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CALIFORNIA PHYSICIANS' SERVICE dba BLUE SHIELD OF CALIFORNIA (sued herein as "Blue Shield of California")

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO COURTHOUSE

JENNIFFER ROIZ, CLAUDINE CASTILLO, CANDYCE MARTO, and KEVIN MAEDEL on behalf of themselves and all others similarly situated,

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

DEFENDANT CALIFORNIA PHYSICIANS' SERVICE DBA BLUE SHIELD OF CALIFORNIA'S REPLY IN SUPPORT OF ITS MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT

Date: August 5, 2026
Time: 2:00 p.m.
Place: Via Zoom
Judge: Hon. William H. Orrick
FAC: March 24, 2026

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I. INTRODUCTION

Plaintiffs Jenniffer Roiz, Claudine Castillo, Candyce Marto, and Kevin Maedel's (collectively, "Plaintiffs") Opposition to California Physicians' Service dba Blue Shield of California's ("Blue Shield") Motion to Dismiss Plaintiffs' First Amended Complaint ("FAC") (the "Motion") confirms the central defect in the FAC: despite its length and rhetoric, it still does not plead actionable misconduct by Blue Shield. Plaintiffs' apparent theory of the case ignores the basic premise of any health plan—that Blue Shield does not, and cannot be expected to, provide benefits in a vacuum. Benefits are furnished in response to claims and requests made under the plan. Yet, nowhere do Plaintiffs allege that any of them actually asked Blue Shield for something owed under their plan and were refused. Instead, they complain anecdotally about their experiences searching mental health provider networks, without tying those experiences to a single claim, request, or benefit that Blue Shield denied. Rather than identify clear contractual promises, concrete statutory violations, particular misrepresentations, or a cognizable denial of plan benefits, Plaintiffs continue to rely on generalized descriptions of Blue Shield's network, anecdotal provider search difficulties, and legal conclusions dressed up as facts. That is insufficient.

The Opposition itself highlights that Plaintiffs cannot prevail on their purported claims as pleaded, and their improper attempts to recast their claims are still deficient. Plaintiffs recast informational and descriptive plan language as enforceable contractual guarantees; convert dissatisfaction with provider searches into supposed statutory violations; attempt to backfill missing factual allegations through opposition briefing; and repackage access-related allegations as fraud, bad faith, fiduciary breach, and MHPAEA disparity without the supporting facts those claims require. But neither rhetoric about an "illusory" network nor repetition of the phrase "ghost network" cures the FAC's failure to plead facts showing entitlement to relief.

Because the FAC still fails to plead any actionable conduct by Blue Shield under any asserted theory—and because Plaintiffs have already amended once without curing these fundamental defects—the FAC should be dismissed without further leave to amend.

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II. ARGUMENT

A. The Opposition Fails to Establish a Breach of Contract Claim Against Blue Shield.

1. Plaintiffs Fail to Demonstrate Actionable Breach.

Plaintiffs' contract theory fails at the threshold because they do not identify a clear contractual obligation that Blue Shield allegedly breached. A plaintiff alleging breach of contract must plead the material obligation allegedly breached and facts showing how the defendant breached that obligation. *Langan v. United Servs. Auto. Ass'n*, 69 F. Supp. 3d 965, 979–81 (N.D. Cal. 2014). Plaintiffs do neither. Their Opposition tries to recast informational and descriptive plan language as "affirmative contractual promises," but the cited provisions do not clearly and unambiguously guarantee perfect directory accuracy, real-time provider availability, immediate appointment access, or automatic out-of-network treatment whenever a member is dissatisfied with search results. At most, the cited language describes resources, processes, and general plan features, not recourse-triggering obligations. Nor can Plaintiffs manufacture contract liability by labeling generalized plan descriptions as "promises" or by substituting their expectations for definite contractual text. *See Langan*, 69 F. Supp. 3d at 979–81 (breach of contract requires pleading of material obligation allegedly breached and facts showing *how* defendant breached it); *Ladas v. California State Auto. Assn.*, 19 Cal. App. 4th 761, 770–71 (1993) (indefinite, generalized descriptors are not enforceable promises).

For instance, Plaintiffs argue that the provider-directory information must be validated or updated at least every 90 days, without pleading when any challenged listing was last validated, when it became inaccurate, or that Blue Shield missed any specific 90-day validation or update period. (*See* Opp. at 9.) Allegations that certain providers were allegedly out of network, unavailable, not accepting new patients, or not offering listed services when Plaintiffs or secret shoppers called them do not plead how long any listing had been inaccurate or whether Blue Shield failed to update it within an applicable period. (*See, e.g.*, FAC ¶¶ 59–60, 102.)

