They allege that "Defendants," again pretending Blue Shield and Magellan are a single entity, made "intentional and fraudulent misrepresentations" as part of a scheme for their own "enrichment." Compl. ¶ 158. The crux of their claim is that "Defendants intentionally lie about the provider networks in order to induce people to enroll in their plans based on misinformation." Compl. ¶ 248. Further, several of the predicate legal violations for Plaintiffs' "unlawful" UCL claim are violations based in fraud. Cal. Bus. & Prof. Code § 17500 (false advertising); Cal. Ins. Code § 790.02 (unfair or deceptive acts); Cal. Health & Safety Code § 1360 (misleading plan information); *see* Compl. ¶¶ 241–46. The claims here are predicated on "a

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[6] Plaintiffs also appear to summarily reference the "unfair" prong of the UCL, *see* Compl. ¶ 253, but they plead no facts to distinguish this version of the claim from the unlawful or fraudulent prongs, both of which they at least attempt to plead more thoroughly. *See Zepeda v. PayPal, Inc.*, 777 F. Supp. 2d 1215, 1223 (N.D. Cal. 2011) (applying Rule 9(b) even though plaintiffs alleged both unfair business practices and consumer fraud because they "claim[ed] to have relied on deceitful marketing materials and representations").

fraudulent course of conduct," consisting of misrepresentations in "marketing materials," misleading consumers and inducing them to make purchases in "reliance on these [mis]representations." *Kearns*, 567 F.3d at 1125–26; *see also Zepeda v. PayPal, Inc.*, 777 F. Supp. 2d 1215, 1223 (N.D. Cal. 2011) (applying Rule 9(b) to UCL claim based on "deceitful marketing materials and representations in deciding to use and pay for [the defendant's] services"). Rule 9(b) therefore applies.

And the complaint flunks Rule 9(b)'s heightened pleading standard spectacularly. Rule 9(b) requires a plaintiff to plead the "who, what, when, where, and how" of the alleged fraudulent conduct; that is, the plaintiff must identify the specific statements alleged to be false, the speaker of the statements, the time and place the statements were made, the manner in which the statements were misleading, and how the plaintiff relied on them. *Colgate v. JUUL Labs, Inc.*, 345 F. Supp. 3d 1178, 1190–91 (N.D. Cal. 2018) (Orrick, J.) (holding Rule 9(b) not satisfied where "neither [the court] nor [the defendant] can determine precisely what statements were allegedly false, misleading, or unfair"). None of these requirements are met with respect to Magellan. All of the fraud-based allegations are directed collectively at "Defendants" without identifying any specific misrepresentation. *See, e.g.*, Compl. ¶¶ 158, 240, 253, 266–68. If Rule 9(b) bars anything, it is this sort of vague collective pleading. *United States v. Corinthian Colls.*, 655 F.3d 984, 997–98 (9th Cir. 2011); *see also Destfino v. Reiswig*, 630 F.3d 952, 958 (9th Cir. 2011) (affirming dismissal where complaint failed to "set out which of the defendants made which of the fraudulent statements" and instead made "'everyone did everything' allegations").

The complaint does not allege what specific false statement Magellan made, when Magellan made it, where the statement appeared, to whom it was directed, or why it was false at the time it was made. Instead, the complaint alleges in conclusory fashion that "Defendants" published directories containing inaccurate information and disseminated misleading marketing materials, without specifying which Defendant made which statement or how each Plaintiff relied on a Magellan statement as opposed to Blue Shield's marketing, plan materials, or evidences of coverage. *See, e.g.*, Compl. ¶¶ 158, 260. This collective pleading is wholly insufficient to put Magellan on notice of the specific fraudulent conduct alleged against it.

Moreover, the complaint does not adequately plead materiality or reliance as to any statement—let alone a false one—by Magellan. The complaint alleges that Plaintiffs searched the Magellan directory and found inaccurate listings, Compl. ¶¶ 53, 78–79, 87, 90, but it does not specify exactly what was inaccurate about them or why that inaccuracy was material. The complaint's theory appears to be that Magellan's directory was generally inaccurate, but Rule 9(b) requires more than generalized allegations of inaccuracy. *Cf. Colgate*, 345 F. Supp. 3d at 1191 (holding that permitting a plaintiff to allege generally that all of the defendant's advertisements were false "would eviscerate Rule 9(b)'s particularity requirement"). Because Plaintiffs have not identified the specific Magellan statements they relied upon, when those statements were made, or how those particular statements were false, Plaintiffs' fraud-based claims against Magellan must be dismissed.[7]

2. Plaintiffs fail to plausibly allege that Magellan committed any non-fraud predicate legal violation.

Even if Plaintiffs' UCL claim rests on predicates that do not sound in fraud, Rule 8 would require dismissal too.[8] Plaintiffs rely on alleged violations of Insurance Code §§ 10133.15 and 10133.54, Health & Safety Code §§ 1367.03 and 1367.27, and 10 C.C.R. § 2240.01. These statutes and regulations impose detailed procedural requirements for directory accuracy and verification, protocols to update the directory, and network adequacy standards. Compl. ¶¶ 247–52. To plead a violation of these statutes against Magellan, Plaintiffs must allege facts showing that Magellan failed to comply with these specific legal requirements, not merely that the directory was inaccurate as a general matter. *See Stearns v. Select Comfort Retail Corp.*, 763 F. Supp. 2d 1128,

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[7] This argument applies with equal force across all of Plaintiffs' claims that are subject to Rule 9(b), *see supra* Section IV.C and *infra* Section V.C.

