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herein as "Blue Shield of California")

14 **UNITED STATES DISTRICT COURT**  
15 **NORTHERN DISTRICT OF CALIFORNIA**  
16 **SAN FRANCISCO COURTHOUSE**

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

20 PLAINTIFFS,

21 v.

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

25 DEFENDANTS.

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

**DEFENDANT CALIFORNIA PHYSICIANS'  
SERVICE DBA BLUE SHIELD OF  
CALIFORNIA'S NOTICE OF MOTION AND  
MOTION TO DISMISS PLAINTIFFS' FIRST  
AMENDED COMPLAINT; MEMORANDUM  
OF POINTS AND AUTHORITIES IN  
SUPPORT THEREOF**

*[Filed Concurrently with [Proposed] Order  
Granting Motion to Dismiss; Request for Judicial  
Notice; Declaration of Veronica Barcena in  
Support of Request for Judicial Notice; and  
[Proposed] Order Granting Request for Judicial  
Notice]*

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

1 TO THE HONORABLE COURT, ALL PARTIES, AND THEIR COUNSEL OF RECORD:

2 PLEASE TAKE NOTICE that on August 5, 2026, at 2:00 p.m., or as soon thereafter as the matter  
3 may be heard, via Zoom videoconference (connection information will be provided by the Court via ECF  
4 notice) for Courtroom 2 of the above-entitled Court, located at 450 Golden Gate Avenue, San Francisco,  
5 CA 94102, Defendant California Physicians’ Service dba Blue Shield of California (“Blue Shield”) will,  
6 and hereby does, move this Court, pursuant to Fed. R. Civ. P. 12(b)(6), for an Order dismissing all of the  
7 claims asserted in the First Amended Complaint (“FAC”) filed by Plaintiffs Jenniffer Roiz, Claudine  
8 Castillo, Candyce Marto, and Kevin Maedel (collectively, “Plaintiffs”) on March 24, 2026.

9 This Motion is based upon this Notice of Motion, the attached Memorandum of Points and  
10 Authorities, [Proposed] Order on the Motion, Request for Judicial Notice, Declaration of Veronica  
11 Barcena in Support of Request for Judicial Notice, [Proposed] Order Granting Request for Judicial Notice,  
12 and supporting materials filed concurrently therewith, the pleadings and records on file in this action, and  
13 upon such oral or documentary evidence or testimony that may be presented to this Court at or before the  
14 hearing on this Motion.

15  
16 DATE: MAY 5, 2026

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1 **I. INTRODUCTION**

2 Plaintiffs Jenniffer Roiz, Claudine Castillo, Candyce Marto, and Kevin Maedel (collectively,  
3 “Plaintiffs”) ask this Court to certify a sweeping statewide class and to transform their personal difficulties  
4 scheduling mental health appointments into over a dozen claims under the Employee Retirement Income  
5 Security Act (“ERISA”), state contract law, California’s Unfair Competition Law (“UCL”), and tort  
6 against California Physicians’ Service dba Blue Shield of California (“Blue Shield”) and three Magellan  
7 entities (collectively with Blue Shield, “Defendants”). The First Amended Complaint (“FAC”) falls far  
8 short of pleading any actionable claims.

9 Stripped of rhetoric about a national “mental health crisis” and “ghost networks,”<sup>1</sup> the FAC’s  
10 allegations are narrow and individual. Plaintiffs’ grievance is not that Blue Shield denied a claim, refused  
11 to honor a specific plan promise, or rejected a request to treat a particular out-of-network provider as  
12 in-network. Rather, they allege that they found it “difficult” to locate an in-network mental health provider  
13 accepting new patients at a convenient time and place, and from those anecdotes, leap to the conclusion  
14 that Blue Shield’s mental health networks and directories are “largely illusory” on a class-wide basis.

15 The pleading defects are fundamental. The FAC relies heavily on language from Blue Shield’s  
16 website and plan documents which purportedly tout the strength of Blue Shield’s mental health network.  
17 However, Plaintiffs fail to tie this generalized language to any specific misconduct, violation of plan terms,  
18 or denial of benefits by Blue Shield. Instead, the FAC focuses on the theory that Plaintiffs expected Blue  
19 Shield’s mental health network to be “robust” and “comprehensive,” and that these expectations were not  
20 met. These vague descriptors are insufficient to support an actionable claim under contract, tort, or  
21 otherwise. Although Plaintiffs invoke a host of statutes and regulations, they do not plausibly plead a  
22 violation of any “borrowed” law. Further, apart from non-actionable, generalized statements, Plaintiffs  
23 never identify a concrete statement by Blue Shield that they actually saw and reasonably relied upon in  
24 choosing their plans. They simply assert that their premiums were “inflated” and their coverage  
25

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26 <sup>1</sup> “Ghost networks” is not a legal or technical term; it is a rhetorical label coined in advocacy, media, and  
27 plaintiffs’ litigation to describe alleged discrepancies between provider directories and real-time  
28 appointment availability. The phrase obscures the undisputed, broader reality that there is a nationwide  
shortage of behavioral health providers and increasing demand for mental health services—conditions that  
affect all payors and markets, not uniquely Blue Shield. Dressing those systemic access challenges up as  
“ghost networks” does not convert them into actionable misstatements or plan-specific violations.

1 “worthless,” without tying those labels to any comparison, metric, or quantifiable loss.

2 At bottom, this is an effort to convert the ordinary realities of a strained behavioral-health market—  
3 difficulties in finding convenient, in-network mental health appointments—into sweeping claims of fraud,  
4 parity violations, network inadequacy, and “inflated premiums” on behalf of a statewide class. The FAC  
5 is long on policy commentary and conclusory labels but short on the specific, well-pleaded facts that Rule  
6 8, Rule 9(b), and controlling precedent require. Because Plaintiffs have not alleged any actionable conduct  
7 by Blue Shield, and because many of their claims are independently barred by ERISA standing, failure to  
8 exhaust, statutes of limitation, the economic loss rule, and the existence of governing contracts, the Court  
9 should dismiss the FAC in its entirety, with prejudice.

10 **II. STATEMENT OF ISSUES TO BE DECIDED**

11 1. Whether Plaintiffs sufficiently allege a short and plain statement of the claims, as required  
12 by Federal Rule of Civil Procedure 8(a)(2), where the FAC lumps all Defendants together across thirteen  
13 causes of action and fails to specify which Defendant engaged in which alleged misconduct.

14 2. Whether the Court should dismiss Plaintiffs’ breach of contract claims for failure to state  
15 a claim, including failure to plead contractual terms Blue Shield allegedly breached.

16 3. Whether the Court should dismiss Plaintiffs’ breach of contract and breach of implied  
17 covenant of good faith and fair dealing claims for failure to plead appreciable and actual damages.

18 4. Whether the Court should dismiss Plaintiffs’ second cause of action for failure to  
19 sufficiently plead third-party beneficiary status.

20 5. Whether Plaintiffs’ bad faith claims should be dismissed for failure to allege a denied  
21 benefit and/or because they are duplicative of Plaintiffs’ breach of contract claims.

22 6. Whether the Court should dismiss Plaintiffs’ UCL claim for failure to plausibly allege any  
23 unlawful, unfair, or fraudulent conduct, and for failure to plead any loss of money or property.

24 7. Whether the Court should dismiss Plaintiffs’ intentional and negligent misrepresentation  
25 claims for failure to plead with particularity as required by Federal Rule of Civil Procedure 9(b).

26 8. Whether the economic loss doctrine, barring tort recovery for purely economic losses  
27 arising from contractual relationships, bars Plaintiffs’ intentional and negligent misrepresentation claims.

28 9. Whether the Court should dismiss Plaintiffs’ restitution for unjust enrichment claim

1 because California does not recognize a standalone cause of action for unjust enrichment.

2 11. Whether the Court should dismiss Plaintiffs’ claim under 29 U.S.C. § 1132(a)(1)(B) for  
3 failure to state a claim, including failure to identify specific plan provisions entitling Plaintiffs to benefits.

4 12. Whether the Court should dismiss Plaintiffs’ claim under 29 U.S.C. § 1132(a)(1)(B) for  
5 failure to exhaust administrative remedies as required by ERISA.

6 13. Whether the Court should dismiss Plaintiffs’ claim for equitable relief under 29 U.S.C.  
7 §§ 1109(a), 1132(a)(2) & (a)(3) as duplicative of their benefits claim, where Plaintiffs fail to state a claim,  
8 and fail to allege a separate and distinct injury beyond the alleged non-payment of plan benefits.

9 14. Whether the Court should dismiss Plaintiffs’ claim for equitable relief under 29 U.S.C.  
10 §§ 1109(a), 1132(a)(2) & (a)(3), where Plaintiffs fail to allege liability to the plan.

11 15. Whether the Court should dismiss Plaintiffs’ Mental Health Parity and Addiction Equity  
12 Act (“MHPAEA”) claim because the FAC fails to allege disparity of treatment compared to  
13 medical/surgical benefits and fails to allege an injury separate from the non-payment of plan benefits.

14 **III. FACTUAL BACKGROUND**

15 **A. Plaintiffs’ Shotgun Putative Class Action FAC**

16 Plaintiffs assert thirteen causes of action on behalf of a putative statewide class against Blue Shield  
17 and three separate Magellan entities. (*See generally* FAC.) They repeatedly allege that “Defendants”  
18 misled them, but largely fail to distinguish among the four corporate defendants or identify which entity  
19 supposedly did what. (*Id.* ¶¶ 17–20, 173–174, 182–183, 185, 194–199, 206–212.)

20 Each Plaintiff is enrolled in a Blue Shield health plan. (*Id.* ¶¶ 14–16.) When describing why they  
21 chose their plans, however, they allege only that they generally relied on unspecified “marketing  
22 materials,” “website[s],” “provider directories,” and “plan documents.” (*Id.* ¶¶ 9, 53, 73, 99, 111.) They  
23 do not point to any particular statement that they saw, when they saw it, where they saw it, or who made  
24 it. Nor do Plaintiffs allege any non-conclusory facts showing that Defendants’ directories or networks are  
25 deficient in relation to any concrete benchmark. They do not plead that any alternative plan they actually  
26 considered offered a superior provider directory or materially different network experience in practice.  
27 Instead, they simply describe difficulty locating convenient mental health appointments and then  
28 conclusorily assert that Defendants’ directories are “ghost networks” and their conduct is unlawful on a

1 class-wide basis. The gravamen of the pleading is that Plaintiffs found it “difficult” to locate a convenient  
2 in-network mental health provider accepting new patients, so they now extrapolate that Defendants’ entire  
3 mental health networks and directories are “largely illusory.” (*Id.* ¶¶ 2, 8, 61, 228, 342, 363.)

4 Plaintiffs plead no concrete facts showing that Blue Shield’s mental health network as a whole  
5 failed to meet governing standards, and—critically—no allegations that they affirmatively invoked the  
6 plan processes they now claim were violated, such as requesting approval to treat an out-of-network  
7 provider as in-network because no in-network provider was available. (*See, e.g., id.* ¶¶ 199–205  
8 (describing those rights in EOCs, but not alleging any Plaintiff actually submitted such a request).)

## 9 **B. Plaintiffs’ Specific Allegations**

### 10 **1. Jenniffer Roiz**

11 Roiz alleges she has been enrolled in Blue Shield’s Platinum Full PPO 0/10 OffEx plan (the  
12 “Platinum Full Plan”) since August 2024. (FAC ¶¶ 51, 55.) The Platinum Full Plan is an  
13 employer-sponsored ERISA plan. (*Id.* ¶ 128.) She allegedly chose it because she “understood it to offer  
14 the most comprehensive coverage” and it “offered \$0 co-payment for in-network mental health services,”  
15 not because of any particular representation about provider counts or directory accuracy. (*Id.* ¶ 52.) She  
16 does not allege that any competing plan offered a superior provider directory, network, or access to mental  
17 health care. (*Id.*) After enrollment, she learned that her existing therapist was not in-network and began  
18 searching for an in-network option. (*Id.* ¶¶ 57–59.) She searched Magellan’s “provider directory by  
19 filtering for female practitioners who specialized in grief and were accepting new patients.” (*Id.* ¶ 60.) She  
20 alleges she called ten providers. (*Id.*) She then “called Blue Shield’s mental health line (which was  
21 operated by Magellan) to submit an Access Complaint,” was told the online directory might not be current,  
22 and was sent a hardcopy directory, which she contends listed the same providers. (*Id.* ¶ 61.) Roiz asserts  
23 that Defendants did not unilaterally “offer” plan remedies, but does not allege she pursued or requested  
24 those remedies. (*Id.* ¶ 62.) Instead, Roiz asserts that she “continued to see her existing therapist, paying  
25 \$150 out-of-pocket per weekly session.” (*Id.* ¶ 63.) She does not allege she submitted any denied claim  
26 for benefits, filed a grievance or appeal, or affirmatively requested that Blue Shield treat the therapist as  
27 in-network because no in-network provider was available.

### 28 **2. Claudine Castillo**

1 Castillo and her 16-year-old son are enrolled in the San Francisco Health Service System Trio  
2 HMO plan. (FAC ¶¶ 71, 75.) She alleges she believed Blue Shield offered more comprehensive coverage  
3 and better service than another insurer and that she relied on misrepresentations about coverage and  
4 network breadth when enrolling, but, as with the other Plaintiffs, identifies no specific statement she  
5 actually saw or relied on. (*Id.* ¶ 72.) Nor does she plead any facts suggesting that the alternative plan had  
6 a superior directory, network, or access mental health providers. (*Id.*)

7 In August 2025, Castillo called Blue Shield for help locating a provider for her son. (*Id.* ¶ 82.)  
8 Blue Shield referred her to Magellan, which provided “several lists of providers.” (*Id.* ¶ 83.) Castillo  
9 “called the providers who were within 45 minutes of her home.” (*Id.* ¶ 84.) She called Magellan again a  
10 month later and received another list of providers, whom she considered not “within a reasonable  
11 distance.” (*Id.* ¶ 86.) Castillo asserts Defendants did not “offer” to unilaterally exercise plan remedies, but  
12 does not allege that she asked Blue Shield to authorize any specific out-of-network provider at in-network  
13 cost-sharing, that she submitted a claim or grievance, or that any such request was denied. (*Id.* ¶ 87.)

### 14 3. Candyce Marto and Kevin Maedel

15 Marto and Maedel, a married couple, have been enrolled in a Blue Shield HMO plan through  
16 Maedel’s public-sector employer since 2000 and, during the relevant period, in the Trio HMO Per Admit  
17 20-250 plan. (FAC ¶¶ 94, 109.) They allege they chose Blue Shield because they believed it offered more  
18 comprehensive coverage and better service than other unnamed “options” and that they “relied on Blue  
19 Shield’s misrepresentations about the breadth of the provider network”; yet, they do not identify any  
20 particular misstatement. (*Id.* ¶¶ 95, 110.) Nor do they allege that the alternative “options” they considered  
21 offered a superior provider directory, network, or access to mental health providers.

22 In 2022, Marto “decided to look for regular talk therapy providers” using Blue Shield’s directory,  
23 was redirected to Magellan, and obtained a list of “hundreds” of supposed in-network providers. (*Id.* ¶  
24 101.) She alleges that roughly fifteen “were out of network, were unavailable to treat Ms. Marto, or did  
25 not offer” certain services. (*Id.* ¶ 102.) She does not allege that she requested authorization of an  
26 out-of-network therapist at in-network rates, or that any claim or grievance was wrongfully denied.  
27 Instead, she states that, because her HMO plan does not cover out-of-network mental health services, she  
28 “has gone without care for the last four years.” (*Id.* ¶ 103.)

1 Maedel alleges that during “the last several years” he periodically searched for a therapist using  
 2 the provider directory and, most recently in August 2025, called providers from a Magellan-generated list  
 3 “within twenty miles of their home,” none of whom were both in-network and accepting new patients. (*Id.*  
 4 ¶¶ 113, 116.) He alleges he “has gone without care for two years.” (*Id.* ¶ 118.) Like Marto, he does not  
 5 allege that he ever affirmatively asked Blue Shield to extend in-network benefits to any particular  
 6 out-of-network provider based on network inadequacy, or that Blue Shield denied any such request.