Plaintiffs' directory and website theories fail for the same reason. Statements such as "Find a Doctor," "Participating Providers in this network at blueshieldca.com," and general descriptors like "robust," "full selection," "wide range," and "among the largest in California" are informational or generalized promotional language. These are not defined contractual guarantees that every listed provider

will be in-network, accepting new patients, offering every listed service, and conveniently located for each Plaintiff at the time of each search. Such indefinite descriptors cannot support a breach of contract claim. *Ladas*, 19 Cal. App. 4th at 770–71.

To the extent Plaintiffs rely on EOC language concerning "current" lists of providers, periodic validation, provider-status changes, timely and geographically accessible services, or assistance scheduling, the Opposition still does not identify clear language unambiguously promising the results Plaintiffs seek to enforce here. Saying that members may use Blue Shield's directory, that information will be validated periodically, or that members have general access rights is not the same as promising that every provider shown will be available to each member at all times, or that Blue Shield is in breach whenever a Plaintiff finds the provider search process unsuccessful. Plaintiffs' characterization of these provisions as binding "promises" does not make them so.

Plaintiffs' reliance on *Duff v. Centene Corp.*, 565 F. Supp. 3d 1004 (S.D. Ohio 2021), *Harvey v. Centene Mgmt. Co. LLC*, 357 F. Supp. 3d 1073 (E.D. Wash. 2018), *Angelo v. Centene Mgmt. Co., LLC*, 2021 WL 352434 (W.D. Tex. Feb. 2, 2021), *Wilson v. Centene Mgmt. Co., L.L.C.*, 168 F.4th 217 (5th Cir. 2026), and *Desai v. CareSource Inc.*, 250 N.E.3d 689 (Ohio Ct. App. 2024), does not compel a different result. Each case involved different plan language, different governing law, and—critically—plaintiffs who alleged that the insurer's directory affirmatively *promised* a "current" or "up-to-date" list and then pleaded specific facts showing pervasive inaccuracies. None addressed whether the plan language at issue here—directing members to an informational tool and describing periodic validation—creates the same enforceable guarantee. Nor did any of those courts confront the defect present here: the absence of any allegation that the health plan missed a specific validation deadline, failed to update within a defined period, or denied a request triggered by the plan's own access-to-care process. Those cases do not excuse the FAC's failure to plead a concrete breach of a definite contractual obligation.

2. Plaintiffs Do Not Establish That They Triggered Any Out-Of-Network Authorization Process.

Even on Plaintiffs' own reading of the plan language, their contract theory fails because they do not plead that they invoked the process they say Blue Shield breached. Plaintiffs' "access to care" theory fails because the cited plan language describes a request and authorization process, not an automatic

entitlement to out-of-network care whenever a member is dissatisfied with directory results. (Opp. at 10.) In fact, the Evidences of Coverage for both the Platinum Full PPO and the Trio HMO Per Admit state that the member "can ask" to see a Non-Participating Provider. (RJN, Ex. 1 at 30; RJN Ex. 7 at 22.) Plaintiffs do not plead that they made such a request and were denied by Blue Shield.

Plaintiff Castillo alleges that Blue Shield referred her to Magellan, that Magellan sent provider lists, and that she called listed providers, but she does not allege that she asked Blue Shield to authorize a specific out-of-network provider at in-network cost-sharing, submitted a claim or grievance, or received a denial from Blue Shield. (*See, e.g.*, FAC ¶ 87.) While Plaintiff Marto alleges that a number of providers were "unavailable" or "did not offer" various services, she fails to allege that she requested authorization of an out-of-network therapist at in-network rates or that any claim or grievance was denied. (*See, e.g.*, FAC ¶¶ 102–03.) The same goes for Plaintiff Maedel, who pleads he has gone without care for a number of years, but does not allege he requested, or that Blue Shield denied, any extension of in-network benefits to out-of-network providers. (*See e.g.*, FAC ¶ 118.) Plaintiffs' Opposition fails to grapple with this point. Blue Shield cannot breach a provision that Plaintiffs never attempted to invoke in the first place.

The Opposition now attempts to recharacterize routine customer service calls as formal triggering requests, asserting that Roiz "repeatedly called customer service" and "requested assistance locating an in-network provider." (Opp. at 25–26.) But the plan language is explicit: the member "can ask" to see a Non-Participating Provider (RJN, Ex. 1 at 30; RJN Ex. 7 at 22), after which the plan administrator will "help you either schedule an appointment with a Participating Provider, or select a Non-Participating Provider" and contact the member "regarding available appointment times." (FAC ¶ 201.) Calling customer service and asking for referral to an *in-network* provider is not the same as requesting authorization of a specific *out-of-network* provider at in-network cost-sharing. Plaintiffs do not allege that any non-ERISA Plaintiff identified a specific provider, asked Blue Shield to authorize that provider, and received a denial. Absent that sequence, the contractual obligation Plaintiffs cite was never triggered—and an untriggered obligation cannot be breached.

