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12 **UNITED STATES DISTRICT COURT**  
13 **NORTHERN DISTRICT OF CALIFORNIA**  
14 **SAN FRANCISCO DIVISION**

16 JENNIFFER ROIZ et al.,

17 Plaintiffs,

18 v.

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

Defendants.

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

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

Date: August 5, 2026  
Time: 2:00 p.m.  
Location: Courtroom 2; 17th Floor  
Judge: William H. Orrick

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

2 **PLEASE TAKE NOTICE** that on August 5, 2026, at 2:00 p.m., or as soon thereafter as  
3 this matter may be heard before the Honorable William H. Orrick, Courtroom 2 on the 17th Floor  
4 of the United States Courthouse located at 450 Golden Gate Avenue, San Francisco, California  
5 94102, Defendants Magellan Health, Inc., Magellan Healthcare, Inc., and Human Affairs  
6 International of California, Inc. (collectively, “Magellan” or the “Magellan Defendants”) will and  
7 hereby do move the Court for an order dismissing Plaintiffs’ First Amended Complaint pursuant  
8 to Rules 8(a), 9(b), and 12(b)(6) of the Federal Rules of Civil Procedure. The Magellan Defendants  
9 respectfully request an order dismissing with prejudice all of Plaintiffs’ claims against them.

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

13 Dated: May 5, 2026

Respectfully submitted,

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

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

19 *Attorneys for Magellan Defendants*

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1 **MEMORANDUM OF POINTS AND AUTHORITIES**

2 **I. Introduction**

3 Plaintiffs' First Amended Complaint (FAC) picks up where its predecessor left off,  
4 dressing up generalized issues with a mental health provider directory with performative rhetoric  
5 and attempting to pass off routine and well-regulated healthcare issues as a grab-bag of contractual  
6 and legal violations. Unpacking these claims on Plaintiffs' second attempt reveals that they still  
7 remain deficient and should be dismissed. Now conceding that they lack any contract with  
8 Magellan, Plaintiffs proceed instead on a third-party beneficiary theory, seeking to enforce  
9 Magellan's contract with Blue Shield even though the plain terms of that contract clearly show no  
10 intent to confer third-party beneficiary rights on Plaintiffs or anyone else. Further, Plaintiffs once  
11 again allege a sweeping fraudulent scheme without the requisite specificity about *how* Magellan  
12 purportedly carried out its fraud. This failure to plead fraud with specificity dooms the claims  
13 under the California Unfair Competition Law, as well as the claims for intentional and negligent  
14 misrepresentation and unjust enrichment, all of which suffer from additional pleading failures  
15 independently warranting dismissal. Finally, Plaintiffs repackage a narrower version of their  
16 ERISA claims against Magellan with a few new allegations, but the FAC still fails to plead either  
17 a denial of benefits under plan terms or a breach of fiduciary duty. All Eight Counts against  
18 Magellan should be dismissed with prejudice.

19 **II. Statement of the Issues to Be Decided**

- 20 1. Whether to dismiss Plaintiffs' contract-based claims against Magellan because Plaintiffs  
21 are not third-party beneficiaries of the contract between Magellan and Blue Shield and  
22 because Plaintiffs fail to plead a specific material breach by Magellan that caused them  
23 harm.
- 24 2. Whether to dismiss Plaintiffs' claim under the California Unfair Competition Law against  
25 Magellan because the FAC (i) fails to plead inadequacy of legal remedies, (ii) fails to plead  
26 fraud by Magellan with particularity as required by Rule 9(b), and (iii) fails to provide  
27 notice of how Magellan allegedly violated any predicate statute or regulation.
- 28 3. Whether to dismiss Plaintiffs' claims for intentional and negligent misrepresentation

1 against Magellan because Plaintiffs fail to plead fraud by Magellan with particularity.

2 4. Whether to dismiss Plaintiffs’ claim for restitution for unjust enrichment against Magellan  
3 because Magellan did not receive any benefit at Plaintiffs’ expense and because Plaintiffs  
4 fail to plead fraud by Magellan with particularity.

5 5. Whether Plaintiffs’ claim for denial of benefits under ERISA against Magellan should be  
6 dismissed because the FAC does not plausibly allege that Magellan denied benefits in  
7 violation of any plan term.

8 6. Whether to dismiss Plaintiffs’ claim for breach of fiduciary duty under ERISA against  
9 Magellan because the FAC does not adequately allege plan-wide injury and the claim is  
10 duplicative of the denial-of-benefits claim.

11 **III. Background<sup>1</sup>**

12 Plaintiffs are four individuals who purchased health insurance through Blue Shield of  
13 California. According to Plaintiffs, their Blue Shield plans’ online directories for mental health  
14 providers were inaccurate—or “ghost networks”—because the directories included providers who  
15 did not return their phone calls, were not accepting new patients, were not actually in-network, or  
16 were otherwise unavailable or inaccessible. FAC ¶¶ 1–3, 145. Based on these allegations,  
17 Plaintiffs assert a bevy of contract, unfair competition, fraud, unjust enrichment, and ERISA claims  
18 against Blue Shield and Magellan.

19 In addition to suing their insurer Blue Shield, the health insurance corporation that  
20 “administers the Blue Shield of California health insurance plans,” FAC ¶ 17, Plaintiffs also name  
21 three different Magellan entities as defendants. Magellan is not affiliated with Blue Shield, nor is  
22 it an insurer. Instead, Magellan subcontracts with Blue Shield to “manage Mental Health and  
23 Substance Use Disorder services through [Magellan’s own] network of providers.” FAC ¶ 122.  
24 That is, Magellan serves as the plan’s “Mental Health Service Administrator” (MHSA), which the  
25 FAC describes as an entity that “administers mental health benefits on behalf of Blue Shield,  
26 including by ‘authoriz[ing] services, process[ing] claims, and address[ing] complaints and  
27 \_\_\_\_\_

28 <sup>1</sup> The facts alleged in the FAC are assumed true for the purposes of this motion only.

1 grievances for those Benefits on behalf of Blue Shield.” FAC ¶ 123.

2 Plaintiff Jenniffer Roiz has been enrolled in an ERISA-governed Blue Shield Platinum Full  
3 PPO plan since August 2024. FAC ¶¶ 14, 51. According to the FAC, Roiz was seeing her therapist  
4 weekly at the time she enrolled in the plan. FAC ¶ 52. Shortly after enrolling, she learned that her  
5 existing therapist was “not in a covered area” and that the therapist was “not in-network.” FAC  
6 ¶¶ 57–58. A Magellan representative told Roiz that her existing therapist would be covered for  
7 three months at the in-network rate, after which she would need to find an in-network therapist.  
8 FAC ¶ 58. Roiz alleges she then searched the Magellan directory for female practitioners who  
9 specialized in grief and were accepting new patients. FAC ¶ 59. She claims she called ten  
10 providers listed on the directory, but “all the providers she called were out of network, were  
11 unavailable to treat. Roiz, or did not offer the services listed.” FAC ¶ 60. Roiz continued seeing  
12 her out-of-network therapist at \$150 per session, and when Blue Shield declined to extend the  
13 three-month in-network coverage period, Roiz stopped therapy due to cost. FAC ¶ 63. The FAC  
14 now alleges that “Magellan, acting on Blue Shield’s behalf, denied Roiz’s request for an extension  
15 of the three-month period covering her existing therapist as in-network, based on its finding that  
16 in-network providers were available.” FAC ¶ 157. The FAC does not allege that Magellan ever  
17 made any coverage determination for any other Plaintiff.

18 Plaintiff Claudine Castillo and her 16-year-old son have been enrolled in a non-ERISA  
19 Blue Shield San Francisco Health Service System Trio HMO plan since 2022. FAC ¶¶ 15, 71. In  
20 February 2022, Castillo searched for a psychiatrist for herself. FAC ¶ 76. Blue Shield referred  
21 her to Magellan, which sent her lists of providers, but she alleges all providers on those lists were  
22 either too far away or, when she called them, “were out of network, were unavailable to treat her,  
23 or did not offer the services she required.” FAC ¶ 77. Castillo “abandoned her search for a  
24 psychiatrist and went without mental health care for over two years.” FAC ¶ 77. She resumed her  
25 search in May 2024 and eventually found a psychiatrist through the Magellan-provided list. FAC  
26 ¶¶ 79–80. In August 2025, Castillo’s son reported suicidal ideation. FAC ¶ 82. Castillo called  
27 Blue Shield, which referred her to Magellan, and asked for assistance locating an available  
28 provider for her son. FAC ¶¶ 82–83. Magellan sent her several lists of providers, but Castillo

1 alleges most were over an hour from her home by car. FAC ¶ 83. She claims all providers within  
2 45 minutes of her home who she called “were out of network, were unavailable to treat her son, or  
3 did not offer the services that Ms. Castillo’s son required.” FAC ¶ 84. The FAC does not allege  
4 that Magellan made any benefit determination regarding care for Ms. Castillo or her son.

5 Plaintiffs Candyce Marto and Kevin Maedel are a married couple enrolled in a non-ERISA  
6 Blue Shield TRIO HMO plan through Maedel’s employer. FAC ¶¶ 16, 94. Marto alleges that in  
7 2022, she searched the Magellan directory and found hundreds of listed providers. FAC ¶ 101.  
8 She contacted approximately 15 providers without finding available in-network care. FAC ¶ 102.  
9 She claims she has gone without care for four years because she was unable to locate an in-network  
10 provider and could not afford out-of-network care. FAC ¶ 103. Maedel alleges he has repeatedly  
11 searched the Blue Shield and Magellan directories for therapy and psychiatric care over the past  
12 several years. FAC ¶ 113. According to the FAC, “the providers were out of network, were  
13 unavailable to treat him, or did not offer the services listed in the directory.” FAC ¶ 113. In the  
14 summer of 2024, his primary care provider referred him to a therapist, but the therapist worked at  
15 a substance abuse-focused practice, which Maedel alleges was inappropriate for his needs. FAC  
16 ¶ 114. He alleges he has contacted more than 20 providers listed in the directory, but none were  
17 “available to provide care.” FAC ¶ 119. The FAC does not allege that Magellan made any benefit  
18 determination for Marto or Maedel.