7 From these four anecdotes, they leap to the conclusion that Blue Shield’s mental health directories  
 8 are “ghost networks” and that Blue Shield has systemically violated ERISA, state law, and its contracts.

### 9 C. The Plans at Issue

#### 10 1. Platinum Full PPO 0/10 OffEx Plan

11 In 2024 and 2025, Roiz was enrolled in the Platinum Full PPO 0/10 OffEx Plan. (*Id.* at ¶ 14.) The  
 12 2024 Evidence of Coverage and 2025 Evidence of Coverage (“Platinum Full Plan EOCs”) are the  
 13 operative plan documents and governing contracts for the Platinum Full Plan, and are governed by ERISA.  
 14 (Request for Judicial Notice (“RJN”), at Exs. 1 & 2.) The EOCs provide that “[m]ental health and  
 15 substance use disorder Benefits are provided through Blue Shield’s Mental Health Service Administrator  
 16 (MHSA).” (RJN, at Exs. 1 & 2, p. 66-68.) Outpatient services by an MHSA Participating Provider cost  
 17 members \$10 per visit, while 40% of the total service amount is not covered when using an MHSA Non-  
 18 Participating Provider. (*Id.*) With regards to administrative remedies, the EOCs provide:

#### 19 Grievance Process

20 Blue Shield has a formal grievance process to address any complaints,  
 21 disputes, requests for reconsideration of health care coverage decisions  
 22 made by Blue Shield, or concerns with the quality of care you received from  
 23 a provider. Blue Shield will receive, review, and resolve your grievance  
 within the required timeframes.

#### 24 Submitting a grievance

25 If you have a question about your Benefits or any action taken by Blue  
 26 Shield (or a Benefit Administrator), your first step is to make an inquiry  
 27 through Customer Service. If Customer Service is not able to fully address  
 28 your concerns, you can then submit a grievance or ask the Customer Service  
 representative to submit one for you. If Blue Shield denies authorization or  
 coverage for health care services, you can appeal the denial and Blue Shield  
 will reconsider your request. [...]

1 (RJN, Ex.1 at p. 96-97; RJN, Ex. 2 at, p. 97-98.) Further, the Platinum Full Plan EOCs’ grievance  
2 process includes a mechanism for the member to appeal Blue Shield’s decisions to the DMHC.

3 **California Department of Managed Health Care review**

4 The California Department of Managed Health Care is responsible for  
5 regulating health care service plans. If you have a grievance against your  
6 health plan, you should first telephone your health plan at (888) 256-3650  
7 and use your health plan’s grievance process before contacting the  
8 Department. [...] If you need help with a grievance involving an emergency,  
9 a grievance that has not been satisfactorily resolved by your health plan, or  
10 a grievance that has remained unresolved for more than 30 days, you may  
11 call the Department for assistance. You may also be eligible for an  
12 Independent Medical Review (IMR). If you are eligible for IMR, the IMR  
13 process will provide an impartial review of medical decisions made by a  
14 health plan [...].

15 (RJN, Ex. 1 at p. 97-98; RJN, Ex. 2 at p. 98-99.) Additionally, the Platinum Full Plan EOCs state:

16 **ERISA review**

17 If your Employer’s health plan is governed by the Employee Retirement  
18 Income Security Act (“ERISA”), you may have the right to bring a civil  
19 action under Section 502(a) of ERISA if all required reviews of your claim  
20 have been completed and your claim has not been approved.

21 (RJN, Ex. 1 at p. 98; RJN, Ex. 2 at p. 99.)

22 **2. TRIO HMO Basic Plan and TRIO HMO Per Admit 20-250 Plan**

23 The health plan at issue for Castillo is the TRIO HMO Basic Plan in effect in 2025, the health  
24 plans at issue for Maedel are the TRIO HMO Per Admit 20-250 Plans in effect from 2020-2025, and the  
25 health plans at issue for Marto are the TRIO HMO Per Admit 20-250 Plans in effect from 2022-2025.

26 (RJN, Exs. 3–4; RJN, Exs. 5–6; RJN, Exs. 7–10.)

27 **IV. LEGAL STANDARD**

28 Under Rule 12(b)(6), a claim must be dismissed if it “fail[s] to state a claim upon which relief can  
be granted.” Fed. R. Civ. P. 12(b)(6). Rule 8 requires “a short and plain statement of the claim showing  
that the pleader is entitled to relief.” To survive dismissal, a complaint must plead “enough facts to state  
a claim to relief that is plausible on its face.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Bell Atl. Corp.*  
*v. Twombly*, 550 U.S. 544, 548 (2007). A plaintiff must allege “factual content that allows the court to  
draw the reasonable inference that the defendant is liable,” and “[w]here the well-pleaded facts do not

1 permit the court to infer more than the mere possibility of misconduct,” the complaint “has not shown” an  
 2 entitlement to relief. *Iqbal*, 556 U.S. at 678–79. This is a “context-specific task” requiring the court to  
 3 draw on its “judicial experience and common sense.” *Id.* at 679.

4 While well-pleaded factual allegations are accepted as true, the Court is not “required to accept as  
 5 true allegations that are merely conclusory, unwarranted deductions of fact, or unreasonable inferences.”  
 6 *Sprewell v. Golden State Warriors*, 266 F.3d 979, 988 (9th Cir. 2001). “[W]hen the allegations in a  
 7 complaint, however true, could not raise a claim of entitlement to relief, this basic deficiency should . . .  
 8 be exposed at the point of minimum expenditure of time and money by the parties and the court.”  
 9 *Twombly*, 550 U.S. at 558 (internal quotation marks omitted); *see also Doe I v. Wal-Mart Stores, Inc.*,  
 10 572 F.3d 677, 683 (9th Cir. 2009); *Iqbal*, 556 U.S. at 678–79.

11 When claims sounding in fraud are alleged, “a party must state with particularity the circumstances  
 12 constituting fraud.” Fed. R. Civ. P. 9(b). This heightened standard applies to UCL claims grounded in  
 13 fraud. *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1127 (9th Cir. 2009); *Vess v. Ciba-Geigy Corp. USA*,  
 14 317 F.3d 1097, 1102–05 (9th Cir. 2003). Allegations must be “specific enough to give defendants notice  
 15 of the particular misconduct which is alleged to constitute the fraud charged,” *Semegen v. Weidner*, 780  
 16 F.2d 727, 731 (9th Cir. 1985), including the “who, what, when, where, and how of the misconduct  
 17 charged,” “what is false or misleading about a statement, and why it is false.” *United States v. United*  
 18 *Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (internal quotation marks omitted).

## 19 **V. ARGUMENT**

### 20 **A. Plaintiffs Fail to Give Defendants Fair Notice.**

21 The FAC is a shotgun pleading that flouts Rule 8’s requirement of a “short and plain statement of  
 22 the claim.” Fed. R. Civ. P. 8(a)(2); *see Rodriguez v. Just Brands USA, Inc.*, 2021 WL 1985031, at \*6 (C.D.  
 23 Cal. May 18, 2021) (shotgun pleadings fail to give adequate notice of claims). Apart from nominally  
 24 separating out two causes of action against the Magellan defendants, the FAC otherwise takes a scattershot  
 25 approach and repeatedly attributes alleged misconduct to undifferentiated “Defendants” across thirteen  
 26 causes of action without specifying which entity supposedly did what to which Plaintiff. *See, e.g.*, FAC  
 27 ¶¶ 172–174, 182–184, 194–200, 207–216; *cf. In re KSL Media Inc.*, 2016 WL 1171956, at \*1 (Bankr.  
 28 C.D. Cal. Mar. 23, 2016) (pleading “disjointed and vague” where complaint does not specify which

1 allegations apply to which defendant). This improper lumping deprives each defendant of fair notice and  
2 warrants dismissal of the FAC in its entirety.

3 **B. Plaintiffs’ Contract-Based Claims (Causes of Action 1, 2, 4, 5) Should Be Dismissed.**

4 **1. Plaintiffs Fail to Identify Sufficiently Definite Contract Terms.**

5 The First Cause of Action asserts breach of direct subscriber contracts between Plaintiffs and  
6 Defendants; the Second Cause of Action asserts breach of contracts between public-sector employers and  
7 Blue Shield. (FAC ¶¶ 250–279.) For both, Plaintiffs must plead the contractual terms “either in haec verba  
8 or according to legal effect” so the Court can “discern at least what material obligation of the contract the  
9 defendant allegedly breached.” *Langan v. United Servs. Auto. Ass’n*, 69 F. Supp. 3d 965, 979–80 (N.D.  
10 Cal. 2014) (quotation omitted). “To be enforceable, a promise must be definite enough that a court can  
11 determine the scope of the duty and the limits of performance must be sufficiently defined to provide a  
12 rational basis for the assessment of damages.” *Ladas v. California State Auto. Assn.*, 19 Cal. App. 4th 761,  
13 770 (1993). “An amorphous promise [...] cannot rise to the level of a contractual duty.” *Id.* at 771.

14 Plaintiffs heavily rely on statements on Blue Shield’s website, including that “[o]ur network of  
15 doctors and hospitals is designed to meet the needs of members,” that Blue Shield has a “full selection of  
16 behavioral health providers,” and that Blue Shield’s “networks are among the largest in California.” (FAC  
17 ¶¶ 255–257.) As a threshold matter, these statements are on Blue Shield’s website, not on any contractual  
18 documents to which Plaintiffs are parties. (*See id.*) While Plaintiffs allege that their plan documents  
19 “direct” members to the Blue Shield website, the FAC provides no allegations to support the conclusion  
20 that the entire Blue Shield website is incorporated by reference into plan documents. Thus, statements on  
21 Blue Shield’s website cannot serve as the basis for Plaintiffs’ contract claims. However, even if those  
22 statements were part of any contractual documents, they are “amorphous” statements that cannot support  
23 a breach of contract claim. *Ladas*, 19 Cal. App. 4th at 770–71. Statements that Blue Shield’s networks are  
24 “among the largest in California,” or that Blue Shield has a “full selection” of providers, or that Blue  
25 Shield’s network is “designed to meet” members’ needs, are general descriptors. They are not “definite”  
26 promises capable of being enforced and cannot support a breach of contract claim. (*Id.*)

27 Plaintiffs go on to allege that the plan documents require Defendants to “provide health insurance  
28 benefits, including mental health benefits” and to “comply with all applicable state and federal statutes

1 and regulations.” (*See, e.g.*, FAC ¶¶ 267–275.) However, Plaintiffs never quote or describe specific  
2 provisions of the employer contracts that expressly impose the alleged duties to maintain particular  
3 network sizes, guarantee appointment availability, or provide benefits in the manner they claim. (*See id.*  
4 ¶¶ 133–140) (describing coverage generally, but not identifying a term promising coverage in the  
5 circumstances alleged). Again, these indefinite statements cannot support a breach of contract claim.

6 To the extent Plaintiffs anchor their contract-based claims on vague statements regarding the  
7 robustness of Blue Shield’s mental health provider network, such amorphous and indefinite statements  
8 cannot support a breach of contract claim. *Langan*, 69 F. Supp. 3d at 980; *Ladas*, 19 Cal. App. 4th at 770–  
9 71. The First and Second Causes of Action therefore fail to state a claim and must be dismissed.

## 10 **2. Plaintiffs Do Not Sufficiently Plead Breach of any Contract Term.**

11 Plaintiffs’ First and Second Causes of Action fail for the independent reason that they fail to allege  
12 breach by Blue Shield. To bring a breach of contract claim, Plaintiffs must sufficiently plead Blue Shield’s  
13 breach of contractual terms. *Fishell v. Nationwide Mut. Ins. Co.*, No. 2:23-CV-00027-DJC-DB, 2023 WL  
14 4626633, at \*5 (E.D. Cal. July 19, 2023). “Conclusory allegations that a defendant breached a contract  
15 are insufficient,” particularly where a plaintiff fails to “provide any examples” of breach. *Franconero v.*  
16 *UMG Recordings Inc.*, No. CV123382JGBAGRX, 2013 WL 11238481, at \*6 (C.D. Cal. Sept. 23, 2013).

17 Conclusory allegations are all Plaintiffs offer here. Plaintiffs’ First Cause of Action alleges Blue  
18 Shield “breached” by “failing to provide meaningful coverage,” “failing to update and convey accurate  
19 information,” and “failing to adhere to promises” regarding out-of-network care. (FAC ¶¶ 263–264.)  
20 Plaintiffs’ Second Cause of Action likewise alleges Blue Shield “breached” employer contracts by failing  
21 to provide an accurate directory, failing to maintain an adequate network, and failing to comply with  
22 various laws. (FAC ¶¶ 273–278.) But those are conclusions, not facts showing an actual breach. Without  
23 “provid[ing] any examples” of breach apart from Plaintiffs’ anecdotal and subjective difficulties with  
24 obtaining mental health care, those allegations are insufficient. *Franconero*, 2013 WL 11238481, at \*6.

25 Plaintiffs further allege that Blue Shield’s health plans will “cover and arrange needed services for  
26 you from an out-of-network provider” where an in-network provider is unavailable. (*See, e.g.*, FAC ¶  
27 260.) However, there is no tether between this provision and any specific breaching conduct by Blue  
28 Shield. Plaintiffs Castillo, Marto, and Maedel (the plaintiffs bringing breach of contract claims) each

1 allege that they were unable to locate an appropriate in-network mental health provider. (*See, e.g.*, FAC  
2 ¶¶ 76–89; 101–106; 113–119.) However, the FAC contains no allegations that Plaintiffs actually informed  
3 Blue Shield that there were no in-network providers, nor that they requested that Blue Shield arrange for  
4 services with an appropriate out-of-network provider. (*See, e.g.*, FAC ¶¶ 101–106; 113–119.)

5 For example, Plaintiff Castillo alleges that she was “[u]nable to find an in-network provider within  
6 an hour’s drive from her home who was accepting new patients.” (FAC ¶ 78.) As an initial matter, Blue  
7 Shield has no control over whether providers in its network accepted Castillo as a patient; nor does the  
8 FAC allege any contractual term that compels Blue Shield to force in-network providers to accept all Blue  
9 Shield members as patients. Moreover, upon “call[ing] 14 providers” and finding they were “out of  
10 network, were unavailable to treat her, or did not offer the services she required,” Castillo admits that she  
11 “abandoned her search for a psychiatrist [*sic*].” (FAC ¶ 78.) In other words, when Castillo was unable to  
12 find an appropriate provider in-network, she never actually contacted Blue Shield to request coverage  
13 outside of her network. Instead, she “abandoned her search” entirely. Blue Shield cannot breach a  
14 contractual provision to arrange out-of-network care when Blue Shield was never made aware of any such  
15 request in the first place. Any averments of actual breach are similarly absent from Plaintiffs Marto and  
16 Maedel’s allegations. (FAC ¶¶ 93–120.) Thus, glaringly absent from the FAC is any allegation that Blue  
17 Shield actually failed to arrange coverage with an out-of-network provider in any specific instance.

18 Like in *Franconero*, Plaintiffs do not “provide any examples” of Blue Shield violating a specific  
19 contractual obligation. 2013 WL 11238481, at \*6. They allege difficulty finding providers and  
20 dissatisfaction with directory results, but they do not allege facts showing that Blue Shield breached any  
21 specific contractual promise to any Plaintiff. Because Plaintiffs plead only generalizations and conclusions  
22 as to breach, Plaintiffs’ First and Second Causes of Action fail.

### 23 **3. Plaintiffs Do Not Plausibly Plead Contract Damages.**

24 Even if a breach were adequately alleged, the contract and bad faith claims against Blue Shield  
25 (Causes of Action 1–2, 4–5) do not plead “appreciable and actual damage.” *Belluomini v. Citigroup, Inc.*,  
26 2013 WL 3855589, at \*4 (N.D. Cal. July 24, 2013) (quotation omitted). Instead, Plaintiffs offer only  
27 generalized assertions that the supposed breaches “have caused millions of dollars in damages,” caused  
28 them to incur “significant out-of-pocket expenses,” to pay “inflated premiums for a virtually worthless

1 product,” and to suffer “severe emotional and psychological distress.” (FAC ¶¶ 265, 279, 301, 312.)