3. Plaintiffs' Damages Allegations Remain Conclusory.

Plaintiffs' contract damages theory fails for the additional reason that it is entirely conclusory. The FAC offers generalized assertions of "inflated premiums," "out-of-pocket expenses," "millions of dollars

in damages," and "worthless" coverage without tying any alleged loss to a specific contractual obligation, a Plaintiff-specific amount, or a factual comparator showing what Plaintiffs would have paid absent the alleged misconduct. (Mot. at 19–20) (citing FAC ¶¶ 265, 279, 301, 312.) The Opposition does not cure that defect. Although Plaintiffs now invoke out-of-network expenses, delayed care, and foregone treatment (Opp. at 6–7), the only specific out-of-pocket therapy payments alleged in the FAC are Plaintiff Roiz's $150 weekly payments to continue seeing her existing therapist—and Roiz is the ERISA plaintiff, not a plaintiff asserting the state-law contract claims. (FAC ¶ 63.) By contrast, Castillo alleges only that she considered out-of-network therapy for her son but could not afford it, and Marto alleges she went without care because she could not find in-network care or afford out-of-network care. (FAC ¶¶ 89, 103.) Those allegations do not plead actual monetary damages or out-of-pocket payments by the non-ERISA contract Plaintiffs, much less payments caused by any Blue Shield denial of an authorization request.

Nor does Plaintiffs' "inflated premium" or "benefit of the bargain" theory cure the defect. Plaintiffs still do not allege how much more they paid, what the "true" price should have been, or that a competing plan offered materially better mental health access at a lower price. Roiz's allegation that she selected the most expensive Platinum plan because she believed it offered comprehensive coverage and $0 in-network mental health copays does not identify any price differential attributable to an actionable Blue Shield misstatement. (FAC ¶ 52.) Nor do Castillo, Marto, and Maedel identify a concrete alternative plan, a measurable overpayment, or any nonconclusory basis to attribute premium inflation to Blue Shield. Simply relabeling this theory as "benefit of the bargain" does not supply the missing facts. "[N]ominal damages, speculative harm, or threat of future harm" cannot support a contract claim. *Belluomini v. Citigroup, Inc.*, 2013 WL 3855589, at *4 (N.D. Cal. July 24, 2013); *see also King v. Nat'l Gen. Ins. Co.*, 129 F. Supp. 3d 925, 937 (N.D. Cal. 2015) (finding overpayment allegations "conclusory and insufficient" to satisfy Rule 12(b)(6) where "basic facts [were] missing," including the "rate that Plaintiffs were actually charged" or "a policy with a lower . . . rate that was not offered to the Plaintiffs"). None of Plaintiffs' cited price-premium authorities support the proposition that contract claims can proceed without allegations showing a measurable overpayment or a nonconclusory basis to infer that Blue Shield's alleged conduct caused them to pay more than they otherwise would have. For example, unlike in *Duff*, the state-law contract Plaintiffs do not allege "valid (in-network) claims have been denied, preauthorizations ignored,

[or] . . . that [they] 'had to pay out of pocket' for several claims that otherwise should have been covered." *Duff v. Centene Corp.*, 565 F. Supp. 3d 1004, 1020 (S.D. Ohio 2021). Thus, even under their own authority, Plaintiffs have not "concretely allege[d]" damages "flow[ing] from the allegedly inaccurate network directory and inadequate network" and depriving them of the "benefit of their bargain." *Id.*

Moreover, even if standing were established, Count Two's breach theory independently fails. The Opposition's chief breach allegation is that employer contracts require Blue Shield to comply with "applicable state and federal statutes and regulations" (Opp. at 13; FAC ¶ 272), and that alleged noncompliance with directory-accuracy and network-adequacy statutes constitutes *per se* contractual breach. But a general compliance clause does not convert every alleged regulatory shortcoming into a privately actionable breach of contract. "To be enforceable, a promise must be definite enough that a court can determine the scope of the duty and the limits of performance must be sufficiently defined to provide a rational basis for the assessment of damages." *Ladas*, 19 Cal. App. 4th at 770. "An amorphous promise […] cannot rise to the level of a contractual duty." *Id.* at 771. This applies here, where Plaintiffs do not allege which specific statutory standard was violated, when the violation occurred, or how Blue Shield's conduct fell short of what the statute actually requires. Moreover, a mere violation of law does not automatically create privately enforceable contract rights in individual plan members. *Farmers Ins. Exch. v. Superior Ct.*, 137 Cal. App. 4th 842, 850 (2006) ("a statute creates a private right of action only if the statutory language or legislative history affirmatively indicates such an intent").

