RICHARD D. WILLIAMS (SBN 58640)
rwilliams@williamslawfirmpc.com
MINA HAKAKIAN (SBN 237666)
mhakakian@williamslawfirmpc.com
WILLIAMS LAW FIRM PC
1539 Westwood Blvd., Second Floor
Los Angeles, California 90024
Tel.: (310) 982-2733; Fax: (310) 277-5952

Attorneys for Plaintiff,
CALIFORNIA SPINE AND NEUROSURGERY INSTITUTE d/b/a SAN JOSE NEUROSPINE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

CALIFORNIA SPINE AND NEUROSURGERY INSTITUTE dba **SAN JOSE NEUROSPINE**, a California Corporation,

Plaintiff,

vs.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Connecticut General Corporation DBA Cigna; **CONNECTICUT GENERAL LIFE INSURANCE COMPANY,** A Connecticut Corporation, and **DOES 1 THROUGH 100,**

Defendants.

Case No.: 5:22-cv-4796

COMPLAINT FOR RECOVERY OF BENEFITS UNDER 29 U.S.C. § 1132(A)(1)(B) AND REASONABLE ATTORNEY'S FEES AND COSTS UNDER 29 U.S.C. § 1132 (G)(1)

Plaintiff, California Spine and Neurosurgery Institute dba San Jose Neurospine, a California corporation, ("Plaintiff" or "SJN"), alleges as follows:

JURISDICTION AND VENUE

1. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because the action arises under the laws of the United States, and pursuant to 29 U.S.C § 1132 (e)(1) because the action seeks to enforce rights under the Employee Retirement Income Security Act of 1974 ("ERISA").

2. This Court is the proper venue for the action pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims alleged herein occurred in this Judicial District where the breaches took place, and because the Defendants conduct a substantial amount of business in this Judicial District.

I. THE PARTIES

a. The Plaintiff

3. SJN is a corporation organized under the laws of the state of California, with its principal place of business located in the Northern District of California. Dr. Abebukola Onibokun is the owner and principal of SJN and is the person who performed the surgery events giving rise to this action.

4. SJN specializes in sophisticated surgical procedures involving minimally invasive spinal decompressive techniques; motion preserving spinal techniques; endoscopic spinal fusion techniques; robotic computer assisted image guided surgery; and complex spinal reconstruction. SJN and its principal Dr. Onibokun possess and utilize world class expertise in the field of minimally invasive surgical techniques.

b. The Defendant

5. Plaintiff is informed and believes that Defendant Connecticut General Life Insurance Company is a Connecticut corporation with its principal place of business in Bloomfield, Connecticut, licensed and doing business in the state of

California.

6. Plaintiff is informed and believes that Defendant Cigna Health and Life Insurance Company is a Connecticut corporation with its principal place of business in Bloomfield, Connecticut, licensed and doing business in the state of California.

7. Plaintiff is informed and believes that Defendants Cigna Health and Life Insurance Company and Connecticut General Life Insurance Company (hereinafter jointly "Cigna" or "Cigna Defendants") are related corporate entities that work together under Cigna name and serve as the claims administrator and/or insurer of employee health benefit plans covered by ERISA (hereafter referred to as "ERISA Plans" or "Plan" or "Plans") that provide, among other benefits, reimbursement for medical expenses incurred by individual Plan participants and/or beneficiaries covered under the Plan.

8. Plaintiff is informed and believes that Cigna performs its claims handling services for a multitude of ERISA Plans, some of which are self-funded and some of which are funded by Cigna acting in its capacity as the insurance underwriter for the Plan. Whether the Plan is self-funded or fully insured, plaintiff is informed and believes that Cigna provides plan members with plan documents, interprets and applies the plan terms, makes coverage and benefits determination, handles the appeals of coverage and benefits decisions, and makes payment to Medical Providers for services rendered. In simple terms, SJN is informed and believes that it was Cigna, and not the ERISA Plans themselves, that had the responsibility and actual control to make benefit determinations for the healthcare services claims of SJN that gives rise to this benefit recovery action.

9. Plaintiff is informed and believes that Cigna carried out its multiple services and functions as a healthcare-benefits claims administrator. Acting with respect to seven members insured either under ERISA Plans or insured through Cigna's self-funded insurance during the period April 1, 2015 through November 22,

2021, Cigna reviewed and evaluated benefits payment claims for healthcare services provided by SJN. As discussed hereinafter in this Complaint, Plaintiff billed Cigna for its healthcare services and facility usage, but Cigna has materially and improperly denied/underpaid the benefit claim amounts due and owing to SJN for the services rendered.

10. In each claim circumstance, SJN would receive a written assignment of Patient rights. A true and correct copy of the form of Assignment utilized by SJN is attached hereto as Exhibit A. The Assignment in each instance conveyed and transferred to SJN all of the Patient's healthcare benefit coverage rights, rights to insurance and rights to healthcare plan reimbursement. The assignments encompassed all rights to appeal or sue, and designated SJN as the Patient's authorized representative.