19 Plaintiffs also allege that their counsel conducted “secret shopper” studies in February and  
20 March 2026 to replicate each plaintiff’s experience searching for a mental health provider. FAC  
21 ¶ 160. For Roiz, the study allegedly found an “80.4% ghost rate,” meaning that it was not possible  
22 to make an appointment with 41 of 50 directory listings called. FAC ¶¶ 163–164. The FAC notes  
23 that an earlier study in July 2025 resulted in an “87% ghost rate.” FAC ¶ 165. For Castillo, the  
24 study allegedly yielded a “94.74% ghost rate,” where it was not possible to make an appointment  
25 with 18 of 19 listings called. FAC ¶ 167–168. For Marto and Maedel, the study allegedly showed  
26 an “87.5% ghost rate,” where it was not possible to make an appointment with 44 of 50 listings  
27 called. FAC ¶¶ 170–171.

28 The studies describe the purported condition of the directory at a particular point in time,

1 but do not allege any facts about Magellan’s failure to comply with specific verification or update  
2 requirements imposed by the statutes and regulations on which Plaintiffs rely. Instead, Plaintiffs  
3 make conclusory allegations devoid of any factual context that Magellan failed to comply with  
4 verification and update requirements. FAC ¶ 148.

#### 5 **IV. Legal Standard**

6 When a defendant raises the defense of lack of subject matter jurisdiction pursuant to Rule  
7 12(b)(1) of the Federal Rules of Civil Procedure, the plaintiff bears the burden of establishing  
8 subject matter jurisdiction. *Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994).

9 In deciding a motion to dismiss for failure to state a claim under Rule 12(b)(6) of the  
10 Federal Rules of Civil Procedure, the court accepts as true all material allegations in the complaint  
11 and views them in the light most favorable to the plaintiff. *Dent v. NFL*, 968 F.3d 1126, 1130 (9th  
12 Cir. 2020). To survive the motion, a complaint must contain sufficient factual allegations to  
13 support a plausible claim for relief. *Id.* When a complaint alleges fraud, the heightened pleading  
14 standard of Rule 9(b) applies, which requires a plaintiff alleging fraud to do so “with particularity,”  
15 including the “who, what, when, where, and how of the misconduct charged.” *Vess v. Ciba-Geigy*  
16 *Corp. USA*, 317 F.3d 1097, 1106 (9th Cir. 2003).

#### 17 **V. Plaintiffs’ State-Law Claims Against Magellan Must Be Dismissed.**

##### 18 **A. Roiz’s state-law claims are preempted by ERISA.**

19 The state-law claims brought by Roiz and the putative class members who purchased or  
20 enrolled in an ERISA plan must be dismissed because they are preempted by ERISA, which  
21 expressly preempts “any and all State laws insofar as they may now or hereafter relate to any  
22 employee benefit plan.” 29 U.S.C. § 1144(a); *see also Bristol SL Holdings, Inc. v. Cigna Health*  
23 *& Life Ins. Co.*, 103 F.4th 597, 602 (9th Cir. 2024) (“This clearly expansive preemption provision  
24 extends to state common law causes of action” (internal quotation marks omitted)). There are two  
25 categories of state law claims that “relate to” an ERISA plan for preemption purposes: (1) claims  
26 that have a reference to an ERISA plan; and (2) claims that have an impermissible connection with  
27 an ERISA plan. *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319–20 (2016).

28 First, “[a] state-law claim has a ‘reference to’ an ERISA plan if it is premised on the

1 existence of an ERISA plan or if the existence of the plan is essential to the claim’s survival.”  
2 *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 665 (9th Cir. 2019) (internal quotation  
3 marks omitted). Here, there is no question that the existence of the ERISA plan is essential to the  
4 survival of Roiz’s state-law claims. Indeed, each of the challenged state-law claims depends on  
5 an evaluation of the benefits promised to Roiz under her Blue Shield Platinum Full PPO plan,  
6 requires review of plan documents and directories to assess the scope of the mental health provider  
7 network therein, and seeks damages based on the alleged delta between what was promised under  
8 the ERISA plan and what was delivered. The same would be true for any other class member  
9 bringing claims based on an ERISA plan. These claims thus have a “reference to” the ERISA plan  
10 and are preempted.

11 Second, “[a] claim has an impermissible ‘connection with’ an ERISA plan if it governs a  
12 central matter of plan administration or interferes with nationally uniform plan administration, or  
13 if it bears on an ERISA-regulated relationship.” *Depot, Inc.*, 915 F.3d at 666 (internal quotation  
14 marks omitted). In *Bristol SL Holdings, Inc.*, the Ninth Circuit found that allowing state-law  
15 liability premised on a healthcare provider’s “overarching system of verifying out-of-network  
16 coverage and authorizing treatment by phone, while later conditioning reimbursement on” certain  
17 member contributions, “would unduly intrude on a central matter of plan administration,” finding  
18 that there was an impermissible connection with an ERISA plan. Similarly here, Plaintiffs  
19 challenge Magellan’s administration of the behavioral-health provider directory and provider  
20 network that was available to members, which falls within the heartland of plan administration  
21 matters. These claims thus have an impermissible connection with an ERISA plan. Because Roiz  
22 and any additional putative class members who purchased or enrolled in an ERISA plan bring  
23 claims that relate to an employee benefit plan within the meaning of ERISA, their claims are  
24 preempted.

25 **B. Plaintiffs’ contract claims against Magellan fail (Counts Three and Six).**

26 Plaintiffs bring two contract-based causes of action against Magellan. Count Three is for  
27 breach of contract and Count Six is for breach of the implied covenant of good faith and fair  
28 dealing. Both claims are brought on behalf of Plaintiffs and putative class members who enrolled

1 in certain non-ERISA Blue Shield plans. FAC ¶¶ 280–92, 313–21. Plaintiffs assert these claims  
2 as third-party beneficiaries of the contract between Blue Shield and Magellan (the “Blue Shield-  
3 Magellan contract”).<sup>2</sup> Plaintiffs, however, are not third-party beneficiaries of the Blue Shield-  
4 Magellan contract, so they cannot bring a breach of contract claim against Magellan. Even if  
5 Plaintiffs could enforce the Blue Shield-Magellan contract, they have not adequately pleaded a  
6 material breach, either of the express contract terms or the implied covenant. Plaintiffs’ lack of a  
7 contractual relationship with Magellan forecloses Plaintiffs’ implied covenant claims as well.  
8 *Lyons v. Coxcom*, 718 F. Supp. 2d 1232, 1239 (S.D. Cal. 2009) (“In order to state a claim for relief  
9 on an implied covenant theory, there must first be a contractual relationship between the parties.”).  
10 Counts Three and Six must therefore be dismissed.

11 **1. Plaintiffs are not third-party beneficiaries of the Blue Shield-Magellan contract.**

12 Plaintiffs cannot sue to enforce the Blue Shield-Magellan contract. Under California law,  
13 “[a] contract, made expressly for the benefit of a third person, may be enforced by him at any time  
14 before the parties thereto rescind it.” Cal. Civ. Code § 1559. To bring suit as a third-party  
15 beneficiary, a plaintiff must meet three requirements: (1) he must in fact benefit from the contract;  
16 (2) a motivating purpose of the contracting parties must have been to provide a benefit to the third  
17 party; and (3) permitting the third-party plaintiff to sue must be consistent with the objectives of  
18 the contract and the reasonable expectations of the contracting parties. *Goonewardene v. ADP*,  
19 *LLC*, 434 P.3d 124, 132–33 (Cal. 2019). This test requires more than the contracting parties’  
20 “knowledge that a benefit to the third party may follow from the contract.” *Id.* at 133. The parties  
21 must have *intended* such a benefit. *Balsam v. Tucows Inc.*, 627 F.3d 1158, 1161 (9th Cir. 2010)  
22 (applying California law).

23 Plaintiffs allege they are intended third-party beneficiaries of the Blue Shield-Magellan  
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25 <sup>2</sup> Magellan includes as Exhibit 1 to this Motion the relevant portion of the Blue Shield-Magellan  
26 contract, as well as “Addendum 2” to that agreement, which was executed in 2016 and governs  
27 the provider directory. These documents are appropriate for the Court to consider on a Rule  
28 12(b)(6) motion to dismiss because Plaintiffs expressly reference, and thereby incorporate, the  
contract into the FAC. *In re Volkswagen “Clean Diesel” Mktg., Sales Prac., & Prod. Liab.*  
*Litig.*, 467 F. Supp. 3d 849, 855 & n.1 (N.D. Cal. 2020).

1 contract, but the unambiguous express terms of the contract say otherwise. *See* Cal. Civ. Code  
2 § 1638 (“The language of a contract is to govern its interpretation, if the language is clear and  
3 explicit, and does not involve an absurdity.”). Under the heading “Third Party Beneficiaries,” the  
4 contract states: “The parties do not intend to confer and this Agreement shall not be construed to  
5 confer any rights or benefits to any person, firm, group, corporation or entity other than the  
6 parties.” Ex. 1 at 53. Such a provision “unambiguously manifests an intent *not* to create any  
7 obligations to third parties.” *Balsam*, 627 F.3d at 1163 (citing Cal. Civ. Code § 1638); *see also In*  
8 *re Accellion, Inc. Data Breach Litig.*, 713 F. Supp. 3d 623, 647 (N.D. Cal. 2024) (“The Court  
9 agrees . . . that the third-party beneficiary disclaimer clause control[s] in this case and preclude[s]  
10 Plaintiffs from recovery as intended third-party beneficiaries.”). This fact alone bars Plaintiffs’  
11 contract-based claims against Magellan.

