EXHIBIT 1

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Pro Hac Vice Application to be filed Promptly

Attorneys for Plaintiffs

IN THE CIRCUIT COURT
OF HAMILTON COUNTY TENNESSEE

DUAL DIAGNOSIS TREATMENT CENTER, INC. d/b/a SOVEREIGN HEALTH OF CALIFORNIA; SOVEREIGN HEALTH OF PHOENIX, INC.; SHREYA HEALTH OF CALIFORNIA, INC. MEDICAL CONCIERGE, INC. d/b/a MEDLINK; SATYA HEALTH OF CALIFORNIA, INC.; and VEDANTA LABORATORIES, INC.; Plaintiffs, vs. BLUE CROSS BLUE SHIELD OF TENNESSEE Defendants.	CIVIL ACTION NO.: 22C227 **COMPLAINT FOR RECOVERY OF BENEFITS OWED AND FOR BREACH OF CONTRACT** **JURY DEMAND**

Plaintiffs Dual Diagnosis Treatment Center, Inc. d/b/a Sovereign Health of California ("Dual Diagnosis"); Sovereign Health of Phoenix, Inc. ("Sovereign Phoenix"); Shreya Health of California, Inc. ("Shreya"); Medical Concierge, Inc. d/b/a Medlink ("Medlink"); Satya Health of California, Inc. ("Satya"); and Vedanta Laboratories, Inc. ("Vedanta") (collectively referred to as the "Plaintiffs") for their complaint against defendants Blue Cross Blue Shield of Tennessee ("BCBS-TN") state:

INTRODUCTION

1. The Blue Cross Blue Shield Association, (the "Association") and its affiliated insurance companies including but not limited to Blue Cross Blue Shield of Tennessee ("BCBS-TN") provide health insurance coverage to about one in three Americans. According to Blue Cross's own press, ninety-one percent of health care providers have contracted with Blue Cross entities to offer discounted services to Blue Cross members, and ninety-seven percent of the claims that Blue Cross pays are to such "in-network" providers.

2. The several plaintiffs in this action treat individuals suffering from drug addiction and/or mental health problems. As a matter of practice, Plaintiffs obtain assignments from their patients.

3. Plaintiffs bring this suit to enforce their valid assignments of benefits and to vindicate their rights under the Employee Retirement Income Security Act of 1974 ("ERISA") and state law, as applicable.

4. In a nutshell, BCBS-TN, as a Blue Cross affiliated company, does everything it can to undermine Plaintiffs' ability to operate as independent, out-of-network ("OON") providers. Specifically, BCBS-TN engages in the following improper conduct, all of which is prohibited by ERISA:

a. misleads Plaintiffs about whether claims are assignable under the governing plan documents, and then later, with no explanation, refuses to pay Plaintiffs and instead pays some unknown amount to the recovering addicts themselves,

b. refuses to honor assignments even when the underlying plan document permits them, and

c. never plainly tells its beneficiaries that the assignments they choose to give will not be honored.

5. This scheme of deception and confusion leaves OON providers like the Plaintiffs misled, confused, and often holding the bag for services rendered in good faith to suffering patients —all of which unfairly increases the cost of running their businesses.

6. Defendant does not even attempt to hide this conduct; as one Blue Cross company described it: "payments for services rendered by providers who do not contract with [Blue Cross] are sent directly to our customers. Thus, out-of-network providers face the inconvenience of attempting to collect payment from the customer and the accompanying possibility of incurring bad debts." *See Blue Perspective: BCBSOK Position on Legislation and Regulatory Issues*, Blue Cross Blue Shield Oklahoma, www.bcbsok.com/grassroots/pdf/blueperspective_aob27-103003.pdf (last visited October 27, 2020).

7. Cutting providers out of the process also saves Defendant money by leaving to unsophisticated patients (i.e., recovering addicts) the responsibility of ensuring that the insurance plans have fully paid the patients' benefit entitlements.

8. By this action, Plaintiffs are seeking to recover the amounts owed by BCBS-TN for services provide to the various patients referenced in this Complaint and to hold BCBS-TN accountable for its violations of ERISA.

THE PARTIES

A. Plaintiffs:

9. Plaintiffs are entities that provided in- and out-patient substance abuse and/or mental health treatment to various patients in California, Arizona, and other locations across the United States.

10. Dual Diagnosis Treatment Center, Inc. d/b/a Sovereign Health of California ("Dual Diagnosis") is a corporation duly organized and existing under the laws of California. At all relevant times, Dual Diagnosis did business as "Sovereign Health of California," and on occasion under other names in accordance with its governing certifications and licensures. At all relevant times, Dual Diagnosis was certified to operate and maintain behavioral health treatment facilities in San Clemente, Culver City and Palm Springs California, among other locations.

11. Sovereign Health of Phoenix ("Sovereign Phoenix") is a corporation duly organized and existing under the law of Delaware, doing business as "Sovereign Health of Phoenix," At all relevant times, Sovereign Phoenix is and was licensed to operate and maintain a behavioral health residential facility in Chandler, Arizona and provided services to several of the patients at issue in this litigation.

12. Medical Concierge, Inc. ("Medlink") is a corporation duly organized and existing under the laws of California, doing business as "Medlink." Medlink is licensed to operate and maintain an adult residential facility ("ARF") for ambulatory mentally ill adults. Medlink provided services to several of the patients at issue in this litigation.

13. Satya Health of California, Inc. ("Satya") is a corporation duly organized and existing under the laws of California. At all relevant times, Satya did business as "Sovereign by the Sea II," and on occasion under other names in accordance with its governing certifications and licensures. At all relevant times, Satya was licensed to operate and maintain behavioral health treatment facilities in San Clemente, Culver City, and Palm Springs, California, among other locations. Satya provided services to several of the patients at issue in this litigation.

14. Shreya Health of California, Inc. ("Shreya") is a corporation duly organized and existing under the laws of California. At all relevant times, Shreya operated as a facility that

provided 24 hour therapeutically planned living and rehabilitative environment for treatment of individuals with behavioral and other disorders. Shreya operated a treatment facility in San Clemente, California, among other locations. Shreya provided services to several of the patients at issue in this litigation.

15. Vedanta Laboratories, Inc. ("Vedanta") is a corporation that was duly organized under the laws of the Delaware. At all relevant times, Vedanta provides toxicology testing and quality assurance programs. Vedanta serves clinicians and healthcare facilities. Vedanta provided services to several of the patients at issue in this litigation.

B. Former Patients:

16. This lawsuit involves behavioral health treatment services rendered by Plaintiffs to many individuals ("Former Patients") who Plaintiffs are informed and believe, at all relevant times, possessed health insurance covering some or all of the services that Plaintiffs provided.