11. SJN does not bring this suit against the ERISA plans for whom Cigna acted as administer or insurer in connection with SJN's claims in this action. Plaintiff is informed and believes that Cigna, and not the ERISA plans themselves, exercised actual control over the determination and payment of the benefits claims submitted by SJN. Plaintiff is informed and believes that Cigna acts as the primary point of contact for members and providers to communicate regarding all aspects of benefits and benefit determination. Plaintiff is informed and believes that Cigna is the responsible party for administering and interpreting the ERISA Plans at issue in this case and is the one solely responsible for the denial of benefits and therefore the proper Defendants in the case.

c. <u>The Doe Defendants</u>

12. The true names and capacities of the Defendants sued herein as DOES are unknown to Plaintiff at this time, and Plaintiff therefore sues such Defendants by fictitious names. Plaintiff is informed and believes that the DOES are those individuals, corporations and/or businesses or other entities that are also in some

fashion legally responsible for the actions, events and circumstances complained of herein, and may be financially responsible to Plaintiff for services, as alleged herein. The Complaint will be amended to allege the DOES' true status and capacities when they have been ascertained.

II. CORE FACTS UNDERLYING THE SJN CLAIMS FOR PAYMENT

13. SJN provided surgical services from April 1, 2015 to November 22, 2021 on eight (8) separate occasions for the ERISA Plan members and their dependents where the subject ERISA Plan was either administered and/or underwritten by Cigna. In total, SJN has performed eight (8) surgical services events for seven (7) Plan members and/or dependents which are the subject of this lawsuit as identified in Exhibit B[1].

14. When Plan members and/or their dependents came to SJN for surgical services they would present medical insurance cards in the name of Cigna, and the relevant insurance contact information on each medical insurance card would direct SJN to Cigna office location and telephone number. A true and correct copy of an exemplar patient insurance card is attached hereto as Exhibit C.

15. In each case, SJN's practice and custom was to have its office staff representative contact a Cigna representative by telephone for benefit eligibility confirmation and member coverage verification proper to performing any surgery

[1] The names and any identifying information about the insured patients are not set forth in this Complaint in order to preserve the protect patient privacy. Plaintiff will make the identifying information available to Defendants pursuant to an appropriate protective order and will request that patient information also be subject to appropriate privacy protection during the course of the litigation proceeding in this Court.

services. The practice was that SJN's office representative, and the Cigna entity representative would discuss the proposed surgery event by telephone in advance of the services being performed, and in each such telephone communication the Cigna entity representative would advise SJN's representative that coverage existed for the patient and benefits were properly payable to SJN as an "out-of-network" provider. The following sets forth in summary form the substance of the telephonic communications between SJN's representative and the Cigna entity representative which occurred prior to surgery services being performed in connection with SJN's claims for Patients asserted in this case:

a) SJN's representative would call the Cigna's number identified on the member identification card presented by the patient.

b) The answering party would identify himself or herself as a representative of Cigna, thereby confirming to SJN that the communication was with an authorized claim administrator and/or underwriter for the ERISA Plan.

c) The Cigna representative would confirm that coverage existed under the subject ERISA plan for the out-of-network provider seeking surgery eligibility verification.

d) In each call, the SJN representative advised the Cigna representative of the identity of the Plan member or dependent; and that the purpose of the call was to verify the existence of coverage for the patient and the eligibility of SJN for payment of benefits as an out-of-network provider.

e) In each call, the Cigna entity representative verified that SJN as an out-of-network provider was eligible to receive benefits payment under the subject plan.

f) In instances where authorizations were required, SJN obtained authorization to perform the surgical events.

16. After the Cigna representative had verified that the specified treatment was covered and that SJN was eligible for payment of ERISA Plan benefits, SJN provided services for the surgery events for which verification was obtained.

17. SJN relied and reasonably relied on the Cigna telephonic representation with respect to Patients at issue in this case by providing surgery services in response to the Cigna affirmation that SJN was eligible to receive benefits. But for the advance representations of the Cigna entity representatives in setting out the eligibility for benefits and the applicable payment methodology, SJN would not have provided or continued to provide surgery services to the Patients.

III. PLAINTIFF'S BILLINGS SUBMITTED TO CIGNA PROVIDED ALL NECESSARY INFORMATION TO SUPPORT CLAIM PAYMENT

18. After the Cigna representative had verified that the specified treatment was covered and that SJN was eligible for payment of ERISA Plan benefits, SJN provided surgery services for the patients for which verification was obtained.

19. In connection with each of the claims where services were provided, SJN has billed Cigna for services rendered to ERISA Plan members and their dependents. SJN's billing forms were submitted on Form 1500, a standard, industry-wide claim submittal form for out-of-network healthcare providers. Each claim form which identified the provider name, address, patient name, patient address, sex and ID number, the date of service, CPT Code[2] and the nature of the services rendered. Each

[2] CPT Code is the medical procedure descriptive identifier - - CPT means "Current Procedural Terminology". The CPT Code is a medical code maintained by the American Medical Association through the CPT Editorial Panel. The CPT codes set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients accreditation organizations, and payors for administrative,

of Plaintiff's claim billing forms set forth all requisite information in standard terminology with sufficient detail to enable Cigna to consider and pay the claim in the ordinary course of business. On each claim Form 1500 submitted to Cigna by SJN, SJN also marked the box with "X" in the box marked "Accept Assignment?" which affirmed that SJN was asserting its claim for payment pursuant to a patient assignment of benefits. An exemplar of the claim form submitted with the patient's name and identifier redacted for privacy is attached hereto as Exhibit D.

20. The charges for healthcare services submitted by SJN to Cigna were in all instances usual, customary, and reasonable, and in accord with SJN's charges to non-Medicare patients insured by entities other than the subject plans in this case. Cigna has abused its discretion and acted in an arbitrary and capricious manner by failing and refusing to honor and pay SJN's claims in accordance with ERISA requirements, practices and provisions, and SJN has suffered resulting damages in an amount to be proven at trial.