12           Moreover, even without such a provision, Plaintiffs are not third-party beneficiaries under  
13 the California Supreme Court’s analysis in *Goonewardene*. There, an employee sued her  
14 employer’s payroll administrator on a third-party beneficiary theory for breach of the agreement  
15 between the employer and the payroll administrator. The employer had hired the payroll  
16 administrator “to perform all of the payroll services for [the employer], including maintaining its  
17 employees’ earnings records, adding hours on their time cards, calculating their wages under the  
18 applicable labor laws, and preparing the paychecks and pay stubs for the employees.”  
19 *Goonewardene*, 434 P.3d at 130. The California Supreme Court held that the employee was not  
20 an intended third-party beneficiary because “the relevant motivating purpose of the contracting  
21 parties is to provide a benefit *to the employer*.” *Id.* at 127. (emphasis in original). “In addition,  
22 permitting each employee to name the payroll company as an additional defendant in any wage  
23 and hour lawsuit an employee may pursue would impose considerable litigation defense costs on  
24 the payroll company . . . a result that would not be consistent with the objectives of the contract  
25 and the reasonable expectations of the employer or the payroll company.” *Id.* The same result  
26 obtains here. The relevant motivating purpose of the Blue Shield-Magellan contract is to benefit  
27 Blue Shield, not Blue Shield’s customers. Blue Shield’s customers gain nothing from the Blue  
28 Shield-Magellan contract that they would not already be entitled to under their separate contracts

1 with Blue Shield. Allowing Blue Shield customers to tack Magellan onto any suit about their  
2 mental health benefits—which are governed by their contracts with their health insurer Blue  
3 Shield—would be inconsistent with the reasonable expectations of the contracting parties.

4 Counts Three and Six should be dismissed with prejudice. Plaintiffs have no contract with  
5 Magellan giving rise to a contract-based implied covenant nor are they third-party beneficiaries of  
6 the Blue Shield-Magellan contract.<sup>3</sup>

7 **2. Plaintiffs have not adequately pleaded any material breach of contract that**  
8 **caused them harm.**

9 Even assuming they could enforce the Blue Shield-Magellan contract, Plaintiffs fail to  
10 plausibly allege that Magellan breached a specific term of that agreement in a way that harmed  
11 them. To survive a motion to dismiss, a plaintiff “must identify a *specific contract provision*  
12 *breached by the defendant.*” *Satvati v. Allstate Northbrook Indem. Co.*, 634 F. Supp. 3d 792, 797  
13 (C.D. Cal. 2022) (emphasis added). Plaintiffs must then show that the breach of that specific  
14 provision caused them harm. *Small v. Allianz Life Ins. Co. of N. Am.*, 122 F.4th 1182, 1191 (9th  
15 Cir. 2024).

16 Plaintiffs fail to identify a specific breach. All Plaintiffs can muster are generalized issues  
17 with Magellan’s provider directory and general allegations of poor performance or service by  
18 Magellan under its contract with Blue Shield. Plaintiffs broadly allege what the contract  
19 “require[s]” and what they take to be the contract’s “objectives,” but they never point to a specific  
20 provision they contend was breached. *See* FAC ¶¶ 281–82, 284. That is not enough. *See Satvati*,  
21 634 F. Supp. 3d at 797 (plaintiff failed to allege breach of contract based on delay in payment  
22 without identifying a specific contractual provision breached by defendant). Plaintiffs need to  
23 allege the breach of a specific term of the contract that caused them harm. *See Andersen v. Stability*  
24 *AI Ltd.*, 700 F. Supp. 3d 853, 878 (N.D. Cal. 2023) (dismissing contract claim because plaintiffs  
25

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26 <sup>3</sup> Plaintiffs’ implied covenant claims in Count Six separately fail because they are based on the  
27 same conduct and injuries as their breach of contract claims, rendering the implied covenant claims  
28 duplicative. *See Green Crush LLC v. Paradise Splash I, Inc.*, 2018 WL 4940824, at \*7 (C.D. Cal.  
Mar. 8, 2018).

1 failed to “identify [the] precise provisions in the” third-party contract they contended was  
2 breached) (Orrick, J.).

3 Even setting aside their failure to identify the breach of a specific term, Plaintiffs have not  
4 alleged that any breach is the source of any injuries they incurred, as is required. *See Adobe Sys.*  
5 *Inc. v. A&S Elecs., Inc.*, 153 F. Supp. 3d 1136, 1146 (N.D. Cal. 2015) (dismissing breach of  
6 contract claim where plaintiff failed to allege “what particular damages” flowed from  
7 “Defendants’ alleged breach” of the contract). The closest the FAC comes to alleging a specific  
8 breach is Castillo’s allegation that Magellan failed to update an inaccurate directory entry after  
9 being notified of it. The Blue Shield-Magellan contract requires Magellan to make updates to the  
10 directory on certain time schedules, including after being notified of an error, along with imposing  
11 detailed and specific procedures for ensuring the directory is reasonably up-to-date based on  
12 information Magellan receives from providers. *See Ex. 1 at 54–57.* Castillo does not actually  
13 allege that Magellan failed to follow these contractual procedures. Even assuming for the sake of  
14 argument that Castillo’s allegation was sufficient to make out a breach of a specific term of the  
15 contract, Plaintiffs still would need to show that the breach *caused* their injuries. *See Small*, 122  
16 F.4th at 1191. This is especially so where the allegations of breach are predicated on statutory  
17 violations—plaintiffs must show that the breach, “in the form of a statutory violation,” caused their  
18 harm. *Id.* So even if Castillo has alleged that Magellan failed to update an inaccurate directory in  
19 violation of the contract or legal requirements, she does not allege how that particular inaccurate  
20 entry (or any other) caused her harm. *See King v. Facebook, Inc.*, 572 F. Supp. 3d 776, 790 (N.D.  
21 Cal. 2021) (dismissing breach of contract action where Plaintiff had alleged that Facebook  
22 breached contract by disabling plaintiff’s account but failed to allege that the account disabling  
23 caused plaintiff cognizable harm). She does not, for example, allege that she incurred out-of-  
24 pocket expenses for treatment from a provider who was erroneously listed in the directory because  
25 Magellan failed to abide by contractual or statutory verification procedures. Without such  
26 causation allegations, Plaintiffs’ breach of contract claims cannot proceed. *See Small*, 122 F.4th  
27 at 1191.

28 In sum, Plaintiffs plead generalized poor performance by Magellan, and the only facts that

1 arguably state a breach of any specific contract term are unconnected to any of Plaintiffs' injuries.  
2 They therefore do not state a valid claim for breach of contract.<sup>4</sup>

3 **C. Plaintiffs' claim under the California Unfair Competition Law fails (Count Seven).**

4 The Unfair Competition Law (UCL) prohibits "unlawful, unfair, or fraudulent" business  
5 practices. Cal. Bus. & Prof. Code § 17200. Because the statute is written disjunctively,  
6 California's courts have recognized essentially three different versions of the cause of action: an  
7 "unlawful" prong, an "unfair" prong, and a "fraudulent" prong. *Moran v. Prime Healthcare*  
8 *Mgmt., Inc.*, 208 Cal. Rptr. 3d 303, 309 (Cal. Ct. App. 2016). The FAC, like its predecessor,  
9 proceeds on both the fraudulent and unlawful prongs. The "fraudulent" prong of a UCL claim  
10 requires that the defendant's action is likely to deceive the public. *Schnall v. Hertz Corp.*, 93 Cal.  
11 Rptr. 2d 439, 457 (Cal. Ct. App. 2000). The unlawful prong requires a plaintiff to plead the  
12 violation of some other law, *i.e.*, to establish the business practice at issue was "unlawful" in some  
13 way. *Id.* at 311.

14 Plaintiffs' UCL claim against Magellan fails for four reasons. First, Plaintiffs lack standing  
15 to seek equitable relief in the form of an injunction against Magellan because Magellan's contract  
16 with Blue Shield is over. Second, because a UCL claim is equitable in nature, Plaintiffs are  
17 required to plead that they lack an adequate remedy at law, which they don't. *See Sonner v.*  
18 *Premier Nutrition Corp.*, 971 F.3d 834, 844 (9th Cir. 2020) (holding federal courts applying the  
19 UCL must require the plaintiff to plead that she lacks a remedy at law). Third, Plaintiffs continue  
20 to base their UCL claims on a fraudulent course of conduct, and despite their best efforts, they still  
21 fail to meet Rule 9(b)'s heightened pleading standard. *See Kearns v. Ford Motor Co.*, 567 F.3d  
22 1120, 1125 (9th Cir. 2009) (applying Rule 9(b) to UCL claims predicated on fraud). Fourth,  
23 Plaintiffs have not sufficiently pleaded that Magellan violated the predicate statutes on which they  
24 seek to pin the "unlawful" prong of their UCL claim.

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25  
26 <sup>4</sup> Plaintiffs also continue to engage in impermissible shotgun pleading with their contract claims,  
27 which incorporate by reference dozens of statutes and regulations without bothering to parse  
28 these laws and how they were violated in breach of the contract. *See Gibson v. City of Portland*,  
165 F. 4th 1265, 1291 (9th Cir. 2026); *see also infra* Section V.B.3.

1           **1. Plaintiffs lack standing.**

2           Plaintiffs do not have standing to seek equitable relief in the form of an injunction against  
3 Magellan. Plaintiffs must demonstrate standing separately as to each form of relief sought. *See*  
4 *Friends of the Earth, Inc. v. Laidlaw Env't Servs. (TOC), Inc.*, 528 U.S. 167, 185 (2000). Past  
5 wrongs are insufficient by themselves to grant standing, *see Davidson v. Kimberly-Clark Corp.*,  
6 889 F.3d 956, 967 (9th Cir. 2018), and Plaintiffs must show that they are under threat of an actual  
7 and imminent injury fairly traceable to Magellan's actions, *Summers v. Earth Island Inst.*, 555  
8 U.S. 488, 493 (2009). Magellan's contract with Blue Shield is over, and thus there is no actual  
9 and imminent injury to Plaintiffs posed by Magellan. *See Davidson v. Kimberly-Clark Corp.*, 889  
10 F.3d 956, 967 (9th Cir. 2018). The Court lacks equitable jurisdiction and should dismiss Plaintiffs'  
11 UCL claim under Rule 12(b)(1).