2 Those allegations are untethered to any particular contractual obligation or to any Plaintiff-specific  
 3 facts. Plaintiffs do not allege, for example, what portion of their monthly contributions they would not  
 4 have paid had they known of the alleged network issues, what specific out-of-pocket amounts they paid  
 5 because a particular contractual promise failed, or how any loss is attributable to a contract breach rather  
 6 than to their own decisions (such as Roiz’s choice to continue with an out-of-network therapist after Blue  
 7 Shield provided three months of in-network coverage). (FAC ¶¶ 57–58, 103, 113–120.) “Nominal  
 8 damages, speculative harm, or threat of future harm” cannot support a contract claim. *Belluomini*, 2013  
 9 WL 3855589, at \*4. The contract counts seek precisely that, and should be dismissed accordingly.

10 **4. Plaintiffs Do Not Adequately Plead Third-Party-Beneficiary Status.**

11 Plaintiffs’ Second Cause of Action should be dismissed because Plaintiffs lack standing to enforce  
 12 a contract between Blue Shield and employers. Under California law, a third party may enforce a contract  
 13 only where “the contracting parties must have intended to benefit that third party, and their intent must  
 14 appear from the terms of the contract.” *Lincoln Alameda Creek v. Cooper Indus., Inc.*, 829 F. Supp. 325,  
 15 329 (N.D. Cal. 1992); *see also Carlson v. Clapper*, 2019 WL 1061743, at \*3 (N.D. Cal. Mar. 6, 2019)  
 16 (dismissing claim where contract was not “expressly for his benefit”).

17 The FAC does not meet that standard. Plaintiffs allege only that they are “intended third-party  
 18 beneficiaries” and that a “motivating purpose” of the employer contracts was for them to benefit. (FAC  
 19 ¶¶ 268, 304.) But those are conclusory assertions. The FAC does not identify any contract language  
 20 showing that Blue Shield and the employers expressly intended to confer enforceable rights on Plaintiffs.  
 21 Such intent must appear from the terms of the contract itself. *Lincoln Alameda Creek*, 829 F. Supp. at 329.  
 22 Absent such allegations, Plaintiffs’ third-party beneficiary theory is conclusory and insufficient.

23 **5. Plaintiffs’ Bad Faith Claims (Causes of Action 4, 5) Are Barred Because No**  
 24 **Benefits Are Due and the Claims Are Duplicative of the Contract Claims.**

25 Plaintiffs’ bad faith claims (Causes of Action 4–5) are barred on multiple independent grounds. It  
 26 is hornbook law that “[a] bad faith claim cannot be maintained unless policy benefits are due.” *Mod. Dev.*  
 27 *Co. v. Navigators Ins. Co.*, 111 Cal. App. 4th 932, 943 (2003); *Love v. Fire Ins. Exch.*, 221 Cal. App. 3d  
 28 1136, 1153 (1990). As explained above, Plaintiffs fail to allege any denial of benefits in the first place.

1 *See supra* Part V.B.1.-2. Plaintiffs’ bad faith claims therefore fail under hornbook insurance law.

2 Plaintiffs’ bad faith claims fail for the additional reason that they are duplicative of their express  
 3 contract claims. A claim for breach of the implied covenant of good faith and fair dealing must “go beyond  
 4 the statement of a mere contract breach.” *P&H Casters Co., Inc. v. P&H Indus., LLC*, 2024 WL 4446546,  
 5 at \*5 (C.D. Cal. Aug. 26, 2024) (quotation omitted). Where the bad faith claim rests on the same alleged  
 6 conduct and seeks the same damages as the contract claim, it is duplicative and must be dismissed. *Id.*;  
 7 *Green Crush LLC v. Paradise Splash I, Inc.*, 2018 WL 4940824, at \*7 (C.D. Cal. Mar. 8, 2018).

8 Here, Plaintiffs allege that Blue Shield breached the implied covenant by failing to maintain  
 9 accurate directories and adequate networks, misrepresenting providers as in-network and accepting new  
 10 patients, failing to assist Plaintiffs in locating accessible in-network care, and requiring out-of-network  
 11 payments where in-network rates should have applied. (FAC ¶¶ 296–297, 308.) Those are the same core  
 12 allegations they advance in support of their First and Second Causes of Action for breach of contract. (*See*,  
 13 *e.g.*, FAC ¶¶ 252–264, 272–279.) The bad faith counts also seek the same damages sought in connection  
 14 with the breach of contract claims. (*Compare* FAC ¶¶ 300–301, 311–312 with FAC ¶¶ 265, 279.) Plaintiffs  
 15 do not identify any separate duty distinct from the contracts themselves, or any injury different from the  
 16 alleged non-performance of those contracts. Their attempt to relabel these theories as “bad faith” is  
 17 therefore superfluous, and the Fourth and Fifth Causes of Action should be dismissed as duplicative.

18 **C. Plaintiffs Have Not Alleged Any Viable Violation of the UCL.**

19 Plaintiffs’ Seventh Cause of Action fails under all three prongs of the UCL—unlawful, unfair, and  
 20 fraudulent—and, to the extent it sounds in fraud, is not pled with the particularity Rule 9(b) requires.

21 **1. Plaintiffs Do Not Plausibly Allege Any “Unlawful” Conduct.**

22 The “unlawful” prong “borrows” violations of other laws, and rises or falls with alleged violations  
 23 of the underlying statute. *Davis v. HSBC Bank*, 691 F.3d 1152, 1168 (9th Cir. 2012) (citing *Cel-Tech*  
 24 *Commc’ns, Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 180 (1999)). It is not sufficient to simply quote  
 25 statutes and allege in conclusory fashion that they were violated. The allegations must plausibly establish  
 26 “that the defendant’s conduct ‘*must violate*’ a borrowed statute or ‘be forbidden by law.’” *Pemberton v.*  
 27 *Nationstar Mortg. LLC*, 331 F. Supp. 3d 1018, 1049 (S.D. Cal. 2018) (emphasis added).

28 Plaintiffs predicate their UCL claim on a wide range of statutes and regulations. (FAC ¶¶ 324–

1 346.) Specifically, Plaintiffs allege that Defendants violated the No Surprises Act, the Affordable Care  
2 Act, and the Internal Revenue Code by failing to provide sufficiently updated provider directories every  
3 90 days. (FAC ¶¶ 325, 327, 329.) However, just as those amorphous allegations are insufficient to support  
4 a breach of contract claim, *see supra* Part V.B.I., they are insufficient to support a UCL claim under the  
5 unlawful prong. *See California Crane Sch., Inc. v. Google LLC*, 722 F. Supp. 3d 1026, 1041 (N.D. Cal.  
6 2024) (plaintiff “cannot bring a UCL claim under the unlawful prong” premised on same allegations as  
7 another claim that was insufficiently pleaded). The FAC contains no allegations regarding the frequency  
8 with which Blue Shield updated provider directories. Plaintiffs merely allege that they were told at  
9 unspecified times that some providers were not within Blue Shield’s network. The conclusion that Blue  
10 Shield violated laws regarding provider directories finds no support in Plaintiffs’ factual allegations.

11 Plaintiffs also allege that Defendants violated the MHPAEA by “providing mental health and  
12 substance use disorder benefits on less favorable terms than medical and surgical benefits.” (FAC ¶ 332.)  
13 However, as explained in greater detail in Part V.F.3., *infra*, the FAC only contains conclusory allegations  
14 that Defendants’ mental health networks are “inadequate” compared to medical/surgical networks. (FAC  
15 ¶ 413.) The allegation that some Plaintiffs, anecdotally, found it easier to obtain certain medical-surgical  
16 benefits (FAC ¶ 67–68), does not plausibly lead to the inference that Blue Shield offered mental health  
17 benefits on “less favorable terms” than medical-surgical benefits. *See Andrew P. v. Blue Cross of*  
18 *California*, No. 5:25-CV-02158-BLF, 2025 WL 3637030, at \*3 (N.D. Cal. Dec. 15, 2025) (dismissing  
19 MHPAEA claim for failure to “specifically allege a disparity between mental health benefits and medical  
20 or surgical benefits”). Because Plaintiffs do not adequately plead a viable predicate violation of law, their  
21 UCL claim fails to the extent it proceeds under the “unlawful” prong.

## 22 2. Plaintiffs Do Not Allege Any “Unfair” Practice.

23 Under *Cel-Tech*, a practice is “unfair” if it threatens an incipient violation of antitrust law, violates  
24 the policy or spirit of such laws, or “otherwise significantly threatens or harms competition.” 20 Cal. 4th  
25 at 187; *Davis*, 691 F.3d at 1168. Alternatively, a plaintiff must allege conduct that “offends an established  
26 public policy” or is “immoral, unethical, oppressive, unscrupulous or substantially injurious to  
27 consumers,” weighing the harm against the utility of the conduct. *Davis*, 691 F.3d at 1169 (quotation  
28 omitted). Here, the FAC does not plausibly allege “unfair” conduct by Blue Shield under either standard.

1 Plaintiffs allege no anticompetitive conduct and no harm to competition. Nor do they plead facts showing  
2 conduct by Blue Shield that is unfair in the UCL sense, as opposed to mere allegations that mental health  
3 providers were difficult to locate or unavailable in the manner Plaintiffs preferred. (See FAC ¶¶ 1–9, 37–  
4 38, 231–238.) Plaintiffs do not plausibly allege conduct by Blue Shield that is “unfair” under the UCL.

5 **3. Plaintiffs Do Not Plead Any “Fraudulent” Conduct With Particularity.**

6 A practice is “fraudulent” under the UCL only if “members of the public are likely to be deceived,”  
7 judged from the standpoint of a reasonable consumer. *Davis*, 691 F.3d at 1169. Because Plaintiffs’ UCL  
8 claim relies on alleged misrepresentations and omissions, they must satisfy Rule 9(b) and plead the “who,  
9 what, when, where, and how” of the supposed fraud. *Vess*, 317 F.3d at 1106–07; *Kearns*, 567 F.3d at 1125.

10 They do not. Although the FAC quotes Blue Shield’s website and plan materials, Plaintiffs do not  
11 plead with particularity which specific statement each Plaintiff saw, when each Plaintiff saw it, who made  
12 it, or how that statement was false. (See FAC ¶¶ 53–54, 73–74, 99–100, 111–112, 174–211.) Instead, each  
13 Plaintiff parrots the same conclusion that they relied on Blue Shield’s representations about the extent of  
14 coverage and the breadth of the provider network when selecting their plan. (See FAC ¶¶ 53, 73, 99, 111.)  
15 That is the kind of generalized pleading Rule 9(b) does not permit. *Vess*, 317 F.3d at 1107.

16 Further, to the extent Plaintiffs rely on broad marketing language—such a “full selection” of  
17 providers, a “wide range” of doctors, or networks that are “among the largest in California”—those are  
18 non-actionable statements of puffery, not concrete factual representations. (See FAC ¶¶ 177–180);  
19 *Madrigal v. Allstate Indem. Co.*, 2015 WL 12746232, at \*10 (C.D. Cal. Oct. 29, 2015) (describing puffery  
20 as “general, subjective, unquantifiable claims that are unlikely to induce consumer reliance”). Plaintiffs  
21 thus fail to allege any particular, actionable misrepresentation capable of supporting a UCL fraud claim.

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

23 To have standing under the UCL, Plaintiffs must plead they “lost money or property” as a result  
24 of the challenged conduct. *Kwikset Corp. v. Superior Court*, 51 Cal. 4th 310, 322 (2011); *Rutter v. Apple*  
25 *Inc.*, 2022 WL 1443336, at \*4 (N.D. Cal. May 6, 2022). Plaintiffs contend that Defendants’ supposed  
26 misrepresentations caused them to pay “inflated premiums” for “a virtually worthless product.” (See FAC  
27 ¶¶ 5, 162, 164, 238, 350, 365, 377.) But they do not allege any facts showing how much more they paid,  
28 or what the “true” price of their coverage should have been. Nor do Plaintiffs allege that any competing

1 plan offered a better mental health network or lower premiums. Absent such comparisons, they cannot  
 2 plausibly show that Blue Shield’s statements caused them to pay more than they otherwise would have.  
 3 Courts have held that the “bare recitation of the word ‘premium’ does not adequately allege a cognizable  
 4 injury”; price-premium theories require factual specificity. *Schippell v. Johnson & Johnson Consumer*  
 5 *Inc.*, 2023 WL 6178485, at \*8 (C.D. Cal. Aug. 7, 2023)). Plaintiffs’ generalized assertions of “inflated  
 6 premiums” and “worthless” coverage, unsupported by facts, are precisely the conclusory allegations that  
 7 fail to establish economic injury under the UCL. The Seventh Cause of Action should be dismissed.

8 **D. The Misrepresentation-Based Claims Fail due to Lack of Particularity, Reliance,**  
 9 **and Actionable Statements, and Under the Economic Loss Rule.**

10 Under California law, intentional misrepresentation requires allegations of (1) misrepresentation;  
 11 (2) knowledge of falsity; (3) intent to induce reliance; (4) actual and justifiable reliance; and (5) resulting  
 12 damage. *Lazar v. Super. Ct.*, 12 Cal. 4th 631, 638 (1996). Negligent misrepresentation requires the same  
 13 elements, except that the defendant must have lacked “reasonable grounds for believing” the statement to  
 14 be true. *Gilmore v. Wells Fargo Bank N.A.*, 75 F. Supp. 3d 1255, 1269 (N.D. Cal. 2014). Both sound in  
 15 fraud and are subject to Rule 9(b). *See id.*; *Pro Water Sols., Inc. v. Angie’s List, Inc.*, 457 F. Supp. 3d 845,  
 16 852 (C.D. Cal. 2020). Plaintiffs must plead the “who, what, when, where, and how” of the alleged  
 17 misconduct and may not lump defendants together. *Evans v. Ariz. Cardinals Football Club, LLC*, 231 F.  
 18 Supp. 3d 342, 352 (N.D. Cal. 2017). The FAC fails to meet this bar.

19 **1. The FAC Does Not Plead Fraud With Particularity.**

20 The Eighth (intentional misrepresentation) and Ninth (negligent misrepresentation) Causes of  
 21 Action are wholly conclusory. They attribute all alleged misrepresentations to generic “Defendants,” made  
 22 to undifferentiated “Plaintiffs,” without identifying who at Blue Shield supposedly said what, to whom,  
 23 when, or by what means, rendering both claims facially deficient. (FAC ¶¶ 352–378.) “A complaint is  
 24 deficient for the purposes of Rule 9(b) when it relies on ‘shotgun’ or ‘puzzle’ pleading . . . . ‘Shotgun  
 25 pleadings are those that incorporate every antecedent allegation by reference into each subsequent claim  
 26 for relief or affirmative defense.’” *In re Metro. Sec. Litig.*, 532 F. Supp. 2d 1260, 1279 (E.D. Wash. 2007).

27 Beyond those causes of action, the FAC states only that at some unspecified time, “Defendants’  
 28 provider directory affirmatively misrepresents to current and prospective members that the mental health

1 providers listed are in fact in-network and will be accessible and available” and that “Defendants’ provider  
2 directory is replete with other inaccuracies, including incorrect addresses and phone numbers, as well as  
3 repeated entries of the same provider.” (FAC ¶¶ 145–146.) The FAC further alleges that in unspecified  
4 “marketing materials, plan documents, and member contracts, Defendants cite and incorporate by  
5 reference this grossly inaccurate directory.” (FAC ¶ 149.) Yet nowhere does the FAC tie *any* particular  
6 statement to *any* particular Plaintiff at *any* particular time. *See Kearns*, 567 F.3d at 1124–25 (Rule 9(b)  
7 demands specificity sufficient to give “notice of the particular misconduct”); *Gilmore*, 75 F. Supp. 3d at  
8 1269 (both claims sound in fraud and are subject to Rule 9(b)).