IV. SJN HAS STANDING TO PURSUE CLAIMS AGAINST CIGNA UNDER ERISA FOR PAYMENT OF BENEFITS AND ATTORNEY'S FEES

21. ERISA governs all aspects of health and medical benefits under ERISA plans, and authorizes a civil action to recover unpaid benefits and attorney's fees. SJN has standing to bring this lawsuit arising from its Assignments from patients.

22. Cigna in this action is the proper party defendant for an ERISA benefits recovery action. *See, Harris Trust & Sav. Bank v. Salomon, Smith Barney, Inc.,* 530 U.S. 238, 247 (2000); *Cyr v. Reliance Standard Life Ins. Co.,* 647 F.3d 1202 (9th Cir. 2011).

---

financial, and analytical purposes.

V. SJN HAS EXHAUSTED ADMINISTRATIVE REMEDIES

23. For the claim events in this action, Cigna provided Explanation of Benefits ("EOB") documents which purported to explain the payment denial/reduction with respect to SJN billing submittals. The EOBs were woefully deficient in their explanations of the purported grounding for the non-payment and/or denial of SJN's bills. The EOBs and appeal documents (where responses to appeals were provided) set fort different grounding in short format for Cigna's claim denial and/or payments. The short statements utilized by Cigna in the EOB did not provide any explanation or basis for denial at all. For example one of the grounding used by Cigna as a claim payment reduction was that for out-of-network services, Cigna will reimburse up to a set Maximum Amount (Known as "Maximum Reimbursable Charge"). A statement that SJN was reimbursed up to a set Maximum is meaningless non sequitur, and provides no explanation or basis for reduction at all. Such a vague and non-specific statement in EOB does not constitute a final determination with respect to the payment of SJN's bills.

24. SJN has appealed many of the billing reductions asserted in connection with the claims in this case. However, the appeals have been futile, except in one case where payment (albeit underpaid) was tendered. Cigna in their EOBs and appeal response (where responses to appeals were provided) documents has violated the applicable claims procedure regulations governing ERISA plans as set forth in 29 C.F.R. section 2560.503-1 (b). Of particular significance in this case are the regulations dealing with "Manner and Content of Notification of Benefit Determination" set forth in 29 C.F.R. section 2560.503-1 (g)(1). That section requires that the plan administrator shall provide a claimant with a written or electronic notification of any adverse benefit determination. The regulations require the following:

"The notification shall set forth, in a manner calculated to be understood by the claimant - -

i. The specific reason or reasons for the adverse determination;

ii. Reference to the specific plan provisions on which the determination is based;

iii. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

iv. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review."

25. These notification requirements were not met by the EOBs and/or appeal response documents in the present action, and the regulations set forth a consequence of a failure by Cigna to comply with adverse benefit notification requirements in its EOBs and/or appeal denials. 29 C.F.R. section 2560.503-1(1) provides:

"(l) Failure to establish and follow reasonable claims procedures:

In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim."

26. SJN is deemed by law to have exhausted administrative remedies because Cigna failed to establish and follow reasonable claims procedures as required by ERISA. Cigna failed to process claims submitted by the Plaintiff in a manner consistent or substantially in compliance with ERISA regulation 29 C.F.R. section

2560.503-1. Among other things, Cigna:

- Failed to set out the specific reason for nonpayment/underpayment of Plaintiff's claims in its responses transmitted to Plaintiff during the administrative review process;
- Failed to reference the specific Plan provisions upon which its nonpayment/underpayment determinations were based;
- Failed to give a description of additional materials or information which was needed to pursue and perfect the claims, and an explanation of why such information was necessary;
- Failed to provide Plan documents, or internal rules, guidance, protocols, or other criteria upon which the nonpayment/underpayment determinations were based;
- Failed to state the nonpayment/underpayment determinations in a manner calculated to be understood by Plaintiff;
- Failed to provide a reasonable opportunity for full and fair review of the nonpayment/underpayment determinations;
- Employed policies designed to unduly hamper the review and appeal of claims submitted by Plaintiff;
- Acted systematically in a manner which rendered the administrative appeal process a futile and meaningless endeavor.

VI. ASSIGNMENTS TO HEALTH CARE PROVIDERS ARE FAVORED UNDER ERISA LAW

27. In *Misic v. Bldg. Services Employees Health & Welfare Trust,* 789 F.2d 1377 (9th Cir. 1989) the Ninth Circuit Court determined that assignments of patient benefits under healthcare plans are a favored practice to ensure efficiency in the delivery of healthcare services. "[P]ermitting the assignment of benefits claims to

healthcare providers makes it easier for plan participants to finance healthcare and therefore advances the congressional intent behind ERISA." *Misic, supra,* at 1378. Assignees of a claim for collection of healthcare benefits have been permitted to bring suit on the basis of derivative standing. *See also, Simon v. Blue Behav. Health, Inc.,* 208 F.3d 1073, 1081 (9th Cir. 2000) (extending derivative standing to healthcare providers to whom beneficiaries assigned their benefits claims for medical care from such providers). Granting standing to healthcare providers furthered the congressional purposes behind ERISA because it enhanced the efficiency and ease of billing among all the interested parties. *See id.* The authority of *Misic* and *Simon* was recently reaffirmed in *Bristol SL Holdings, Inc. v. Cigna Health and Life Ins. Co.,* (9th Cir. No. 20-56122, January 14, 2022).