17. To protect their personal health information, the Former Patients are identified by their initials. The Former Patients who had health insurance provided by an employer-sponsored plan include the following: Aa.Br., An.Yo., BA.Al., Br.Al., Co.Cu., Da.Sm., Sr.Al., Dw.Ri., Ha.Ke., Ja.Br., Ja.Is., Je.St., Jo.Ha., Ke.Ha., Ke.Ca., La.We., Le.St., Ma.Wh., Ro.Re., Sa.St., Sh.Ke., So.Ta.and Ta.Cu.[1]

C. Defendants:

18. Based upon documents obtained by Plaintiffs to date, Plaintiffs are informed and believe that the health insurance of each of the Former Patients listed in paragraph 20 above was obtained through what ERISA defines as an "employee benefit plan." 29 U.S.C. § 1002(3).

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[1] Defendant will be provided specific information as to each Former Patient, so that it can identify the patient and appropriate provide the administrative record in this action.

19. Blue Cross Blue Shield of Tennessee ("BCBS-TN") has been providing health insurance products and services to Tennessee Families, including the Former Patients at issue in this action.

20. The BCBS-TN website boasts that "we've been part of the community for over 75 years as the trusted insurer for individuals, families, and employees in Tennessee. So, you can expect excellent coverage, benefits, and support for all your health care needs." Unfortunately, in this instance, BCBS-TN has not lived up to these expectations.

VENUE

21. Venue is proper in the Circuit Court of Hamilton County for each claim governed by ERISA, pursuant to ERISA §502(e).

22. Venue is proper in the Circuit Court of Hamilton County for each claim governed under State law, pursuant to Tenn. Code Ann. §20-4-104.

RELEVANT FACTS:

A. Plaintiffs Provide Gold Standard Treatment Services.

23. Plaintiffs are leading providers of comprehensive addiction and mental health treatment programs and other services to individuals in various locations across the United States.

24. It is widely accepted that the services rendered by Plaintiffs and similar providers are extremely important. For example, according to the National Institute on Drug Abuse, every $1 spent on substance abuse treatment saves $4.87 in health care costs and $7.00 in crime costs. See Nat'l Inst. on Drug Abuse, Principles of Drug Addiction Treatment: A Research-Based Guide (3d ed. 1999).

25. Plaintiff's approach to addiction and other mental health treatment was consistent with best practices in the industry. Its proven track record also earned Plaintiffs accolades from trade and government groups. Dual Diagnosis, for example, received the Gold Seal of Approval from the Joint Commission, an independent not-for-profit organization that is the nation's oldest and largest standards-setting and accrediting body in health care. And the California Board of Behavioral Health Sciences, the California Association for Alcohol/Drug Educators, and the National Association for Alcoholism and Drug Abuse Counsels approved Plaintiffs' entities to provide continuing education to licensed professionals.

B. Plaintiffs Investigate Prospective Patients' Health Insurance Coverage.

26. Plaintiffs, who are for-profit enterprises, allow prospective patients to pay for their services out-of-pocket or with health insurance. Unfortunately, many individuals in need of treatment cannot afford to pay for Plaintiffs' services up front. Plaintiffs are only able to treat those individuals who have health insurance covering some or all of their services.

27. Before agreeing to treat any patient, Plaintiffs take steps to ensure that they will be compensated for their services.

28. When a prospective patient seeks to pay with his or her health insurance, Plaintiffs investigate whether and to what extent the patient's insurance policy covers their various levels of service.

29. When each Former Patient first sought treatment, as a matter of intended general practice described below, Plaintiffs or their agents verified that he or she was insured and ascertained the scope of his or her coverage through various procedures.

30. Plaintiffs or its agents first secured the Former Patient's consent to contact his or her health insurance company, along with the identifying information necessary for Plaintiffs to interact with the insurer.

31. Plaintiffs or their agents also asked for the dedicated phone number of healthcare providers associated with the Former Patient's insurance policy ("Provider Hotline"). Plaintiffs are informed and believe that each Former Patient authorized Plaintiffs to contact the Provider Hotline of a Blue Cross Defendant. Plaintiffs or their agents generally, but not always, recorded this information in the top box of a comprehensive document entitled "Insurance Verification Form."

32. Plaintiffs or their agents called the Provider Hotline listed on the Insurance Verification Form on each Former Patient's behalf. When it reached a BCBS-TN representative, Plaintiffs or their agents relayed the Former Patient's identifying information and requested details about his or her coverage.

33. Plaintiffs or their agents generally recorded the information learned from the Blue Cross Defendant on the bottom of the Insurance Verification Form.

34. To attempt to complete Plaintiffs' Insurance Verification Form, Plaintiffs or their agents generally inquired exhaustively into the characteristics of the Former Patient's health insurance coverage, including with respect to:

a. The general characteristics of the health insurance policy (including fields for effective date and renewal date, the type of plan, and whether it covers preexisting conditions, among other things);

b. The existence and scope of any substance abuse or mental health coverage (including fields regarding deductible for in-network and out-of- network

services and maximum out-of-pocket payments for in-network and out-of-network services, among other things);

c. Any precertification requirements (including fields indicating whether precertification required for inpatient treatment, residential treatment, partial hospitalization, intensive outpatient treatment, and/or outpatient treatment by in-network and out-of-network providers); and

d. Copayments for each type of treatment and any limits on the length of treatment.

35. Plaintiffs or their agents generally also investigated the logistics of securing authorization and payment for Plaintiffs' services, including:

a. How to comply with precertification requirements (including fields for pre-certification company and telephone number);

b. The name of the insurance company and the entity to which benefit claims should be submitted (including fields for insurance company and claims address); and

c. Whether the Former Patient's health insurance benefits were assignable. The answer to this question was supposed to be recorded by circling "Yes" or "No" (or "Y" or "N") next to the word "assignable" on the Insurance Verification Form.

36. After the insurance verification process, Plaintiffs then contacted each Former Patient to discuss his or her insurance policy and to make appropriate arrangements for treatment.

37. During the verification of insurance benefits, Plaintiffs also confirm the available coverage under the various plans.

38. The verification process was performed for the benefits provided to each of the patients at issue in this action and the amounts owed, per the plan verification ranged from 50-80% of the billed charges depending on the services provided and the particular plan itself.

39. At no point in time did BCBS-TN or any of its representatives inform Plaintiffs that they were denying or underpaying the various claims at issue in this litigation based on the medical necessity criteria or any other issue. Rather, BCBS-TN simply unjustifiably refused to pay the full claim, paid pennies on the dollar for various claims, and/or made improper payments to patients as opposed to Plaintiffs directly.

40. Further, at no time has there been any claim made by BCBS-TN that the necessary services for each of the patients was not covered under the policies/plans issued. Rather, payments were simply paid incorrectly, not paid at all, or significantly underpaid contrary to the requirements of the Former Patients plan documents.

C. Each Former Patient Had "Preferred Provider Organization" Coverage for Substance Abuse and Mental Health Treatment Services.

41. Plaintiffs only wish to provide services that prospective patients can afford. As such, as a matter of course Plaintiffs investigate whether the treatment needed by a patient (including the Former Patients) was covered by insurance.