12           **2. Plaintiffs have legal remedies available.**

13           The UCL provides only equitable remedies and does not authorize legal damages. *Korea*  
14 *Supply Co. v. Lockheed Martin Corp.*, 63 P.3d 937, 943 (Cal. 2003). In federal court, a plaintiff  
15 seeking equitable relief under the UCL must plead that she lacks an adequate remedy at law.  
16 *Sonner*, 971 F.3d at 844. This requirement reflects “the traditional principle that equitable relief  
17 is not available when there is an adequate remedy at law,” which “has been applied in federal court  
18 since the founding of the Republic.” *Id.* at 843–44. Courts in this district have repeatedly  
19 recognized and applied this principle to UCL claims such as those Plaintiffs bring here. *Weizman*  
20 *v. Talkspace, Inc.*, 705 F. Supp. 3d 984, 990 (N.D. Cal. 2023) (dismissing UCL claim where  
21 plaintiff failed to allege inadequate remedy at law); *Guthrie v. Transamerica Life Ins. Co.*, 561 F.  
22 Supp. 3d 869, 875 (N.D. Cal. 2021) (same) (Orrick, J.) (collecting cases). Applying that principle  
23 here warrants dismissal of Plaintiffs' UCL claim.

24           The complaint plainly does not allege that Plaintiffs lack an adequate remedy at law for the  
25 harms underlying their UCL claim. Where, as here, a plaintiff seeks damages for the same conduct  
26 that supplies her UCL claim, equitable relief under the UCL is unavailable. *Sonner*, 971 F.3d at  
27 844. Because Plaintiffs have failed to allege that there is no adequate remedy at law, the UCL  
28 claim should be dismissed.

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

2           Plaintiffs again advance a “fraudulent” UCL claim, relying on alleged misrepresentations  
3 in public-facing directories and marketing, purportedly made to induce Plaintiffs to choose Blue  
4 Shield plans. FAC ¶ 176–81. And they continue to peg their “unlawful” UCL claim to several  
5 statutes based in fraud. Cal. Bus. & Prof. Code § 17500 (false advertising); Cal. Ins. Code § 790.02  
6 (unfair or deceptive acts); Cal. Health & Safety Code § 1360 (misleading plan information); *see*  
7 FAC ¶¶ 324–46. The FAC thus follows Plaintiffs’ original complaint in “alleg[ing] a unified  
8 course of fraudulent conduct and rely[ing] entirely on that course of conduct as the basis of” their  
9 UCL claim. *Kearns*, 567 F.3d at 1125. Rule 9(b) therefore applies. *Id.*

10           The FAC fails to meet Rule 9(b)’s heightened standard. Rule 9(b) requires a plaintiff to  
11 plead the “who, what, when, where, and how” of the alleged fraudulent conduct. That is, the  
12 plaintiff must identify the specific statements alleged to be false, who said them, when and where  
13 they were made, the manner in which the statements were misleading, and how the plaintiff relied  
14 on them. *Colgate v. JUUL Labs, Inc.*, 345 F. Supp. 3d 1178, 1190–91 (N.D. Cal. 2018) (Orrick,  
15 J.) (finding Rule 9(b) not satisfied where “neither [the court] nor [the defendant] can determine  
16 precisely what statements were allegedly false, misleading, or unfair”). Plaintiffs do none of this.  
17 For example, Plaintiffs allege that “Magellan representatives lied to [Roiz and Castillo] that they  
18 must choose a provider in the directory.” FAC ¶ 208. Despite the bald assertion that this was a  
19 “lie,” Plaintiffs do not explain why that statement was false at the time it was made, why the falsity  
20 of the statement was material, how they relied on it, or who said it to them. That is not sufficient.

21           Moreover, Plaintiffs direct fraud allegations collectively at “Defendants” without  
22 identifying any specific misrepresentation. A complaint must “set out which of the defendants  
23 made which of the fraudulent statements” instead of alleging “everyone did everything”. *Destfino*  
24 *v. Reiswig*, 630 F.3d 952, 958 (9th Cir. 2011). But the FAC simply and repeatedly alleges that  
25 “Defendants hold themselves out to consumers . . . as having a robust network of available  
26 providers to meet members’ mental health care needs. These representations are deceptive.” FAC  
27 ¶ 173. Plaintiffs say that “Defendants provide consumers with deceptive and materially misleading  
28 marketing and program materials about the benefits offered under their plans.” FAC ¶ 174. And

1 “Defendants” apparently “also encourage members and prospective members to rely on Evidence  
2 of Coverage documents.” FAC ¶ 174 n.41. This sort of vague and collective fraud pleading is not  
3 permissible under Rule 9(b). *United States v. Corinthian Coll.*, 655 F.3d 984, 997–98 (9th Cir.  
4 2011).

5 To further illustrate the point, the FAC quotes several statements from *Blue Shield’s*  
6 website and marketing materials, FAC ¶¶ 177–79, alleging that “[o]n information and belief,  
7 Magellan’s website and publicly available marketing materials featured substantially similar  
8 statements regarding the accuracy and robustness of the mental health network,” FAC ¶ 181. But  
9 despite the “publicly available” nature of Magellan’s supposedly fraudulent statements,  
10 Plaintiffs—on their second attempt to do so—cannot muster a single specific statement that  
11 Magellan made which they allege to be false. Again, Plaintiffs’ theory appears to be that  
12 Magellan’s directory was generally inaccurate, but Rule 9(b) requires more than generalized  
13 allegations of inaccuracy. *Cf. Colgate*, 345 F. Supp. 3d at 1191 (holding that permitting a plaintiff  
14 to allege generally that all the defendant’s advertisements were false “would eviscerate Rule 9(b)’s  
15 particularity requirement”). Because Plaintiffs have not identified the specific Magellan  
16 statements they relied upon, when those statements were made, or how those particular statements  
17 were false, Plaintiffs’ fraud-based claims against Magellan must be dismissed.<sup>5</sup>

18 **4. Plaintiffs fail to plausibly allege that Magellan committed any non-fraud**  
19 **predicate legal violation.**

20 To the extent the FAC can be read to plead non-fraud statutory and regulatory violations  
21 as a basis for an unlawful UCL claim, Plaintiffs’ shotgun pleading runs afoul of Rule 8.<sup>6</sup> To  
22

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23 <sup>5</sup> This argument applies with equal force across all of Plaintiffs’ claims that are subject to Rule  
24 9(b).

25 <sup>6</sup> Magellan’s position remains that Plaintiffs’ entire UCL claim sounds in fraud and is thus subject  
26 to Rule 9(b). *See Kearns*, 567 F.3d at 1126; *see also Hadley v. Kellogg Sales Co.*, 243 F. Supp.  
27 3d 1074, 1094 (N.D. Cal. 2017) (holding that where Plaintiff alleges a unified course of fraudulent  
28 conduct, the entire UCL claim is subject to Rule 9(b)). But to the extent that the Court disagrees  
as to certain predicates for the unlawful prong of the claim, Magellan presents these arguments as  
to the sufficiency of those predicates under Rule 8 in the alternative.

1 support their UCL claim, Plaintiffs rely on alleged violations of “the No Surprises Act, the  
2 Affordable Care Act, ERISA, the Internal Revenue Code, the MHPAEA<sup>7</sup>, California Business &  
3 Professions Code Section 17500, California Insurance Code Sections 790.02, 10133.15, and  
4 10133.54, Sections 1367.03, 1367.27, and 1360 of the Knox-Keene Act, Section 2240.01 of  
5 Chapter 10 of the California Code of Regulations and California Health & Safety Code Section  
6 1374.72.” FAC ¶ 324. Plaintiffs describe at a general level what each of these provisions requires  
7 and then allege in conclusory fashion that “Defendants violated” each one by not adhering to the  
8 general requirements of the statutes, making false statements, and publishing an inaccurate  
9 directory. *See* FAC ¶¶ 326, 328, 330, 334, 336, 338, 340, 342, 344, 346.

10           Nowhere in these paragraphs do Plaintiffs bother to put Magellan on notice of how exactly  
11 they allege it violated any of the more than one dozen state and federal statutes and regulations on  
12 which Plaintiffs pursue a UCL claim. Such broad incorporation by reference of multiple legal  
13 violations against multiple defendants rolled into a single claim “is a classic shotgun pleading.”  
14 *Gibson*, 165 F. 4th at 1291. Nor do Plaintiffs include the *factual matter* that would establish a  
15 violation of any of these statutory provisions, as opposed to conclusory assertions that the law was  
16 not followed. *See Stearns v. Select Comfort Retail Corp.*, 763 F. Supp. 2d 1128, 1150 (N.D. Cal.  
17 2010) (“[A]llegations in support of [a UCL] claim must state with reasonable particularity the facts  
18 supporting the statutory elements of the alleged violation.”).<sup>8</sup> Plaintiffs “cannot merely list statutes  
19 . . . without alleging specific facts to satisfy each element of the identified statute.” *Heejoon Chung*  
20 *v. U.S. Bank, N.A.*, 250 F. Supp. 3d 658, 678 (D. Haw. 2017).

21           Accordingly, Plaintiffs have not pleaded a UCL claim against Magellan, and Count Seven  
22

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23 <sup>7</sup> Plaintiffs do not actually allege that Magellan violated the MHPAEA, but rather that Blue  
24 Shield did so “with Magellan’s assistance.” FAC ¶ 332.

25 <sup>8</sup> In addition to their failure to plead these underlying violations with sufficient detail under Rule  
26 8, Plaintiffs also fail to tie their economic injuries to the specific statutory violations they seek to  
27 enforce; an unlawful UCL claim requires that the plaintiff’s injuries actually be caused by the  
28 specific legal violation by the defendant, *i.e.*, that the plaintiff would not have been injured if the  
Defendant had complied with the law. *Haynish v. Bank of America, N.A.*, 284 F. Supp. 3d 1037,  
1051–52 (N.D. Cal. 2018); *cf. supra* Section V.A.2.

1 should be dismissed.