9 The allegations as to “when” and “where” are equally deficient. Roiz “called ten providers listed  
10 on Defendants’ directory” and “called Blue Shield’s mental health line” at unspecified times and called  
11 “six providers” listed in Blue Shield’s directory “[i]n early 2026.” (FAC ¶¶ 60–61, 65.) Castillo “called  
12 Blue Shield” and received a “list of in-network psychiatrists” from Magellan in February 2022, then called  
13 the “14 providers,” some of whom were out of network, before “abandon[ing] her search” for two years.  
14 (*Id.* ¶¶ 76–77.) After “resum[ing] her search” in May 2024, she received another list and found an in-  
15 network psychiatrist, whom she has seen “regularly over the past two years.” (*Id.* ¶¶ 79–80.) Marto  
16 “decided to look for regular talk therapy providers” “[i]n 2022” and “called 15 providers” at unspecified  
17 times. (FAC ¶¶ 101–102.) Maedel “has been searching for a therapist for the last several years using the  
18 provider directory” (*id.* ¶ 113) and “contacted more than 20 providers” at unspecified times. (*Id.* ¶ 119.)

19 Such amorphous temporal windows do not satisfy Rule 9(b). *See R Power Biofuels, LLC v. Chemex*  
20 *LLC*, 2016 WL 6663002, at \*13 (N.D. Cal. Nov. 11, 2016) (rejecting statements spanning eight-month  
21 period). Nor do vague references to contacting providers after viewing directories supply the “how” of  
22 alleged fraud. The test is not whether innumerable, unspecified statements might be misrepresentations  
23 when “considered as a whole” (FAC ¶ 361), but rather, whether the pleading sets forth the “who, what,  
24 when, where, and how.” *Evans*, 231 F. Supp. 3d at 352. Because Plaintiffs do not plead the requisite  
25 specific representations by Blue Shield, both misrepresentation claims fail at the pleading stage.

## 26 2. The Alleged Statements Are Non-Actionable Puffery.

27 Even if the alleged statements satisfied Rule 9(b), they are non-actionable puffery. “A statement  
28 that is quantifiable, that makes a claim as to the ‘specific or absolute characteristics of a product,’ may be

1 an actionable statement of fact while a general, subjective claim ... is non-actionable puffery.” *Newcal*  
 2 *Indus., Inc. v. Ikon Office Sol.*, 513 F.3d 1038, 1053 (9th Cir. 2008) (citation omitted). Courts routinely  
 3 dismiss misrepresentation claims that are rooted in puffery on a Rule 12(b)(6) motion. *Cook, Perkiss &*  
 4 *Liehe, Inc. v. N. Cal. Collection Serv. Inc.*, 911 F.2d 242, 245–46 (9th Cir. 1990).

5 Plaintiffs complain about statements that Blue Shield’s networks are “robust” and offer a “full  
 6 selection” of behavioral-health providers, and that Blue Shield “makes every attempt to validate” directory  
 7 information, including by updating it “every 90 days.” (FAC ¶¶ 4, 6, 9, 52, 74, 100, 112, 144, 173–175,  
 8 177, 192, 255.) “Robust” network assurances and similar “optimistic” expressions of quality are  
 9 paradigmatic puffery. *See In re Splash Tech. Holdings, Inc. Sec. Litig.*, 160 F. Supp. 2d 1059, 1077 (N.D.  
 10 Cal. 2001) (terms like “robust” are “vague and nonactionable”); *In re Impac Mortg. Holdings, Inc. Sec.*  
 11 *Litig.*, 554 F. Supp. 2d 1083, 1097 (C.D. Cal. 2008) (same). Likewise, statements that Blue Shield  
 12 “regularly” updates its directories, provides a network “among the largest in California,” or provides  
 13 “inpatient and outpatient options” are too indefinite and qualitative to be objectively falsified in the way  
 14 Plaintiffs posit. (*See* FAC ¶¶ 179, 180, 357.) These general, subjective statements cannot reasonably be  
 15 relied upon as concrete guarantees and cannot support a fraud claim.

### 16 3. Plaintiffs Do Not Plausibly Allege Justifiable Reliance.

17 The FAC also fails to plead actual, justifiable reliance by any Plaintiff on any particular statement  
 18 by Blue Shield. The FAC repeatedly asserts that Plaintiffs relied on “misrepresentations” about the  
 19 “extent” of coverage and the “breadth” of the provider network in choosing Blue Shield. (FAC ¶¶ 72, 110,  
 20 221, 231.) But again, it does not identify a single “explicit representation[]” related to any purported “bait-  
 21 and-switch scheme” that any Plaintiff actually saw and relied upon at enrollment or renewal. (*See id.* ¶¶  
 22 9, 64, 78, 95–96, 98–99, 104, 110–112, 120, 141, 144, 172.) The FAC merely alleges “misrepresentations  
 23 and omissions” were “made before and throughout Plaintiffs’ enrollment.” (*Id.* ¶ 172.)

24 Plaintiffs also never identify any “better, cheaper option[]” they would have selected but for the  
 25 alleged misrepresentations. (*See id.* ¶¶ 52, 72, 95, 110, 359.) Without alleging a concrete “but-for”  
 26 choice—what plan they would have bought instead, on what terms—they cannot plausibly plead that the  
 27 challenged statements caused their enrollment decisions or their alleged economic loss. “[I]f the person  
 28 who was allegedly deceived by the misrepresentation (plaintiff or not) would have acted in the same way

1 regardless of the misrepresentation, then the misrepresentation cannot be a but-for, much less proximate,  
2 cause of the plaintiffs' injury." *Sergeants Benevolent Ass'n Health & Welfare Fund v. Sanofi-Aventis U.S.*  
3 *LLP*, 806 F.3d 71, 87 (2d Cir. 2015).

4 Plaintiffs' own allegations show that their plan choices were driven by other factors, such as  
5 selecting the "most expensive" Platinum option (*id.* ¶ 52) and interpreting Blue Shield plans to offer "the  
6 best coverage" of a selection of unspecified health plan options (*id.* ¶¶ 72, 95, 110). Finally, any alleged  
7 misrepresentations present in the directory itself cannot retroactively create reliance at the time of  
8 enrollment. *See* FAC ¶¶ 265, 279, 292, 301, 312, 350, 365; *see In re Boeing 737 MAX Pilots Litig.*, 638  
9 F. Supp. 3d 838, 868 (N.D. Ill. 2022) (where "Plaintiffs already made the decision" to undergo pilot  
10 training, "statements and omissions at the training" could not establish causation or reliance). The FAC's  
11 allegations fail to establish reliance on any alleged misstatement about network size or directory accuracy.

12 Moreover, Plaintiffs' extensive histories of attempting to locate in-network providers with Blue  
13 Shield undercut any claim of reasonable reliance. (*See* FAC ¶¶ 60–61, 65, 76–77, 79–80, 101–102, 113,  
14 119.) Every Plaintiff alleges substantial experience in navigating Blue Shield's directory and speaking to  
15 representatives. (*Id.* ¶¶ 58–61, 76–81, 96, 101–102, 113–114, 116.) For example, Marto and Maedel  
16 "review Blue Shield's website" "[e]very year during open enrollment," and Maedel claims he has been  
17 searching for a therapist "for the last several years using the provider directory." (*Id.* ¶¶ 96, 113.) These  
18 allegations demonstrate that Plaintiffs possess substantial, first-hand experience with Blue Shield's  
19 network and directory tools, making it implausible that they could reasonably rely on vague marketing  
20 language about "robust" networks when enrolling and re-enrolling in their plans. *See Hoffman v. 162 N.*  
21 *Wolfe LLC*, 228 Cal. App. 4th 1178, 1194 (2014) (reliance evaluated in light of plaintiff's "particular  
22 knowledge and experience"). Plaintiffs' frustration with finding convenient mental health appointments  
23 cannot be transmuted into legally cognizable reliance on specific misrepresentations.

#### 24 **4. The Economic Loss Rule Bars Both Misrepresentation Claims.**

25 The FAC's Eighth and Ninth Causes of Action are further barred by the economic loss doctrine.  
26 That rule "is designed to maintain a distinction between damage remedies for breach of contract and tort."  
27 *Giles v. Gen. Motors Acceptance Corp.*, 494 F.3d 865, 873 (9th Cir. 2007). It generally precludes tort  
28 recovery for purely economic losses arising from a contractual relationship, absent breach of some

1 independent duty imposed by law. *See S.M. Wilson & Co. v. Smith Int'l, Inc.*, 587 F.2d 1363, 1373 (9th  
 2 Cir. 1978); *UMG Recordings, Inc. v. Glob. Eagle Entm't, Inc.*, 117 F. Supp. 3d 1092, 1103 (C.D. Cal.  
 3 2015); *Food Safety Net Servs. v. Eco Safe Sys. USA, Inc.*, 209 Cal. App. 4th 1118, 1130 (2012) (fraud  
 4 claim is barred where there is no duty “independent of a breach of the contract”).

5 Here, Plaintiffs seek only economic damages in connection with their intentional and negligent  
 6 misrepresentation claims: “millions of dollars in damages”; denial of “benefits to which they were entitled  
 7 under their health plans”; “inflated premiums for a virtually worthless product”; and “significant  
 8 out-of-pocket expenses for out-of-network provider payments.” (FAC ¶ 377; *see also id.* ¶¶ 265, 279, 292,  
 9 301, 312, 321, 350, 365.) Those are quintessential contract-based injuries, allegedly arising from the terms  
 10 of the written plans and EOCs. The FAC identifies no independent, non-contractual duty that Blue Shield  
 11 owed regarding directory content or network composition. Plaintiffs’ intentional and negligent  
 12 misrepresentation claims are thus improper attempts to re-plead contract claims in tort, and are barred by  
 13 the economic loss rule. For these reasons, the Eighth and Ninth Causes of Action should be dismissed.

14 **E. Plaintiffs’ Unjust Enrichment Claim Is Barred.**

15 Plaintiffs’ Tenth Cause of Action for “unjust enrichment” fails as a matter of law. “In California,  
 16 there is no standalone cause of action for ‘unjust enrichment,’ which is synonymous with ‘restitution.’”  
 17 *Astiana v. Hain Celestial Grp., Inc.*, 783 F.3d 753, 762 (9th Cir. 2015); *see LaCourt v. Specific Media,*  
 18 *Inc.*, 2011 WL 1661532, at \*8 (C.D. Cal. Apr. 28, 2011) (unjust enrichment “cannot serve as an  
 19 independent cause of action”). Even if construed as a quasi-contract claim, such a claim is unavailable  
 20 where an express, written contract governs the parties’ relationship. *Astiana*, 783 F.3d at 762; *Markaryan*  
 21 *v. Bank of Am. NA*, 2013 WL 12130257, at \*2 (C.D. Cal. May 29, 2013). Plaintiffs’ relationship with Blue  
 22 Shield is governed by written health plan contracts—employer insurer agreements and subscriber EOCs  
 23 that define premiums, benefits, networks, and cost sharing. (FAC ¶¶ 128-140, 250-279, 303.) Plaintiffs’  
 24 unjust enrichment theory simply repackages alleged failures to perform under those contracts, claiming  
 25 that Defendants “falsely portray[ed] their provider network,” induced enrollment, and thereby “enriched  
 26 themselves” by having increased membership and premiums in return. (FAC ¶¶ 379-389.)

27 Nor does pleading unjust enrichment “in the alternative” (FAC ¶ 379) save the claim. Courts reject  
 28 pleading alternative claims for unjust enrichment where plaintiffs also plead “the existence of an

1 enforceable agreement and their unjust enrichment claim did not deny the existence or enforceability of  
 2 that agreement.” *Klein v. Chevron U.S.A., Inc.*, 202 Cal. App. 4th 1342, 1389–90, 137 (2012). The same  
 3 applies here. Since the subject matter of the Tenth Cause of Action is covered by written contracts,  
 4 Plaintiffs cannot pursue quasi-contract restitution. The Tenth Cause of Action should be dismissed.

5 **F. Roiz’s ERISA Claims Fail Because Her Claims Are Deficient as a Matter of Law.**

6 **1. The Eleventh Cause of Action Fails Because Plaintiffs Do Not Allege a**  
 7 **Cognizable Denial of Benefits or Exhaustion of Plan Remedies.**

8 The Eleventh Cause of Action seeks to recover plan benefits under ERISA pursuant to 29 U.S.C.  
 9 § 1132(a)(1)(B). (FAC ¶¶ 391–396.) It is fundamental to an ERISA benefits claim that a plaintiff must  
 10 identify the ERISA plan and the specific plan provision that “confers the benefit in question” and that the  
 11 defendant allegedly failed to pay. *Raygoza v. ConAgra Foods, Inc. Welfare Benefit Wrap Plan*, 2016 WL  
 12 9454419, at \*5 (C.D. Cal. Nov. 4, 2016) (quotation omitted); *Almont Ambulatory Surgery Ctr., LLC v.*  
 13 *UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015) (a “plaintiff must allege facts that  
 14 establish the existence of an ERISA plan as well as the provisions of the plan that entitle it to benefits.”);  
 15 *Forest Ambulatory Surgical Assocs., L.P. v. United HealthCare Ins. Co.*, 2011 WL 2748724, at \*5 (N.D.  
 16 Cal. July 13, 2011). The requirement of identifying a specific plan term is “indispensable.” *Raygoza*, 2016  
 17 WL 9454419, at \*5 (“Indispensable is the requirement that ‘a plaintiff who brings a claim for benefits  
 18 under ERISA must identify a specific plan term that confers the benefit in question.’”). Time and time  
 19 again, courts have held that failure to plead a plan term entitling a plaintiff to benefits is grounds for  
 20 dismissal. *See, e.g., Bates v. Blue Shield of California*, 2019 WL 2177641, at \*3 (C.D. Cal. May 17, 2019);  
 21 *B.R. v. Beacon Health Options*, 2017 WL 2351973, at \*2-3 (N.D. Cal. May 31, 2017).

22 The FAC does not point to any ERISA plan term promising the benefits Plaintiffs claim they were  
 23 denied. For example, Plaintiffs do not identify any plan term requiring Blue Shield to permanently cover  
 24 Roiz’s out-of-network therapist at in-network rates because she found it difficult to locate a different  
 25 provider. Nor do Plaintiffs identify any plan term that would require Blue Shield to do the same for any  
 26 putative class member. At bottom, Plaintiffs’ ERISA benefits claim fails for the same reasons their breach  
 27 of contract claims fail—failure to plead a concrete contractual term that was breached. *See supra* Part  
 28 V.B.; *Blood Sys., Inc. v. Roesler*, 972 F. Supp. 2d 1150, 1154 n.4 (D. Ariz. 2013) (“A claim for benefits

1 [...] under ERISA section 502(a)(1)(B) [...] [is] routinely viewed as analogous to claims for breach of  
2 contract.”). Plaintiffs do not allege any ERISA plan terms separate from the allegations applicable to their  
3 breach of contract claims. (See, e.g., FAC ¶¶ 390-396.) Plaintiffs’ failure to plead the most basic,  
4 “indispensable” element of an ERISA benefits claim is fatal. See *Raygoza*, 2016 WL 9454419, at \*5.

