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THE UNITED STATES DISTRICT COURT
DISTRICT OF UTAH, CENTRAL DIVISION

S.S., and E.S., Plaintiffs, vs. CIGNA HEALTH and LIFE INSURANCE COMPANY, and the INTEL CORPORATION BENEFITS PLAN. Defendants.	COMPLAINT Case No. 2:21-cv-00544 - CMR
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Plaintiffs S.S. and E.S., through their undersigned counsel, complain and allege against Defendants Cigna Health and Life Insurance Company (“Cigna”) and the Intel Corporation Benefits Plan (“the Plan”) as follows:

PARTIES, JURISDICTION AND VENUE

1. S.S. and E.S. are natural persons residing in Loudoun County, Virginia. S.S. is E.S.’s father.

2. Cigna is an insurance company headquartered in Bloomfield, Connecticut and was the third-party claims administrator, as well as the fiduciary under ERISA for the Plan during the treatment at issue in this case.
3. The Plan is a self-funded employee welfare benefits plan under 29 U.S.C. §1001 *et. seq.*, the Employee Retirement Income Security Act of 1974 (“ERISA”). S.S. was a participant in the Plan and E.S. was a beneficiary of the Plan at all relevant times. S.S. and E.S. continue to be participants and beneficiaries of the Plan.
4. E.S. received medical care and treatment at SUWS of the Carolinas (“SUWS”) from September 20, 2018, to December 5, 2018, and Dragonfly Transitions (“Dragonfly”) from December 7, 2018, to August 21, 2019. These are treatment facilities which provide sub-acute inpatient treatment to adolescents with mental health, behavioral, and/or substance abuse problems. SUWS is located in North Carolina and Dragonfly is located in Oregon
5. Cigna, acting in its own capacity or through its subsidiary and affiliate Cigna Behavioral Health denied claims for payment of E.S.’s medical expenses in connection with her treatment at SUWS and Dragonfly.
6. This Court has jurisdiction over this case under 29 U.S.C. §1132(e)(1) and 28 U.S.C. §1331.
7. Venue is appropriate under 29 U.S.C. §1132(e)(2) and 28 U.S.C. §1391(c) based on ERISA’s nationwide service of process and venue provisions and because Cigna does business in Utah and across the United States. Moreover, Intel Corporation, the sponsor of the Plan, has business offices in Salt Lake County and Utah County and has, and is committing to growing, its business presence in Utah. In addition, venue in Utah will

save the Plaintiffs costs in litigating this case. Finally, in light of the sensitive nature of the medical treatment at issue, it is the Plaintiffs' desire that the case be resolved in the State of Utah where it is more likely their privacy will be preserved.

8. The remedies the Plaintiffs seek under the terms of ERISA and under the Plan are for the benefits due under the terms of the Plan, and pursuant to 29 U.S.C. §1132(a)(1)(B), for appropriate equitable relief under 29 U.S.C. §1132(a)(3) based on the Defendants' violation of the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), an award of prejudgment interest, and an award of attorney fees and costs pursuant to 29 U.S.C. §1132(g).

BACKGROUND FACTS

E.S.'s Developmental History and Medical Background

9. As a young child, E.S. struggled with learning new concepts and paying attention. She began seeing a psychiatrist and was diagnosed with ADHD. She would often act out and throw angry tantrums during which she would throw things, destroy property, and physically attack others. E.S. also started seeing a therapist.
10. E.S. was caught with cigarettes in her possession on multiple occasions but when confronted would always deny that they were hers. E.S.'s violent behaviors escalated as she got older and the police were often called. On one occasion, E.S. got into a physical altercation with her father and then claimed that she had been abused and filed a report with child protective services. The abuse claim was found to be without merit and was dismissed. E.S. later made another claim concerning sexual abuse which she later recanted and which was also dismissed.