42. When Plaintiffs or their agents called the Blue Cross Defendants' Provider Hotlines, they learned that each Former Patient's health insurance policy had at least the following key features: (1) coverage for substance abuse/mental health treatment offered by Plaintiffs, and (2) preferred provider organization ("PPO") coverage.

43. A PPO plan covers medical expenses incurred when the insured visits either an "in-network" provider (i.e., a provider who has a contractual relationship with the insurance company) or an "out-of-network" provider (i.e., one who does not have a contractual relationship with the insurance company).

44. PPO coverage tends to be significantly more expensive than health maintenance organization ("HMO") coverage because it gives insureds the option to visit the providers of their choice. Many insureds are nevertheless willing to pay a premium for PPO coverage to gain access to a bigger and better pool of providers.

45. No law required the plans to offer PPO coverage instead of HMO coverage. Each Plan chose to offer the more robust and expensive insurance to their employees, and each Former Patient or subscriber enrolled in and paid for that premium level of coverage.

46. Plaintiffs are out-of-network with respect to BCBS-TN. In other words, Plaintiffs are not contracted with BCBS-TN to provide services to their insureds at a discounted rate.

47. In short, Plaintiffs and their agents learned from the BCBS-TN representatives that each Former Patient had PPO coverage for substance abuse and mental health treatments and services, and that BCBS-TN was the relevant insurance company administrator, and/or contact for the Former Patient plans.

D. The Assignments to the Patients and the Coverage Owed Under the BCBS-TN Policies.

48. Plaintiffs (or their agents, on Plaintiffs' behalf) obtained and obtain a valid assignment of benefits ("Assignment") from all patients before treating them.

49. The Assignments give Plaintiffs the right to be paid directly for any services rendered to patients, and also entitle Plaintiffs to assert patients' legal rights to recover benefits.

These legal rights include the right to file claims and appeals, to request and obtain information and documents relating to the plan, and to bring suit.

50. The Assignments entitle Plaintiffs to collect payment for services provided to the Former Patients directly from BCBS-TN.

51. The Assignments also confer legal standing on Plaintiffs to assert various legal claims against the Plans and BCBS-TN, including the claims asserted in this Complaint.

Patient Aa.Br.:

52. Patient Aa.Br. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

53. Prior to providing services, Shreya Health of California required Patient Aa.Br. to execute an assignment of benefits.

54. The assignment from Patient Aa.Br.to Shreya Health of California and Sovereign California, provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties

55. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties
>
> I hereby authorize my insurance benefits to be paid to provider.

56. In addition to the assignment from Patient Aa.Br., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Aa.Br. had under his plan with BCBS-TN and the payments required to be made per the plan language.

57. Specifically, plaintiffs confirmed for Patient Aa.Br. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $3,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. The policy pays 50% of benefits for out of network and 50% of labs;

e. Precertification is needed for all levels of care except outpatient;

f. Codes 80305, 90837, and 82075 are all eligible and covered; and

g. No out of state restrictions on the plan.

58. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Aa.Br., despite requests to do so, and therefore, the verification process had to be done over the phone.

59. In all, for Patient Aa.Br., there were $350 in billed charges and BCBS-TN paid a grand total of $85.94, which was paid directly to Patient Aa.Br. virtually assuring that Plaintiffs would not get paid the amounts owed per the plan documents. In fact, Plaintiffs were not paid anything from the amounts paid to Patient Aa.Br.

Patient An.Yo.:

60. Patient An.Yo. was covered under a BCBS-TN plan at the time services were provided by Medlink and Vedanta Labs.

61. Prior to providing services, Medlink required Patient An.Yo. to execute an assignment of benefits.

62. The assignment to Patient An.Yo. provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties

63. The assignment went on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties
>
> I hereby authorize my insurance benefits to be paid to provider.

64. Vedanta Labs required Patient An.Yo. to execute an assignment of benefits.

65. The assignment from Patient An.Yo. to Vedanta Labs provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

66. In addition to the assignment from Patient An.Yo., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient An.Yo. had under her plan with BCBS-TN and the payments required to be made per the plan language.

67. Specifically, plaintiffs confirmed for Patient An.Yo. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $6000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. Authorization is required for In-patient care; and

g. No out of state restrictions on the plan

68. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient An.Yo., despite requests to do so, and therefore the verification had to be done over the phone.

69. In all, for Patient An.Yo., there were $70,300 in billed charges of which BCBS-TN paid $31,543.72 directly to Patient An.Yo. virtually assuring that Plaintiffs would not get paid the amounts owed per the plan documents. In fact, Plaintiffs were not paid anything from the amount paid to Patient An.Yo.

Patient Ba.Al.:

70. Patient Ba.Al. was covered under a BCBS-TN plan at the time services were provided by Sovereign Phoenix.

71. Prior to providing services, Sovereign required Patient Ba.Al. to execute an assignment of benefits.

72. The assignment from Patient Ba.Al. to Sovereign Phoenix provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

73. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

74. In addition to the assignment from Patient Ba.Al., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ba.Al. had under her plan with BCBS-TN and the payments required to be made per the plan language.

75. Specifically, plaintiffs confirmed for Patient Ba.Al. the following relevant plan provisions and benefits:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $1,100;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. Precertification is needed for all IP levels of care, including intensive outpatient care and there is a penalty if preauthorization is not obtained;

g. No out of state restrictions on the plan.

76. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ba.Al., despite requests to do so, and therefore the verification had to be done over the phone.

77. In all, for Patient Ba.Al., there were $39,450 in billed charges and BCBS-TN only paid $4,136.88, which was paid directly to Patient Ba.Al., virtually assuring that Plaintiffs would not get paid the amounts owed per the plan documents. In fact, Plaintiffs were not paid anything by Patient Ba.Al. from the amounts paid by BCBS-TN.

Patient Br.Al.:

78. Patient Br.Al. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California and Vedanta Labs.

79. Prior to providing services, Shreya Health of California required Patient Br.Al. to execute an assignment of benefits.

80. The assignment from Patient Br.Al. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

81. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

82. Vedanta Labs also required Patient Br.Al. to execute an assignment of benefits, which provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

83. In addition to the assignment from Patient Br.Al., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Br.Al. had under her plan with BSBS-TN and the payments required to be made per the plan language.

84. Specifically, plaintiffs confirmed for Patient Br.Al. the following relevant plan provisions and benefits:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $5,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. No limitations and no exclusions for Lab Testing and Out of Network.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient and if precertification is not obtained the claim may be denied; and

i. No out of state restrictions on the plan.

85. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Br.Al., despite requests to do so, and therefore the verification had to be done over the phone.