5 Plaintiffs’ ERISA benefits claim also fails for the independent reason that they fail to allege  
6 exhaustion of administrative remedies. “Before bringing suit under § 502, an ERISA plaintiff claiming a  
7 denial of benefits must avail himself or herself of a plan’s own internal review procedures.” *Korman v.*  
8 *ILWU-PMA Claims Off.*, No. 218CV07516SVWJPR, 2019 WL 1324021 (C.D. Cal. Mar. 19, 2019);  
9 *Discovery House, LLC v. Cigna Corp.*, 2024 WL 441116, at \*4 (C.D. Cal. Jan. 2, 2024) (dismissing  
10 ERISA claims for failure to exhaust administrative remedies). Failure to exhaust administrative remedies  
11 is dispositive even at the pleading stage. *Id.*

12 Plaintiff Roiz (the only named Plaintiff with an ERISA plan) alleges that, after difficulty finding  
13 an in-network therapist, she “called Blue Shield,” continued seeing her out-of-network therapist, and that  
14 Blue Shield voluntarily agreed to cover three months of those services at the in-network rate before  
15 applying the out-of-network cost-sharing required by the plan. (FAC ¶¶ 56–58.) She further alleges she  
16 “called Blue Shield’s mental health line” and gave an “Access Complaint” over the phone. But nowhere  
17 does she allege submission of a written grievance, receipt of a written decision after 30 days, or seeking  
18 review by the DMHC, as set forth in her plan. (*Id.* ¶ 61.) The Platinum Full Plan sets out a formal grievance  
19 and appeal process, including a written grievance, a written decision within 30 days, and the opportunity  
20 to seek review by the California Department of Managed Health Care (“DMHC”); and only after “all  
21 required reviews” have been completed and a claim remains unapproved does the plan state that a member  
22 “may have the right to bring a civil action under Section 502(a) of ERISA.” (RJN, Ex. 1 at p. 98; RJN Ex.  
23 2 at p. 99.) Since the FAC does not allege that Roiz pursued, much less completed, “all required reviews”  
24 under the plan, her § 1132(a)(1)(B) claim must be dismissed for failure to exhaust administrative remedies.

25 **2. The Twelfth Cause of Action Fails Because the Fiduciary-Duty Claim Is**  
26 **Duplicative and Seeks Unavailable Relief.**

27 The Twelfth Cause of Action fails as a matter of law, as it merely repackages Plaintiffs’ claim for  
28 ERISA benefits under 29 U.S.C. § 1132(a)(1)(B). Under *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996),

1 equitable relief under § 1132(a)(3) is “appropriate” only where Congress has not provided an adequate  
2 remedy elsewhere in ERISA. Thus, the Ninth Circuit has held that § 1132(a)(3) relief is barred “where  
3 another section of ERISA already provided [plaintiffs] with an adequate remedy.” *Bowles v. Rease*, 198  
4 F.3d 752, 760 (9th Cir. 1999); *see Wise v. Verizon Commc’ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010).  
5 That bar applies regardless of whether the § 1132(a)(1)(B) claim ultimately succeeds, or is even adequately  
6 pleaded; what matters is that § 1132(a)(1)(B) provides the vehicle to redress the alleged denial-of-benefits  
7 injury. *Wise*, 600 F.3d at 1190 (holding that, barring a “separate and distinct” injury, relief under  
8 § 1132(a)(3) is unavailable “irrespective of the degree of success obtained on a claim for recovery of  
9 benefits under § 502(a)(1)(B)”; *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 372 (6th Cir. 2015).  
10 Because Roiz alleges no “separate and distinct” injury beyond the asserted non-payment of plan benefits,  
11 her fiduciary-duty claim under § 1132(a)(3) is impermissibly duplicative and must be dismissed. *See id.*

12 Plaintiffs’ attempt to frame the claims as being brought under 29 U.S.C. §§ 1109(a), 1132(a)(2) &  
13 (a)(3) is unavailing. 29 U.S.C. § 1109 only obligates a plan fiduciary “to make good *to such plan* any  
14 losses to the plan” resulting from a breach of fiduciary duties. 29 U.S.C. § 1109(a) (emphasis added). The  
15 allegation that any alleged misrepresentations “harmed the ERISA plan as a whole” (FAC ¶ 403) is purely  
16 conclusory and, in any event, does not give right to a claim under ERISA. It is axiomatic that under 29  
17 U.S.C. § 1109(a), “a fiduciary who breaches his fiduciary duty is liable to the plan—not to the  
18 beneficiaries individually.” *Walter v. Int’l Ass’n of Machinists Pension Fund*, 949 F.2d 310, 317 (10th  
19 Cir. 1991). Thus, Roiz “is not entitled to relief under section 1109.” *Id.*; *Kessen v. Plumbers’ Pension*  
20 *Fund, Loc. 130*, 877 F. Supp. 1198, 1205 (N.D. Ill. 1995); *Est. of Mattern v. Honeywell Int’l, Inc.*, 241 F.  
21 Supp. 2d 540, 543 (D. Md. 2003) (it is “abundantly clear” that suits under § 1109 “cannot be for  
22 individualized relief”). “Any action that the plaintiff brings under § 1109(a) must be dismissed, for she  
23 seeks recovery on her own behalf and not on behalf of the plan.” *Cunningham v. Dun & Bradstreet Plan*  
24 *Servs., Inc.*, 889 F. Supp. 932, 935 (N.D. Miss. 1995). An amendment asserting entitlement to individual  
25 relief under this section is “futile.” *Kennedy v. Metro. Life Ins. Co.*, 357 F. Supp. 2d 1346, 1348 (M.D.  
26 Fla. 2005). Further, “[t]o the extent Plaintiff relies on § 1132(a)(3) as authority for her claim for breach of  
27 fiduciary duty,” such an “amendment would likewise be futile.” *Id.* Here, “[t]he complaint’s factual  
28 allegations focus on harm suffered by the putative class members, in that the value of their health coverage

1 was diminished.” *Nechis v. Oxford Health Plans, Inc.*, 328 F. Supp. 2d 469, 477 (S.D.N.Y. 2004).  
2 “Because she fails to allege injury to the plan, as opposed to herself and other class members,” Roiz fails  
3 to plead a viable § 1109(a) claim. *Id.*

4 Even if Roiz were entitled to relief under the statute, she fails to plead plausibly that Blue Shield  
5 “harmed the ERISA plan as a whole by measurably reducing the value of the plan’s assets (here, its  
6 provider network).” (FAC ¶ 403); *Iqbal*, 556 U.S. at 678; *Twombly*, 550 U.S. at 548. First, a provider  
7 network is not an ERISA “plan asset.” *See* 29 C.F.R. §§ 2510.3-101, 2510.3-102 (defining “plan assets”).  
8 Even if it were, however, “‘general fiduciary duties under ERISA [are] not triggered[.]’ . . . when the  
9 decision at issue is, ‘at its core, a corporate business decision, and not one of a plan administrator.’” *Am.*  
10 *Psychiatric Ass’n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 357 (2d Cir. 2016) (affirming dismissal for  
11 lack of an ERISA cause of action). Such “‘business decisions’ that do not fall under the purview of  
12 ERISA” include contracting with providers. *Trs. of Int’l Union of Bricklayers & Allied Craftworkers Loc.*  
13 *1 Connecticut Health Fund v. Elevance, Inc.*, No. 3:22-CV-1541 (VDO), 2024 WL 1707223, at \*8 (D.  
14 Conn. Apr. 22, 2024) (granting 12(b)(6) motion). Further, “ERISA fiduciary duties do not govern the  
15 distribution of marketing materials to potential plan participants.” *Weiss v. CIGNA Healthcare, Inc.*, 972  
16 F. Supp. 748, 753, n. 4 (S.D.N.Y. 1997) (granting motion to dismiss ERISA claim). Accordingly, Roiz  
17 fails to overcome the “the threshold determination in making out an ERISA claim of misrepresentation”—  
18 “‘whether the decision taken was a business corporate management decision or whether it was an action  
19 falling within the fiduciary functions delineated by ERISA.’” *Vartanian v. Monsanto Co.*, 880 F. Supp.  
20 63, 70 (D. Mass. 1995) (internal citations omitted).

21 Roiz’s claim as predicated on 29 U.S.C. § 1132(a)(2) fails for the same reasons. That subsection  
22 provides an action may be brought “by the Secretary, or by a participant, beneficiary or fiduciary for  
23 appropriate relief under section 1109 of this title.” 29 U.S.C. § 1132(a)(2). Because Roiz is not entitled to  
24 relief under 29 U.S.C. § 1109(a), she is not entitled to relief under 29 U.S.C. § 1132(a)(2).

### 25 3. The Thirteenth Cause of Action Under the MHPAEA Fails.

26 The MHPAEA requires that financial requirements and treatment limitations for mental health and  
27 substance use disorder (“MH/SUD”) benefits be no more restrictive than those for medical/surgical  
28 benefits. *Andrew P. v. Blue Cross of California*, 2025 WL 3637030, at \*3 (N.D. Cal. Dec. 15, 2025). To

1 state a claim, Roiz must allege that Blue Shield imposed a discriminatory financial requirement,  
2 quantitative treatment limitation, or nonquantitative treatment limitation (“NQTL”) on MH/SUD benefits  
3 compared to substantially all medical/surgical benefits, with specific comparative facts. *Id.*

4 She does not. The FAC offers only conclusory assertions that Defendants’ mental health networks  
5 are “inadequate” while medical/surgical networks are “adequate.” (FAC ¶ 413.) Her most concrete  
6 allegation—that during the period she struggled to locate a nearby mental health provider, she successfully  
7 received in-network primary care, gastroenterology, and gynecology services (*id.* ¶ 67–68)—says nothing  
8 about any specific NQTL, process, or standard being applied more stringently to MH/SUD claims than to  
9 medical/surgical claims. There are no pleaded criteria, metrics, or side-by-side comparisons within any  
10 benefit classification. That is insufficient as a matter of law. *See Andrew P.*, 2025 WL 3637030, at \*3  
11 (dismissing MHPAEA claim for failure to “specifically allege a disparity between mental health benefits  
12 and medical or surgical benefits”). Nor do her citations to 29 C.F.R. § 2590.712 plead any actual specific  
13 disparity—they merely recite the regulations. (FAC ¶ 412.)

14 Further, Roiz merely recasts her alleged parity injury as a fiduciary-duty violation and seeks  
15 equitable relief under § 1132(a)(3). Her claim is therefore barred for the same reasons discussed with  
16 respect to her Twelfth Cause of Action. Where § 1132(a)(1)(B) provides an avenue to redress an alleged  
17 denial of benefits—including parity issues—equitable relief under § 1132(a)(3) is not “appropriate.”  
18 *Varity Corp.*, 516 U.S. at 515; *Wise*, 600 F.3d at 1190. The Cause of Action alleges no injury separate  
19 from the asserted non-payment of plan benefits and no inadequacy in the remedy afforded by  
20 § 1132(a)(1)(B). *See Kenneth P. v. Blue Shield of California*, 2018 WL 11437253, at \*2 (N.D. Cal. Dec.  
21 12, 2018) (dismissing claim because plaintiff “d[id] not allege facts from which the Court could infer the  
22 first claim for relief would not provide an adequate remedy for injuries caused by conduct that violated  
23 the MHPAEA.”). The MHPAEA-based request for equitable relief must therefore also be dismissed.

## 24 **VI. CONCLUSION**

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

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15 **UNITED STATES DISTRICT COURT**  
16 **NORTHERN DISTRICT OF CALIFORNIA**  
17 **SAN FRANCISCO COURTHOUSE**

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

21 **PLAINTIFFS,**

22 v.

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

26 **DEFENDANTS.**

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

**[PROPOSED] ORDER GRANTING  
DEFENDANT CALIFORNIA PHYSICIANS'  
SERVICE DBA BLUE SHIELD OF  
CALIFORNIA'S MOTION TO DISMISS  
PLAINTIFFS' FIRST AMENDED  
COMPLAINT**

*[Filed concurrently with Notice and Motion to  
Dismiss and Memorandum in Support Thereof;  
Request for Judicial Notice; Declaration of  
Veronica Barcena in Support of Request for  
Judicial Notice; and [Proposed] Order Granting  
Request for Judicial Notice]*

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

**[PROPOSED] ORDER**

1  
2 Defendant California Physicians’ Service dba Blue Shield of California’s (“Blue Shield”) Motion  
3 to Dismiss Plaintiffs Jennifer Roiz, Claudine Castillo, Candyce Marto, and Kevin Maedel’s (“Plaintiffs”)   
4 First Amended Complaint (“FAC”) (the “Motion”) came on for hearing on August 5, 2026, at 2:00 p.m.  
5 via Zoom teleconference for Courtroom 2 of the above-entitled Court, located at 450 Golden Gate Avenue,  
6 San Francisco, CA 94102, the Honorable William H. Orrick presiding. Appearances were stated on the  
7 record.

8 The Court, having considered the pleadings in this matter and all arguments and papers submitted  
9 in support of, and in opposition to, the Motion, and good cause appearing therefore, hereby **GRANTS**  
10 Blue Shield’s Motion and **ORDERS** as follows:

11 **Notice**

12 The First Amended Complaint is a shotgun pleading that flouts Rule 8’s requirement of a “short  
13 and plain statement of the claim.” Fed. R. Civ. P. 8(a)(2); *see Rodriguez v. Just Brands USA, Inc.*, 2021  
14 WL 1985031, at \*6 (C.D. Cal. May 18, 2021) (shotgun pleadings fail to give adequate notice of the claims  
15 and grounds). It repeatedly attributes all alleged misconduct to undifferentiated “Defendants” across  
16 thirteen causes of action and incorporates all prior paragraphs into each count, without specifying which  
17 entity supposedly did what to which Plaintiff. (*See, e.g.*, FAC ¶¶ 172–174, 182–184, 194–200, 207–216);  
18 *cf. In re KSL Media Inc.*, 2016 WL 1171956, at \*1 (Bankr. C.D. Cal. Mar. 23, 2016) (pleading “disjointed  
19 and vague” where complaint does not specify which allegations apply to which defendant). This improper  
20 lumping deprives each defendant of fair notice and warrants dismissal of the FAC as a matter of law.

21 **First Cause of Action (Breach of Contract between Plaintiffs and Blue Shield) and Second Cause**  
22 **of Action (Breach of Contract between Public-Sector Employees and Blue Shield)**

23 For breach of contract claims, plaintiffs must plead the contractual terms “either in haec verba or  
24 according to legal effect” so the Court can “discern at least what material obligation of the contract the  
25 defendant allegedly breached.” *Langan v. United Servs. Auto. Ass’n*, 69 F. Supp. 3d 965, 979–80 (N.D.  
26 Cal. 2014) (quotation omitted). “To be enforceable, a promise must be definite enough that a court can  
27 determine the scope of the duty and the limits of performance must be sufficiently defined to provide a  
28 rational basis for the assessment of damages.” *Ladas v. California State Auto. Assn.*, 19 Cal. App. 4th

1 761, 770 (1993). “An amorphous promise [...] cannot rise to the level of a contractual duty.” *Id.* at 771.

2 The FAC fails to meet these requirements.

3 Plaintiffs heavily rely on statements on Blue Shield’s website, including that “[o]ur network of  
4 doctors and hospitals is designed to meet the needs of members,” that Blue Shield has a “full selection of  
5 behavioral health providers,” and that Blue Shield’s “networks are among the largest in California.” (FAC  
6 ¶¶ 255–257.) As a threshold matter, these statements are on Blue Shield’s website, not on any contractual  
7 documents to which Plaintiffs are parties. (*See id.*) While Plaintiffs allege that their plan documents  
8 “direct” members to the Blue Shield website, the FAC provides no allegations to support the conclusion  
9 that the entire Blue Shield website is incorporated by reference into plan documents. Thus, statements on  
10 Blue Shield’s website cannot serve as the basis for Plaintiffs’ contract claims. However, even if those  
11 statements were part of any contractual documents, they are “amorphous” statements that cannot support  
12 a breach of contract claim. *Ladas*, 19 Cal. App. 4th at 770–71. Statements that Blue Shield’s networks are  
13 “among the largest in California,” or that Blue Shield has a “full selection” of providers, or that Blue  
14 Shield’s network is “designed to meet” members’ needs, are general descriptors. They are not “definite”  
15 promises capable of being enforced and cannot support a breach of contract claim. (*Id.*)

16 Plaintiffs go on to allege that the plan documents require Defendants to “provide health insurance  
17 benefits, including mental health benefits” and to “comply with all applicable state and federal statutes  
18 and regulations.” (*See, e.g.*, FAC ¶¶ 267–275.) However, Plaintiffs never quote or describe specific  
19 provisions of the employer contracts that expressly impose the alleged duties to maintain particular  
20 network sizes, guarantee appointment availability, or provide benefits in the manner they claim. (*See id.*  
21 ¶¶ 133–140) (describing coverage generally, but not identifying a term promising coverage in the  
22 circumstances alleged). Again, these indefinite statements cannot support a breach of contract claim.