B. Count Two's Third-Party Beneficiary Theory Still Fails.

Plaintiffs' third-party beneficiary theory fails because they still do not plead that the contracting parties intended to confer enforceable rights on employees to sue over the administrative obligations asserted here. Plaintiffs' Opposition relies on an October 2025 Upland Unified School District contract with Blue Shield. (Opp. at 12.) This document does not cure Plaintiffs' lack of standing to enforce a contract between Blue Shield and employers. First, the Upland contract does not establish the terms of all employer contracts for each Plaintiff and all relevant periods. (*See* Cohen Decl., ¶ 4 (stating Upland Unified School District is the employer for Plaintiffs Marto and Maedel.)) The current 2025 version of the Upland contract cannot supply missing terms for Plaintiff Castillo's unrelated employer plan, nor can it establish the governing terms for all years at issue in the FAC.

Second, a supposed third-party beneficiary must show actual benefit, a motivating purpose to benefit the third party, and consistency between third-party enforcement and the contract's objectives and reasonable expectations. *Goonewardene v. ADP, LLC*, 6 Cal. 5th 817, 830 (2019). "The circumstance that a literal contract interpretation would result in a benefit to the third party is not enough to entitle that party to demand enforcement. The contracting parties must have intended to confer a benefit on the third party." *Neverkovec v. Fredericks*, 74 Cal. App. 4th 337, 348 (1999). To support their contention, Plaintiffs cite language stating that "'Blue Shield agrees to provide Benefits of this Contract to covered Employees and their covered Dependents.'" (Opp. at 12.) This language, at most, shows that members receive plan benefits, not that the contracting parties' motivating purpose of the contract was to benefit the potential employees, such that these employees may sue Blue Shield directly for the alleged obligations asserted.

Further, additional language in the cited contract cuts against Plaintiffs' overbroad enforcement theory. For instance, the application language states that the agreement is "solely between the Contractholder and Blue Shield." (Cohen Decl., Ex. 1 at 1.) Plaintiffs attempt to characterize the absence of plan language disclaiming third-party beneficiary status for employees (Opp. at 20-23) as a supposed admission by Blue Shield that employees are third-party beneficiaries. However, the "intent" to confer third-party beneficiary status "must appear from the terms of the contract," and cannot merely be inferred from silence. *Lincoln Alameda Creek v. Cooper Indus., Inc.*, 829 F. Supp. 325, 329 (N.D. Cal. 1992).

Lastly, Plaintiffs' reliance on *Baglione v. Health Net of California, Inc.*, 97 Cal. App. 5th 882 (2023), does not change the result. *Baglione* involved whether arbitration provisions in a county employee health plan complied with statutory disclosure requirements. *Baglione*, 97 Cal. App. 5th at 892. The court recognized that an employer health plan is negotiated primarily for employees in that statutory disclosure context. *Id.* It did not hold that employees may enforce every administrative term of a group health contract, nor did it displace the considerations in *Goonewardene*. As such, Plaintiffs do not (and cannot) support a third-party beneficiary theory, and Count Two should be dismissed. Plaintiffs' other cited authorities likewise do not establish that employees may sue to enforce every administrative or service-related provision in a group health agreement merely because they receive benefits under it. *See Neverkovec*, 74 Cal. App. 4th at 348 (receiving benefits under a contract is insufficient; the parties must have intended to confer a benefit enforceable by the third party);

Goonewardene, 6 Cal. 5th at 830 (third-party enforcement must be consistent with the contract's objectives and reasonable expectations).

C. The Implied Covenant Claims Are Duplicative and Unsupported by a Withheld Benefit.

Plaintiffs' Opposition argues that the implied covenant claims are not duplicative because Defendants allegedly frustrated Plaintiffs' ability to use benefits through customer service conduct. (Opp. at 16.) That argument fails because an insurance bad-faith claim requires benefits due and unreasonable withholding of those benefits. *Love v. Fire Insurance Exchange*, 221 Cal. App. 3d 1136, 1151–53 (1990). When no benefits are due, the implied covenant has no independent existence detached from the contract. *Love*, 221 Cal. App. 3d at 1153. Plaintiffs do not plead that Blue Shield withheld benefits from the non-ERISA Plaintiffs, as they do not allege that Plaintiffs Castillo, Marto, or Maedel requested out-of-network authorization, submitted a claim or grievance, and received a denial from Blue Shield. (FAC ¶ 87.)

