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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

RJ, as the representative of her beneficiary son, and on behalf of and all others similarly situated,

Plaintiff,

vs.

CIGNA BEHAVIORAL HEALTH, INC., a Minnesota Corporation, and VIANT, INC., a Nevada corporation,

Defendants.

Case No.:

CLASS ACTION COMPLAINT

JURY TRIAL DEMANDED FOR ALL ISSUES SO TRIABLE

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CLASS ACTION COMPLAINT

Plaintiff, RJ, on behalf of her son, a behavioral health patient, and of all others similarly situated, brings this action against Defendants, Cigna Behavioral Health, Inc., ("Cigna") and Viant, Inc. ("Viant") (collectively, "Defendants"), and alleges the following:

INTRODUCTORY STATEMENT

1. RJ files this action on behalf of her son, SJ, (both names are pseudonyms) and all others similarly situated in the United States (the "Plaintiff Class") whose behavioral health claims for benefits have been systematically undervalued and underpaid by Defendants and who, because of Defendants' actions, owe money or have paid out-of-pocket all or a portion of the difference between what their insurance *should* have covered and what was actually paid.

2. SJ sought treatment for behavioral health disorders, including for mental health and substance use disorders, from licensed, accredited, treatment providers. SJ was a member of an active health insurance policy offering out of network benefits that Cigna administered on behalf of his mother's employer, Intuit, Inc. Cigna charges higher premiums for plans like Plaintiff's that give their members the freedom to choose their own healthcare providers, including those outside of Cigna's "network." For RJ and SJ, Cigna broke this promise, punishing them for SJ seeing out-of-network providers while reaping large profits from his supposedly premier, gold-plated plan.

3. Cigna and Viant colluded to illegally withhold and systematically underpay out-of-network benefits for SJ. They accomplished this by using a dishonest and self-serving reimbursement scheme. Specifically, Cigna, without Plaintiff's consent or authority, contracted with Viant to "negotiate" the amounts that Cigna would ultimately pay for Plaintiff's out-of-network claims. Cigna contracted with Viant to create an illegal enterprise to underpay out-of-network benefits, shield Cigna from the providers and insureds they cheated, and create impenetrable, systemic, administrative barriers to circumvent rights protected by federal laws.

4. Cigna and Viant's scheme forced Plaintiff and the Class to pay and/or be responsible for, out of their own pockets, the difference between the amount Cigna should have paid and the amount that Cigna did pay for services. This difference often ran into the tens, and

sometimes hundreds, of thousands of dollars *per patient* and is on top of the premium paid for their healthcare plans. Every excess dollar paid by a patient is a dollar that Cigna unjustly retained and used to pay a kick-back to Viant. Consequently, Cigna and Viant unjustly retain tens of millions, or more, of dollars taken from patients who expected Cigna to be "[their] partner in total health and wellness. And we're here for [them] 24/7 – caring for [their] body and mind.[1]"

5. Plaintiff brings this suit against Cigna to recover the money she unjustly overpaid or now owes for care that Cigna should have reimbursed. This suit is also brought against Viant for the role it played as Cigna's agent and claim profiteer in this sordid enterprise.

6. Every claim at issue in this litigation is for intensive outpatient ("IOP") mental health and/or substance use disorder services that Cigna was required to pay at usual, customary, or reasonable rates. Plaintiff was insured under a Cigna health insurance policy. The policy provided coverage for out-of-network benefits for mental health and substance use disorder treatment at usual, customary or reasonable rates.

7. While Cigna issued, underwrote and/or administered Plaintiff's health insurance policy, Viant determined the reimbursement rate for every underpaid claim in the present litigation. After receiving treatment, Plaintiff's claims were submitted to Cigna for pricing and payment according to the out-of-network payment rate.

8. In the plan documents, this rate is referred to as the "Usual, Customary and Reasonable" rate, the "Reasonable and Customary" amount, the "Usual and Customary" amount, the "Reasonable Charge," the "Prevailing Rate," the "Usual Fee," the "Competitive Fee," or some other similar phrase (hereafter the "UCR" rate).

9. Cigna classifies reimbursement rates as the Maximum Reimbursable Charge ("MRC"). Cigna administered health insurance plans are subcategorized as either MRC I, or MRC II. Plaintiff's plan, and the plans of the class members are MRC I plans.

10. For each of the claims at issue here, Cigna reported, in both plan language and on telephonic verification of benefits, that it would reimburse patients and/or their assignees at the

[1] https://www.cigna.com/about-us/ (last visited March 17, 2020)

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