2 **D. Plaintiffs’ intentional and negligent misrepresentation claims against Magellan fail**  
3 **(Counts Eight and Nine).**

4 Plaintiffs also assert claims for intentional misrepresentation and negligent  
5 misrepresentation. Rule 9(b) applies to these claims as well. Intentional misrepresentation is  
6 essentially coextensive with common law fraud. *See Rodriguez v. JP Morgan Chase & Co.*, 809  
7 F. Supp. 2d 1291, 1296 (S.D. Cal. 2011) (equating intentional misrepresentation and actual fraud  
8 and applying Rule 9). And, while the law in this Circuit is unsettled as to whether Rule 9(b) applies  
9 to *negligent* misrepresentation, *see Anschutz Corp. v. Merrill Lynch & Co. Inc.*, 785 F. Supp. 2d  
10 799, 823 (N.D. Cal. 2011), the Court should apply the heightened standard here because Plaintiffs’  
11 allegations are plainly grounded in fraud rather than negligence. *See Kearns*, 567 F.3d at 1125  
12 (holding Rule 9(b) applies when plaintiff alleges an entirely fraudulent course of conduct).  
13 Applying Rule 9(b) to these common law misrepresentation claims requires dismissal for the same  
14 reasons articulated above. *See supra* Section V.B.2. The FAC directs the misrepresentation  
15 allegations collectively at “Defendants.” FAC ¶¶ 352–78. The word “Magellan” appears only  
16 once in the paragraphs supporting either count, when Plaintiffs allege that their premiums “were  
17 passed on to Magellan.” FAC ¶ 362. This does not pass muster under Rule 8, let alone Rule 9,  
18 because Plaintiffs do not allege a single misrepresentation by Magellan that could even be  
19 construed as negligent or intentional. Counts Eight and Nine should be dismissed as well.

20 **E. Plaintiffs’ claim for “restitution for unjust enrichment” fails (Count Ten).**

21 Plaintiffs assert a claim for restitution for unjust enrichment “in the alternative to their  
22 breach of contract claims.” FAC ¶ 379. As to Magellan, this claim fails for two reasons.

23 First, the FAC does not plead that Magellan retained a benefit at *Plaintiffs’* expense. A  
24 plaintiff asserting unjust enrichment must allege that “the defendant received and unjustly retained  
25 a benefit at the plaintiff’s expense.” *ESG Capital Partners, LP v. Stratos*, 828 F.3d 1023, 1038  
26 (9th Cir. 2016); *see also Lectrodryer v. SeoulBank*, 77 Cal. App. 4th 723, 726 (2000) (elements  
27 are “receipt of a benefit and unjust retention of the benefit at the expense of another”). Here,  
28 Plaintiffs allege that they paid premiums to *Blue Shield* and that Blue Shield subsequently passed

1 on some of those premiums to Magellan as compensation for delegating certain of Blue Shield’s  
2 obligations to Magellan. But Plaintiffs do not allege that this benefit came at *their expense* because  
3 they have no legal or equitable right to the money that Blue Shield paid Magellan. *City of Oakland*  
4 *v. Oakland Raiders*, 83 Cal. App. 5th 458, 479 (2022). In other words, any benefit incurred by  
5 Magellan came at the expense of Blue Shield and not Plaintiffs. *See Tindell v. Murphy*, 22 Cal.  
6 App. 5th 1239, 1254 (2018) (affirming dismissal of unjust enrichment claim where third party, not  
7 the plaintiff, paid the benefit at issue to the defendant). “Proof merely that the defendant has  
8 received a windfall, that the plaintiff has been ill-treated, and that the third party’s payment to the  
9 defendant . . . violates rules of good faith, basic fairness, or common decency, does not suffice to  
10 make out a claim in restitution.” *City of Oakland*, 83 Cal. App. 5th at 479.

11 Second, Plaintiffs base their restitution claim entirely on a unified fraudulent course of  
12 conduct, and, as with the other claims already addressed, this pleading choice triggers the  
13 heightened scrutiny of Rule 9(b). *Smith v. GlaxoSmithKline Consumer Healthcare Holdings (US)*  
14 *LLC*, 660 F. Supp. 3d 863, 875 (N.D. Cal. 2023) (“[C]ourts have consistently applied Rule 9(b)’s  
15 heightened pleading requirements to claims arising under the UCL, . . . as well as claims for  
16 fraudulent misrepresentation, negligent misrepresentation, fraud by omission, *and unjust*  
17 *enrichment.*” (emphasis added)) (collecting cases). Plaintiffs base their unjust enrichment claim  
18 on the premise that “Defendants’ lies artificially inflated the list price of, and induced Plaintiffs to  
19 enroll in, Blue Shield’s plan, which increased the premiums paid to Defendants.” FAC ¶ 381. But,  
20 as with their other claims, they plead no facts sufficient to establish particular fraud or  
21 misrepresentations by Magellan—and that defect is fatal. *See* Sections V.B.II and V.C. Count  
22 Ten against Magellan should thus be dismissed as well.

## 23 **VI. Plaintiff Roiz’s ERISA Claims Against Magellan Must Be Dismissed.**

24 Roiz asserts two ERISA claims against Magellan: (1) improper denial of benefits pursuant  
25 to § 1132(a)(1)(B); and (2) breach of fiduciary duty under §§ 1132(a)(1)(B) and (a)(3). As before,  
26 both of these claims fail.

### 27 **A. Roiz’s claim for improper denial of benefits against Magellan fails (Count Eleven).**

28 To state a claim for denial of benefits under § 1132(a)(1)(B), a plaintiff must allege that

1 her ERISA plan entitled her to benefits that the defendant failed to provide. *See Almont*  
2 *Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1159 (C.D. Cal.  
3 2015). The only denial of benefits Roiz alleges is that “Magellan, acting on Blue Shield’s behalf,  
4 denied Ms. Roiz’s request for an extension of the three-month period covering her existing  
5 therapist as in-network, based on its finding that in-network providers were available.” FAC ¶  
6 157. Roiz alleges that this violated plan terms that entitled her to coverage for an out-of-network  
7 provider “since there were no in-network providers available within a reasonable distance of Ms.  
8 Roiz.” FAC ¶ 158. She alleges that, despite Magellan’s finding to the contrary, she herself  
9 “confirmed” that in-network providers in her area “were not taking new patients.” FAC ¶ 157.  
10 The relevant factual allegations in support of that claim are that Roiz “searched Defendants’  
11 provider directory by filtering for female practitioners who specialized in grief,” that she called  
12 ten such providers, but that all of them were either “out of network, were unavailable to treat Ms.  
13 Roiz, or did not offer the services listed.” FAC ¶ 60. But Roiz does not allege that Magellan or  
14 Blue Shield was required by plan documents to provide her out-of-network coverage because she  
15 could not specifically locate “female practitioners who specialized in grief.” *See Almont*  
16 *Ambulatory Surgery Ctr.*, 99 F. Supp. 3d at 1158 (dismissing denial of benefits claim where  
17 plaintiff failed to allege that “the specific services” at issue “were covered under the terms of the  
18 relevant plans”).

19         Moreover, Roiz relies on the fact that certain providers in her area “did not offer the  
20 services listed” in the directory, without specifying what those services were or why she was  
21 specifically in need of a provider who offered them. From Roiz’s allegations, it is not actually  
22 clear that she was unable to locate any in-network mental health providers in her area who were  
23 available to treat her. At most, she alleges that she could not locate an available in-network  
24 provider that met certain criteria imposed by Roiz, but those criteria don’t appear in the plan terms.  
25 *Cf. CIGNA Corp. v. Amara*, 563 U.S. 421, 436 (2011) (“The statutory language [in  
26 § 1132(a)(1)(B)] speaks of *enforcing* the terms of the plan, not of *changing* them.” (cleaned up)  
27 (emphasis in original)). To survive a motion to dismiss, the plaintiff needs to allege facts that, if  
28 proven, would establish the legal violation she pursues. But here, even if Roiz proved that she was

1 unable to access in-network female practitioners who specialized in grief, or who did not offer  
2 certain unspecified services she was seeking, that would not establish that she was denied benefits  
3 under the terms of her plan when Magellan and Blue Shield declined to extend out-of-network  
4 coverage to her existing therapist.

5 Roiz does not adequately allege that Magellan denied her benefits that it was “obligated to  
6 pay but failed to pay.” *Glendale Outpatient Surgery Ctr. v. United Healthcare Servs., Inc.*, 805  
7 Fed. App’x 530, 531 (9th Cir. 2020). Accordingly, Roiz fails to plead a claim for denial of benefits  
8 under ERISA, and Count Eleven should be dismissed.

9 **B. Roiz’s claim for breach of fiduciary duty against Magellan fails (Count Twelve).**

10 To maintain a claim for breach of fiduciary duty under ERISA, a plaintiff must allege that  
11 “(1) the defendant was a fiduciary; (2) the defendant breached a fiduciary duty; and (3) the plaintiff  
12 suffered damages.” *Bafford v. Northrup Grumman Corp.*, 994 F.3d 1020, 1026 (9th Cir. 2021).  
13 Specifically, the defendant must have been a fiduciary when “taking” the specific “action subject  
14 to complaint.” *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). The plaintiff also is required to  
15 allege, separate from any individual injury, “that the fiduciary injured the benefit plan or otherwise  
16 jeopardized the entire plan or put at risk plan assets.” *Wise v. Verizon Comms., Inc.*, 600 F.3d  
17 1180, 1189 (9th Cir. 2010). Roiz’s claim fails here because she is merely repackaging her  
18 individual denial of benefits claim as a breach of fiduciary duty claim, and for the same reason she  
19 has not pleaded a distinct injury to the plan as a whole.