VII. CIGNA HAS WAIVED AND/OR IS ESTOPPED FROM ASSERTING ANY "ANTI-ASSIGNMENT" CLAUSES CONTAINED IN THE PATIENTS' HEALTHCARE PLANS

28. Under federal ERISA law, a healthcare plan and its claim administrators are subject to specific rules where benefits are to be denied with respect to claims of a healthcare provider.

29. When making a claim determination under ERISA, "an administrator may not hold in reserve a known or reasonably knowable reason for denying a claim, and give that reason for the first time when the claimant challenges a benefits denial in court." *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1296 (9th Cir. 2014) ("*Spinedex*"); *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 719 (9th Cir. 2012) ("*Harlick*"). "A plan administrator may not fail to give a reason for a benefits denial during the administrative process and then raise that reason for the first time when the denial is challenged in federal court[.]" See *id.*

30. Anti-assignment clauses in ERISA health plans are valid and enforceable." *Spinedex*, *supra,* 770 F.3d at 1296. However, a plan administrator can

waive the right to enforce an anti-assignment provision. *See Spinedex supra*. at 1296–97 (acknowledging the right to assert waiver, but concluding on the specific facts of *Spinedex* that the defendant-claims administrator was not required to raise the anti-assignment provision during the administrative claim process in that case because "there [wa]s no evidence that [the claims administrator] was aware, or should have been aware, during the administrative process that [the plaintiff-medical provider] was acting as its patient's assignee").

31. Waiver is "the intentional relinquishment of a known right." *Gordon v. Deloitte & Touche LLP Grp. Long Term Disability Plan*, 749 F.3d 746, 752 (9th Cir. 2014) (citing *Intel Corp. v. Hartford Accident & Indem. Co*., 952 F.2d 1551, 1559 (9th Cir. 1991) (Waiver occurs when "a party intentionally relinquishes a right, or when that party's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished.")). To show that a claims administrator waived an anti-assignment provision that would otherwise foreclose the healthcare services provider from having statutory standing in an ERISA action, the provider must plead sufficient facts to show that the plan administrator "was aware or should have been aware, during the administrative [claim] process that [the provider] was acting as its patients' assignee." *See Spinedex*, 770 F.3d at 1297. SJN has pleaded waiver facts in this action in accordance with *Spinedex* and *Harlick*. Each SJN billing form included an "X" in the Form 1500 which notified the claims administrator that the claim was being pursued by way of an assignment. Moreover, the claims administrator in each claim paid a part of the claim submitted by SJN except one claim that remained unpaid. These facts establish that Cigna has waived any purported anti-assignment clause in any of the ERISA Plans and Cigna is estopped from asserting any such clause.

32. Cigna at all relevant times was aware that Plaintiff was pursuing its claims on the basis of written assignments of benefits. At no time prior to the filing

the present litigation has Cigna ever asserted that any bar or legal impediment existed in the Plans with respect to Plaintiff's unfettered right to receive payment of benefits as an Out-of-Network provider under the Plans. Specifically, Cigna never stated any intention to assert any anti-assignment clause during the pre-litigation administrative review process.

33. Further, Cigna is estopped from asserting anti-assignment by the fact that during the claim administration review process it represented that SJN was eligible to receive plan benefits. The authority of *Spinedex* and *Harlick* on the waiver and estoppel issues was reaffirmed in *Beverly Oaks Physicians Surgery Center, LLC v. Blue Cross and Blue Shield of Illinois,* 983 F. 3d 435 (9th Cir. 2020) ("*Beverly Oaks*"). Under *Beverly Oaks*, the promise that SJN was eligible to receive plan benefits as an out-of-network healthcare provider is sufficient to estop Cigna from asserting a plan anti-assignment clause in this case.

VIII. CIGNA HAS NO GROUNDING TO ASSERT STATUTE OF LIMITATIONS WITH RESPECT TO PLAINTIFF'S CLAIMS

A. Cigna Failed To Provide A Final Determination; And Accordingly, No Statute Of Limitations Has Begun To Run

34. After *Beverly Oaks* was decided on December 18, 2020, this Court's determination became the subject of a District Court opinion issued May 25, 2021 in *Brand Tarzana Surgical Institute, Inc. v. Aetna Life Insurance Company, Inc., et. al.,* Case No. 18-9434 DSF (AGRx) ("*Brand v. Aetna"*). In its Order involving anti-assignment defenses (Dkt. 72), the District Court in *Brand v. Aetna* concluded that there was no final determination in that case due to a failure of the insurer to submit adequate notification of adverse benefits determinations:

> Aetna argues some claims are untimely because some of the plans limit the time period in which one must seek recovery, and Brand's lawsuit is outside those time periods. Br. at 14-17; Aetna Suppl. Br. at 16-17. However, given the

inadequacies of the adverse benefit notifications discussed above, there was no final decision on those claims. The contractual limitations therefore do not apply. (Dkt. 72, p. 8)

35. The District Court in *Brand v. Aetna* cited to earlier Ninth Circuit authority as the basis for its statute of limitations determination:

White v. Jacobs Engineering Group Long Term Disability Benefit Plan, 896 F.2d 344, 350 (9th Cir. 1989) supports this conclusion. In *White*, the Ninth Circuit held that "[w] hen a benefits termination notice fails to explain the proper steps for appeal, the plan's time bar is not triggered." *Id*. (Dkt. 72, p. 8-9)

36. The *Brand v. Aetna* court grounded its statute of limitations determination on the ERISA claims procedures regulations:

In reaching its decision, the Ninth Circuit [in *White*] reasoned that an administrator should not be permitted to deter a claimant from filing a timely appeal "by sending vague and inadequate appeal notices, withholding information claimants need to appeal effectively." *Id*. at 351. (Dkt, 72, p. 9)

37. The District Court in *Brand v. Aetna* found the reasoning in *White* was applicable to contractual time limits for filing a civil action in addition to an administrative appeal. The District Court cited to *Bourgeois v. Employees of Santa Fe International Company*, 215 F.3d 475, 482 (5th Cir. 2000) (holding where an employer's failure to give an employee adequate claims procedure information caused the employee to fail to exhaust his administrative remedies and extinguished the employee's time to apply for benefits, his claim should be remanded to the plan administrator and the employer was estopped from arguing the employee's claim was time-barred); and *Bilyeu v. Morgan Stanley Long Term Disability Plan*, 683 F.3d 1083, 1089 (9th Cir. 2012) (holding a district court abused its discretion by finding a claim was time-barred because the letter outlining administrative remedies and time to sue was ambiguous and "[a] communication from a claims administrator to a plan

participant should clearly apprise her of her rights and obligations under the plan"); and *Chuck v. Hewlett Packard Co.,* 455 F.3d 1026 (9th Cir. 2006) (finding the failure to comply with ERISA's notification procedures was a "highly significant factor" for determining whether the statutory limitations period began running).

38. Similarly in the present action, the Cigna EOBs and appeal responses (where responses to appeals were provided) failed to provide adverse benefits notification sufficient to trigger the running of a statute of limitations. Absent a final determination, the Plaintiff claims remain fully open for further administration claim consideration and claim resolution at trial.

B. A Three-Year Period of Equitable Tolling Applies To Preclude Cigna From Asserting Statute of Limitations as a Defense to the Claims Asserted by SJN in this Action

(1) California Law Applies For Statute of Limitations Purposes As The State Where The Claims Arose

39. The statute of limitations in this case is subject to equitable tolling for the period December 18, 2017 to December 17, 2020. All of the subject claims fall within the statute if equitable tolling is applied.

40. ERISA is silent as to the statute of limitations to be applied to the benefits claims asserted by SJN in this case. Where a statute of limitations is lacking in federal court litigation, the District Court is to look to and apply (i.e. borrow) the most analogous state statute. The Ninth Circuit has ruled that the applicable borrowing statute in the context of an action for ERISA benefits is the state where the claim for benefits arose. *Gordon v. Deloitte & Touche LLP Group Long Term Disability Plan,* 749 F. 3d 746, 750 (9th Cir. 2014) (citing *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Insurance Program,* 222 F. 3d 643 (9th Cir. 2000).

41. In the present case, the claims for benefits arose in California, and the applicable statute is the 4-year California statute for breach of contract. *See Northern Cal. Retail Clerks v. Jumbo Markets, Inc.* 906 F. 2d. 1371, 1372 (9th Cir. 1990) However, when a statute of limitations is borrowed, the tolling and suspension provisions which are part of the statute under applicable state law must also be borrowed in the federal court action, and in the present case California equitable tolling provisions will apply to extend the application of the statute. *See, also, Heimeshoff v. Hartford Life & Accident Ins. Co.,* 571 U.S. 99, 113 (2013) (equitable tolling of a statute of limitations may be appropriate in extraordinary circumstances).

(2) Waiver And Estoppel Apply and Provide a Grounding For Equitable Tolling of the Statute of Limitations

42. The Supreme Court in *Heimeshoff* stated (571 U.S. at 104) that waiver and estoppel may prevent a claims administrator from invoking a limitations period as a defense. Here, waiver and estoppel both apply to preclude Cigna from asserting statute of limitations without an extension for a 3-year equitable tolling period, as defined below.

(3) Equitable Tolling Begins To Run No Later Than December 18, 2017 And Continues To Apply Until December 17, 2020

43. It appeared to be settled law in the Ninth Circuit from and after 2014 that waiver of an anti-assignment clause by a healthcare plan claims administrator would occur if the administrator was aware, or should have been aware during the administrative process that a healthcare provider was asserting claims pursuant to a patient assignment. *Spinedex, supra,* 770. F. 3d at 1296-97. Under *Spinedex,* and the Ninth Circuit's 2012 decision in *Harlick*, a healthcare claims administrator was barred by waiver and estoppel from failing to give a reason for a benefits denial during the pre-litigation claim administration process and then raising that reason for the first time when the denial of plan benefits was challenged by the healthcare provider in

federal court.