23 To the extent Plaintiffs anchor their contract-based claims on vague statements regarding the  
24 robustness of Blue Shield’s mental health provider network, such amorphous and indefinite statements  
25 cannot support a breach of contract claim. *Langan*, 69 F. Supp. 3d at 980; *Ladas*, 19 Cal. App. 4th at 770–  
26 71.

27 Plaintiffs’ First and Second Causes of Action fail for the independent reason that they fail to allege  
28 a breach by Blue Shield. To bring a breach of contract claim, Plaintiffs must sufficiently plead Blue

1 Shield’s breach of contractual terms. *Fishell v. Nationwide Mut. Ins. Co.*, No. 2:23-CV-00027-DJC-DB,  
2 2023 WL 4626633, at \*5 (E.D. Cal. July 19, 2023). “Conclusory allegations that a defendant breached a  
3 contract are insufficient,” particularly where a plaintiff fails to “provide any examples” of breach.  
4 *Franconero v. UMG Recordings Inc.*, No. CV123382JGBAGR, 2013 WL 11238481, at \*6 (C.D. Cal.  
5 Sept. 23, 2013) (citation omitted).

6 Conclusory allegations are all Plaintiffs offer here. Plaintiffs’ First Cause of Action alleges Blue  
7 Shield “breached” by “failing to provide meaningful coverage,” “failing to update and convey accurate  
8 information,” and “failing to adhere to promises” regarding out-of-network care. (FAC ¶¶ 263–264.)  
9 Plaintiffs’ Second Cause of Action likewise alleges Blue Shield “breached” employer contracts by failing  
10 to provide an accurate directory, failing to maintain an adequate network, and failing to comply with  
11 various laws. (FAC ¶¶ 273–278.) But those are conclusions, not facts showing an actual breach. Without  
12 “provid[ing] any examples” of breach apart from Plaintiffs’ anecdotal and subjective difficulties with  
13 obtaining mental health care, those allegations are insufficient. *Franconero*, 2013 WL 11238481, at \*6.

14 Plaintiffs further allege that Blue Shield’s health plans will “cover and arrange needed services for  
15 you from an out-of-network provider” where an in-network provider is unavailable. (*See, e.g.*, FAC ¶  
16 260.) However, there is no tether between this provision and any specific breaching conduct by Blue  
17 Shield. Plaintiffs Castillo, Marto, and Maedel (the plaintiffs bringing breach of contract claims) each  
18 allege that they were unable to locate an appropriate in-network mental health provider. (*See, e.g.*, FAC  
19 ¶¶ 76–89; 101–106; 113–119.) However, the FAC contains no allegations that Plaintiffs actually informed  
20 Blue Shield that there were no in-network providers, nor that they requested that Blue Shield arrange for  
21 services with an appropriate out-of-network provider. (*See, e.g.*, FAC ¶¶ 101–106; 113–119.)

22 For example, Plaintiff Castillo alleges that she was “[u]nable to find an in-network provider within  
23 an hour’s drive from her home who was accepting new patients.” (FAC ¶ 78.) As an initial matter, Blue  
24 Shield has no control over whether providers in its network accepted Castillo as a patient; nor does the  
25 FAC allege any contractual term that compels Blue Shield to force in-network providers to accept all Blue  
26 Shield members as patients. Moreover, upon “call[ing] 14 providers” and finding they were “out of  
27 network, were unavailable to treat her, or did not offer the services she required,” Castillo admits that she  
28 “abandoned her search for a psychiatrist [sic].” (FAC ¶ 78.) In other words, when Castillo was unable to

1 find an appropriate provider in-network, she never actually contacted Blue Shield to request coverage  
2 outside of her network. Instead, she “abandoned her search” entirely. Blue Shield cannot breach a  
3 contractual provision to arrange out-of-network care when Blue Shield was never made aware of any such  
4 request in the first place. Any averments of actual breach are similarly absent from Plaintiffs Marto and  
5 Maedel’s allegations. (FAC ¶¶ 93–120.) Thus, glaringly absent from the FAC is any allegation that Blue  
6 Shield actually failed to arrange coverage with an out-of-network provider in any specific instance.

7 Like in *Franconero*, Plaintiffs do not “provide any examples” of Blue Shield violating a specific  
8 contractual obligation. 2013 WL 11238481, at \*6. They allege difficulty finding providers and  
9 dissatisfaction with directory results, but they do not allege facts showing that Blue Shield breached any  
10 specific contractual promise to any Plaintiff. Because Plaintiffs plead only generalizations and conclusions  
11 as to breach, Plaintiffs’ First and Second Causes of Action fail.

12 Further, even if a breach were adequately alleged, the contract claims against Blue Shield do not  
13 plead “appreciable and actual damage.” *Belluomini v. Citigroup, Inc.*, 2013 WL 3855589, at \*4 (N.D. Cal.  
14 July 24, 2013) (quotation omitted). Instead, Plaintiffs offer only generalized assertions that the supposed  
15 breaches “have caused millions of dollars in damages,” caused them to incur “significant out of pocket  
16 expenses,” to pay “inflated premiums for a virtually worthless product,” and to suffer “severe emotional  
17 and psychological distress.” (FAC ¶¶ 265, 279, 301, 312.)

18 Those allegations are untethered to any particular contractual obligation or to any Plaintiff specific  
19 facts. Plaintiffs do not allege, for example, what portion of their monthly contributions they would not  
20 have paid had they known of the alleged network issues, what specific out of pocket amounts they paid  
21 because a particular contractual promise failed, or how any loss is attributable to a contract breach rather  
22 than to their own decisions (such as Roiz’s choice to continue with an out of network therapist after Blue  
23 Shield provided three months of in network coverage). (FAC ¶¶ 57–58, 103, 113–120.) “Nominal  
24 damages, speculative harm, or threat of future harm” cannot support a contract claim. *Belluomini*, 2013  
25 WL 3855589, at \*4.

26 Plaintiffs’ Second Cause of Action must also be dismissed because Plaintiffs lack standing to  
27 enforce a contract between Blue Shield and employers. Under California law, a third party may enforce a  
28 contract only where “the contracting parties must have intended to benefit that third party, and their intent

1 must appear from the terms of the contract.” *Lincoln Alameda Creek v. Cooper Indus., Inc.*, 829 F. Supp.  
 2 325, 329 (N.D. Cal. 1992); *see also Carlson v. Clapper*, 2019 WL 1061743, at \*3 (N.D. Cal. Mar. 6, 2019)  
 3 (dismissing claim where contract was not “expressly for his benefit”).

4 The FAC does not meet that standard. Plaintiffs allege only that they are “intended third-party  
 5 beneficiaries” and that a “motivating purpose” of the employer contracts was for them to benefit. (FAC  
 6 ¶¶ 268, 304.) But those are conclusory assertions. The FAC does not identify any contract language  
 7 showing that Blue Shield and the employers expressly intended to confer enforceable rights on Plaintiffs.  
 8 Such intent must appear from the terms of the contract itself. *Lincoln Alameda Creek*, 829 F. Supp. at 329.  
 9 Absent such allegations, Plaintiffs’ third-party beneficiary theory is conclusory and insufficient.

10 The First and Second Causes of Action therefore fail to state a claim and are dismissed with  
 11 prejudice.

12 **Fourth Cause of Action (Breach of the Implied Covenant Between Plaintiffs and Blue**  
 13 **Shield) and Fifth Cause of Action (Breach of the Implied Covenant Between Public-Sector**  
 14 **Employees and Blue Shield)**

15 Plaintiffs’ bad faith claims are barred on multiple independent grounds. “A bad faith claim cannot  
 16 be maintained unless policy benefits are due.” *Mod. Dev. Co. v. Navigators Ins. Co.*, 111 Cal. App. 4th  
 17 932, 943 (2003); *Love v. Fire Ins. Exch.*, 221 Cal. App. 3d 1136, 1153 (1990). As explained *supra*,  
 18 Plaintiffs fail to allege any denial of benefits in the first place. Plaintiffs’ bad faith claims therefore fail as  
 19 a matter of law.

20 Plaintiffs’ bad faith claims fail for the additional reason that they are duplicative of their express  
 21 contract claims. A claim for breach of the implied covenant of good faith and fair dealing must “go beyond  
 22 the statement of a mere contract breach.” *P&H Casters Co., Inc. v. P&H Indus., LLC*, 2024 WL 4446546,  
 23 at \*5 (C.D. Cal. Aug. 26, 2024) (quotation omitted). Where the bad faith claim rests on the same alleged  
 24 conduct and seeks the same damages as the contract claim, it is duplicative and must be dismissed. *Id.*;  
 25 *Green Crush LLC v. Paradise Splash I, Inc.*, 2018 WL 4940824, at \*7 (C.D. Cal. Mar. 8, 2018).

26 Here, Plaintiffs allege that Blue Shield breached the implied covenant by failing to maintain  
 27 accurate directories and adequate networks, misrepresenting providers as in network and accepting new  
 28 patients, failing to assist Plaintiffs in locating accessible in-network care, and requiring out of network

1 payments where in network rates should have applied. (FAC ¶¶ 296–297, 308.) Those are the same core  
2 allegations they advance in support of their First and Second Causes of Action for breach of contract. (*See*,  
3 *e.g.*, FAC ¶¶ 252–264, 272–279.) The bad faith counts also seek the same damages sought in connection  
4 with the breach of contract claims. (*Compare* FAC ¶¶ 300–301, 311–312 *with* FAC ¶¶ 265, 279.) Plaintiffs  
5 do not identify any separate duty distinct from the contracts themselves, or any injury different from the  
6 alleged nonperformance of those contracts. Their attempt to relabel these theories as “bad faith” is  
7 therefore superfluous, and the Fourth and Fifth Causes of Action are duplicative.

8 Finally, the bad faith claims fail because Plaintiffs do not plead “appreciable and actual damage.”  
9 *Belluomini v. Citigroup, Inc.*, 2013 WL 3855589, at \*4 (N.D. Cal. July 24, 2013) (quotation omitted).  
10 Instead, Plaintiffs offer only generalized assertions that the supposed breaches “have caused millions of  
11 dollars in damages,” caused them to incur “significant out of pocket expenses,” to pay “inflated premiums  
12 for a virtually worthless product,” and to suffer “severe emotional and psychological distress.” (FAC ¶¶  
13 265, 279, 301, 312.)

14 Accordingly, Plaintiffs’ Fourth and Fifth Causes of Actions fail and are dismissed with prejudice.

15 **Seventh Cause of Action (UCL – California Bus. & Prof. Code § 17200 et seq.)**

16 Plaintiffs’ Seventh Cause of Action fails under all three prongs of the UCL—unlawful, unfair, and  
17 fraudulent—and, to the extent it sounds in fraud, is not pled with the particularity Rule 9(b) requires.

18 The “unlawful” prong “borrows” violations of other laws, and rises or falls with alleged violations  
19 of the underlying statute. *Davis v. HSBC Bank*, 691 F.3d 1152, 1168 (9th Cir. 2012) (citing *Cel-Tech*  
20 *Commc’ns, Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 180 (1999)). It is not sufficient to simply quote  
21 statutes and allege in conclusory fashion that they were violated. The allegations must plausibly establish  
22 “that the defendant’s conduct ‘must violate’ a borrowed statute or ‘be forbidden by law.’” *Pemberton v.*  
23 *Nationstar Mortg. LLC*, 331 F. Supp. 3d 1018, 1049 (S.D. Cal. 2018).

24 Plaintiffs predicate their UCL claim on a wide range of statutes and regulations. (FAC ¶¶ 324–  
25 346.) Specifically, Plaintiffs allege that Defendants violated the No Surprises Act, the Affordable Care  
26 Act, and the Internal Revenue Code by failing to provide sufficiently updated provider directories every  
27 90 days. (FAC ¶¶ 325, 327, 329.) However, just as those amorphous allegations are insufficient to support  
28 a breach of contract claim, they are insufficient to support a UCL claim under the unlawful prong. *See*

1 *California Crane Sch., Inc. v. Google LLC*, 722 F. Supp. 3d 1026, 1041 (N.D. Cal. 2024) (plaintiff “cannot  
2 bring a UCL claim under the unlawful prong” premised on same allegations as another claim that was  
3 insufficiently pleaded). The FAC contains no allegations regarding the frequency with which Blue Shield  
4 updated provider directories. Plaintiffs merely allege that they were told at unspecified times that some  
5 providers were not within Blue Shield’s network. The conclusion that Blue Shield violated laws regarding  
6 provider directories finds no support in Plaintiffs’ factual allegations.

7 Plaintiffs also allege that Defendants violated the MHPAEA by “providing mental health and  
8 substance use disorder benefits on less favorable terms than medical and surgical benefits.” (FAC ¶ 332.)  
9 However, the FAC only contains conclusory allegations that Defendants’ mental health networks are  
10 “inadequate” compared to medical/surgical networks. (See FAC ¶ 413.) The allegation that some  
11 Plaintiffs, anecdotally, found it easier to obtain certain medical-surgical benefits (FAC ¶ 67–68), does not  
12 plausibly lead to the inference that Blue Shield offered mental health benefits on “less favorable terms”  
13 than medical-surgical benefits. See *Andrew P.*, 2025 WL 3637030, at \*3 (dismissing MHPAEA claim for  
14 failure to “specifically allege a disparity between mental health benefits and medical or surgical benefits”).  
15 Because Plaintiffs do not adequately plead a viable predicate violation of law, their UCL claim fails to the  
16 extent it proceeds under the “unlawful” prong.

17 Under *Cel-Tech*, a practice is “unfair” if it threatens an incipient violation of antitrust law, violates  
18 the policy or spirit of such laws, or “otherwise significantly threatens or harms competition.” 20 Cal. 4th  
19 at 187; *Davis*, 691 F.3d at 1168. Alternatively, a plaintiff must allege conduct that “offends an established  
20 public policy” or is “immoral, unethical, oppressive, unscrupulous or substantially injurious to  
21 consumers,” weighing the harm against the utility of the conduct. *Davis*, 691 F.3d at 1169 (quotation  
22 omitted). Here, the FAC does not plausibly allege “unfair” conduct by Blue Shield under either standard.  
23 Plaintiffs allege no anticompetitive conduct and no harm to competition. Nor do they plead facts showing  
24 conduct by Blue Shield that is unfair in the UCL sense, as opposed to mere allegations that mental health  
25 providers were difficult to locate or unavailable in the manner Plaintiffs preferred. (See FAC ¶¶ 1–9, 37–  
26 38, 231–238.) Plaintiffs do not plausibly allege conduct by Blue Shield that is “unfair” under the UCL.

27 A practice is “fraudulent” under the UCL only if “members of the public are likely to be deceived,”  
28 judged from the standpoint of a reasonable consumer. *Davis*, 691 F.3d at 1169. Because Plaintiffs’ UCL

1 claim relies on alleged misrepresentations and omissions, they must satisfy Rule 9(b) and plead the “who,  
2 what, when, where, and how” of the supposed fraud. *Vess*, 317 F.3d at 1106–07; *Kearns*, 567 F.3d at 1125.

3 They do not. Although the FAC quotes Blue Shield’s website and plan materials, Plaintiffs do not  
4 plead with particularity which specific statement each Plaintiff saw, when each Plaintiff saw it, who made  
5 it, or how that statement was false. (*See* FAC ¶¶ 53–54, 73–74, 99–100, 111–112, 174–211.) Instead, each  
6 Plaintiff parrots the same conclusion that they relied on Blue Shield’s representations about the extent of  
7 coverage and the breadth of the provider network when selecting their plan. (*See* FAC ¶¶ 53, 73, 99, 111.)  
8 That is the kind of generalized pleading Rule 9(b) does not permit. *Vess*, 317 F.3d at 1107.