11. E.S. continued to struggle and her school performance significantly declined. E.S. started attending an intensive outpatient program and afterwards started seeing a new therapist. E.S.'s therapist became concerned about the unfounded abuse allegations E.S. was making and recommended that she meet with a psychologist.
12. E.S. continued to escalate her behaviors and on one occasion when she was arguing with her mother she became enraged and punched her in the face, resulting in the police being called and E.S. being hospitalized for psychiatric treatment. While at the hospital, E.S. accused her mother of abuse and of pushing her down the stairs. This resulted in yet another investigation but the claims were again found to be unsubstantiated.
13. E.S. made abuse allegations concerning her teachers as well. E.S. was required to meet with a juvenile probation officer and follow a behavioral contract, however she refused to stop smoking and abide by the terms of the contract and was made to complete additional community service.
14. E.S. engaged in increasingly erratic behaviors and threatened to run away from home and spend her time using drugs while homeless. E.S. often left home without permission and on at least two occasions slept in a car with someone she just met. S.S. worried that if E.S. did not soon receive some kind of therapeutic intervention she was at a highly elevated risk of danger such as falling prey to human traffickers, or even death.

SUWS

15. E.S. was admitted to SUWS on September 20, 2018.
16. In a series of Explanation of Benefits ("EOB") statements, Cigna denied payment for E.S.'s treatment under code A0: "YOUR PLAN BOOKLET LISTS THE SERVICES

AND PROCEDURES COVERED BY YOUR PLAN. THE PLAN WILL ONLY PAY FOR SERVICES LISTED IN THE BOOKLET.” (emphasis in original)

17. On November 22, 2019, S.S. appealed the denial of payment for E.S.’s treatment. S.S. stated that he was entitled to certain protections under ERISA, including a requirement that Cigna take into account all of the information he provided, that it utilize appropriately qualified reviewers, that it provide him with a clear and specific response which referenced the Plan language on which the denial was based, and that it provide him with a full, fair, and thorough review.
18. S.S. contended that the treatment provided at SUWS was a covered benefit under the terms of the Plan as SUWS was a licensed and accredited facility which clearly met the requirements listed in the insurance policy for an “Other Health Care Facility.”
19. S.S. asked Cigna to perform a MHPAEA compliance analysis and in the event the denial was upheld he asked Cigna to address all of the issues he had raised in the appeal and explain how its decision was compliant with federal law and the terms and conditions of the insurance policy.
20. S.S. additionally asked to be provided with the specific reasons for the denial along with any corresponding evidence, any administrative service agreements that existed, any clinical guidelines or medical necessity criteria related to the claim, the Plan’s mental health, substance use, skilled nursing, inpatient rehabilitation, and hospice criteria, as well as any reports from any physician or other professional regarding the claim.

(collectively the “Plan Documents”)
21. After Cigna failed to respond to the appeal in a timely manner, S.S. reached out to Cigna and in a February 2020, email was told by Cigna representative Jasmine K. that the

appeal had not been processed as the documents submitted had mistakenly been classified as being related to Dragonfly. The representative assured S.S. that his appeal would be resubmitted and processed.

22. In a letter dated March 2, 2020, Cigna upheld the denial of payment under the following rationale:

The clinical basis for this decision is: Based upon current available information, coverage for the requested service cannot be approved because there is insufficient scientific evidence to demonstrate the safety and/or effectiveness of Wilderness Therapy Programs. At the present time, per Cigna Coverage Policy Complementary and Alternative Medicine (0086), this treatment falls under the category of experimental/investigational/unproven. Your benefit plan does not cover experimental/investigational/unproven services.

Please note that claims for therapeutic services rendered by an independently licensed health care professional for the treatment of a mental health condition and/or substance use disorder while residing at the wilderness program may be submitted for benefit coverage subject to the terms and conditions of the Cigna customer's health plan.