44. Despite what should have been a controlling body of Ninth Circuit law, a District Court in the Central District of California in 2016 struck out in an unexpected and erroneous new direction in the handling of anti-assignment clauses. In the case of *Brand Tarzana Surgical Institute, Inc. v. International Longshore & Warehouse Union-Pacific Maritime Association Welfare Plan*, District Court No. 2-14-cv-03191-FMO-AGRx ("*Brand Tarzana v. ILWU*") the District Court entered an Order Regarding Cross Motions for Summary Judgment on March 8, 2016. (Dkt. 69) In its Order, the District Court concluded that Plaintiff Brand Tarzana had failed to prove waiver of an anti-assignment clause that was contained in the ILWU-PMA Welfare Plan which was the subject of that case. The District Court Order dated March 8, 2016, concluded that the Plan's failure to raise the anti-assignment clause prior to litigation did not constitute waiver, since the anti-assignment clause was not "a substantive basis for denial" (Dkt 69, p. 15) The District Court wrongly concluded in *Brand Tarzana v. ILWU* - - in direct contradiction to the controlling authority of *Spinedex* and *Harlick* - - that the failure to raise the anti-assignment clause was irrelevant to a pre-litigation denial of a healthcare claim since, until a suit was filed, there was nothing that occurred within the range of conduct the anti-assignment clauses purported to prohibit. (Dkt. 69, pp. 15-16) In the *Brand Tarzana v. ILWU* circumstance, where none of the claims at issue were denied in the pre-litigation administrative claim process on the basis of the anti-assignment clause, the District Court erroneously decided that any failure to raise the clause pre-litigation as a ground for denial of plaintiff's claims did not constitute a waiver of the provision. (Dkt. 69, p. 16) This District Court ruling on March 8, 2016 put in place an unfortunate and ill-conceived framework for addressing anti-assignment clauses which rendered it impossible for healthcare providers to file and pursue ERISA benefits recovery lawsuits where the subject ERISA plans contained an anti-assignment provision. The

erroneous framework which was adopted by the District Court in 2016 was subsequently put aside on December 17, 2020 when the Ninth Circuit put anti-assignment law back on a proper footing in its published *Beverly Oaks* decision, but until corrective action was taken in *Beverly Oaks* in 2020, healthcare providers such as SJN had no realistic or viable means of pursuing their assignment-based healthcare claims in federal court. In the present action, the healthcare claims which arose during the period when Ninth Circuit law was premised on a mistaken conceptual framework favoring anti-assignment and the claims where the right to bring an action in court matured during this period should be subject to equitable tolling.

45. Brand Tarzana immediately appealed the adverse District Court ruling of March 8, 2016. *See* Ninth Circuit Case No. 16-55503, *Brand Tarzana Surgical Institute, Inc v. ILWU-PMA Welfare Plan,* 706 F.App'x 442 (9th Cir. 2017). However, the Ninth Circuit panel that heard the case on appeal affirmed the District Court ruling by way of a Memorandum Decision filed December 18, 2017. (Dkt. 76) The Ninth Circuit in *Brand Tarzana v. ILWU* erroneously agreed with the District Court that the anti-assignment clause could indeed be held in reserve during the pre-litigation claims administrative process, and then be put forward for the first time in benefits recovery litigation as a "litigation defense".

46. The legal issue of anti-assignment clauses as a "litigation defense" was the subject of ongoing litigation over a period of three years from the time the *Brand Tarzana v. ILWU* Memorandum Decision was entered in the Ninth Circuit (December 18, 2017) to December 17, 2020 when the published opinion in *Beverly Oaks* was issued which put the anti-assignment issue to rest once and for all. The Ninth Circuit filed its published opinion in *Beverly Oaks,* on December 17, 2020, which effectively repudiated and reversed its earlier *Brand Tarzana v. ILWU* Memorandum Decision. Anti-assignment in the case of *Brand Tarzana v. ILWU* had been considered a "litigation defense" and not a substantive basis for claim denial - - but this "litigation

defense" framework only lasted in this Circuit for three years until it was rejected in *Beverly Oaks* on December 17, 2020. The *Beverly Oaks* panel decided that there was "no rationale" for condoning an insurer or plan administrator's course of conduct in failing to raise the anti-assignment provision during the administrative claims process and then later asserting that provision as a "litigation defense" to avoid payment of benefits. The *Beverly Oaks* Court found that the *Brand Tarzana v. ILWU* "litigation defense" framework as a basis to deny waiver of the anti-assignment clause left an insurer or plan administrator unaccountable for prior conduct contrary to its litigation provision.

47. Indeed, taking it a step further, the *Beverly Oaks* Court further concluded that Blue Cross in that case made an actionable misrepresentation to the surgery center plaintiff in *Brand Tarzana v. ILWU*, by stating that plaintiff was "eligible' to receive plan benefits. The *Beverly Oaks* Court in its published opinion of December 17, 2020 concluded that this misrepresentation estopped Blue Cross from asserting the anti-assignment defense.

48. Waiver and estoppel apply in this case to preclude an anti-assignment defense, just as they did in *Beverly Oaks,* and *Beverly Oaks* reopened the door for filing of ERISA benefits recovery actions by healthcare providers based on patient assignments of benefits. The statute of limitations for the claims that are the subject of this lawsuit should be tolled for the three-year period in which the door to benefits recovery was improperly closed.

(4) SJN Filed A Test Case Against Anthem Blue Cross To Challenge The Law As It Was Erroneously Framed In *Brand Tarzana v. ILWU*

49. Confronted with the adverse ruling of *Brand Tarzana v. ILWU,* SJN went forward in the Northern District with a test lawsuit against another insuring entity - Anthem Blue Cross while holding its other similar claims in reserve. The case of