9 Further, to the extent Plaintiffs rely on broad marketing language—such a “full selection” of  
10 providers, a “wide range” of doctors, or networks that are “among the largest in California”—those are  
11 non-actionable statements of puffery, not concrete factual representations. (*See* FAC ¶¶ 177–180);  
12 *Madrigal v. Allstate Indem. Co.*, 2015 WL 12746232, at \*10 (C.D. Cal. Oct. 29, 2015) (describing puffery  
13 as “general, subjective, unquantifiable claims that are unlikely to induce consumer reliance”). Plaintiffs  
14 thus fail to allege any particular, actionable misrepresentation capable of supporting a UCL fraud claim.

15 To have standing under the UCL, Plaintiffs must plead they “lost money or property” as a result  
16 of the challenged conduct. *Kwikset Corp. v. Superior Court*, 51 Cal. 4th 310, 322 (2011); *Rutter v. Apple*  
17 *Inc.*, 2022 WL 1443336, at \*4 (N.D. Cal. May 6, 2022). Plaintiffs contend that Defendants’ supposed  
18 misrepresentations caused them to pay “inflated premiums” for “a virtually worthless product.” (*See* FAC  
19 ¶¶ 5, 162, 164, 238, 350, 365, 377.) But they do not allege any facts showing how much more they paid,  
20 or what the “true” price of their coverage should have been. Nor do Plaintiffs allege that any competing  
21 plan offered a better mental health network or lower premiums. Absent such comparisons, they cannot  
22 plausibly show that Blue Shield’s statements caused them to pay more than they otherwise would have.  
23 Courts have held that the “bare recitation of the word ‘premium’ does not adequately allege a cognizable  
24 injury”; price-premium theories require factual specificity. *Schippell v. Johnson & Johnson Consumer*  
25 *Inc.*, 2023 WL 6178485, at \*8 (C.D. Cal. Aug. 7, 2023)). Plaintiffs’ generalized assertions of “inflated  
26 premiums” and “worthless” coverage, unsupported by facts, are precisely the conclusory allegations that  
27 fail to establish economic injury under the UCL.

1 For all of these reasons—the absence of a viable predicate violation, the failure to plead unfair or  
 2 fraudulent conduct with the required specificity, and the lack of economic injury—the Seventh Cause of  
 3 Action fails and is dismissed with prejudice.

4 **Eighth Cause of Action (Intentional Misrepresentation) and Ninth Cause of Action (Negligent**  
 5 **Misrepresentation)**

6 Under California law, intentional misrepresentation requires allegations of (1) misrepresentation;  
 7 (2) knowledge of falsity; (3) intent to induce reliance; (4) actual and justifiable reliance; and (5) resulting  
 8 damage. *Lazar v. Super. Ct.*, 12 Cal. 4th 631, 638 (1996). Negligent misrepresentation requires the same  
 9 elements, except that the defendant must have lacked “reasonable grounds for believing” the statement to  
 10 be true. *Gilmore v. Wells Fargo Bank N.A.*, 75 F. Supp. 3d 1255, 1269 (N.D. Cal. 2014). Both sound in  
 11 fraud and are subject to Rule 9(b). *See id.*; *Pro Water Sols., Inc. v. Angie’s List, Inc.*, 457 F. Supp. 3d 845,  
 12 852 (C.D. Cal. 2020). Plaintiffs must plead the “who, what, when, where, and how” of the alleged  
 13 misconduct and may not lump defendants together. *Evans v. Ariz. Cardinals Football Club, LLC*, 231 F.  
 14 Supp. 3d 342, 352 (N.D. Cal. 2017). The FAC fails to meet this bar.

15 The Eighth (intentional misrepresentation) and Ninth (negligent misrepresentation) Causes of  
 16 Action are wholly conclusory. They attribute all alleged misrepresentations to generic “Defendants,” made  
 17 to undifferentiated “Plaintiffs,” without identifying who at Blue Shield supposedly said what, to whom,  
 18 when, or by what means, rendering both claims facially deficient. (FAC ¶¶ 352–378.) “A complaint is  
 19 deficient for the purposes of Rule 9(b) when it relies on ‘shotgun’ or ‘puzzle’ pleading . . . . ‘Shotgun  
 20 pleadings are those that incorporate every antecedent allegation by reference into each subsequent claim  
 21 for relief or affirmative defense.’” *In re Metro. Sec. Litig.*, 532 F. Supp. 2d 1260, 1279 (E.D. Wash. 2007).

22 Beyond those causes of action, the FAC states only that at some unspecified time, “Defendants’  
 23 provider directory affirmatively misrepresents to current and prospective members that the mental health  
 24 providers listed are in fact in-network and will be accessible and available” and that “Defendants’ provider  
 25 directory is replete with other inaccuracies, including incorrect addresses and phone numbers, as well as  
 26 repeated entries of the same provider.” (FAC ¶¶ 145–146.) The FAC further alleges that in unspecified  
 27 “marketing materials, plan documents, and member contracts, Defendants cite and incorporate by  
 28 reference this grossly inaccurate directory.” (FAC ¶ 149.) Yet nowhere does the FAC tie any particular

1 statement to any particular Plaintiff at any particular time. *See Kearns*, 567 F.3d at 1124–25 (Rule 9(b)  
2 demands specificity sufficient to give “notice of the particular misconduct”); *Gilmore*, 75 F. Supp. 3d at  
3 1269 (both claims sound in fraud and are subject to Rule 9(b)).

4 The allegations as to “when” and “where” are equally deficient. Roiz “called ten providers listed  
5 on Defendants’ directory” and “called Blue Shield’s mental health line” at unspecified times and called  
6 “six providers” listed in Blue Shield’s directory “[i]n early 2026.” (FAC ¶¶ 60–61, 65.) Castillo “called  
7 Blue Shield” and received a “list of in-network psychiatrists” from Magellan in February 2022, then called  
8 the “14 providers,” some of whom were out of network, before “abandon[ing] her search” for two years.  
9 (*Id.* ¶¶ 76–77.) After “resum[ing] her search” in May 2024, she received another list and found an in-  
10 network psychiatrist, whom she has seen “regularly over the past two years.” (*Id.* ¶¶ 79–80.) Marto  
11 “decided to look for regular talk therapy providers” “[i]n 2022” and “called 15 providers” at unspecified  
12 times. (FAC ¶¶ 101–102.) Maedel “has been searching for a therapist for the last several years using the  
13 provider directory” (*id.* ¶ 113) and “contacted more than 20 providers” at unspecified times. (*Id.* ¶ 119.)

14 Such amorphous temporal windows do not satisfy Rule 9(b). *See R Power Biofuels, LLC v. Chemex*  
15 *LLC*, 2016 WL 6663002, at \*13 (N.D. Cal. Nov. 11, 2016) (rejecting statements spanning eight-month  
16 period as “unclear”). Nor do vague references to contacting providers after viewing the directories supply  
17 the required “how” of alleged fraud. The test is not whether innumerable, unspecified statements might  
18 be misrepresentations when “considered as a whole from the perspective of a reasonable consumer” (FAC  
19 ¶ 361), but rather, whether the pleading sets forth the “who, what, when, where, and how.” *Evans*, 231 F.  
20 Supp. 3d at 352. Because Plaintiffs do not plead the requisite specific representations by Blue Shield, both  
21 misrepresentation claims fail at the pleading stage.

22 Even if the alleged statements satisfied Rule 9(b), they are non-actionable puffery. “A statement  
23 that is quantifiable, that makes a claim as to the ‘specific or absolute characteristics of a product,’ may be  
24 an actionable statement of fact while a general, subjective claim ... is non-actionable puffery.” *Newcal*  
25 *Indus., Inc. v. Ikon Office Sol.*, 513 F.3d 1038, 1053 (9th Cir. 2008) (citation omitted). Courts routinely  
26 dismiss misrepresentation claims that are rooted in puffery on a Rule 12(b)(6) motion. *Cook, Perkiss &*  
27 *Liehe, Inc. v. N. Cal. Collection Serv. Inc.*, 911 F.2d 242, 245–46 (9th Cir. 1990).

1 Plaintiffs complain about statements that Blue Shield’s networks are “robust” and offer a “full  
2 selection” of behavioral-health providers, and that Blue Shield “makes every attempt to validate” directory  
3 information, including by updating it “every 90 days.” (FAC ¶¶ 4, 6, 9, 52, 74, 100, 112, 144, 173–175,  
4 177, 192, 255.) “Robust” network assurances and similar “optimistic” expressions of quality are  
5 paradigmatic puffery. *See In re Splash Tech. Holdings, Inc. Sec. Litig.*, 160 F. Supp. 2d 1059, 1077 (N.D.  
6 Cal. 2001) (terms like “robust” are “vague and nonactionable”); *In re Impac Mortg. Holdings, Inc. Sec.*  
7 *Litig.*, 554 F. Supp. 2d 1083, 1097 (C.D. Cal. 2008) (same). Likewise, statements that Blue Shield  
8 “regularly” updates its directories, provides a network “among the largest in California,” or provides  
9 “inpatient and outpatient options” are too indefinite and qualitative to be objectively falsified in the way  
10 Plaintiffs posit. (*See* FAC ¶¶ 179, 180, 357.) These general, subjective statements cannot reasonably be  
11 relied upon as concrete guarantees and cannot support a fraud claim.

12 The FAC also fails to plead actual, justifiable reliance by any Plaintiff on any particular statement  
13 by Blue Shield. The FAC repeatedly asserts that Plaintiffs relied on “misrepresentations” about the  
14 “extent” of coverage and the “breadth” of the provider network in choosing Blue Shield. (FAC ¶¶ 72, 110,  
15 221, 231.) But again, it does not identify a single “explicit representation[]” related to any purported “bait-  
16 and-switch scheme” that any Plaintiff actually saw and relied upon at enrollment or renewal. (*See id.* ¶¶  
17 9, 64, 78, 95–96, 98–99, 104, 110–112, 120, 141, 144, 172.) The FAC merely alleges “misrepresentations  
18 and omissions” were “made before and throughout Plaintiffs’ enrollment.” (*Id.* ¶ 172.)

19 Plaintiffs also never identify any “better, cheaper option[]” they would have selected but for the  
20 alleged misrepresentations. (*See id.* ¶¶ 52, 72, 95, 110, 359.) Without alleging a concrete “but-for”  
21 choice—what plan they would have bought instead, on what terms—they cannot plausibly plead that the  
22 challenged statements caused their enrollment decisions or their alleged economic loss. “[I]f the person  
23 who was allegedly deceived by the misrepresentation (plaintiff or not) would have acted in the same way  
24 regardless of the misrepresentation, then the misrepresentation cannot be a but-for, much less proximate,  
25 cause of the plaintiffs’ injury.” *Sergeants Benevolent Ass’n Health & Welfare Fund v. Sanofi-Aventis U.S.*  
26 *LLP*, 806 F.3d 71, 87 (2d Cir. 2015).

27 Plaintiffs’ own allegations show that their plan choices were driven by other factors, such as  
28 selecting the “most expensive” Platinum option (*id.* ¶ 52) and interpreting Blue Shield plans to offer “the

1 best coverage” of a selection of unspecified health plan options (*id.* ¶¶ 72, 95, 110). Finally, any alleged  
2 misrepresentations present in the directory itself cannot retroactively create reliance at the time of  
3 enrollment. *See* FAC ¶¶ 265, 279, 292, 301, 312, 350, 365; *see In re Boeing 737 MAX Pilots Litig.*, 638  
4 F. Supp. 3d 838, 868 (N.D. Ill. 2022) (where “Plaintiffs already made the decision” to undergo pilot  
5 training, “statements and omissions at the training” could not establish causation or reliance). The FAC’s  
6 allegations fail to establish reliance on any alleged misstatement about network size or directory accuracy.

7 Moreover, Plaintiffs’ extensive histories of attempting to locate in-network providers with Blue  
8 Shield undercut any claim of reasonable reliance. (*See* FAC ¶¶ 60–61, 65, 76–77, 79–80, 101–102, 113,  
9 119.) Every Plaintiff alleges substantial experience in navigating Blue Shield’s directory and speaking to  
10 representatives. (*Id.* ¶¶ 58–61, 76–81, 96, 101–102, 113–114, 116.) For example, Marto and Maedel  
11 “review Blue Shield’s website” “[e]very year during open enrollment,” and Maedel claims he has been  
12 searching for a therapist “for the last several years using the provider directory.” (*Id.* ¶¶ 96, 113.) These  
13 allegations demonstrate that Plaintiffs possess substantial, first-hand experience with Blue Shield’s  
14 network and directory tools, making it implausible that they could reasonably rely on vague marketing  
15 language about “robust” networks when enrolling and re-enrolling in their plans. *See Hoffman v. 162 N.*  
16 *Wolfe LLC*, 228 Cal. App. 4th 1178, 1194 (2014) (reliance evaluated in light of plaintiff’s “particular  
17 knowledge and experience”). Plaintiffs’ frustration with finding convenient mental health appointments  
18 cannot be transmuted into legally cognizable reliance on specific misrepresentations.

19 The FAC’s Eighth and Ninth Causes of Action are further barred by the economic loss doctrine.  
20 That rule “is designed to maintain a distinction between damage remedies for breach of contract and tort.”  
21 *Giles v. Gen. Motors Acceptance Corp.*, 494 F.3d 865, 873 (9th Cir. 2007). It generally precludes tort  
22 recovery for purely economic losses arising from a contractual relationship, absent breach of some  
23 independent duty imposed by law. *See S.M. Wilson & Co. v. Smith Int’l, Inc.*, 587 F.2d 1363, 1373 (9th  
24 Cir. 1978); *UMG Recordings, Inc. v. Glob. Eagle Entm’t, Inc.*, 117 F. Supp. 3d 1092, 1103 (C.D. Cal.  
25 2015); *Food Safety Net Servs. v. Eco Safe Sys. USA, Inc.*, 209 Cal. App. 4th 1118, 1130 (2012) (fraud  
26 claim is barred where there is no duty “independent of a breach of the contract”).

27 Here, Plaintiffs seek only economic damages in connection with their intentional and negligent  
28 misrepresentation claims: “millions of dollars in damages”; denial of “benefits to which they were entitled

1 under their health plans”; “inflated premiums for a virtually worthless product”; and “significant  
2 out-of-pocket expenses for out-of-network provider payments.” (FAC ¶ 377; *see also id.* ¶¶ 265, 279, 292,  
3 301, 312, 321, 350, 365.) Those are quintessential contract-based injuries, allegedly arising from the terms  
4 of the written plans and EOCs. The FAC identifies no independent, non-contractual duty that Blue Shield  
5 owed regarding directory content or network composition. Plaintiffs’ intentional and negligent  
6 misrepresentation claims are thus improper attempts to re-plead contract claims in tort, and are barred by  
7 the economic loss rule.

8 For all of these reasons, the Eighth and Ninth Causes of Action fail and are dismissed with  
9 prejudice.

#### 10 **Tenth Cause of Action (Restitution for Unjust Enrichment)**

11 Plaintiffs’ Tenth Cause of Action for “unjust enrichment” fails as a matter of law. “In California,  
12 there is no standalone cause of action for ‘unjust enrichment,’ which is synonymous with ‘restitution.’”  
13 *Astiana v. Hain Celestial Grp., Inc.*, 783 F.3d 753, 762 (9th Cir. 2015); *see LaCourt v. Specific Media,*  
14 *Inc.*, 2011 WL 1661532, at \*8 (C.D. Cal. Apr. 28, 2011) (unjust enrichment “cannot serve as an  
15 independent cause of action”). Even if construed as a quasi-contract claim, such a claim is unavailable  
16 where an express, written contract governs the parties’ relationship. *Astiana*, 783 F.3d at 762; *Markaryan*  
17 *v. Bank of Am. NA*, 2013 WL 12130257, at \*2 (C.D. Cal. May 29, 2013). Plaintiffs’ relationship with Blue  
18 Shield is governed by written health plan contracts—employer insurer agreements and subscriber EOCs  
19 that define premiums, benefits, networks, and cost sharing. (FAC ¶¶ 128-140, 250-279, 303.) Plaintiffs’  
20 unjust enrichment theory simply repackages alleged failures to perform under those contracts, claiming  
21 that Defendants “falsely portray[ed] their provider network,” induced enrollment, and thereby “enriched  
22 themselves” by having increased membership and premiums in return. (FAC ¶¶ 379-389.)