86. In all, for Patient Br.Al., there were $90,981.00 in billed charges and BCBS-TN paid $2,150.63, which was paid directly to the patient virtually assuring that Plaintiffs would not get paid the amounts owed per the plan documents. In fact, Plaintiffs were not paid anything from the amounts paid to Patient Br.Al.

Patient Co.Cu.:

87. Patient Co.Cu. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

88. Prior to providing services, Shreya Health of California required Patient Co.Cu. to execute an assignment of benefits.

89. The assignment from Patient Co.Cu. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

90. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

91. In addition to the assignment from Patient Co.Cu., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Co.Cu. had under her plan with BCBS-TN and the payments required to be made per the plan language.

92. Specifically, plaintiffs confirmed for Patient Co.Cu. the following relevant plan provisions and benefits:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $4,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse and it is based on medical necessity;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. Benefits and labs are based on medical necessity

g. Code US 80305 is covered.

h. All HCPC codes are valid and billable.

i. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

j. Telehealth is covered by the plan.

k. Precertification is needed for all levels of care except outpatient and there is a penalty if preauthorization is not obtained;

l. There is no copay for any level of care.

m. Visit limit usage is based on medical necessity.

n. No out of state restrictions on the plan

93. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Co.Cu., despite requests to do so, and therefore the verification had to be done over the phone.

94. In all, for Patient Co.Cu., there were $380 in billed charges and BCBS-TN paid $41.07, which was paid directly to the Patient Co.Cu. virtually assuring that Plaintiffs would not get paid the amounts owed per the plan documents. In fact, Plaintiffs were not paid any of the amounts received by Patient Co.Cu.

Patient Da.Sm.:

95. Patient Da.Sm. was covered under a BCBS-TN policy at the time services were provided by Shreya Health of California.

96. Prior to providing services, Shreya Health of California required Patient Da.Sm. to execute an assignment of benefits.

97. The assignment from Patient Da.Sm. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

98. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

99. In addition to the assignment from Patient Da.Sm., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Da.Sm. had under his plan with BCBS-TN and the payments required to be made per the plan language.

100. Specifically, plaintiffs confirmed for Patient Da.Sm. the following relevant plan provisions and benefits:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $4,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. For code 80305 it is valid and billable, no authorization required and is not diagnosis driven.

g. For code 90849, it is valid and billable, no authorization required.

h. Benefits are based on medical necessity.

i. The plan does cover combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

j. Precertification is needed, but if not obtained there is a 40% reduction in the allowable charges, not to exceed $2500

k. No out of state restrictions on the plan.

101. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Da.Sm., despite requests to do so, and therefore the verification had to be done over the phone.

102. In all, for Patient Da.Sm., there were $480 in billed charges of which BCBS-TN paid $118.93 directly to the patient virtually assuring that Plaintiffs would not get paid the amounts owed per the plan documents. In fact, Plaintiffs were not paid any of the amounts received by Patient Da.Sm.

Patient Dr.Al.:

103. Patient Dr.Al. was covered under a BCBS-TN plan at the time services were provided by Satya Health of California.

104. The assignment from Patient Dr.Al. to Satya, provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

105. The assignment went on to state:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

106. In addition to the assignment from Patient Dr.Al., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Dr.Al. had under her plan with BCBS-TN and the payments required to be made per the plan language.

107. Specifically, plaintiffs confirmed for Patient Dr.Al. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $500;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. Precertification is required for all levels of care except outpatient.

g. Out of state benefits are covered.

h. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

i. Precertification is needed for all levels of care except outpatient and there is a penalty if preauthorization is not obtained;

108. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Dr.Al., despite requests to do so, and therefore the verification had to be done over the phone.

109. In all, for Patient Dr.Al. there were $14,490 in billed charges of which BCBS-TN paid #3,216.06 to the patient and Plaintiffs were able to recover $2,949.72 from Patient Dr.Al. – significantly less than what is owed per the plan documents.

Patient Dw.Ri.:

110. Patient Dw.Ri. was covered under a BCBS-TN plan at the time services were provided by Vedanta Labs and Shreya Health of California.

111. The assignment from Shreya provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

112. The assignment went on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

113. In addition, Vedanta Labs required Patient Dw.Ri. to execute an assignment of benefits, which provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

114. In addition to the assignments from Patient Dw.Ri., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Dw.Ri. had under his plan with BCBS-TN and the payments required to be made per the plan language.

115. Specifically, plaintiffs confirmed for Patient Dw.Ri. the following relevant plan provisions and benefits:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $4,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. Revenue Codes 1001, 1002, 126, 912, 913, S9480, 906 are valid and billable.

g. Benefits are based on medical necessity.

h. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

i. Precertification is needed and if not obtained, plan pays at 40%;

j. Visits are based on medical necessity.

k. No out of state restrictions on the plan.

116. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Dw.Ri., despite requests to do so, and therefore the verification had to be done over the phone.

117. In all, for Patient Dw.Ri. there was $60,374 in billed charges of which BCBS-TN paid $2,654.41 and the Plaintiffs recovered from Patient Dw.Ri. $1,309.53, which is significantly less than what was owed under the plan.

Patient Ha.Ke.:

118. Patient Ha.Ke. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

119. Shreya required Patient Ha.Ke. to execute an assignment of benefits, which provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

120. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

121. In addition to the assignment from Patient Ha.Ke., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ha.Ke. had under her plan with BCBS-TN and the payments required to be made per the plan language.

122. Specifically, plaintiffs confirmed for Patient Ha.Ke. the following relevant plan provisions and benefits:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $11,300;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. No limitations or exclusions for labs – they are based on medical necessity – and for Code G0477, no authorization was required.

g. Benefits are based on medical necessity.

h. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

i. Precertification is needed for all levels of care except outpatient and there is a penalty if preauthorization is not obtained;

j. Visits are limited based on medical necessity.

k. No out of state restrictions on the plan.

123. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ha.Ke, despite requests to do so, and therefore the verification had to be done over the phone.

124. In all, for Patient Ha.Ke there were $830 in billed charges of which BCBS-TN paid $209 to Patient Ha.Ke virtually assuring that Plaintiffs would not get paid the amounts owed per the plan documents. In fact, none of that amount was recovered by Plaintiffs.

Patient Ja.Br.:

125. Patient Ja.Br. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California and Vedanta Labs.

126. Prior to providing services, Shreya Health of California required Patient Ja.Br. to execute an assignment of benefits.

127. The assignment from Patient Ja.Br. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third

party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

128. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

129. Vedanta Labs also required Patient Ja.Br. to execute an assignment of benefits, which provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

130. In addition to the assignment from Patient Ja.Br., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ja.Br. had under his plan with BCBS-TN and the payments required to be made per the plan language.

131. Specifically, plaintiffs confirmed for Patient Ja.Br. the following relevant plan provisions and benefits:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $5,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. All codes (H0010, H0015, H0018, H0035, and G0477) are valid and billable.

g. Benefits are based on medical necessity.

h. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

i. Precertification is needed for all levels of care if there is no precertification, the benefits are denied.;

j. There is no copay for any level of care.

k. Visits are unlimited.

l. No out of state restrictions on the plan.

132. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ja.Br., despite requests to do so, and therefore the verification had to be done over the phone.

133. In all, for Patient Ja.Br. there were $4,462 in billed charges and BCBS-TN only paid $184.90 directly to Patient Ja.Br. virtually assuring that Plaintiffs would not get paid. In fact, Plaintiffs were not paid any of the amounts received by Patient Ja.Br.

Patient Ja.Is.:

134. Patient Ja.Is. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California and Vedanta.

135. Prior to providing services, Shreya Health of California required Patient Ja.Is. to execute an assignment of benefits.

136. The assignment from Patient Ja.Is. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

137. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

138. Vedanta Labs also required Patient Ja.Is. to execute an assignment of benefits, which provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

139. In addition to the assignment from Patient Ja.Is., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ja.Is. had under his plan with BCBS-TN and the payments required to be made per the plan language.

140. Specifically, plaintiffs confirmed for Patient Ja.Is. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $4,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. Visits are based on medical necessity.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care. If precertification is not obtained, but the services are medically necessary, the plan pays 40% of benefits;

i. All HCPC and Revenue codes are valid and billable.

j. No out of state restrictions on the plan

141. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ja.Is., despite requests to do so, and therefore the verification had to be done over the phone

142. In all, for Patient Ja.Is. there were $40,865 in billed charges of which BCBS-TN paid a total of $914.25 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs were not paid any of the amounts received by Patient Ja.Is.

Patient Je.St.:

143. Patient Je.St. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

144. Prior to providing services, Shreya Health of California required Patient Je.St. to execute an assignment of benefits.

145. The assignment from Patient Je.St. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

146. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

147. In addition to the assignment from Patient Je.St., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Je.St. had under his plan with BCBS-TN and the payments required to be made per the plan language.

148. Specifically, plaintiffs confirmed for Patient Je.St. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $4,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. Visits are based on medical necessity.

g. The plan covers combined Alcohol and Substance Abuse but not Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient. If precertification is not obtained, but the services are medically necessary, the plan reduces benefits by 10%;

i. All HCPC and Revenue codes are valid and billable.

j. No out of state restrictions on the plan

149. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Je.St., despite requests to do so, and therefore the verification had to be done over the phone

150. In all, for Patient Je.St. there were $730 in billed charges of which BCBS-TN paid a total of $197.98 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs were not paid any of the amounts received by Patient Je.St.

Patient Jo.Ha.:

151. Patient Jo.Ha. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

152. Prior to providing services, Shreya Health of California required Patient Jo.Ha. to execute an assignment of benefits.

153. The assignment from Patient Jo.Ha. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third

party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

154. The assignment goes on to provide that:

I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

155. In addition to the assignment from Patient Jo.Ha., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Jo.Ha. had under his plan with BCBS-TN and the payments required to be made per the plan language.

156. Specifically, plaintiffs confirmed for Patient Jo.Ha. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $5,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient. If precertification is not obtained, but the services are medically necessary, the plan reduces benefits by 40%;

i. All HCPC and Revenue codes are valid and billable.

j. No out of state restrictions on the plan

157. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Jo.Ha., despite requests to do so, and therefore the verification had to be done over the phone

158. In all, for Patient Jo.Ha. there were $1,525 in billed charges of which BCBS-TN paid a total of $80 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs were not paid any of the amounts received by Patient Jo.Ha.

Patient Ke.Ha.:

159. Patient Ke.Ha. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

160. Prior to providing services, Shreya Health of California required Patient Ke.Ha. to execute an assignment of benefits.

161. The assignment from Patient Ke.Ha. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

162. The assignment goes on to provide that:

I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

163. In addition to the assignment from Patient Ke.Ha., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ke.Ha. had under his plan with BCBS-TN and the payments required to be made per the plan language.

164. Specifically, plaintiffs confirmed for Patient Ke.Ha. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $4,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient. If precertification is not obtained, the claim for services is denied.

i. All HCPC codes are valid and billable.

j. No out of state restrictions on the plan

165. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ke.Ha., despite requests to do so, and therefore the verification had to be done over the phone.

166. In all, for Patient Ke.Ha. there were $3,520 in billed charges of which BCBS-TN paid a total of $812.87 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs only recovered $236.72 from the amounts received by Patient Ke.Ha.

Patient Ke.Ca.:

167. Patient Ke.Ca. was covered under a BCBS-TN plan at the time services were provided by Vedanta.

168. Prior to providing services, Vedanta required Patient Ke.Ca. to execute an assignment of benefits.

169. The assignment from Patient Ke.Ca. to Vedanta provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

170. In addition to the assignment from Patient Ke.Ca., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ke.Ca. had under his plan with BCBS-TN and the payments required to be made per the plan language.

171. Specifically, plaintiffs confirmed for Patient Ke.Ca. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $5,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient. If precertification is not obtained, the claim for services will be reduced by 10% or denied.

i. All HCPC codes are valid and billable.

j. No out of state restrictions on the plan

172. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ke.Ca., despite requests to do so, and therefore the verification had to be done over the phone.

173. In all, for Patient Ke.Ca. there were $3,662 in billed charges of which BCBS-TN paid a total of $67.94 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not get paid anything from the amounts received by Patient Ke.Ca.

Patient La.We.:

174. Patient La.We. was covered under a BCBS-TN plan at the time services were provided by Vedanta.

175. Prior to providing services, Vedanta required Patient La.We. to execute an assignment of benefits.

176. The assignment from Patient La.We. to Vedanta provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

177. In addition to the assignment from Patient La.We., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient La.We. had under his plan with BCBS-TN and the payments required to be made per the plan language.

178. Specifically, plaintiffs confirmed for Patient La.We. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $500;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care.

i. All HCPC codes are valid and billable.

j. No out of state restrictions on the plan

179. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient La.We., despite requests to do so, and therefore the verification had to be done over the phone.

180. In all, for Patient La.We. there were $7,624 in billed charges of which BCBS-TN paid a total of $94.70 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not get paid anything from the amounts received by Patient La.We.

Patient Le.St.:

181. Patient Le.St. was covered under a BCBS-TN plan at the time services were provided by Vedanta.

182. Prior to providing services, Vedanta required Patient Le.St. to execute an assignment of benefits.

183. The assignment from Patient Le.St. to Vedanta provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

184. In addition to the assignment from Patient Le.St., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Le.St. had under his plan with BCBS-TN and the payments required to be made per the plan language.

185. Specifically, plaintiffs confirmed for Patient Le.St. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $500;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 70% of benefits for out of network and 70% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care.

i. All HCPC codes are valid and billable.

j. No out of state restrictions on the plan

186. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Le.St., despite requests to do so, and therefore the verification had to be done over the phone.