California Spine and Neurosurgery Institute v. Blue Cross of California, Case No. 18-cv-4777-PJH (Northern District of California) (*SJN v. Blue Cross*) involved one SJN claim as a test case, and came on for hearing on motion to dismiss on December 12, 2018. (Dkt. 32) The Northern District Court filed its ruling on the test case on January 7, 2019, dismissing SJN's complaint with prejudice on the basis of an anti-assignment clause. *SJN v. Blue Cross,* 358 F. Supp. 3d 349 (N.D. Cal. January 7, 2019). The Northern District Court's test case ruling in Case No. 18-cv-4777 involved the same set of facts about SJN's claim administration practices as are raised in the present action in the context of the Exhibit B claims. In Northern District Case No. 18-cv-4777, SJN had submitted a bill to Anthem Blue Cross in the amount of $93,000.00 on February 2, 2017, but Anthem Blue Cross had paid the claim in the amount of only $2,095.34. (Dkt. 32, p. 2) The issue of anti-assignment was exhaustively litigated in the test case, with Anthem Blue Cross relying upon *Brand Tarzana v. ILWU* as its primary authority for the "litigation defense" argument which had previously been incorrectly set forth as a proper grounding under Ninth Circuit law. (Dkt. 32, p. 5-7)

50. The Northern District Court in Case No. 18-CV-04777 recognized the core provisions of ERISA law that should have been applicable (*Spinedex* and *Harlick*); However, the Northern District Court went on to reject this proper ERISA framework:

> Blue Cross did not deny SJN's claim because of the anti-assignment clause, or because HR attempted to assign his rights under the plan. The anti-assignment clause is a litigation defense raised by defendant - - not a reason it denied SJN's claim. Two unpublished Ninth Circuit opinions have recently agreed with the assessment. An ERISA plan's "anti-assignment provision, however, is a litigation defense, not a substantive basis for claim denial. The Plan did not need to raise it during the claim administration process." *Brand*

Tarzana Surgical Inst., Inc. v. Int'l Longshore & Warehouse Union-Pac. Mar. Ass'n Welfare Plan, 706 F. App/x 442, 443 (9th Cir. 2017); *Eden Surgical Ctr. V. Cognizant Tech. Sols. Corp.,* 720 F. App'x 862, 863 (9th Cir. 2018) ("Defendants raised the anti-assignment provision after the suit commenced to contest Eden's standing to sue, not as a reason to deny benefits."). Under that reasoning, Blue Cross did not waive the legal defense that SJN cannot bring this ERISA claim due to the anti-assignment clause, even though it is raising that defense for the first time now. (Dkt. 32, p. 6-7)

51. The Northern District Court in SJN's test case decided that the Memorandum Decisions in *Brand Tarzana v. ILWU* and *Eden Surgical* applied even in the face of the contrary *Spinedex* and *Harlick* authority:

> The court appreciates that Plaintiff has adopted a plausible - - if expansive - - reading of *Spinedex* that would put it in tension with *Brand Tarzana* and *Eden Surgical Center.* However, this court declines to read *Spinedex* so expansively. Plaintiff's reading would overextend *Spinedex's* holding to reach beyond the factual scenario that court considered, and it would read the opinion's efforts to distinguish *Hermann Hospital* as a broad adoption of Fifth Circuit precedent. Instead, this court reads *Spinedex* in concert with the subsequent Ninth Circuit decisions that are directly on point with the issue presented here. In doing so, the court notes that all three opinions rely on *Harlick; Brand Tarzana* itself relies on *Spinedex;* and Judge Bybee sat on the panels that decided both *Spinedex* in 2014 and *Eden Surgical Center* less than four years later. This court - - like the three opinions themselves and Judge Bybee - - reads their holdings harmoniously. This conclusion cannot be overcome by an amended pleading. (Dkt. 32, p. 7)

52. SJN did not give up on its test case in the face of the adverse ruling in the Northern District Court. An appeal was taken in the Ninth Circuit (No. 19-15192),

and on June 30, 2020, the Ninth Circuit entered a Memorandum Decision reversing the Northern District judgment in part and remanding SJN's test case to the lower court. *Cal. Spine & Neurosurgery Inst. v. Blue Cross of Cal.,* 2020 U.S. App. LEXIS 20533 (9th Cir. June 20, 2020). The Ninth Circuit panel found that SJN had adequately pleaded waiver of the Anthem Blue Cross anti-assignment provision. (Dkt. 40, p. 2-3) With respect to estoppel the Ninth Circuit Court ordered that the record was incomplete, and that the Northern District Court should consider remaining estoppel factors on remand. (Dkt. 40, p. 3)

53. The reversal in SJN's test case was a significant victory in the Ninth Circuit, but it remained for the Ninth Circuit panel in *Beverly Oaks* to put the anti-assignment clause fully to rest in its published opinion filed December 17, 2020 in that separate action. In *Beverly Oaks*, the flawed "litigation defense" rationale was firmly, and finally, rejected. Premised upon *Beverly Oaks,* SJN now proceeds with its remaining claims against Cigna based upon equitable tolling of the California statute of limitations during the period December 18, 2017 to December 17, 2020. None of SJN's claims should be barred by the statute.

C. California Emergency Rule 9 Tolls the Statute of Limitations for 178 days between April 6, 2020 to October 1, 2020

54. On March 4, 2020 Governor Gavin Newsom declared a state of emergency in response to the spread of Covid-19 in California. On March 19, a state wide stay-at-home order was issued. On March 27, 2020 Governor Newsom issued Executive Order N-38-20 which, among other thing, gave the Judicial Council of California the authority to take actions necessary to maintain access to the essential operation of California's court system while protecting the health and safety of California residents. Over the course of several months in 2020, the Judicial Council adopted 13 emergency Rules.

55. Amongst the 13 emergency rules is the emergency Rule 9 which is intended to apply broadly to toll any statute of limitations on the filing of a pleading in court asserting a civil cause of action. Under Emergency Rule 9, Statute of Limitations that exceed 180 days are tolled between April 6, 2020 and October 1, 2020 (Total of 178 days). SJN proceeds with the claims against Cigna based on the tolling of the statue of limitation during the period between April 6, 2020 to October 1, 2020 premised upon California Emergency Rule 9. None of SJN's claims should be barred by the statute.