20 Roiz seeks to hold Magellan liable as a “functional fiduciary,” which is an entity that  
21 exercises discretion over an ERISA plan. *See Bafford*, 994 F.3d at 1026. To do so, she needs to  
22 allege that Magellan was exercising such discretion, *i.e.*, acting as a fiduciary, “during the  
23 purported violation.” *Id.* The only contact between Roiz and Magellan during which Magellan  
24 could possibly have been exercising sufficient discretion to be a functional fiduciary was  
25 Magellan’s alleged denial of Roiz’s request for an extension of out-of-network coverage for her  
26 existing therapist. *See CSA 401(k) Plan v. Pension Professionals, Inc.*, 195 F.3d 1135, 1140 (9th  
27 Cir. 1999) (discretionary fiduciary functions include “approval and rejection of claims and the  
28 rendering of ultimate decisions regarding benefits eligibility”). Roiz’s interactions with Magellan

1 outside of that specific denial—searches in the provider directory and customer service phone  
2 calls—are plainly ministerial functions that lack the kind of discretion necessary to make Magellan  
3 an ERISA fiduciary. *See Chaganti v. Ceridian Benefits Servs., Inc.*, 208 Fed. App’x 541, 547 (9th  
4 Cir. 2006) (recognizing that “communicating with beneficiaries about their rights and options  
5 under the plan” is a ministerial, non-fiduciary function).

6 But the specific denial Roiz alleges does not support her claim for breach of fiduciary duty  
7 under ERISA. Unlike denial of benefit claims under § 1132(a)(1)(B), individual injuries do not  
8 give rise to breach of fiduciary duty claims under § 1132(a)(3). Rather, fiduciary claims are limited  
9 to circumstances where there is an injury “to the ERISA plan as a whole.” *Wise*, 600 F.3d at 1189.  
10 For that reason, a defendant’s mere “mishandling of an individual benefit claim does not violate  
11 any of the fiduciary duties defined in ERISA.” *Amalgamated Clothing & Textiles Workers Union,*  
12 *AFL-CIO v. Murdock*, 861 F.2d 1406, 1414 (9th Cir. 1988). Put another way, Roiz does not (and  
13 could not) “allege that the plan as a whole incurred an injury as a result of [Magellan’s]  
14 mishandling of her claim.”<sup>9</sup> *Wise*, 600 F.3d at 1189.

15 Here, the only discretionary action Roiz alleges Magellan took is denying her request for  
16 an extension of out-of-network coverage for her therapist. The injuries she pleads are therefore  
17 entirely individualized, and the proper remedy is a denial of benefits claim under § 1132(a)(1)(B).  
18 Roiz cannot bring a duplicative claim for breach of fiduciary duty. *Castillo v. Metropolitan Life*

19 \_\_\_\_\_  
20 <sup>9</sup> Although the FAC contains the conclusory allegation that “Defendants’ misrepresentations,  
21 omissions, and false statements about the size of their provider network harmed the ERISA plan  
22 as a whole by measurably reducing the value of the plan’s assets (here, its provider network),”  
23 FAC ¶ 403, this allegation again impermissibly conflates the allegations against Magellan and  
24 Blue Shield. As to Magellan, the only specific denial that could plausibly support a functional-  
25 fiduciary duty is the denial of Roiz’s request for an extension of out-of-network coverage for her  
26 existing therapist, which is plainly not a “misrepresentation[], omission[], [or] false statement[]  
27 about the size of the[] provider network.” Even if it were, it is far from clear how a denial  
28 predicated on Roiz’s individual circumstances could “measurably reduc[e] the value of the plan’s  
assets.” Nor is it the case that a provider directory or a provider network is a plan asset within  
the meaning of ERISA because Plaintiffs do not have a property interest in either the provider  
directory or network. *See Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 658 (9th Cir.  
2019) (“[P]lan ‘assets’ under 29 U.S.C. § 1002(A)(21)(i) are to be identified based on ordinary  
notions of property rights.”). Thus, Plaintiffs fail to plausibly allege that *Magellan’s* actions  
resulted in injury to the plan as a whole.

1 *Ins. Co.*, 970 F.3d 1224, 1229 (9th Cir. 2020) (no remedy for ERISA breach of fiduciary duty  
2 “when a more specific section of the statute, such as § 1132(a)(1)(B), provides a remedy similar  
3 to what the plaintiff seeks under the equitable catchall provision, § 1132(a)(3)”). Count Twelve  
4 must therefore be dismissed as well.

5 **VII. Conclusion**

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

8 Dated: May 5, 2026

Respectfully submitted,

9 By: /s/ Steven M. Cady

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*Attorneys for Magellan Defendants*

21  
22 **CERTIFICATE OF SERVICE**

23 I certify that on May 5, 2026, I electronically filed the foregoing Motion to Dismiss with  
24 the Clerk of Court using the ECF system, which sent notification of such filing to all counsel of  
25 record.

26 By: /s/ Steven M. Cady

27 Steven M. Cady

# **EXHIBIT 1:**

## **Excerpt of Blue Shield-Magellan Contract**

**BEHAVIORAL HEALTH SERVICES AGREEMENT  
BETWEEN  
HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA  
AND  
BLUE SHIELD OF CALIFORNIA**

This BEHAVIORAL HEALTH SERVICES AGREEMENT (this “**Agreement**”), is entered into effective June 15, 2011 (the “**Effective Date**”), by and between Human Affairs International of California, a California corporation (“**HAI-CA**”), and California Physicians’ Service, a California nonprofit mutual benefit corporation dba Blue Shield of California (“**BSC**”).

**RECITALS**

A. BSC is licensed as a prepaid health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 and the regulations promulgated thereunder, each as amended (the “**Knox-Keene Act**”). BSC contracts with individuals, associations, employer groups, and governmental entities to provide or to arrange for the provision of covered health care services and/or related administrative services to individuals enrolled in Benefit Plans (as defined herein) underwritten or administered by BSC.

B. HAI-CA is licensed as a specialized health care service plan under the Knox-Keene Act, and through its contracted network of professional and facility providers, is able to provide or arrange for the delivery of professional mental health and substance abuse services and related administrative services.

C. HAI-CA and BSC desire that HAI-CA provide or arrange for the delivery of mental health and substance abuse services, to Members (as defined herein) and provide related administrative services, in accordance with the terms of this Agreement.

**ARTICLE 1**  
**DEFINITIONS**

For purposes of this Agreement, the following capitalized terms shall have the meanings ascribed to them below:

**1.1 Administrative Manual:** The manuals developed by BSC which set forth the operational rules and procedures applicable to the provision of services by HAI-CA pursuant to this Agreement, comprised of the applicable portions of the HMO IPA/Medical Group Procedures Manual, the HMO Benefit Guidelines, the Blue Shield Medical Interface Manual, the BSC Provider Manual, BSC Delegation Standards and criteria, BSC credentialing policies and procedures, BSC Medicare Advantage contractual obligations, outpatient drug formulary and drug prior authorization requirements, and the Blue Shield Medical Policy Manual.

**1.2 Affiliate:** means, in respect of any Person, any other Person that is directly or indirectly controlling, controlled by, or under common control with such Person or any of its subsidiaries, and the term “control” (including the terms “controlled by” and “under common control with”) means having, directly or indirectly, the power to direct or cause the direction of the management and policies of a Person, whether through ownership of voting securities or by contract or otherwise.

**1.3 Association:** The Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

**1.4 Benefit Plan:** A plan of benefits which includes health care coverage, is issued or administered in whole or in part by BSC and contains the terms and conditions of a Member's coverage. For purposes of this Agreement, "Benefit Plan" shall include the benefit plans of all other independent licensees of the Association which entitle its enrollees to obtain health care services within the Service Area through the Association's Blue Card Program ("**Blue Card Plans**").

**1.5 Blue Card Member:** An enrollee in a Blue Card Plan.

**1.6 BSC Behavioral Health Provider:** A BSC Provider who provides mental health and/or substance abuse services to Non-Risk Members.

**1.7 BSC Provider:** A duly licensed health care professional or facility that has an executed written agreement in effect with BSC to provide Covered Services to Members.

**1.8 Capitation Payment:** An amount equal to a single Capitation Rate multiplied by the number of Members who are enrolled in the Benefit Plan(s) (other than Blue Card Plans) to which the Capitation Rate applies.

**1.9 Capitation Rate:** The amount to be paid to HAI-CA for each Member per month, as specified in Exhibit C hereto, including the MHSA Capitation Rates, the Self-Funded Administrative Rates and the FEP Administrative Rates.

**1.10 CMS:** the Centers for Medicare and Medicaid Services.

**1.11 Commencement Date:** January 1, 2012.

**1.12 Copayment:** Any copayments, deductibles, or coinsurance specifically described as the financial responsibility of the Member for a Covered Service in the applicable Benefit Plan in effect as of the date of service.

**1.13 Covered Services:** The Medically Necessary health care services and supplies covered by a Member's Benefit Plan, including, without limitation, Covered MHSA Services.

**1.14 Covered MHSA Services:** Those mental health and substance abuse services and supplies that are: (a) Covered Services under a Full-Risk Member's Full-Risk Benefit Plan; (b) included in the list of Covered MHSA Services attached hereto as Exhibit D; and (c) not listed in the list of Exclusions from Covered MHSA Services attached hereto as Exhibit E. Such mental health and substance abuse services and supplies shall be Covered Services only when determined to be Medically Necessary.

**1.15 Eligible Employees:** Persons who are employees of BSC and not enrolled for coverage under a Benefit Plan, but by virtue of such employment are eligible to receive Work/Life Services (as defined in Section 6.1), and such persons' dependents.

**1.16 Emergency Services:** Covered MHSA Services required to address an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the Member's health or that of another person or unborn child in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. Emergency Services shall also include any other services as regulated by applicable federal or state regulations, laws or statutes, including without limitation, for Members enrolled in a BSC Medicare Advantage Benefit Plan, any other services defined as emergency services in 42 C.F.R. § 422.113.

**1.17 Enrolling Unit:** The employer or other defined or otherwise legally constituted group with whom a Benefit Plan is in effect.

**1.18 Full-Risk Benefit Plans:** Those Benefit Plans that are underwritten by BSC and identified in Section 1 of Exhibit A hereto.

**1.19 Full-Risk Member:** An individual who is eligible for and enrolled in a Full-Risk Benefit Plan.

**1.20 Governmental Entity:** any federal, state, or municipal court or other governmental department, commission, board, bureau, agency, or instrumentality, governmental or quasi-governmental, domestic or foreign.