23. On April 7, 2020, S.S. submitted a second level one appeal of the denial. S.S. expressed concern that Cigna appeared to have altered its denial rationale from SUWS not being a covered service to being excluded due to being an experimental/investigational service. He stated that Cigna appeared to be engaging in a "trial run" of different denials in an attempt to wait until his appeals were exhausted and deprive him of the opportunity to respond. He accused Cigna of acting in bad faith and stated that a second level one appeal was necessary to address Cigna's new denial.
24. S.S. contended that Cigna had not addressed his arguments and had not abided by its responsibilities under ERISA. S.S. reiterated that the terms of the insurance policy did not exclude the outdoor behavioral health treatment E.S. received and according to the insurance policy, this treatment was a covered benefit.

25. S.S. quoted the Plan's definition of an "Other Health Care Facility" and stated that SUWS clearly met this definition as it was a licensed and accredited facility which met all of the stringent requirements set by the State of North Carolina to provide these therapeutic services to adolescents in an outdoor residential setting.
26. S.S. then quoted the Plan's definition for "experimental, investigational, or unproven" care and contended that the treatment provided at SUWS did not meet this definition, and furthermore, extensive peer reviewed literature had shown outdoor behavioral health facilities to be both effective and evidence based.
27. S.S. also quoted the Plan's definition for "Medically Necessary/Medical Necessity" and stated that E.S.'s treatment also satisfied this definition. S.S. reminded Cigna that his insurance policy superseded any other criteria it elected to use.
28. S.S. wrote that as E.S.'s treatment was not excluded under the terms of the Plan and was in fact covered under several definitions, it appeared that Cigna had relied on proprietary internal criteria to deny care. S.S. quoted a portion of Cigna's residential treatment criteria which equated wilderness care with "boot camps" and stated that they frequently did not utilize adequately trained staff, or provide an appropriate intensity or variety of services, and they were "nearly universally" denied accreditation by regulatory agencies such as the Joint Commission.
29. S.S. argued that Cigna was relying on outdated data which was more than a decade old. He stated that E.S. did receive appropriate clinical treatment from a multidisciplinary team of psychologists, therapists, and psychiatrists. He stated that the primary distinction between traditional residential treatment centers and outdoor behavioral health programs was not the content of the treatment, but rather where the services took place.

30. S.S. reminded Cigna that SUWS was a licensed and accredited treatment program. He stated that outdoor behavioral health services were an effective and well recognized treatment modality and included articles to that effect, including contact information for Dr. Michael Gass Ph.D., LMFT, one of the leading experts in the field. S.S. encouraged Cigna to reach out to Dr. Gass with any questions it had regarding the efficacy of wilderness treatment.
31. S.S. voiced his concern that Cigna's denial violated MHPAEA. He reminded Cigna that MHPAEA compelled insurers to offer mental health benefits "at parity" with medical or surgical benefits at the same level of care. He wrote that SUWS was an intermediate level mental health treatment facility and the appropriate medical or surgical analogues were environments like hospice, skilled nursing, or inpatient rehabilitation facilities.
32. S.S. referenced a court ruling in *Johnathan Z. v. Oxford Health Plans* in which the court confirmed that these facilities were the appropriate analogues to outdoor behavioral health care.
33. He contended that Cigna was in violation of MHPAEA in three major respects:
1. It evaluated the medical necessity of E.S.'s treatment using proprietary criteria but appeared to have no such clinical criteria for analogous medical or surgical care. S.S. stated that Cigna had done this despite the fact that his insurance policy contained no exclusion for wilderness treatment, and this exclusion was only found in proprietary criteria.
 2. It placed a limitation on facility type by requiring outdoor behavioral health facilities to be licensed as a residential treatment center but having no comparable restriction on the licensure of medical or surgical services.
 3. It restricted the availability of outdoor behavioral treatment based not on the content of the services offered, but instead denied care primarily because the services did not take place in a "brick-and-mortar setting."
34. S.S. voiced his suspicions that Cigna denied any and all outdoor behavioral health claims automatically as they were all easily identifiable due to their use of the "1006" revenue

code used to submit claims. He stated that this was another example of Cigna's discrimination against wilderness providers.