187. In all, for Patient Le.St. there were $51,268 in billed charges of which BCBS-TN paid a total of $8,148.98 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not get paid anything from the amounts received by Patient Le.St.

Patient Ma.Wh.:

188. Patient Ma.Wh. was covered under a BCBS-TN plan at the time services were provided by Vedanta.

189. Prior to providing services, Vedanta required Patient Ma.Wh. to execute an assignment of benefits.

190. The assignment from Patient Ma.Wh. to Vedanta provided that:

> I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

191. In addition to the assignment from Patient Ma.Wh., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ma.Wh. had under his plan with BCBS-TN and the payments required to be made per the plan language.

192. Specifically, plaintiffs confirmed for Patient Ma.Wh. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $5,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care, if precertification is not obtained, the claim is denied.

i. All HCPC codes are valid and billable.

j. No out of state restrictions on the plan

193. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ma.Wh., despite requests to do so, and therefore the verification had to be done over the phone.

194. In all, for Patient Ma.Wh. there were $3,662 in billed charges of which BCBS-TN paid a total of $139.90 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not get paid anything from the amounts received by Patient Ma.Wh.

Patient Ro.Re.:

195. Patient Ro.Re. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

196. Prior to providing services, Shreya Health of California required Patient Ro.Re. to execute an assignment of benefits.

197. The assignment from Patient Ro.Re. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

198. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

199. In addition to the assignment from Patient Ro.Re., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ro.Re. had under his plan with BCBS-TN and the payments required to be made per the plan language.

200. Specifically, plaintiffs confirmed for Patient Ro.Re. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $3,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient. If precertification is not obtained, the claim for services is reduced by 40%.

i. Services are based on medical necessity.

j. All HCPC codes are valid and billable.

k. No out of state restrictions on the plan

201. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ro.Re., despite requests to do so, and therefore the verification had to be done over the phone.

202. In all, for Patient Ro.Re. there were $1,525 in billed charges of which BCBS-TN paid a total of $120 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not recover any of the amounts received by Patient Ke.Ha.

Patient Sa.St.:

203. Patient Sa.St. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California and Vedanta.

204. Prior to providing services, Shreya Health of California required Patient Sa.St. to execute an assignment of benefits.

205. The assignment from Patient Sa.St. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to

me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

206. The assignment goes on to provide that:

I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

207. Vedanta also required Patient Sa.St. to execute an assignment of benefits, which provided that:

I irrevocably assign, transfer and convey to Vedanta the exclusive rights to benefits, insurance proceeds or other monies due to me for services rendered by Vedanta ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third part ("Liable Third Parties" and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

208. In addition to the assignments from Patient Sa.St., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Sa.St. had under his plan with BCBS-TN and the payments required to be made per the plan language.

209. Specifically, plaintiffs confirmed for Patient Sa.St. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $6,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 60% of benefits for out of network and 60% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient.

i. Services are based on medical necessity.

j. All HCPC codes are valid and billable.

k. No out of state restrictions on the plan

210. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Sa.St., despite requests to do so, and therefore the verification had to be done over the phone.

211. In all, for Patient Sa.St. there were $34,430 in billed charges of which BCBS-TN paid a total of $6,141.50 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not recover any of the amounts received by Patient Sa.St.

Patient Sh.Ke.:

212. Patient Sh.Ke. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

213. Prior to providing services, Shreya Health of California required Patient Sh.Ke. to execute an assignment of benefits.

214. The assignment from Patient Sh.Ke. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to

me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

215. The assignment goes on to provide that:

I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

216. In addition to the assignments from Patient Sh.Ke., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Sh.Ke. had under his plan with BCBS-TN and the payments required to be made per the plan language.

217. Specifically, plaintiffs confirmed for Patient Sh.Ke. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $9,200;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care except outpatient.

i. Services are based on medical necessity.

j. All HCPC codes are valid and billable.

k. No out of state restrictions on the plan

218. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Sh.Ke., despite requests to do so, and therefore the verification had to be done over the phone.

219. In all, for Patient Sh.Ke. there were $625 in billed charges of which BCBS-TN paid a total of $25 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not recover any of the amounts received by Patient Sa.St.

Patient So.Ta.:

220. Patient So.Ta. was covered under a BCBS-TN plan at the time services were provided by Satya Health of California.

221. Prior to providing services, Satya Health of California required Patient So.Ta. to execute an assignment of benefits.

222. The assignment from Patient So.Ta. to Satya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

223. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

224. In addition to the assignments from Patient So.Ta., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient So.Ta. had under his plan with BCBS-TN and the payments required to be made per the plan language.

225. Specifically, plaintiffs confirmed for Patient So.Ta. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $6,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 60% of benefits for out of network and 60% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all IP levels of care and that includes PHP and IOP.

i. Services are based on medical necessity.

j. No out of state restrictions on the plan

226. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient So.Ta., despite requests to do so, and therefore the verification had to be done over the phone.

227. In all, for Patient So.Ta. there were $44,850 in billed charges of which BCBS-TN paid a total of $7,930.32 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not recover any of the amounts received by Patient Sa.St.

Patient Ta.Cu.:

228. Patient Ta.Cu. was covered under a BCBS-TN plan at the time services were provided by Shreya Health of California.

229. Prior to providing services, Shreya Health of California required Patient Ta.Cu. to execute an assignment of benefits.

230. The assignment from Patient Ta.Cu. to Shreya Health of California provided that:

> I patient/policyholder irrevocably assign, transfer, and convey to Provider the exclusive rights to benefits, insurance proceeds or other moneys otherwise due to me for services rendered by Providers ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties") and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties.

231. The assignment goes on to provide that:

> I understand that the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide to me. Accordingly, I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist in recovering Benefits from Liable Third Parties.

232. In addition to the assignments from Patient Ta.Cu., Plaintiffs also contacted BCBS-TN directly to get details of the type of coverage Patient Ta.Cu. had under his plan with BCBS-TN and the payments required to be made per the plan language.

233. Specifically, plaintiffs confirmed for Patient Ta.Cu. the following relevant plan provisions and benefits, among others:

a. The type of plan – was a self-funded PPO plan;

b. The out of network deductible for substance abuse/mental health was $3,000;

c. The policy covers, In-patient care, residential treatment, partial hospitalization, intensive outpatient care, and outpatient care for mental health/substance abuse;

d. There is no annual maximum benefits under the plan;

e. The policy pays 50% of benefits for out of network and 50% of labs;

f. There are no copays for any level of care.

g. The plan covers combined Alcohol and Substance Abuse and Combined Alcohol, Substance Abuse, and Mental Health.

h. Precertification is needed for all levels of care, if no precertification, the claim is denied.

i. Services are based on medical necessity.

j. All HCPC codes are valid and billable.

k. No out of state restrictions on the plan

234. Importantly, BCBS-TN never provided the actual plan documents to Plaintiffs or to Patient Ta.Cu., despite requests to do so, and therefore the verification had to be done over the phone.