These claims also duplicate the contract claims. A claim for breach of the implied covenant must involve something beyond breach of a contractual duty itself. *Careau & Co. v. Security Pacific Business Credit, Inc.*, 222 Cal. App. 3d 1371, 1395 (1990). When an implied covenant claim relies on the same acts and seeks the same damages as a companion contract claim, it is superfluous. *Green Crush LLC v. Paradise Splash I, Inc.*, No. CV 17-05682, 2018 WL 4940824, at *7 (C.D. Cal. Mar. 8, 2018). Plaintiffs' implied covenant counts rely on the same alleged directory inaccuracies, network inadequacy, failure to assist, and out-of-network charges that support their contract counts. (FAC ¶¶ 252–264, 272, 279, 296–297, 308.) The FAC likewise pleads the implied covenant theory through allegations about accurate directories, adequate networks, customer service, out-of-network cost-sharing, and denied or unpaid claims. (FAC ¶ 308.) Plaintiffs cannot state an implied covenant theory by quoting directory update or out-of-network access language without pleading that Blue Shield missed an applicable update deadline, refused a required authorization request, or withheld a benefit due.

The Opposition's attempt to differentiate the implied covenant claims fares no better. Plaintiffs contend the claims are not duplicative because Blue Shield "purposely" made "the customer service line difficult to access," "fail[ed] to train and supervise customer service representatives," and had representatives "falsely informing Plaintiffs that they had no recourse but to select a provider from the

inaccurate directory." (Opp. at 16; FAC ¶¶ 297, 300, 308.) But these allegations do not identify any *withheld benefit* separate from the contract claims' theory of directory inaccuracy. They merely repackage the same core allegation—that the directory was inadequate and Blue Shield did not help Plaintiffs find care—with the additional label of "bad faith." An implied covenant claim still requires that benefits were *due* and *unreasonably withheld*. *Love*, 221 Cal. App. 3d at 1151–53. Alleging that customer service representatives were unhelpful does not transform directory-accuracy complaints into an independent wrong when no Plaintiff alleges that a benefit was requested through the plan's process and denied.

D. Plaintiffs Have Not Alleged Any Viable Violation of the UCL.

The Opposition does not rescue Plaintiffs' UCL theory under any prong. Plaintiffs still do not plead unlawful, unfair, or fraudulent conduct, or a cognizable loss of money or property.

1. Plaintiffs Do Not Plead a Viable "Unlawful" Prong Claim.

Plaintiffs' Opposition argues that provider search allegations and secret shopper allegations establish violations of the No Surprises Act, the ACA, the Knox-Keene Act, California insurance law, the MHPAEA, and California Health and Safety Code section 1374.72. (Opp. at 17.) But the unlawful prong requires an adequately pleaded violation of borrowed law. *Davis v. HSBC Bank Nevada, N.A.*, 691 F.3d 1152, 1168 (9th Cir. 2012). Here, Plaintiffs infer statutory violations from anecdotal provider search experiences and directory complaints, but that does not plausibly allege a concrete statutory violation by Blue Shield. Nor can Plaintiffs cure those defects by reframing or expanding their statutory theories in opposition. The FAC must stand or fall on its own allegations; it cannot be amended through briefing. *Cyph, Inc. v. Zoom Video Commc'ns, Inc.*, 642 F. Supp. 3d 1034, 1043 (N.D. Cal. 2022).

Plaintiffs' MHPAEA-based UCL predicate fails for the same reason their standalone MHPAEA claim fails. They do not plead a specific discriminatory financial requirement, quantitative treatment limitation, nonquantitative treatment limitation, process, criterion, or side-by-side comparison between mental health and medical/surgical benefits. *Andrew P. v. Blue Cross of California*, 2025 WL 3637030, at *3 (N.D. Cal. Dec. 15, 2025).

2. Plaintiffs Do Not Plead an "Unfair" Practice.

Plaintiffs' "unfair" theory merely repackages the same deficient allegations: that Defendants created the illusion of a robust mental health network and charged inflated premiums. (Opp. at 18.) But

Plaintiffs still do not plead facts showing anticompetitive conduct, harm to competition, or conduct that "offends an established public policy" or is "immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers." *See Cel-Tech Commc'ns, Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 187 (1999); *Davis v. HSBC Bank*, 691 F.3d 1152, 1168 (9th Cir. 2012). At most, the FAC alleges difficulty locating preferred mental health providers. That is insufficient.