35. S.S. asked that if he were incorrect in his assessment that Cigna violated MHPAEA that it demonstrate its compliance using specific examples. He also asked Cigna to conduct a MHPAEA analysis of the Plan and to provide him with a copy of the results of this analysis. He stated that he was entitled to these materials under both ERISA and MHPAEA. S.S. also requested a copy of the Plan Documents.

36. In a letter dated July 1, 2020, Cigna upheld the denial of payment for E.S.'s treatment.

The letter gave the following justification for the denial:

Based upon current available information, coverage for the requested service cannot be approved because there is insufficient scientific evidence to demonstrate the safety and/or effectiveness of Wilderness Therapy Programs. At the present time, per Medical Coverage Policy Complementary and Alternative Medicine (0086), this treatment falls under the category of experimental/investigational/unproven. Your benefit plan does not cover experimental/ investigational/unproven services. Please note that claims for therapeutic services rendered by an independently licensed health care professional for the treatment of a mental health condition and/or substance use disorder while residing at the wilderness program may be submitted for benefit coverage subject to the terms and conditions of the Cigna customer's health plan.

Dragonfly

37. E.S. was admitted to Dragonfly on December 7, 2018.

38. In a letter dated July 18, 2019, Cigna denied payment for E.S.'s treatment under the following rationale:

Based upon the available clinical information, your symptoms did not meet Behavioral Health Medical Necessity Criteria for admission and continued stay at the Residential Mental Health Treatment for Adults level of care from 12/7/2018 – 12/31/2019 as the information provided described you as being able to understand information presented to you and being in behavioral control. There was no report of any physical instability or psychosis driving your behaviors. There was no evidence of threat to anybody. As there was nothing proposed requiring around-the-clock structure and interventions, there was nothing

suggesting that you would not be able to successfully and safely use structured outpatient services to continue working on your trauma issues and mastery of healthy coping skills and for medication management rather than an extended stay in an around-the-clock setting.

39. On November 26, 2019, S.S. appealed the denial of payment for E.S.'s treatment. S.S.

once more reminded Cigna that it was required under ERISA to provide him with a full, fair, and thorough review.

40. S.S. argued that Cigna had evaluated E.S.'s treatment using standards for the incorrect level of care. He wrote that Dragonfly provided transitional care to E.S. – a level of care designed to help individuals transition between residential treatment and home life – however Cigna had evaluated E.S.'s treatment as if it had been traditional residential treatment care. He argued that because E.S. was not receiving residential treatment services, whether or not she met Cigna's residential treatment criteria was irrelevant.

41. S.S. argued that transitional services were a covered benefit under the terms of the Plan.

He pointed out that while Cigna did not appear to have specific criteria for transitional living, it did have guidelines for halfway houses which were very similar to transitional services. He stated that Dragonfly was a licensed and accredited transitional living facility and if it were a halfway house, it would have met those criteria.

42. S.S. argued that Cigna's denial violated generally accepted standards of medical practice and that its denial had more in common with acute inpatient hospitalization than residential treatment and its requirements of factors such as "physical instability or psychosis" were impermissible. He also contended that these requirements violated MHPAEA as they were not required of analogous medical or surgical services.

43. S.S. asked Cigna to perform a MHPAEA compliance analysis and to forward him the results of this analysis as well as a copy of the Plan Documents.

44. S.S. included multiple letters of medical necessity with the appeal. In a letter dated September 28, 2019, Gregory Law, MD, wrote in part:

It was clinically evident that outpatient or intensive outpatient programs were not effective for [E.S.]. She required a higher level of care. The above residential programs were medically necessary.

