IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS, GALVESTON DIVISION

TRUE VIEW SURGERY CENTER ONE L.P., PLAINTIFF	§	**CIVIL ACTION NUMBER**
	§	_____
VS.	§	
CHICAGO BRIDGE AND IRON MEDICAL PLAN, CHICAGO BRIDGE AND IRON COMPANY, AND DENNIS FOX, DEFENDANTS.	§	

PLAINTIFF'S ORIGINAL COMPLAINT

Plaintiff TRUE VIEW SURGERY CENTER ONE L.P. files this Original Complaint against Defendants CHICAGO BRIDGE AND IRON MEDICAL PLAN, CHICAGO BRIDGE AND IRON COMPANY, and DENNIS FOX (collectively "Defendants") and would show the following:

I. Parties

1. Plaintiff True View Surgery Center One, L.P ("Plaintiff" or "True View") is a Texas limited partnership that operates a surgical center located in Houston, Texas. True View's corporate headquarters is located in the city of Pearland in Brazoria County, Texas. Plaintiff is the lawful assignee of the claims asserted herein.

2. Defendant Chicago Bridge and Iron Company ("CB&I") is a foreign corporation with its corporate headquarters located in The Hague, Netherlands. CB&I is a multinational company specializing in oil and gas project services. CB&I employs over 50,000 individuals worldwide, many of whom are residents of the greater Houston area. The worldwide administrative office for CB&I is located at One CB&I Plaza, 2103 Research Forest Drive, in The

Woodlands, Texas 77380.

3. During all material times, CB&I acted as the Plan Sponsor and Plan Administrator for Defendant Chicago Bridge and Iron Medical Plan ("the Plan"). Defendant CB&I may be served by serving its registered agent, C.T. Corporation System, 350 N. St. Paul Street, Dallas, Texas 75201.

4. CB&I appointed its employee Defendant Dennis Fox to serve as the Plan's official Plan Administrator, by and through his position as the Director of Compensation and Benefits for CB&I. Defendant Dennis Fox resides and works within this district and may be personally served at his usual place of business, at One CB&I Plaza, 2103 Research Forest Drive, The Woodlands, Texas, 77380.

5. The Plan is a self-funded welfare benefits plan governed by ERISA. The Plan may be served with process by serving its Plan Administrator, Dennis Fox or CB&I, at One CB&I Plaza, 2103 Research Forest Drive, The Woodlands, Texas, 77380.

II. Jurisdiction and Venue

6. Plaintiff's claims arise *in part* under 29 U.S.C. §§1001 *et seq.*, Employee Retirement Income Security Act ("ERISA"), under 28 U.S.C. §1331 (federal question jurisdiction) including without limitation 29 U.S.C. §1132(a)(1)(B).

7. Venue is appropriate in this Court under 29 U.S.C. §1391 because CB&I conducts a substantial amount of business in this district, operates its global administrative offices in this district, and employs and provides benefits to residents of this district. Additionally, a substantial part of the events or omissions giving rise to the claims occurred in this district, such as: the collection and contributions of premiums for the Plan, the making of promises and representations as to covered medical benefits to plan beneficiaries (who also work and reside in this district), the

provision of health care services to plan beneficiaries, the making of promises and representations as to insurance coverage for those health care services, the filing of claims and appeals to the Plan, the exchange of correspondence relating to those claims appeals, and the decision making by fiduciaries of the Plan relating to the issuance of benefits and protection of plan funds.

III. Introduction

8. Plaintiff asserts claims sounding in ERISA as well as applicable state law.

9. This dispute arises out of Defendants' ongoing and systematic ERISA violations stemming from an elaborate scheme to withhold, embezzle and convert ERISA plan assets through a pattern of fraudulent benefits transactions and prohibited self-dealing misconduct. Rather than protect the Plan's funds or otherwise ensure prompt payment of health claims submitted by the Plan's beneficiaries, as they are statutorily obligated to do, in breach of their fiduciary duties, Defendants assisted, encouraged, and colluded with Cigna, their agent and co-fiduciary, to engage in statutorily prohibited transfers of plan funds deceptively masked through falsified benefits transactions.

10. Specifically, in spite of the glaring conflict of interest and inherent breach of fiduciary duties, Defendants agreed to an unlawful compensation structure that financially rewards Cigna for wrongfully denying and underpaying benefits claims. Under this backdrop, together Defendants and Cigna concocted an intricate scheme to transfer and embezzle plan funds. Transfers are first concealed by processing out-of-network claims under a fabricated Preferred Provider Organization (PPO) "contractual obligation," even though Defendants and Cigna are fully aware that no such contract exists. Then, Defendants and Cigna knowingly implemented a system to willfully and wrongfully refuse payments to the out-of-network provider under a sham "fee-forgiveness" protocol. As a result of the wrongful claims denials, the transferred plan funds

are ultimately misappropriated by Cigna, who then fraudulently pays itself with the plan funds, falsely declaring the embezzled funds as compensation generated through managed care and out-of-network cost containment "savings," when in truth the claims were never paid and the plan beneficiaries were left exposed to personal liability for their unpaid medical bills.