3. Plaintiffs Do Not Plead Any "Fraudulent" Conduct With Particularity.

A UCL claim grounded in fraud must satisfy Rule 9(b). *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1124 (9th Cir. 2009). Plaintiffs still do not plead which specific statement each Plaintiff saw, when each Plaintiff saw it, who made it, or how it was false. (*See, e.g.*, FAC ¶¶ 53–54, 73–74, 99–100, 111–112, 174–211.) Their reliance on collective allegations against "Defendants" is likewise deficient. *See United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184 (9th Cir. 2016). That failure independently defeats any UCL fraud theory.

4. Plaintiffs Fail to Plead Economic Injury and Therefore Lack UCL Standing.

Plaintiffs also fail to plead a cognizable loss of money or property caused by Blue Shield's alleged conduct. *See Kwikset Corp. v. Superior Court*, 51 Cal. 4th 310, 322 (2011); *Rutter v. Apple Inc.*, 2022 WL 1443336, at *4 (N.D. Cal. May 6, 2022). The Opposition's "benefit of the bargain" theory does not supply the missing facts. Plaintiffs still do not plead a measurable overpayment, a factual comparator, or any nonconclusory basis for a price-premium theory. As Blue Shield explained in its Motion, the "bare recitation of the word 'premium'" does not adequately plead economic injury. (Mot. at 24) (citing *Schippell v. Johnson & Johnson Consumer Inc.*, 2023 WL 6178485, at *8 (C.D. Cal. Aug. 7, 2023)).

E. Plaintiffs Concede Unjust Enrichment Is Not Available Against Blue Shield.

Plaintiffs concede that they cannot pursue unjust enrichment against Blue Shield because they have enforceable contracts with Blue Shield. (Opp. at 23, fn. 13.) Alternative quasi-contract pleading may be available when a plaintiff is uncertain whether an enforceable agreement exists, but quasi-contract recovery is not available where an enforceable agreement governs the same subject matter. *Klein v. Chevron U.S.A., Inc.*, 202 Cal. App. 4th 1342, 1388–89 (2012). The FAC makes clear that Plaintiffs' relationship with Blue Shield is governed by written health plan contracts. (FAC ¶¶ 128-140, 250–279, 303.) That concession requires dismissal of Count Ten as to Blue Shield.

F. Plaintiffs' Misrepresentation Claims Fail.

Plaintiffs' intentional and negligent misrepresentation claims fail for three independent reasons: they are barred by the economic loss rule, they do not satisfy Rule 9(b), and they do not adequately plead justifiable reliance.

1. The Economic Loss Rule Bars Both Misrepresentation Claims.

Plaintiffs argue the economic loss rule does not apply because the alleged misrepresentations occurred outside the contract and before enrollment. (Opp. at 22.) But timing alone does not avoid the rule. To survive the economic loss rule's bar, a plaintiff must plead personal damages independent of the plaintiff's economic loss arising from contract. *Soil Retention Prods., Inc. v. Brentwood Indus., Inc.*, 521 F. Supp. 3d 929, 954 (S.D. Cal. 2021) (citing *Robinson Helicopter Co. v. Dana Corp.*, 34 Cal. 4th 979, 993 (2004)). Plaintiffs allege no such injury here. They seek only economic damages identical to their alleged damages arising from contract—e.g., premiums, out-of-pocket costs, and related economic loss. (FAC ¶ 377; *see also id.* ¶¶ 265, 279, 292, 301, 312, 321, 350, 365.) That is precisely the type of claim barred by the economic loss rule.

2. Plaintiffs Do Not Plead Misrepresentation With Particularity.

Both misrepresentation claims sound in fraud and must satisfy Rule 9(b). *Gilmore v. Wells Fargo Bank N.A.*, 75 F. Supp. 3d 1255, 1270–71 (N.D. Cal. 2014); *Kearns*, 567 F.3d at 1125. Plaintiffs do not plead with particularity which specific statement each Plaintiff saw, when each Plaintiff saw it, who made it, or how it was false. Instead, they allege in general terms that they relied on representations about the provider directory and network when selecting plans. (*See* FAC ¶¶ 53–54, 73–74, 99–100, 111–112, 174–211.) That is insufficient under Rule 9(b).

3. Plaintiffs Do Not Adequately Plead Justifiable Reliance.

Plaintiffs also fail to plead justifiable reliance. The FAC alleges only that each Plaintiff generally believed Blue Shield offered comprehensive coverage and relied on statements regarding the provider network and directory. (*See* FAC ¶¶ 52–54, 72–74, 95–100, 110–112.) But Plaintiffs do not identify any particular representation that induced enrollment, and generic allegations about the directory's function or later deficiencies do not establish reasonable reliance on an actionable misstatement. Nor does the allegation that Blue Shield encouraged prospective members to review the directory before enrolling

transform the directory into a guarantee of real-time availability.