235. In all, for Patient Ta.Cu. there were $2,655 in billed charges of which BCBS-TN paid a total of $218.93 to the patient, virtually assuring that Plaintiffs would not get paid the amounts due per the Plan documents. In fact, Plaintiffs did not recover any of the amounts received by Patient Ta.Cu.

E. After Providing Covered Services, Plaintiffs Submitted Claims for Benefits to the Blue Cross Defendants Following Blue Cross Procedures.

236. Plaintiffs provided medically necessary services to the Former Patients that were covered by their plans.

237. Plaintiffs then sought payment by submitting the appropriate documents to BCBS-TN. The claims for payment notified the BCBS-TN that Plaintiffs had obtained valid Assignments from the Former Patients and asserted Plaintiffs' right to receive any benefits owed to the Former Patients under the terms of their health plans.

238. After the verification of benefits, Defendants (or their agents) repeatedly continued to interact with Plaintiffs (or their agents) with respect to the Former Patients and claims for whom Plaintiffs received assignments. In addition to verification of services, such interaction, which was over a long period of time, included receiving and processing UB-04 claim forms for payment for the services, communicating with Plaintiffs (or their agents) about the services and claims, and requesting additional documentation for the claims.

F. The Blue Cross Defendants Approved Plaintiffs Claims But Arbitrarily Disregarded Their Assignments and/or significantly underpaid claims.

239. During this continued interaction neither BCBS-TN nor their agents notified Plaintiffs or their agents that BCBS-TN would not honor any assignment of benefits. Nor did BCBS-TN refuse to deal directly with Plaintiffs or their agents with respect to the claims of the Former Patients. Indeed, BCBS-TN (or their agents) regularly informed Plaintiffs' agents through express words in many cases, but at a minimum impliedly through their actions, that the claims of Former Patients at issue were freely assignable.

240. A valid assignment obligates the debtor to pay the assignee, not the original creditor.

241. When there is a valid assignment in place, performance under a contract runs to the assignee. Thus, when a creditor assigns its interest in an existing debt owed to it, the debtor must generally pay the debt to the assignee, not the original creditor. Indeed, after a debtor has received notice of a valid assignment, or obtained knowledge of it in any manner, assignor or any person other than the assignee is at the debtor's peril and does not to the assignee.

242. Plaintiffs are informed and believe that BCBS-TN approved and authorized payment on Plaintiffs' claims for benefits in connection with the services provided to the Former Patients, but did not pay Plaintiffs (apparently on the grounds that Plaintiffs were assignees).

243. In other words, despite BCBS-TN being informed of and provided with written notice that Plaintiffs were assignees— and despite BCBS-TN approving the underlying claim for covered services—BCBS either mailed checks directly to the Former Patients and not to Plaintiffs or failed to pay the claim entirely.

244. Plaintiffs are informed and believe that the Blue Cross Defendants' disregard of Plaintiffs' Assignments is consistent with acknowledged BlueCard policy to disregard the assignments of out-of-network providers like Plaintiffs. As one Blue Cross Company put it: "payments for services rendered by providers who do not contract with [Blue Cross] are sent directly to our customers. Thus, out-of-network providers face the inconvenience of attempting to collect payment from the customer and the accompanying possibility of incurring bad debts." See *Blue Perspective: BCBSOK Position on Legislation and Regulatory Issues,* Blue Cross Blue Shield Oklahoma, www.bcbsok.com/grassroots/pdf/blueperspective_aob27-103003.pdf (last visited 10/28/20)

245. Indeed, when Plaintiffs sought payment for covered claims the Former Patients had assigned to it, Blue Cross uniformly refused to pay, or even to acknowledge, Plaintiffs'

benefit claims. Neither Plaintiffs' initial UB-04 requests for payment nor its follow-up letters resulted in payment.

246. In this litigation, BCBS-TN's policy of misleading Plaintiffs on the assignability of claims and/or disregarding assignments to out-of- network providers like Plaintiffs led them to send large sums of money to chemically dependent individuals. That practice was patently reckless with respect to the health and safety of the Former Patients, as well as the health and safety of the general public. It also all but guaranteed that Plaintiffs would receive only a fraction of what it was owed for their services.

247. In addition to disregarding the assignments of various patients, BCBS-TN improperly paid only a fraction of the billed charges for the particular medical services at issue in this litigation.

248. Even taking into account the amounts that BCBS-TN may contend are the patients' responsibility, the payments made by BCBS-TN are still woefully inadequate and well below what should have been paid per the confirmed plan coverage information – obtained prior to providing services to the various patients.

249. In fact, there is more than $475,000 still due and owing from BCBS-TN.

250. In violation of their duties under ERISA and Tennessee State law, BCBS-TN failed and refused to: i) pay plaintiffs for the health care services provided to the patients who are covered by various Blue Cross plans; ii) failed and refused to provide full and fair review of the plaintiffs charges; and iii)failed and refused to provide a meaningful review process.

251. Because of the Blue Cross Defendants actions, plaintiffs have been paid substantially less than they should have been for the services provided.

FIRST CLAIM FOR RELIEF
CLAIM TO RECOVER BENEFITS UNDER ERISA AND TENNESSEE STATE LAW

252. Plaintiffs repeat the allegations contained in each of the preceding paragraphs of this Complaint.

253. As noted above, this litigation involves twenty-three Former Patients who paid for Plaintiffs' services through health insurance provided by various plans; such plans and their benefits being governed by ERISA and/or Tennessee State law and require payment according to the Plan terms.

254. The Former Patients who had health insurance provided by an employer-sponsored plan and who are the subject of this claim for relief are: Aa.Br., An.Yo., BA.Al., Br.Al., Co.Cu., Da.Sm., Sr.Al., Dw.Ri., Ha.Ke., Ja.Br., Ja.Is., Je.St., Jo.Ha., Ke.Ha., Ke.Ca., La.We., Le.St., Ma.Wh., Ro.Re., Sa.St., Sh.Ke., So.Ta.and Ta.Cu.

255. ERISA is a landmark federal law enacted to promote the interests of employees and their beneficiaries in employee benefit plans and to protect contractually defined benefits owed to those employees and beneficiaries.

256. To that end, ERISA imposes extensive procedural requirements on employee benefit plans. For example, it mandates that a written instrument be established and maintained, 29 U.S.C. § 1102; that a straightforward summary of material plan terms be furnished to participants and beneficiaries, *id.* § 1022; that a grievance and appeals process be established, *id.* § 1133; and that fiduciary duties be satisfied by those who manage the plan, *id.* § 1104.

257. ERISA also gives plan participants and their beneficiaries the right to sue for benefits, 29 U.S.C. § 1132(a)(1)(B), to enforce or clarify their rights under the plan, ibid., to enjoin violations of ERISA or the terms of the plan, *id.* § 1132(a)(3)(A), and "to obtain other appropriate equitable relief . . . ," *id.* § 1132(a)(3)(B).