[8] To be clear, Magellan's position is that Plaintiffs' entire UCL claim sounds in fraud and is thus subject to Rule 9(b), but to the extent that the Court disagrees as to certain predicates for the unlawful prong of the claim, Magellan presents these arguments as to the sufficiency of those predicates under Rule 8 in the alternative. *See Kearns*, 567 F.3d at 1126; *see also Hadley v. Kellogg Sales Co.*, 243 F. Supp. 3d 1074, 1094 (N.D. Cal. 2017) (holding that where Plaintiff alleges a unified course of fraudulent conduct, the entire UCL claim is subject to Rule 9(b)).

1150 (N.D. Cal. 2010) ("[A]llegations in support of [a UCL] claim must state with reasonable particularity the facts supporting the statutory elements of the alleged violation. (internal quotation marks omitted)). But the complaint does not allege what actions by Magellan violated the requirements of these various statutes and regulations, nor does the complaint allege that Magellan has ever received an adverse finding by the relevant California regulators that enforce these provisions. Plaintiffs plead nothing about, for example, what procedures Magellan uses to verify its directory, how frequently Magellan updates its directory information, or how Magellan's procedures fall short of any specific statutory or regulatory requirement. *See, e.g.*, Compl. ¶¶ 247–48 (pleading violations of statutes that require insurers to update their directories at least quarterly and at least weekly when informed of a change). A directory may contain temporary inaccuracies, such as when a provider stops accepting patients after the most recent verification, despite Magellan's compliance with verification protocols. Without factual allegations tying Magellan's specific conduct to specific statutory requirements, Plaintiffs have not stated a plausible claim for these violations.[9]

The complaint's reliance on collective allegations against "Defendants" once again compounds this deficiency. *See Gibson*, 165 F.4th at 1291 (holding allegations insufficient where complaint "asserts multiple claims against multiple defendants without identifying who did what"). The complaint alleges that "Defendants do not take reasonable or appropriate steps to ensure the accuracy of the information listed in their directories," Compl. ¶ 248, but it does not specify which defendant is responsible for which regulatory duty, what specific conduct by Magellan (as opposed to Blue Shield) violated which specific statutory or regulatory requirement, or how Magellan's role as MHSA translates into liability for particular regulatory violations. The

[9] In addition to their failure to plead these underlying violations with sufficient detail under Rule 8, Plaintiffs also fail to tie their injuries to the specific statutory violations they seek to enforce; for example, Plaintiffs do not allege that they saw a provider in the directory whose entry was inaccurate *because* Magellan failed to comply with a specific regulatory requirement. An unlawful UCL claim requires that the plaintiff's injuries actually be caused by the specific legal violation by the defendant, *i.e.,* that the plaintiff would not have been injured but for the defendant's noncompliance with the law. *Haynish v. Bank of Am., N.A.*, 284 F. Supp. 3d 1037, 1051 (N.D. Cal. 2018). Plaintiffs don't allege enough to meet that standard here.

complaint's failure to disaggregate the two Defendants' respective roles and allege Magellan-specific violations is separately fatal to the UCL claim.

The factual allegations the complaint does make about Magellan further illustrate this pleading failure. The complaint alleges that Plaintiffs searched the "Magellan directory" and found providers who were unavailable or not accepting patients, Compl. ¶¶ 53, 78–79, 87, 90, and that a "secret shopper" study revealed an "87% ghost rate," Compl. ¶¶ 117–22. But these are outcome-based, not process-based, allegations; they describe the purported condition of the directory at a particular point in time, not Magellan's failure to comply with specific verification or update requirements imposed by the statutes and regulations on which Plaintiffs rely. The complaint does not allege that Magellan failed to verify provider information within the timeframes required by statute, failed to remove providers who could not be verified, or failed to update the directory within the required period after learning of changes. Plaintiffs therefore do not state a claim for relief that depends on these legal violations. Count Nine should be dismissed.