4. The Alleged Representations Are Non-Actionable Puffery.

Finally, to the extent Plaintiffs rely on broad statements such as "full selection," "among the largest," or "designed to meet the needs of members," those statements are non-actionable puffery, not specific and measurable factual claims. *See Levit v. Nature's Bakery, LLC*, 767 F. Supp. 3d 955, 964 (2025); *Morris v. Princess Cruises, Inc.*, 236 F.3d 1061, 1068 (9th Cir. 2001).

G. The Opposition Does Not Salvage Roiz's Deficient ERISA Claims.

1. Roiz Does Not Identify Any Denial of Any Cognizable Benefit.

"To prevail on a claim for benefits, a plaintiff must show that (1) the plan is covered by ERISA, (2) the plaintiff is a participant or beneficiary of the plan, and (3) the plaintiff was wrongfully denied benefits owed under the plan." *Andrew P.*, 2025 WL 3637030, at *2 (citing *Forest Ambulatory Surgical Assocs., L.P. v. United HealthCare Ins. Co.*, No. 10-cv-04911-EJD, 2011 WL 2748724, at *5 (N.D. Cal. July 13, 2011)) (emphasis added). Roiz does not do so here.

The Opposition repackages various access-related allegations as denials of "benefits"—including "in-network mental health coverage," "timely and geographically accessible" services, a "reliable, up-to-date directory," scheduling assistance, an appointment within 10 business days, and out-of-network coverage at in-network rates. (Opp. at 26.) But neither the FAC nor the Opposition alleges a specific request for any such benefit, a denied authorization or claim, a grievance or appeal over any such denial, or completion of the plan's review process. Those omissions are fatal. "Indispensable is the requirement that 'a plaintiff who brings a claim for benefits under ERISA must identify a specific plan term that confers the benefit in question.'" *Raygoza v. ConAgra Foods, Inc. Welfare Benefit Wrap Plan*, 2016 WL 9454419, at *5 (C.D. Cal. Nov. 4, 2016). Roiz identifies no request, claim, grievance, or appeal submitted to Blue Shield whereby Roiz even requested—much less would be entitled to—benefits pursuant to any plan term. Blue Shield is not required to provide benefits in a vacuum. Statutory access standards (including appointment-timing requirements or network-adequacy mandates imposed on health plans generally) cannot be recharacterized as individually enforceable ERISA "benefits" owed to a specific participant without a request, claim, or denial. Nor do references to provider directories, appointment timing, or assistance locating care become independently recoverable ERISA "benefits" simply because Plaintiffs

label them as such.

Roiz's claim independently fails for lack of exhaustion. The "general rule governing ERISA claims [is] that a claimant must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court." *Diaz v. United Agr. Emp. Welfare Ben. Plan & Tr.*, 50 F.3d 1478, 1483 (9th Cir. 1995); *Korman v. ILWU-PMA Claims Off.*, No. 218CV07516SVWJPR, 2019 WL 1324021 (C.D. Cal. Mar. 19, 2019). The Platinum Full Plan sets out a formal grievance and appeal procedure and states that a member "may have the right to bring a civil action under Section 502(a) of ERISA" only after "all required reviews" have been completed and a claim remains unapproved. (RJN, Ex. 1 at p. 98; RJN Ex. 2 at p. 99.) That cannot reasonably be read as permitting a participant to bypass formal internal review altogether.

Roiz's contrary argument—that the process is "optional" because the plan uses words like "can"—ignores the plan's express limitation on the right to sue. And even on her own framing, the FAC alleges only that she "repeatedly called customer service." Opp. at 25–26; (*see* FAC ¶¶ 58, 61.) That is not exhaustion where the plan separately identifies further review steps, including submitting a grievance, appealing a denial, and seeking DMHC review. (RJN, Ex. 1 at p. 96–98; RJN Ex. 2 at p. 97–99.) Nor can Roiz salvage the claim through a belated futility argument raised only in opposition. The FAC pleads no futility, and "the complaint may not be amended by the briefs in opposition to a motion to dismiss." *Cyph, Inc. v. Zoom Video Commc'ns, Inc.*, 642 F. Supp. 3d 1034, 1043 (N.D. Cal. 2022). In any event, "bare assertions of futility are insufficient to bring a claim within the futility exception." *Diaz*, 50 F.3d at 1485; *see also Grenell v. UPS Health & Welfare Package*, 390 F. Supp. 2d 932, 935–36 (C.D. Cal. 2005).