**1.21 HAI-CA Provider:** A health care professional or facility that is qualified and duly licensed and/or certified and has an executed written agreement in effect with HAI-CA to provide mental health and/or substance abuse services to Full-Risk Members.

**1.22 Medicare Advantage Member:** An individual who is eligible for and enrolled in a BSC Medicare Advantage Full-Risk Benefit Plan.

**1.23 Medically Necessary:** Mental health or substance abuse services and supplies which are provided in accordance with recognized professional practices and standards, and which are determined by BSC or HAI-CA (to the extent such determination is delegated to HAI-CA pursuant to this Agreement) to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such medical condition; (c) not furnished primarily for the convenience of the Member, the Member's family, or the treating provider or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) with respect to inpatient services, could not have been provided in a health care provider's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. The fact that a provider has performed or prescribed a procedure or treatment or the fact that such procedure or treatment may be the only procedure or treatment for a particular condition, injury, sickness or mental illness does not mean that such procedure or treatment is Medically Necessary. The definition of Medically Necessary used in this Agreement relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.

**1.24 Member:** An individual who: (a) has applied for and is enrolled in an individual Benefit Plan; or (b) meets the eligibility requirements specified by the Enrolling Unit and is enrolled in such Enrolling Unit's group Benefit Plan.

**1.25 Non-Risk Benefit Plans:** Those Benefit Plans that are not Full-Risk Benefit Plans and are identified in Section 2 of Exhibit A hereto, in support of which HAI-CA may provide administrative services and bears no financial risk or financial responsibility.

**1.26 Non-Risk Member:** A Member enrolled in a Non-Risk Benefit Plan.

**1.27 PCP:** A BSC Provider who is a family practitioner, general practitioner, internist, or pediatrician who provides primary care services to Full-Risk Members and is responsible for coordinating, referring, and managing the delivery of health care services to Full-Risk Members. A PCP may include an obstetrician-gynecologist who has agreed to serve as a PCP.

**1.28 Person:** any individual, partnership, limited partnership, corporation, limited liability company, association, joint stock company, trust, joint venture, unincorporated organization, or Governmental Entity.

**1.29 Proposal:** The proposal to provide mental health and substance abuse services submitted on behalf of HAI-CA to BSC, dated July 27, 2009, and as amended thereafter.

**1.30 Self-Funded Member:** An individual who is eligible for and enrolled in a self-funded Benefit Plan that is administered in whole or in part by BSC and that includes a managed behavioral health services rider.

**1.31 Service Area:** The geographic area in which BSC is licensed as a health care service plan, as set forth in Exhibit B hereto.

**1.32 Urgent Care Services:** Covered MHSA Services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment can not reasonably be delayed. For Medicare Advantage Members, Urgent Care Services, at a minimum, include all services which are defined by CMS as "Urgently Needed Services".

**1.33 UM Services:** A system of reviewing a Member's Covered Services to facilitate the continuity, cost effectiveness and appropriateness of care, including clinical triage, referral, prior authorization, concurrent review, retrospective review, discharge planning and case management to ensure appropriate use of resources.

## **ARTICLE 2** **MHSA SERVICES**

**2.1 Mental Health and Substance Abuse Services.** Commencing on the Commencement Date, HAI-CA shall provide or arrange for the provision of Covered MHSA Services to Full-Risk Members and shall perform certain related administrative services supporting the Full-Risk Benefit Plans and the Non-Risk Benefit Plans for and on behalf of BSC, as set forth in this Agreement (collectively, "MHSA Services"):

**2.2 Transition of Care.** HAI-CA's responsibility for outpatient Covered MHSA Services shall commence on the Commencement Date. HAI-CA's responsibility for inpatient and residential care Covered MHSA Services shall commence on: (a) the Commencement Date, for inpatient and residential care admissions occurring on or after the Commencement Date, or (b) the twenty-third (23<sup>rd</sup>) day following the Commencement Date for inpatient and residential care admissions occurring prior to the Commencement Date. Any Member in outpatient treatment with a provider who/that is not contracted with HAI-CA to furnish Covered MHSA Services to BSC Members as of the Commencement Date or such other time following the Commencement Date that such person becomes a Member may continue in treatment with such provider at the in-network benefit level for a period of at least sixty (60) days following the Commencement Date depending on the Member's clinical needs and specific benefit plan coverage. After such sixty (60) day period (or more), treatment through a provider that is not an HAI-CA Provider shall be treated as out-of-network, subject to the terms of Section 9.1 of this Agreement.

**2.3 Development and Management of HAI-CA Network.**

(a) HAI-CA shall establish and maintain a network of professional and facility health

care providers contracted with HAI-CA to furnish Covered MHSA Services to Full-Risk Members (the “**HAI-CA Provider Network**”). The HAI-CA Provider Network shall satisfy at all times and in all markets within the Service Area the access standards established by applicable state and federal law (including, without limitation, the Knox-Keene Act) and BSC, as well as the Minimum Network Access Standards from time to time promulgated by the Association and communicated to HAI-CA by BSC with no fewer than ninety (90) days advance notice; provided, however, that HAI-CA shall be excused from satisfying the Association’s Minimum Network Access Standards in a given rural area, if a sufficient number of providers are not available in such rural area and provided that the Association has granted BSC a waiver of compliance for such rural area. Upon written request by BSC, HAI-CA shall provide BSC a copy of HAI-CA’s then current provider agreements, all of which shall comply with the applicable requirements of the Knox-Keene Act and the Social Security Act.

(b) HAI-CA shall establish and maintain a credentialing and re-credentialing process that is compliant with the applicable requirements of the Knox-Keene Act, the National Committee for Quality Assurance (“**NCQA**”), the Utilization Review Accreditation Commission (“**URAC**”) and CMS, to which all HAI-CA Providers shall be subject. HAI-CA shall provide a copy of HAI-CA’s credentialing process to BSC for approval, which approval shall not be unreasonably withheld. Prior to implementing any change to its credentialing process, HAI-CA shall provide a copy of the proposed change to BSC for review and approval, which approval shall not be unreasonably withheld.

(c) On or before the fifteenth (15<sup>th</sup>) day of each month, HAI-CA shall provide BSC with a current listing of HAI-CA Providers, including such related data and in such format as from time to time agreed upon by the parties. HAI-CA shall promptly notify BSC, in writing, if at any time HAI-CA determines that the HAI-CA network of licensed HAI-CA Providers no longer satisfies the requirements of the Knox-Keene Act or otherwise becomes out of compliance with the Minimum Network Access Standards. In the event BSC reasonably determines that there are not sufficient HAI-CA Providers to provide Covered MHSA Services to Full-Risk Members, BSC shall notify HAI-CA of the alleged deficiency. Within thirty (30) days of such notice, BSC and HAI-CA shall meet to assess the alleged deficiency, and, if appropriate, develop a mutually satisfactory plan of correction.

#### **2.4 Customer and Intake Services.**

(a) HAI-CA shall operate a telephone service center to support customer service operations with respect to the provision of Covered MHSA Services to Full-Risk Members and Medical Management (as defined in Section 2.9(b)) services with respect to Self-Funded Members. Such telephone service center shall be staffed with customer service representatives who are familiar with the Full-Risk Benefit Plans to which this Agreement applies and who are trained and qualified to receive comments (including expressions of customer dissatisfaction) and to respond to questions from Full-Risk Members and HAI-CA Providers regarding such Full-Risk Benefit Plans, including (without limitation) questions relating to Covered MHSA Services, questions relating to the identity and location of HAI-CA Providers, and questions relating to the payment of claims for the provision of Covered MHSA Services to Full-Risk Members.

(b) A twenty-four (24)-hour, toll-free telephone line shall be staffed by HAI-CA for Full-Risk Members. Services provided by HAI-CA through such phone line shall include referral of Full-Risk Members for required Covered MHSA Services, crisis intervention, and responding to Full-Risk Member inquiries and questions regarding Covered MHSA Services. The services of an appropriately qualified health care professional shall also be made available by HAI-CA through such telephone line. Services after normal business hours shall be limited to crisis services.

**2.5 Mixed Services.** When a Full-Risk Member has a condition or illness which requires Covered MHSA Services and non-Covered MHSA Services, HAI-CA shall be responsible for

providing or arranging and paying for only the Covered MHSA Services. BSC or the Full-Risk Member shall be responsible for payment of any non-Covered MHSA Services. In determining whether certain services shall be considered Covered MHSA Services or non-Covered MHSA Services, HAI-CA and BSC shall refer to the list of Covered MHSA Services attached hereto as Exhibit D, the Exclusions contained in Exhibit E and the Mixed Services Protocol set forth in the Blue Shield Medical Interface Manual.

## **2.6 Provisions for Emergency Services.**

(a) Notice to HAI-CA. Full-Risk Members requiring Emergency Services may receive such services without the need to obtain prior approval from HAI-CA. However, such Full-Risk Members may notify HAI-CA's toll-free telephone line prior to obtaining such service. The toll-free telephone line clinician will refer the call to an appropriate HAI-CA Provider, who will conduct a preliminary mental health needs assessment for the Full-Risk Member and, as medically appropriate, either provide such services or refer the Full-Risk Member to another HAI-CA Provider. Providers of care may contact HAI-CA's toll-free telephone line prior to rendering Emergency Services to a Full-Risk Member. The toll-free telephone line clinician will authorize such services as are necessary to evaluate, treat and stabilize the Full-Risk Member's emergency condition.

(b) Follow-up Care. All treatment and services provided following the provision of Emergency Services and stabilization of a Full-Risk Member's condition, which are not themselves Emergency Services, shall be covered hereunder only if provided by HAI-CA Providers and in accordance with HAI-CA's care authorization requirements. HAI-CA will arrange for Full-Risk Members who have received Emergency Services from a non-HAI-CA Provider to be referred to an HAI-CA Provider for follow-up care.

(c) Denial of Coverage. Any treatment or services provided to a Full-Risk Member that have not been authorized in advance by HAI-CA as described in Section 2.6(a) (where such prior authorization is required under the applicable Benefit Plan), and that are later determined by HAI-CA not to have been Emergency Services, shall not be Covered MHSA Services and shall not be covered hereunder, unless otherwise authorized by HAI-CA.