C. Plaintiffs' intentional and negligent misrepresentation claims against Magellan fail (Counts Ten and Eleven).

Plaintiffs also assert claims for intentional misrepresentation and negligent misrepresentation. Right off the bat, these claims are also subject to dismissal for failure to comply with Rule 9(b)'s heightened pleading standard for fraud. Intentional misrepresentation is essentially coextensive with a claim for common law fraud. *See Rodriguez v. JP Morgan Chase & Co.*, 809 F. Supp. 2d 1291, 1296 (S.D. Cal. 2011) (equating intentional misrepresentation and actual fraud and applying Rule 9). And, while the law in this Circuit is unsettled as to whether Rule 9(b) applies to negligent misrepresentation, *see Anschutz Corp. v. Merrill Lynch & Co.*, 785 F. Supp. 2d 799, 823 (N.D. Cal. 2011), the Court should apply the heightened standard here because Plaintiffs' allegations are plainly grounded in fraud rather than negligence. *Cf. Kearns*, 567 F.3d at 1125 (holding Rule 9(b) applies when plaintiff alleges an entire fraudulent course of conduct). Applying Rule 9(b) to these common law misrepresentation claims requires dismissal for the same reasons articulated above. *See supra* Section V.B.1. Plaintiffs have not pleaded a specific material misrepresentation by Magellan on which they detrimentally and justifiably relied.

Counts Ten and Eleven should be dismissed as well.

D. Plaintiffs cannot claim unjust enrichment or restitution against Magellan (Count Twelve).

Plaintiffs' unjust enrichment (or restitution) claim fails for two independent reasons. First, under California law, a plaintiff asserting unjust enrichment must allege that "the defendant received and unjustly retained a benefit at the plaintiff's expense." *ESG Cap. Partners, LP v. Stratos*, 828 F.3d 1023, 1038 (9th Cir. 2016); *see also Lectrodryer v. SeoulBank*, 91 Cal. Rptr. 2d 881, 883 (Ct. App. 2000) (stating elements are "receipt of a benefit and unjust retention of the benefit at the expense of another"). Plaintiffs allege they paid premiums through Blue Shield and/or their employers for their health insurance plans, Compl. ¶¶ 52, 64, 75, 85, but the complaint contains no allegation that any portion of these premiums was remitted to *Magellan* or that Plaintiffs conferred any other benefit on Magellan. Because Magellan is not alleged to have received anything from Plaintiffs, there is no benefit for Magellan to "restore," and the restitution claim fails as a matter of law.

Second, Plaintiffs allege the existence of express contracts governing their health insurance coverage. They assert breach of contract claims (Counts Five and Six) and breach of implied covenant claims (Counts Seven and Eight) based on those same contractual relationships. Compl. ¶¶ 199–237. Unjust enrichment is unavailable where an express contract governs the subject matter of the dispute. *Paracor Fin., Inc. v. Gen. Elec. Cap. Corp.*, 96 F.3d 1151, 1167 (9th Cir. 1996). Plaintiffs cannot simultaneously allege that express contracts govern their relationships with Defendants and pursue a quasi-contractual remedy for unjust enrichment arising from the same alleged conduct. Count Twelve should therefore be dismissed.

VII. Conclusion

For the foregoing reasons, the Magellan Defendants respectfully request that the Court dismiss Plaintiffs' complaint against Magellan with prejudice.

Dated: February 24, 2026

Respectfully submitted,

By: */s/ Steven M. Cady*
Steven M. Cady (*pro hac vice*)

scady@wc.com
Dylan C. McDevitt (*pro hac vice*)
dmcdevitt@wc.com
WILLIAMS & CONNOLLY LLP
680 Maine Avenue, SW
Washington, DC 20024
Telephone: (202) 434-5000
Facsimile: (202) 434-5029

By: */s/ Lily Becker*
Lily Becker (CA Bar No. 251145)
lily@stevensbecker.com
STEVENS BECKER P.C.
345 West Portal Avenue, Suite 110
San Francisco, CA 94127
Telephone: (415) 237-3830

Counsel for Magellan Defendants

CERTIFICATE OF SERVICE

I certify that on February 24, 2026, I electronically filed the foregoing Motion to Dismiss with the Clerk of Court using the ECF system, which sent notification of such filing to all counsel of record.

By: */s/ Steven M. Cady*
Steven M. Cady

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

JENNIFFER ROIZ et al.,

Plaintiffs,

v.

CALIFORNIA PHYSICIANS' SERVICE DBA BLUE SHIELD OF CALIFORNIA, MAGELLAN HEALTH, INC., MAGELLAN HEALTHCARE, INC., and HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA,

Defendants.

Case No. 3:25-cv-09978-WHO

[PROPOSED] ORDER GRANTING THE MAGELLAN DEFENDANTS' MOTION TO DISMISS THE COMPLAINT AGAINST MAGELLAN

[Filed Concurrently with Notice and Motion to Dismiss and Memorandum in Support Thereof]

Date: April 29, 2026
Time: 2:00 p.m.
Location: Courtroom 2; 17th Floor
Judge: William H. Orrick

The Court, having considered the pleadings in this matter and all arguments and papers submitted in support of, and in opposition to, the motion to dismiss filed by Defendants Magellan Health, Inc., Magellan Healthcare, Inc., and Human Affairs International of California, Inc. (collectively the "Magellan Defendants"), and good cause appearing therefore, the Court

GRANTS the Magellan Defendants' Motion and DISMISSES Plaintiffs' Complaint against the Magellan Defendants with PREJUDICE.

Dated: _____

_____
Hon. William H. Orrick
United States District Judge