2. Roiz's Fiduciary-Duty Claim Seeks Unavailable Relief.

Roiz's fiduciary duty claim is duplicative of her ERISA benefits claim. Both are predicated on the same alleged deficiencies in Defendants' provider network and directory. (*See* FAC ¶¶ 390–96, 402.) The only material difference is the requested relief. But § 1132(a)(3) relief is "appropriate" only where ERISA does not otherwise provide an adequate remedy. *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996); *Bowles v. Rease*, 198 F.3d 752, 760 (9th Cir. 1999); *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010). The Opposition effectively concedes as much by acknowledging that Roiz seeks individual relief, if at all, under § 1132(a)(3). (Opp. at 30, fn. 14.) Because ERISA already provides a vehicle to redress an alleged denial of benefits, Roiz cannot repackage the same theory as a fiduciary-duty claim

simply by requesting equitable relief. *Wise*, 600 F.3d at 1190; *see also Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 372 (6th Cir. 2015); *Katz v. Comprehensive Plan Of Grp. Ins.*, 197 F.3d 1084, 1088 (11th Cir. 1999); *Kennedy v. Metro. Life Ins. Co.*, 357 F. Supp. 2d 1346, 1348 (M.D. Fla. 2005).

H. Roiz Does Not Sufficiently Plead Disparity Under MHPAEA.

The MHPAEA claim fails because Plaintiffs do not plead a specific treatment limitation or a plausible comparator-based disparity. A facial parity claim requires identification of the "relevant treatment limitation supporting that charge." *A.Z. by & through E.Z. v. Regence Blueshield*, 333 F. Supp. 3d 1069, 1081 (W.D. Wash. 2018). The FAC alleges no specific discriminatory financial requirement, quantitative treatment limitation, nonquantitative treatment limitation, or more stringent process or standard applied to MH/SUD claims versus medical/surgical claims. That is insufficient. *Andrew P.*, 2025 WL 3637030, at *3.

Nor does *Ryan S. v. UnitedHealth Group, Inc.*, 98 F.4th 965 (9th Cir. 2024), change the result. *Ryan S.* did not eliminate the need to identify a challenged limitation, process, or standard and plead facts supporting disparity; it addressed what may suffice where plaintiffs identify a specific challenged practice and allege facts showing that it applied more restrictively to MH/SUD benefits. Here, Plaintiffs offer only generalized conclusions that Blue Shield maintained poorer mental health network adequacy and directory accuracy than for medical/surgical care, without identifying any concrete comparator, process, strategy, evidentiary standard, or factor actually applied more stringently to MH/SUD claims. *Id.* at 973 (plaintiff must "allege facts sufficient to suggest that the challenged process is specific to [mental health] claims"); *Andrew P.*, 2025 WL 3637030, at *3 (dismissing where plaintiff alleged only that "the Plan violated the [MHPAEA] 'in application or effect'" without identifying specific disparate treatment). Plaintiffs here fare no better: alleging that Blue Shield "maintained network adequacy and directory accuracy standards that were much lower for mental health providers than medical providers" (Opp. at 31) is a conclusory label, not a factual allegation. Roiz does not identify *what specific standard* Blue Shield applies to medical or surgical providers, how it differs from the mental health standard, or any factual basis—such as a comparative audit, plan document, or internal policy—from which the Court could plausibly infer disparate treatment.

That defect is fatal whether the claim is framed as facial or as-applied. The FAC offers only

"formulaic recitations of the law without factual support," and therefore "fail[s] to specifically allege a disparity between mental health benefits and medical or surgical benefits." *Andrew P.*, 2025 WL 3637030, at *3; *see also A.H. by & through G.H. v. Microsoft Corp. Welfare Plan*, No. C17-1889-JCC, 2018 WL 2684387, at *7 (W.D. Wash. June 5, 2018). Even assuming network adequacy or directory accuracy theories could, in some circumstances, implicate a nonquantitative treatment limitation, the FAC still does not identify a specific policy, process, strategy, evidentiary standard, or factor used more stringently for MH/SUD than for medical/surgical providers. Anecdotes about difficulty locating mental health providers do not plausibly plead the comparative disparity the statute requires.

Finally, the MHPAEA claim independently fails because Roiz alleges no injury separate from the asserted non-payment of plan benefits and no inadequacy in the remedy afforded by § 1132(a)(1)(B). *See Kenneth P. v. Blue Shield of California*, 2018 WL 11437253, at *2 (N.D. Cal. Dec. 12, 2018); *Varity Corp.*, 516 U.S. at 515. Nor does she clearly articulate equitable relief unavailable under her other ERISA theories. (*See* FAC ¶¶ 409–16.) For that reason as well, the MHPAEA claim should be dismissed.

III. CONCLUSION

For the reasons set forth above and in the Motion, Blue Shield respectfully requests that the Court dismiss the First Amended Complaint with prejudice.

DATE: JULY 7, 2026

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