D. The Statute of Limitations for Breach of Contract does not begin to run until the Contract no Longer is Executory

56. The Supreme Court in *Mather v. Mather* (1944) 25 Cal.2d 582, 586 stated:

> [T]the law recognizes, as a matter of classification, two kinds of contracts - - executory and executed. The former is one in which some acts remain to be done, while the latter is one where everything is completed at the time of agreement, without any outstanding promise calling for fulfillment by the further act of either party.

57. In general, insurance policies including health insurance plans require the policy holder to share a portion of the future financial risk covered by policy either through deductibles, self-insured retentions or retrospective premiums. In healthcare insurance policies where the insurer has a continuing obligation to provide coverage and the insured has continuing obligation to pay standard premium, deductible, co-pay, the insurance contract is an executory contract. The insurance policy in essence is an agreement for the insured to pay the insurer for continuously providing coverage and therefore is an executory contract.

58. Under California law, statutes of limitations for breach of contract do not commence to run as long as the contract is executory. In *Lubin* v. *Lubin* (1956) 144 Cal.App.2d 781, 791 the court stated:

> "In those cases where a continuing contract involves the rendering of benefits to the plaintiff before the date for final performance the rule is as stated in 16 California Jurisprudence, section 110, page 511: 'In the case of a continuing executory contract, if the parties do not mutually abandon and rescind it, it is optional with the plaintiff to sue immediately upon the breach or to wait until the expiration of the time designated in the contract before commencing his action.' " *Oil Base, Inc. v. Cont'l Cas. Co.* (1969) 271 Cal. App. 2d 378, 389–90 (citations omitted).

59. In *Oil Base,* the insured sued the insurer for breach of contract and reformation. The trial court entered judgment for the insurer based on its determination that the claims were barred by the statute of limitations. The Court of Appeal reversed based on the continuing executory nature of the liability insurance policy issued by Continental. Similar to *Oil Base,* Cigna as the insurer has a continuing duty to provide coverage under the health insurance plan for covered services and the patients/insured likewise have the continuing obligation under the Policy to pay their premium in installments and cover their co-pay and deductibles for the services received.

60. Each Insurance Plan in this action remains executory with respect to the Named Insured (Patient/Beneficiary) premium payment obligations, deductible and co-payments and Cigna's continued obligation to provide coverage for services rendered until each patient has made its final installment payment of premium for the active policy period and/or co-pay, deductible obligations. As the obligations to pay co-pay and deductible continues and the Cigna's obligations to pay for covered expenses continues with respect to claims in Exhibit B, the statute of limitations has

not matured and has not begun to run until either the duty to pay premium, co-pay and/or deductible has extinguished or the ERISA Plan has been rescinded or terminated by Cigna. None of SJN's claims should be barred by the statute.

FIRST COUNT

(Against Cigna Defendants)

Enforcement Under 29 U.S.C. Section 1132 (a)(1)(B) For Failure To Pay ERISA Plan Benefits And For Recovery Of Reasonable Attorney's Fees And Costs Under 29 U.S.C. Section 1132 (G)(1)

61. The allegations of the prior paragraphs (paragraphs 1 to 60) of this Complaint are hereby incorporated by reference in this First Count as if fully set forth at length.

62. This cause of action is alleged by Plaintiff for relief in connection with claims for medical services rendered in connection with ERISA Plans administered and/or underwritten by Cigna.

63. SJN seeks to recover ERISA Plan benefits and enforce rights to benefits payment under 29 U.S.C. section 1132 (a)(1)(B); and under 29 U.S.C. section 1132 (g)(1) for recovery of reasonable attorney's fees and costs. SJN has standing to pursue these claims as the assignee of member benefits. As the assignee of benefits, Plaintiff is a "beneficiary" entitled to collect benefits, and is the "claimant" for the purposes of the ERISA statute and regulations. ERISA authorizes actions under 29 U.S.C. section 1132 (a)(1)(B) to be brought directly against Cigna as the party with actual control over the benefit and payment determinations with respect to SJN's claims.

64. By reason of the foregoing, SJN is entitled to recover ERISA benefits due and owing in an amount to be proven at trial, and SJN seeks recovery of such benefits by way of the present action.

65. 29 U.S.C. section 1132 (g)(1) authorizes the Court to allow recovery of reasonably attorney's fees and costs incurred in this action. SJN has incurred, and continues to incur, attorney's fees and costs in its pursuit of benefits, and is entitled to recover its reasonable attorney's fees and costs in an amount to be proven at trial.

WHEREFORE, Plaintiff prays for judgment against Cigna Defendants as follows:

1. For damages against Cigna Defendants in an amount to be proven at trial in connection with the healthcare benefits claim properly due and payable with respect to the services rendered to the Patients identified in Exhibit B hereto under the terms of the ERISA Plans at issue in this case.
2. For interest at the applicable legal rate.
3. For reasonable attorney's fees and costs in an amount to be proven at trial.
4. For such other relief as the Court may deem just and proper.

Dated: August 22, 2022

Respectfully submitted,

WILLIAMS LAW FIRM PC

By: /s/ Richard D. Williams

Richard D. Williams,
Mina Hakakian,
Attorneys for Plaintiff California Spine and Neurosurgery Institute dba San Jose Neurospine