Laurie Mowry-Hesler, MA, ATR-BC, ATCS, LMFT, wrote in part in a letter dated September 25, 2019:

By [E.S.]’s sophomore year she was demonstrating consistent evidence of Oppositional Defiant Disorder. There were periods of time when she needed almost round the clock supervision due to running away behaviors, lying to parents, school personnel and the police on multiple occasions, smoking and suspected marijuana use, and was verbally and physically assaultive toward family members and classmates. She also accused her father of physical abuse, which was investigated by CPS and the case was dropped due to [E.S.]’s unreliable reporting. [E.S.]’s parents attempted to bring her in for family therapy, again, but due to [E.S.]’s highly uncooperative and hostile manner it was recommended that the family begin to investigate residential treatment for [E.S.]. By the spring/summer of 2017 the [S. family] were actively seeking residential placement for [E.S.] due to the degree of treatment and care she required.

Stacey Hoffman, MA, PsyD, LCP, wrote in part in a letter dated October 1, 2019:

Given [E.S.]’s increasingly aggressive and assaultive behaviors, I began a more intensive level of treatment, that included home visits and crisis response to attempt to prevent psychiatric inpatient hospitalization as well as criminal charges. There were multiple emergency calls to police, and [E.S.] incurred pending criminal charges and placed into a diversion program in the spring of 2018. In spite of home-based clinical visits and her presence in the Juvenile Court Diversion Program, [E.S.] began to regress in the late summer of 2018. [E.S.] began to present as a danger to herself (running away from home to meet strange men, making plans to live in car or camper with an adult male in West Virginia, using illegal drugs and alcohol, and presenting with very poor reality testing related to grave safety concerns. As such, I recommended that she be placed in residential treatment in September of 2018 (SUWS of the Carolinas, in particular).

It is noted that I have had several other clients in my 20 years of clinical practice that were enrolled in SUWS of the Carolinas. Each of these clients maintained the clinical gains that resulted from that treatment for years after their discharge. Each of those clients was able to verbalize after discharge that they would likely have become incarcerated or in a cycle of acute care psychiatric hospitalizations if not

for the residential intervention. It became quite evident that [E.S.] would not be stabilized in a less restrictive setting, and required residential placement. In spite of home-based services with a crisis response component and accompanying juvenile court support, [E.S.] continued to deteriorate and repeatedly placed herself in imminent danger. As a result of her residential placement, [E.S.] is now able to return to outpatient treatment, and is presenting with many gains from the residential interventions.

K. Alice Cennamo, LCSW, LCAS, wrote in part in a letter dated September 5, 2019:

While [E.S.] accomplished improved compliance, self-confidence, emotion management, and motivation towards sobriety, she remained easily dysregulated and often decompensated into defiant, self-destructive, or risk-taking patterns. It was strongly recommended that [E.S.] continue her treatment in a therapeutic residential setting (i.e., a young adult residential treatment program) following successful completion of SUWS programming.

Anna Edwards, Ph.D. wrote in part in a November 2018 psychological evaluation:

[E.S.] continues to show vulnerability in emotional, social and behavioral domains. Thus, the continued need for treatment is indicated.

Specific Treatment Recommendations:

1. Following her placement at SUWS, it is highly recommended that [E.S.] continue in a structured, therapeutic residential setting such as a residential treatment center. Outside of this type of structure, [E.S.] is likely to experience further declines in functioning. She is at-risk of significant impulsivity and other self-destructive behaviors. In a setting with less support, progress could be hindered by her therapist's lack of objective data

E.S.'s discharge summary from SUWS stated in part:

It is recommended that [E.S.] continue her growth in a therapeutic and transitional living environment. The environment should include both individual and family therapy sessions for the duration of her time in the program. In addition, a defined daily structure will be necessary and any significant challenges faced with adherence to this structure should be discussed within individual or family therapy sessions.

S.S. also included two letters from Dragonfly documenting E.S.'s aggressive behaviors, minimal group participation, manipulative behaviors, and brief expulsion from the program due to threats of violence.