23 Nor does pleading unjust enrichment “in the alternative” (FAC ¶ 379) save the claim. Courts reject  
24 pleading alternative claims for unjust enrichment where plaintiffs also plead “the existence of an  
25 enforceable agreement and their unjust enrichment claim did not deny the existence or enforceability of  
26 that agreement.” *Klein v. Chevron U.S.A., Inc.*, 202 Cal. App. 4th 1342, 1389–90, 137 (2012). The same  
27 applies here. Since the subject matter of the Tenth Cause of Action is covered by written contracts,  
28 Plaintiffs cannot pursue quasi-contract restitution.

1 The Tenth Cause of Action fails as a matter of law and is dismissed with prejudice.

2 **Eleventh Cause of Action (Improper Denial of Benefits Under ERISA – 29 U.S.C. § 1132(a)(1)(B))**

3 The Eleventh Cause of Action seeks to recover plan benefits under ERISA pursuant to 29 U.S.C.  
4 § 1132(a)(1)(B). (FAC ¶¶ 391–396.) It is fundamental to an ERISA benefits claim that a plaintiff must  
5 identify the ERISA plan and the specific plan provision that “confers the benefit in question” and that the  
6 defendant allegedly failed to pay. *Raygoza v. ConAgra Foods, Inc. Welfare Benefit Wrap Plan*, 2016 WL  
7 9454419, at \*5 (C.D. Cal. Nov. 4, 2016) (quotation omitted); *Almont Ambulatory Surgery Ctr., LLC v.*  
8 *UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015) (a “plaintiff must allege facts that  
9 establish the existence of an ERISA plan as well as the provisions of the plan that entitle it to benefits.”);  
10 *Forest Ambulatory Surgical Assocs., L.P. v. United HealthCare Ins. Co.*, 2011 WL 2748724, at \*5 (N.D.  
11 Cal. July 13, 2011). The requirement of identifying a specific plan term is “indispensable.” *Raygoza*, 2016  
12 WL 9454419, at \*5 (“Indispensable is the requirement that ‘a plaintiff who brings a claim for benefits  
13 under ERISA must identify a specific plan term that confers the benefit in question.’”). Time and time  
14 again, courts have held that failure to plead a plan term entitling a plaintiff to benefits is grounds for  
15 dismissal. *See, e.g., Bates v. Blue Shield of California*, 2019 WL 2177641, at \*3 (C.D. Cal. May 17, 2019);  
16 *B.R. v. Beacon Health Options*, 2017 WL 2351973, at \*2-3 (N.D. Cal. May 31, 2017).

17 The FAC does not point to any ERISA plan term promising the benefits Plaintiffs claim they were  
18 denied. For example, Plaintiffs do not identify any plan term requiring Blue Shield to permanently cover  
19 Roiz’s out-of-network therapist at in-network rates because she found it difficult to locate a different  
20 provider. Nor do Plaintiffs identify any plan term that would require Blue Shield to do the same for any  
21 putative class member. At bottom, Plaintiffs’ ERISA benefits claim fails for the same reasons their breach  
22 of contract claims fail—failure to plead a concrete contractual term that was breached. *See Blood Sys.,*  
23 *Inc. v. Roesler*, 972 F. Supp. 2d 1150, 1154 n.4 (D. Ariz. 2013) (“A claim for benefits [...] under ERISA  
24 section 502(a)(1)(B) [...] [is] routinely viewed as analogous to claims for breach of contract.”). Plaintiffs  
25 do not allege any ERISA plan terms separate from the allegations applicable to their breach of contract  
26 claims. (*See, e.g.,* FAC ¶¶ 390-396.) Plaintiffs’ failure to plead the most basic, “indispensable” element  
27 of an ERISA benefits claim is fatal. *See Raygoza*, 2016 WL 9454419, at \*5.

1 Plaintiffs' ERISA benefits claim also fails for the independent reason that they fail to allege  
2 exhaustion of administrative remedies. "Before bringing suit under § 502, an ERISA plaintiff claiming a  
3 denial of benefits must avail himself or herself of a plan's own internal review procedures." *Korman*, 2019  
4 WL 1324021, at \*12; *Discovery House, LLC v. Cigna Corp.*, 2024 WL 441116, at \*4 (C.D. Cal. Jan. 2,  
5 2024) (dismissing ERISA claims for failure to exhaust administrative remedies). Failure to exhaust  
6 administrative remedies is dispositive even at the pleading stage. *Id.*

7 Plaintiff Roiz (the only named Plaintiff with an ERISA plan) alleges that, after difficulty finding  
8 an in-network therapist, she "called Blue Shield," continued seeing her out-of-network therapist, and that  
9 Blue Shield voluntarily agreed to cover three months of those services at the in-network rate before  
10 applying the out-of-network cost-sharing required by the plan. (FAC ¶¶ 56–58.) She further alleges she  
11 "called Blue Shield's mental health line" and gave an "Access Complaint" over the phone. But nowhere  
12 does she allege submission of a written grievance, receipt of a written decision after 30 days, or seeking  
13 review by the DMHC, as set forth in her plan. (*Id.* ¶ 61.) The Platinum Full Plan sets out a formal grievance  
14 and appeal process, including a written grievance, a written decision within 30 days, and the opportunity  
15 to seek review by the California Department of Managed Health Care ("DMHC"); and only after "all  
16 required reviews" have been completed and a claim remains unapproved does the plan state that a member  
17 "may have the right to bring a civil action under Section 502(a) of ERISA." (RJN, Ex. 1 at p. 98; RJN Ex.  
18 2 at p. 99.) Since the FAC does not allege that Roiz pursued, much less completed, "all required reviews"  
19 under the plan, her § 1132(a)(1)(B) claim must be dismissed for failure to exhaust administrative remedies.

20 For these reasons, the Tenth Cause of Action fails and is dismissed with prejudice.

21 **Twelfth Cause of Action (Breach of Fiduciary Duty Under ERISA – 29 U.S.C. §§ 1109(a),**

22 **1132(a)(2) & (a)(3))**

23 The Twelfth Cause of Action fails as a matter of law, as it merely repackages Plaintiffs' claim for  
24 ERISA benefits under 29 U.S.C. § 1132(a)(1)(B). Under *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996),  
25 equitable relief under § 1132(a)(3) is "appropriate" only where Congress has not provided an adequate  
26 remedy elsewhere in ERISA. Thus, the Ninth Circuit has held that § 1132(a)(3) relief is barred "where  
27 another section of ERISA already provided [plaintiffs] with an adequate remedy." *Bowles v. Rease*, 198  
28 F.3d 752, 760 (9th Cir. 1999); see *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010).

1 That bar applies regardless of whether the § 1132(a)(1)(B) claim ultimately succeeds, or is even adequately  
2 pleaded; what matters is that § 1132(a)(1)(B) provides the vehicle to redress the alleged denial-of-benefits  
3 injury. *Wise*, 600 F.3d at 1190 (holding that, barring a “separate and distinct” injury, relief under §  
4 1132(a)(3) is unavailable “irrespective of the degree of success obtained on a claim for recovery of benefits  
5 under § 502(a)(1)(B)”); *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 372 (6th Cir. 2015). Because  
6 Roiz alleges no “separate and distinct” injury beyond the asserted non-payment of plan benefits, her  
7 fiduciary-duty claim under § 1132(a)(3) is impermissibly duplicative and must be dismissed. *See id.*

8 Plaintiffs’ attempt to frame the claims as being brought under 29 U.S.C. §§ 1109(a), 1132(a)(2) &  
9 (a)(3) is unavailing. 29 U.S.C. § 1109 only obligates a plan fiduciary “to make good to such plan any  
10 losses to the plan” resulting from a breach of fiduciary duties. 29 U.S.C. §§ 1109(a). The allegation that  
11 any alleged misrepresentations “harmed the ERISA plan as a whole” (FAC ¶ 403) is purely conclusory  
12 and, in any event, does not give right to a claim under ERISA. It is axiomatic that under 29 U.S.C. §  
13 1109(a), “a fiduciary who breaches his fiduciary duty is liable to the plan—not to the beneficiaries  
14 individually.” *Walter v. Int’l Ass’n of Machinists Pension Fund*, 949 F.2d 310, 317 (10th Cir. 1991). Thus,  
15 Roiz “is not entitled to relief under section 1109.” *Id.*; *Kessen v. Plumbers’ Pension Fund, Loc. 130*, 877  
16 F. Supp. 1198, 1205 (N.D. Ill. 1995); *Est. of Mattern v. Honeywell Int’l, Inc.*, 241 F. Supp. 2d 540, 543  
17 (D. Md. 2003) (it is “abundantly clear” that suits under § 1109 “cannot be for individualized relief”). “Any  
18 action that the plaintiff brings under § 1109(a) must be dismissed, for she seeks recovery on her own  
19 behalf and not on behalf of the plan.” *Cunningham v. Dun & Bradstreet Plan Servs., Inc.*, 889 F. Supp.  
20 932, 935 (N.D. Miss. 1995). An amendment asserting entitlement to individual relief under this section is  
21 “futile.” *Kennedy v. Metro. Life Ins. Co.*, 357 F. Supp. 2d 1346, 1348 (M.D. Fla. 2005). Further, “[t]o the  
22 extent Plaintiff relies on § 1132(a)(3) as authority for her claim for breach of fiduciary duty,” such an  
23 “amendment would likewise be futile.” *Id.* Here, “[t]he complaint’s factual allegations focus on harm  
24 suffered by the putative class members, in that the value of their health coverage was diminished.” *Nechis*  
25 *v. Oxford Health Plans, Inc.*, 328 F. Supp. 2d 469, 477 (S.D.N.Y. 2004). “Because she fails to allege  
26 injury to the plan, as opposed to herself and other class members,” Roiz fails to plead a viable § 1109(a)  
27 claim. *Id.*

1 Even if Roiz were entitled to relief under the statute, she fails to plead plausibly that Blue Shield  
 2 “harmed the ERISA plan as a whole by measurably reducing the value of the plan’s assets (here, its  
 3 provider network).” (FAC ¶ 403); *Ashcroft*, 556 U.S. at 678; *Twombly*, 550 U.S. at 548. First, a provider  
 4 network is not an ERISA “plan asset.” See 29 C.F.R. §§ 2510.3-101, 2510.3-102 (defining “plan assets”).  
 5 Even if it were, however, “‘general fiduciary duties under ERISA [are] not triggered[]’ . . . when the  
 6 decision at issue is, ‘at its core, a corporate business decision, and not one of a plan administrator.’” *Am.*  
 7 *Psychiatric Ass’n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 357 (2d Cir. 2016) (affirming dismissal for  
 8 lack of an ERISA cause of action). Such “‘business decisions’ that do not fall under the purview of  
 9 ERISA” include contracting with providers. *Trs. of Int’l Union of Bricklayers & Allied Craftworkers Loc.*  
 10 *1 Connecticut Health Fund v. Elevance, Inc.*, No. 3:22-CV-1541 (VDO), 2024 WL 1707223, at \*8 (D.  
 11 Conn. Apr. 22, 2024) (granting 12(b)(6) motion). Further, “ERISA fiduciary duties do not govern the  
 12 distribution of marketing materials to potential plan participants.” *Weiss v. CIGNA Healthcare, Inc.*, 972  
 13 F. Supp. 748, 753, n. 4 (S.D.N.Y. 1997) (granting motion to dismiss ERISA claim). Accordingly, Roiz  
 14 fails to overcome the “the threshold determination in making out an ERISA claim of misrepresentation”—  
 15 “‘whether the decision taken was a business corporate management decision or whether it was an action  
 16 falling within the fiduciary functions delineated by ERISA.’” *Vartanian v. Monsanto Co.*, 880 F. Supp.  
 17 63, 70 (D. Mass. 1995) (internal citations omitted).

18 Roiz’s claim as predicated on 29 U.S.C. § 1132(a)(2) fails for the same reasons. That subsection  
 19 provides an action may be brought “by the Secretary, or by a participant, beneficiary or fiduciary for  
 20 appropriate relief under section 1109 of this title.” 29 U.S.C. § 1132(a)(2). Because Roiz is not entitled to  
 21 relief under 29 U.S.C. § 1109(a), she is not entitled to relief under 29 U.S.C. § 1132(a)(2).

22 For these reasons, the Twelfth Cause of Action fails and is dismissed with prejudice.

23 **Thirteenth Cause of Action (Parity in Mental Health Benefits Under ERISA & MHPAEA – 29**

24 **U.S.C. §§ 1132(a)(1)(B), 1132(a)(3), and 1185a)**

25 The MHPAEA requires that financial requirements and treatment limitations for mental health and  
 26 substance use disorder (“MH/SUD”) benefits be no more restrictive than those for medical/surgical  
 27 benefits. *Andrew P. v. Blue Cross of California*, 2025 WL 3637030, at \*3 (N.D. Cal. Dec. 15, 2025). To  
 28 state a claim, Roiz must allege that Blue Shield imposed a discriminatory financial requirement,

1 quantitative treatment limitation, or nonquantitative treatment limitation (“NQTL”) on MH/SUD benefits  
2 compared to substantially all medical/surgical benefits, with specific comparative facts. *Id.*

3 She does not. The FAC offers only conclusory assertions that Defendants’ mental health networks  
4 are “inadequate” while medical/surgical networks are “adequate.” (FAC ¶ 413.) Her most concrete  
5 allegation—that during the period she struggled to locate a nearby mental health provider, she successfully  
6 received in-network primary care, gastroenterology, and gynecology services (*id.* ¶ 67–68)—says nothing  
7 about any specific NQTL, process, or standard being applied more stringently to MH/SUD claims than to  
8 medical/surgical claims. There are no pleaded criteria, metrics, or side-by-side comparisons within any  
9 benefit classification. That is insufficient as a matter of law. *See Andrew P.*, 2025 WL 3637030, at \*3  
10 (dismissing MHPAEA claim for failure to “specifically allege a disparity between mental health benefits  
11 and medical or surgical benefits”). Nor do her citations to 29 C.F.R. § 2590.712 plead any actual specific  
12 disparity—they merely recite the regulations. (FAC ¶ 412.)

13 Further, Roiz merely recasts her alleged parity injury as a fiduciary-duty violation and seeks  
14 equitable relief under § 1132(a)(3). Her claim is therefore barred for the same reasons discussed with  
15 respect to her Twelfth Cause of Action. Where § 1132(a)(1)(B) provides an avenue to redress an alleged  
16 denial of benefits—including parity issues—equitable relief under § 1132(a)(3) is not “appropriate.”  
17 *Varity Corp.*, 516 U.S. at 515; *Wise*, 600 F.3d at 1190. The Cause of Action alleges no injury separate  
18 from the asserted non-payment of plan benefits and no inadequacy in the remedy afforded by §  
19 1132(a)(1)(B). *See Kenneth P. v. Blue Shield of California*, 2018 WL 11437253, at \*2 (N.D. Cal. Dec. 12,  
20 2018) (dismissing claim because plaintiff “d[id] not allege facts from which the Court could infer the first  
21 claim for relief would not provide an adequate remedy for injuries caused by conduct that violated the  
22 MHPAEA.”).

23 For these reasons, the Thirteenth Cause of Action fails as a matter of law and is dismissed with  
24 prejudice.

25 \* \* \*

26 For the foregoing reasons, the Court **HEREBY GRANTS** Blue Shield’s Motion in its entirety and  
27 **DISMISSES WITH PREJUDICE** all claims against Blue Shield in Plaintiffs’ First Amended  
28 Complaint.

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Dated:

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Hon. William H. Orrick  
United States District Judge