(d) Transfer of Inpatient. If, incident to the provision of Emergency Services, a Full-Risk Member becomes an inpatient or resident of a hospital or other facility, HAI-CA may, as medically appropriate, transfer the Full-Risk Member to a hospital or other facility that is an HAI-CA Provider. If HAI-CA makes such a transfer, HAI-CA shall pay all necessary and reasonable costs of transportation to the HAI-CA Provider.


(e) Reimbursement Provision. If a Full-Risk Member receives Emergency Services or Urgent Care Services in accordance with the requirements of this Section from a provider that is not an HAI-CA Provider, HAI-CA shall, as applicable, compensate the Provider for such services or reimburse the Full-Risk Member for charges paid by the Full-Risk Member for such services, less any applicable Copayments, in accordance with the applicable Benefit Plan. To be eligible to receive reimbursement, a Full-Risk Member must submit to HAI-CA, in person or by mail, a written claim explaining the charges incurred and including a copy of any statement, receipt or bill obtained from the provider for those charges. A claim for reimbursement must state the Full-Risk Member's name, address and social security number, as well as the providers name and address, the description and charges for the services rendered, and a mental health diagnosis. Claims shall be allowed only if submitted to HAI-CA within one (1) year after the date on which the first services described by the claim were provided.

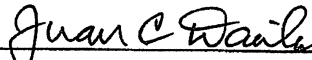
FINAL EXECUTION COPY 06/15/11

19.17 **Third Party Beneficiaries.** The parties do not intend to confer and this Agreement shall not be construed to confer any rights or benefits to any person, firm, group, corporation or entity other than the parties.

**HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA**

**BLUE SHIELD OF CALIFORNIA**

By   
Print Name Pamela Masters  
Print Title President  
Date 6/20/11

By   
Print Name Juan C Davila  
Print Title SNR VP NETWORK mgmt  
Date 6-20-11



**SECOND ADDENDUM  
TO THE  
BEHAVIORAL HEALTH SERVICES AGREEMENT  
BETWEEN  
HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA  
AND  
BLUE SHIELD OF CALIFORNIA**

This Second Addendum (this “Second Addendum”) is entered into by and between California Physicians’ Service, dba Blue Shield of California, a California, nonprofit mutual benefit corporation (“BSC”), and Human Affairs International of California, a California corporation (“HAI-CA”), and amends and supplements the terms of that certain Behavioral Health Services Agreement, with an original effective date of June 15, 2011, by and between BSC and HAI-CA, as supplemented and amended to date (the “Agreement”). Except as otherwise defined herein, all capitalized terms shall have the meaning ascribed to them in the Agreement.

**RECITALS**

- A. The State of California recently enacted Section 1367.27 of the Health & Safety Code and Section 10133.15 of the Insurance Code (collectively “Provider Directory Statutes”), both of which require BSC to publish and maintain a provider directory (or directories) with information on contracting providers that deliver health care services to BSC’s enrollees and insureds (collectively, “Enrollees”).
- B. BSC has delegated to HAI-CA the responsibility for maintaining HAI-CA’s directory of Specialized Health Plan Providers (as defined below).
- C. The Provider Directory Statutes obligate BSC to contractually require its contracted specialized health care service plans to comply with certain provisions that are required by BSC to satisfy the requirements for each of the providers that contract with the specialized health care service plan (“Specialized Health Plan Provider”).

**AGREEMENT**

The parties hereto agree as follows:

- 1. HAI-CA shall create, maintain, and update provider directory(ies), in accordance with the Agreement, containing accurate and current information on Specialized Health Plan Providers that deliver services to Enrollees in compliance with the requirements of the Provider Directory Statutes for each BSC benefit program to which this Agreement applies.
- 2. HAI-CA shall publish and make available both electronic and paper copies of the directory(ies) to Enrollees and the general public in accordance with the requirements of the Provider Directory Statutes. Furthermore, HAI-CA shall distribute a paper copy of HAI-CA’s directory(ies) to Enrollees, potential Enrollees, and the general public upon request.



3. HAI-CA's directory(ies) shall contain all Specialized Health Plan Provider information required by the Provider Directory Statutes, including, but not limited to: (a) the Specialized Health Plan Provider's name, practice location or locations, and contact information; (b) type of practitioner; (c) National Provider Number (NPI); (d) California license number and type of license; (e) the area of specialty, including board certification, if any; (f) the Specialized Health Plan Provider's office email address, if available; (g) the name of each affiliated provider group currently under contract with HAI-CA through which the Specialized Health Plan Provider sees Enrollees; (h) the names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with HAI-CA; (i) for physicians, the admitting privileges, if any, at hospitals contracted with HAI-CA; (j) the non-English language, if any, spoken by a Specialized Health Plan Provider or by a qualified medical interpreter, if any, on Specialized Health Plan Provider's staff; (k) identification of Specialized Health Plan Providers who no longer accept new patients for some or all of HAI-CA's products; and (l) all other applicable information necessary to conduct a Specialized Health Plan Provider search.
4. The contract between HAI-CA and a Specialized Health Plan Provider shall include a requirement that the Specialized Health Plan Provider inform HAI-CA within five (5) business days when either of the following occur:
  - (a) the Specialized Health Plan Provider is not accepting new patients;
  - (b) if the Specialized Health Plan Provider had previously not accepted new patients, the Specialized Health Plan Provider is currently accepting new patients.
5. HAI-CA shall investigate and undertake corrective action within thirty (30) business days to ensure the accuracy of the directory(ies) if HAI-CA is informed of a possible inaccuracy in the provider directory. When investigating a report, HAI-CA shall, at a minimum, do the following: (a) contact the affected Specialized Health Plan Provider no later than five (5) business days following receipt of the report; (b) document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories; and (c) update HAI-CA's online Specialized Health Plan Provider directory(ies), as applicable, no later than the next scheduled weekly update, or, if inadequate time, the update immediately following that update, or sooner if required by federal law or regulations, and HAI-CA's printed Specialized Health Plan Provider directory(ies), as applicable, no later than the next required update, or sooner if required by federal law or regulations.
6. It is the responsibility of HAI-CA to ensure the accuracy of provider directory information for each Specialized Health Plan Provider and update the online directory(ies) at least weekly, or more frequently, if required by federal law, and printed directory(ies) at least quarterly, or more frequently, if required by federal law, in accordance with requirements of the Provider Directory Statutes.



7. HAI-CA shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in HAI-CA's directory(ies) in accordance with the Provider Directory Statutes.
8. HAI-CA's directory(ies) shall include both an email address and a telephone number for members of the public and Specialized Health Plan Providers to notify the plan if the provider directory(ies) information appears to be inaccurate. This information shall be disclosed prominently in the directory(ies) and on HAI-CA's Internet Web site.
9. HAI-CA's directory(ies) shall include disclosures informing Enrollees that they are entitled to both of the following: (a) language interpreter services, at no cost to the Enrollee, including how to obtain interpretation services in accordance with the Provider Directory Statutes; and (b) full and equal access to Covered Services, including Enrollees with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.
10. In accordance with the Provider Directory Statutes, HAI-CA shall notify Specialized Health Plan Providers at least once every six months and comply with all provider notification requirements of the Provider Directory Statutes.
11. HAI-CA shall remove Specialized Health Plan Providers from the directory(ies) as required by the Provider Directory Statutes and notify BSC of the removals.
12. HAI-CA shall ensure processes are in place to allow Specialized Health Plan Providers to promptly verify or submit changes to information to be in the directory(ies) pursuant to the requirements in the Provider Directory Statutes. Those processes shall, at a minimum, include an online interface for Specialized Health Plan Providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from HAI-CA. Specialized Health Plan Providers shall verify or submit changes to information required to be in the directory or directories pursuant to the Provider Directory Statutes using the process required by HAI-CA.
13. HAI-CA shall cooperate with BSC in making the HAI-CA's directory(ies) available via a link on BSC's website.
14. Notwithstanding anything in the Agreement to the contrary, failure to comply with the requirements of the Provider Directory Statutes shall be deemed a material breach of the Agreement.
15. HAI-CA shall notify BSC immediately, in writing, of any enforcement action taken by, or deficiencies cited by, the Department of Managed Health Care or the California Department of Insurance related to HAI-CA's compliance with the Provider Directory Statutes.
16. When executed by both parties, this Second Addendum shall be effective as of July 1, 2016. Except as specifically set forth in this Second Addendum, all other conditions contained in the Agreement shall continue in full force and effect. After the effective date of this Second



Addendum, any reference to the Agreement shall mean the Agreement as supplemented by this Second Addendum. Notwithstanding anything to the contrary in the Agreement, in the event of a conflict between the terms and conditions of this Second Addendum and those contained within the Agreement, the terms and conditions of this Second Addendum shall prevail.

- 15. This Second Addendum may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties have caused this Second Addendum to be executed by their authorized representatives:

**BLUE SHIELD OF CALIFORNIA**

Signature: Armin Papouchian

Print Name: Arminé Papouchian, MBA, FLMI

Title: Vice President, Provider Contracting, Relations and Analytics

Date: 9/30/16

**HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA**

Signature: Richard T. Clarke

Print Name: Richard T. Clarke

Title: CEO

Date: 9/26/16

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**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
SAN FRANCISCO DIVISION**

JENNIFFER ROIZ et al.,

Plaintiffs,

v.

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

Defendants.

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

**[PROPOSED] ORDER GRANTING THE  
MAGELLAN DEFENDANTS’ MOTION  
TO DISMISS THE FIRST AMENDED  
COMPLAINT AGAINST MAGELLAN**

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

Date: August 5, 2026  
Time: 2:00 p.m.  
Location: Courtroom 2; 17th Floor  
Judge: William H. Orrick

**[PROPOSED] ORDER**

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

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

Dated: \_\_\_\_\_

\_\_\_\_\_  
Hon. William H. Orrick  
United States District Judge