45. S.S. argued that it was overwhelmingly clear that E.S.'s treatment team considered her care to be medically necessary. He asked Cigna to elaborate on why it disagreed with the medical professionals who had treated E.S. on a firsthand basis.

46. In a letter dated December 27, 2019, Cigna upheld the denial of payment for E.S.'s treatment under the following justification:

Based upon the available clinical information received initially and with this appeal, your symptoms did not meet Behavioral Health Medical Necessity Criteria for admission and continued stay at Residential Mental Health Treatment for Adults level of care from 12/7/2018 - 8/22/2019. There was a 1349 page document provided supporting the opinion that this treatment being needed. [sic] Although there was a very helpful summary of your lifetime behavioral process the remaining hundreds of pages largely were copies of definitions and copies of articles on generic treatment approaches. Not included in this documentation was a clear description of specific intervention proposed by the identified facility during your considered stay although there was a brief description of your consistent engagement in the treatment groups as being minimal. In a smaller document of your time in the residential setting it was noted that after the years of outpatient services, the prior exposure to the wilderness program and several months of exposure to this around-the-clock program you were described in May 2019 to be "unwilling to take accountability...downplaying behaviors". Your consistent descriptions had been of showing lack of respect for authority or boundaries established by others. It had been documented that you had been found to have an unaccounted for substance in your drug testing while in the program. The information provided described that the benefit from both the wilderness program and the residential stay considered came largely from the supervision provided with behavioral shaping rather than you're [sic] incorporating and consistently using healthier and less oppositional coping strategies. There was no focused new intervention to which you had not previously been exposed and would be expected to generate a more robust and sustainable benefit. Thus as the same benefit would be expected to generate in a therapeutic group home or other highly structured and supervises [sic] living setting until such time as you showed evidence of truly engaging in the treatment goals and methods of your team through use of outpatient individual and group therapy, authorization of extended residential services cannot be justified even though there is the risk for your continued use of unhealthy methods of manipulating your environment to achieve personal goals.

47. The Plaintiffs exhausted their pre-litigation appeal obligations under the terms of the Plan and ERISA.

48. The denial of benefits for E.S.'s treatment was a breach of contract and caused S.S. to incur medical expenses that should have been paid by the Plan in an amount totaling over \$94,000.

49. Cigna failed to conduct a MHPAEA analysis or to produce a copy of the Plan Documents including any medical necessity criteria for mental health and substance use disorder treatment and for skilled nursing or rehabilitation facilities in spite of S.S.'s requests.

FIRST CAUSE OF ACTION

(Claim for Recovery of Benefits Under 29 U.S.C. §1132(a)(1)(B))

50. ERISA imposes higher-than-marketplace quality standards on insurers and plan administrators. It sets forth a special standard of care upon plan fiduciaries such as Cigna, acting as agent of the Plan, to discharge its duties in respect to claims processing solely in the interests of the participants and beneficiaries of the Plan. 29 U.S.C. §1104(a)(1).

51. Cigna and the Plan failed to provide coverage for E.S.'s treatment in violation of the express terms of the Plan, which promise benefits to employees and their dependents for medically necessary treatment of mental health and substance use disorders.

52. ERISA also underscores the particular importance of accurate claims processing and evaluation by requiring that administrators provide a "full and fair review" of claim denials and to engage in a meaningful dialogue with the Plaintiffs in the pre-litigation appeal process. 29 U.S.C. §1133(2).

53. Cigna and the agents of the Plan breached their fiduciary duties to E.S. when they failed to comply with their obligations under 29 U.S.C. §1104 and 29 U.S.C. §1133 to act solely in E.S.'s interest and for the exclusive purpose of providing benefits to ERISA participants and beneficiaries, to produce copies of relevant documents and information

to claimants upon request, and to provide a full and fair review of E.S.'s claims.

54. The actions of Cigna and the Plan in failing to provide coverage for E.S.'s medically necessary treatment are a violation of the terms of the Plan and its medical necessity criteria.