258. Each of the plans covered the mental health and/or substance abuse treatment services provided by Plaintiffs to the Former Patients.

259. BCBS-TN, who insured the various plans, had independent financial incentives to keep benefit costs low because they paid for covered health care services themselves.

260. Plaintiffs are "beneficiaries" under ERISA with standing to assert the claims of their assignors. See *Misic v. Bldg. Servs. Emps. Health & Welfare Trust,* 789 F.2d 1374, 1379 (9th Cir. 1986).

261. And any beneficiary—including an assignee—who makes a claim is a "claimant" under federal law. 29 C.F.R. § 2560.503-1(a) ("[T]his section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants).")

262. Plaintiffs formally asserted claims for ERISA benefits and for benefits to be paid in accordance with Tennessee State law by submitting UB-04s to the BCBS-TN for services provided to the Former Patients.

263. Plaintiffs never received any response from BCBS-TN. As Plaintiffs learned only later and at great expense, BCBS-TN instead had approved and authorized payment on the claims for Plaintiffs' services to the Former Patients. BCBS-TN then issued payment checks to the Former Patients.

264. When BCBS-TN sent claims payment checks to the Former Patients, Plaintiffs received no written notice that payment had been made. As a result, Plaintiffs did not know whether BCBS-TN had acted on their claims at all, what decisions they had reached if they had, or why they never received payment.

265. Only recently, after a costly and protracted investigation, were Plaintiffs able to ascertain, based on the currently available information, the amounts that are owed with respect to some of the Former Patients.

266. Plaintiffs were unable to challenge any of the payments made to the Former Patients because they were not given notice of the payments and were not given copies of the Explanation of Benefits. Even now, despite repeated requests, Plaintiffs do not have the operative plan documents for most if not all of the Former Patients. In addition, for all of the Former Patients BCBS-TN has not explained the method by which it calculated the amount paid, as required by 29 C.F.R. § 2560.503-1.

267. Defendants have violated ERISA and Tennessee State laws and regulations and the terms on the applicable plans in the following ways:

a. Failing to honor Plaintiffs' valid Assignments of Benefits and, instead, making payment directly to Former Patients;

b. Failing to promptly notify Plaintiffs or Former Patients if additional information was needed to honor a valid Assignment of Benefits;

c. Failing to promptly notify Plaintiffs or Former Patients that a valid Assignment of Benefits would not be honored;

d. Failing to produce plan documents;

e. Failing to provide explanation of benefits;

f. Failing to properly interpret plan language so as to properly pay plan benefits; and

g. Failing to properly explain the calculation of the payment of benefits.

h. Paying substantially less than the amounts owed for the services provided to the patients.

268. As a result, Plaintiffs have been damaged in the following ways, among others:

a. Plaintiffs were not paid in accordance with valid Assignments of Benefits;

b. Plaintiffs had to recover payments from Former Patients, at their own expense;

c. Plaintiffs have been unable to recover all payments from all Former Patients;

d. Plaintiffs have been unable to participate in the administrative appeal process as they were not given proper notice;

e. Plaintiffs have been unable to ascertain whether payments to some Former Patients were proper, as they do not have plan documents, explanation of benefits, and/or explanations of the calculation of the payment of benefits; and

f. Plaintiffs, in pursuing this action, has been required to incur attorneys' costs and fees. Pursuant to 29 U.S.C. § 1132(g)(1), Plaintiffs are entitled to have such fees and costs paid by Defendants.

WHEREFORE, Plaintiffs demands relief under this First Count of the Complaint as follows:

a. For compensatory damages, including all amounts owed to date for the required and covered services to the Former Patients;

b. For attorneys fees as permitted by law;

c. Interest and costs of suit;

d. Such other relief that the Court deems appropriate.

SECOND CLAIM FOR RELIEF
BREACH OF CONTRACT

266. Plaintiffs repeat the allegations contained in each of the preceding paragraphs of this Complaint.

267. As described above, BCBS-TN failed to pay for covered health benefits provided by plaintiffs or significantly underpaid the health benefits provided by plaintiffs.

268. The failure of BCBS-TN to pay the required benefits under the various health plans covering the 23 Former Patients who are the subject of this claim for relief, including Aa.Br., An.Yo., BA.Al., Br.Al., Co.Cu., Da.Sm., Sr.Al., Dw.Ri., Ha.Ke., Ja.Br., Ja.Is., Je.St., Jo.Ha., Ke.Ha., Ke.Ca., La.We., Le.St., Ma.Wh., Ro.Re., Sa.St., Sh.Ke., So.Ta.and Ta.Cu is a breach of the insurance contract as a result of which plaintiffs have been damaged.

269. Specifically, BCBS-TN have violated Tennessee State laws and breached their insurance contract in the following ways:

a. Failing to honor Plaintiffs' valid Assignments of Benefits and, instead, making payment directly to Former Patients;

b. Failing to promptly notify Plaintiffs or Former Patients if additional information was needed to honor a valid Assignment of Benefits;

c. Failing to promptly notify Plaintiffs or Former Patients that a valid Assignment of Benefits would not be honored;

d. Failing to produce plan documents;

e. Failing to provide explanation of benefits;

f. Failing to properly interpret plan language so as to properly pay plan benefits; and

g. Failing to properly explain the calculation of the payment of benefits.

h. Paying substantially less than the amounts owed for the services provided to the patients.

270. As a result, Plaintiffs have been damaged in the following ways, among others:

a. Plaintiffs were not paid in accordance with valid Assignments of Benefits;

b. Plaintiffs had to recover payments from Former Patients, at their own expense;

c. Plaintiffs have been unable to recover all payments from all Former Patients;

d. Plaintiffs have been unable to participate in the administrative appeal process as they were not given proper notice;

e. Plaintiffs have been unable to ascertain whether payments to some Former Patients were proper, as they do not have plan documents, explanation of benefits, and/or explanations of the calculation of the payment of benefits; and

f. Plaintiffs, in pursuing this action, has been required to incur attorneys' costs and fees.

WHEREFORE, Plaintiffs demands relief under this Second Count of the Complaint as follows:

a. For compensatory damages, including all amounts owed to date for the required and covered services to the Former Patients;

b. For attorney's fees as permitted by law;

c. Interest and costs of suit;

d. Such other relief that the Court deems appropriate

Dated: February 14, 2022 **ERIC BUCHANAN & ASSOCIATES, PLLC**

Attorneys for Plaintiffs

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CERTIFICATION

HUDSON T. ELLIS declares as follows:

I am an attorney in the law firm of **ERIC BUCHANAN & ASSOCIATES, PLLC**, the attorneys for plaintiff in this action. Under Federal Rule of Civil Procedure 11, by signing below, I certify to the best of my knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: February 14, 2022

HUDSON T. ELLIS