SECOND CAUSE OF ACTION

(Claim for Violation of MHPAEA Under 29 U.S.C. §1132(a)(3))

55. MHPAEA is incorporated into ERISA and is enforceable by ERISA participants and beneficiaries as a requirement of both ERISA and MHPAEA. The obligation to comply with both ERISA and MHPAEA is part of Cigna's fiduciary duties.
56. Generally speaking, MHPAEA requires ERISA plans to provide no less generous coverage for treatment of mental health and substance use disorders than they provide for treatment of medical/surgical disorders.
57. MHPAEA prohibits ERISA plans from imposing treatment limitations on mental health or substance use disorder benefits that are more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits and also makes illegal separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. 29 U.S.C. §1185a(a)(3)(A)(ii).
58. Impermissible nonquantitative treatment limitations under MHPAEA include, but are not limited to, medical management standards limiting or excluding benefits based on medical necessity; refusal to pay for higher-cost treatment until it can be shown that a lower-cost treatment is not effective; and restrictions based on geographic location, facility type, provider specialty, or other criteria that limit the scope or duration of

benefits for mental health or substance use disorder treatment. 29 C.F.R.

§2590.712(c)(4)(ii)(A), (F), and (H).

59. The medical necessity criteria used by Cigna for the intermediate level mental health treatment benefits at issue in this case are more stringent or restrictive than the medical necessity criteria the Plan applies to analogous intermediate levels of medical or surgical benefits.
60. Comparable benefits offered by the Plan for medical/surgical treatment analogous to the benefits the Plan excluded for E.S.'s treatment include sub-acute inpatient treatment settings such as skilled nursing facilities, inpatient hospice care, and rehabilitation facilities. For none of these types of treatment does Cigna exclude or restrict coverage of medical/surgical conditions by imposing restrictions such as an acute care requirement for a sub-acute level of care. To do so, would violate not only the terms of the insurance contract, but also generally accepted standards of medical practice.
61. When Cigna and the Plan receive claims for intermediate level treatment of medical and surgical conditions, they provide benefits and pay the claims as outlined in the terms of the Plan based on generally accepted standards of medical practice. Cigna and the Plan evaluated E.S.'s mental health claims using medical necessity criteria that deviate from generally accepted standards of medical practice. This process resulted in a disparity because the Plan denied coverage for mental health benefits when the analogous levels of medical or surgical benefits would have been paid.
62. As an example of disparate application of medical necessity criteria between medical/surgical and mental health treatment, Cigna's reviewers improperly utilized acute medical necessity criteria to evaluate the non-acute treatment that E.S. received.

Cigna's improper use of acute inpatient medical necessity criteria is revealed in the statements in Cigna's denial letters such as "There was no report of any physical instability or psychosis driving your behaviors." This improper use of acute inpatient criteria was a nonquantitative treatment limitation that cannot permissibly be applied to evaluate the sub-acute level of care that E.S. received.

63. The Plan does not require individuals receiving treatment at sub-acute inpatient facilities for medical/surgical conditions to satisfy acute medical necessity criteria in order to receive Plan benefits.

64. The treatment provided in an acute care environment is necessarily distinct from treatment provided in a non-acute environment. Utilizing acute criteria to evaluate a non-acute claim will result in a near universal denial of benefits, regardless of the medical necessity, clinical appropriateness, or nature of the treatment.

65. Another example of the way in which the Defendants violated MHPAEA was in basing their denial of coverage for the treatment provided at SUWS and Dragonfly on the absence of E.S. having recently obtained treatment at the intensive outpatient and partial hospitalization program level of care before being able to continue to be treated at SUWS and Dragonfly.

66. This "fail-first" requirement is evident through Cigna's statement that "until such time as you showed evidence of truly engaging in the treatment goals and methods of your team through use of outpatient individual and group therapy, authorization of extended residential services cannot be justified." Requirement such as these are specifically referenced in the Final Rules of MHPAEA as constituting an impermissible nonquantitative treatment limitation.

67. In addition to the above, S.S. identified three specific areas in which Cigna violated MHPAEA. He stated that Cigna used restrictive proprietary criteria to evaluate E.S.'s mental healthcare but had no equivalent criteria for analogous medical or surgical services. S.S. directed Cigna to produce such criteria along with the rest of the Plan Documents if it had it, but Cigna either could not or did not comply.
68. S.S. also alleged that Cigna imposed strict licensure requirements on mental health services which it did not equally apply to analogous medical or surgical services.
69. Finally, S.S. argued that Cigna imposed a restriction based on geographical location for wilderness services, as it issued blanket denials for wilderness care without regard to licensure, accreditation, or the effectiveness of the treatment, but would have approved this same treatment if it took place inside. S.S. stated that Cigna had no such restriction for medical or surgical care.
70. In this manner, the Defendants violate 29 C.F.R. §2590.712(c)(4)(i) because the terms of the Plan and the medical necessity criteria utilized by the Plan and Cigna, as written or in operation, use processes, strategies, standards, or other factors to limit coverage for mental health or substance use disorder treatment in a way that is inconsistent with, and more stringently applied, than the processes, strategies, standards or other factors used to limit coverage for medical/surgical treatment in the same classification.
71. S.S. repeatedly requested that Cigna perform a parity analysis on the Plan and to address his contention that it violated MHPAEA. Cigna and the Plan did not produce the documents the Plaintiffs requested to evaluate medical necessity and MHPAEA compliance, nor did they address in any substantive capacity the Plaintiffs' allegations that Cigna and the Plan were not in compliance with MHPAEA.

72. The violations of MHPAEA by Cigna and the Plan are breaches of fiduciary duty and also give the Plaintiffs the right to obtain appropriate equitable remedies as provided under 29 U.S.C. §1132(a)(3) including, but not limited to:

- (a) A declaration that the actions of the Defendants violate MHPAEA;
- (b) An injunction ordering the Defendants to cease violating MHPAEA and requiring compliance with the statute;
- (c) An order requiring the reformation of the terms of the Plan and the medical necessity criteria utilized by the Defendants to interpret and apply the terms of the Plan to ensure compliance with MHPAEA;
- (d) An order requiring disgorgement of funds obtained by or retained by the Defendants as a result of their violations of MHPAEA;
- (e) An order requiring an accounting by the Defendants of the funds wrongly withheld by each Defendant from participants and beneficiaries of the Plan as a result of the Defendants' violations of MHPAEA;
- (f) An order based on the equitable remedy of surcharge requiring the Defendants to provide payment to the Plaintiffs as make-whole relief for their loss;
- (g) An order equitably estopping the Defendants from denying the Plaintiffs' claims in violation of MHPAEA; and
- (h) An order providing restitution from the Defendants to the Plaintiffs for their loss arising out of the Defendants' violation of MHPAEA.

73. In addition, Plaintiffs are entitled to an award of prejudgment interest pursuant to U.C.A. §15-1-1, and attorney fees and costs pursuant to 29 U.S.C. §1132(g)

WHEREFORE, the Plaintiffs seek relief as follows:

1. Judgment in the total amount that is owed for E.S.'s medically necessary treatment at SUWS and Dragonfly under the terms of the Plan, plus pre and post-judgment interest to the date of payment;
2. Appropriate equitable relief under 29 U.S.C. §1132(a)(3) as outlined in Plaintiffs' Second Cause of Action;
3. Attorney fees and costs incurred pursuant to 29 U.S.C. §1132(g); and
4. For such further relief as the Court deems just and proper.

DATED this 16th day of September, 2021.

By s/ Brian S. King
Brian S. King
Attorney for Plaintiffs

County of Plaintiffs' Residence:
Loudoun County, Virginia