11. At the heart of this action is Defendants' wholesale failure to uphold their statutory fiduciary duties owed to beneficiaries of the Plan. That is, in direct violation of their statutory fiduciary duties, Defendants knowingly entered into an unlawful agreement with their co-fiduciary Cigna that blatantly ignores, overlooks, and even directly creates prohibited conflicts of interest, permitting Cigna to withhold and claim as compensation to itself amounts Cigna declares as "savings" to the Plan, "savings" that are, in truth, generated by wrongfully denying valid benefits claims. Thus, despite a clear, statutory bar to this type of prohibited, self-dealing transaction, Defendants agreed to a compensation structure that financially rewards Cigna for wrongfully denying even valid benefits claims – resulting in an arrangement where Cigna, a co-fiduciary, reprehensively competes with the Plan's own beneficiaries for entitlement to plan funds. Even more, the amounts Cigna pays to itself are grossly excessive and fundamentally unfair.

12. Despite actual knowledge of Cigna's self-dealing misconduct stemming from repeated alerts and warnings from Plaintiff's numerous official ERISA appeals, Defendants systematically refused to take corrective action, and instead, delegated investigation of the suspected embezzlement to Cigna – the identified perpetrator of the misconduct. Further, Defendants continued to promote, enable, authorize, and ratify Cigna's wrongful misappropriation of plan funds at the direct expense of the Plan's beneficiaries. Defendants violated their statutory fiduciary (and co-fiduciary) duties by promoting, encouraging, authorizing, assisting, and enabling Cigna, their designated agent and co-fiduciary, to unjustly enrich itself through an intricate

embezzlement scheme that inflated Cigna's reported "savings" to the Plan, which Cigna in turn paid to itself as resulting from its "out-of-network cost containment" efforts.

13. The overall harm caused by this embezzlement scheme spans universally, as it has likely caused misleading and inaccurate tax filings reported to the U.S. Department of Treasury, Internal Revenue Service, and Department of Labor Pension and Welfare Benefits Administration. Despite Plaintiff's efforts to alert Defendants of suspected errors and inaccuracies in their filings (such as inflated non-taxable benefits payments amounts believed to include plan funds retained by Cigna as a form of compensation) were wholly ignored and Defendants refused to act.

14. Time and time again, instead of paying the valid benefits claims submitted by the Plan's participants and beneficiaries, Defendants systematically breached their statutory fiduciary duties and knowingly encouraged, enabled, assisted, and colluded with their agent and co-fiduciary Cigna to engage in a scheme of self-dealing misconduct that permitted Cigna to wrongfully profit and embezzle plan funds.

IV. General Allegations

A. Background as to Self-Funded Health Plans Governed by ERISA

15. Generally speaking, throughout America, individuals not eligible for Medicare or Medicaid typically obtain health insurance coverage through his or her own employer, or through a family member's employer. Those employers can provide health insurance on either a fully-insured or self-funded basis. When an employer provides fully-insured health insurance, the employer and/or employees pay premiums to a third party commercial insurance company, and the medical costs of the employees are paid using the insurance company's funds.

16. By contrast, when health insurance is offered by an employer on a self-funded basis, the employer assumes the risk for payment of the medical claims by sponsoring a benefits plan

that forms a specific fund for that purpose. The resulting fund enjoys certain tax breaks, and is funded by the employer and/or employees who contribute premium payments. The health care claims of the enrolled employees and their dependents are then paid with the finances of the fund.

17. Unless exempted, self-funded health benefit plans are governed and regulated by the Employee Retirement Income Security Act of 1974 ("ERISA"). Pursuant to ERISA, by statute, a self-funded health benefit plan must set forth in a written official plan document or plan instrument specific details, such as the terms of eligibility for enrollees, the benefits covered, and more.

18. Often times, an employer who elects to have a self-funded health plan contracts with a third party commercial insurance company to oversee the claims processing and other administrative services. The employer and the third party commercial insurance company, also known as the Third Party Administrator ("TPA"), enter into an Administrative Services Only ("ASO") contract or agreement.

19. Cigna is a third party commercial insurance company that provides TPA administrative services to various self-funded plans under ASO contracts. In exchange for the payment of fees, Cigna provides claims processing and other administrative services to the plans, as well as access to Cigna's network of providers. Cigna's network of providers are considered in-network because they enter into Preferred Provider Organization ("PPO") contracts with Cigna.

20. Pursuant to the PPO contracts between Cigna and its in-network providers, Cigna's in-network providers agree to accept negotiated lower amounts for their services. In-network providers agree to the lower rates in exchange for a higher volume of patients that results from being part of Cigna's published managed care network. Thus, when a plan beneficiary receives health care services from an in-network provider, the Plan is only obligated to pay the in-network

provider the negotiated amount set by the PPO contract. Critically, pursuant to the PPO contract between the in-network provider and Cigna, the in-network provider agreed to accept the lower negotiated rate as payment in full for the service. That is, under the PPO contract with Cigna, the in-network provider agreed to have no recourse against the patient for any difference in amount between the provider's normal charge for the procedure and the negotiated lower rate. In other words, by contract, the in-network provider is precluded from ever balance-billing the patient.[1]

21. Since the amount owed by the Plan to the in-network provider is already determined by the pre-negotiated fee rates set by the PPO contract with Cigna, and because the PPO contract also precludes the in-network provider from ever balance-billing the patient, the in-network provider's request for payment from the Plan is deemed to be governed by the PPO contract, and is therefore not considered an ERISA claim for benefits.[2]

22. By contrast, an out-of-network provider has no contract with Cigna or the Plan, and is not bound to accept the same lower negotiated rates set forth by any PPO contract or fee schedule. Since there is no contract between the out-of-network provider and Cigna or the Plan, the out-of-network provider is free to "balance bill" the patient for any amounts unpaid by the

[1] Balance billing, sometimes also called extra billing, is the industry practice of billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

[2] According to FAQ A-8 of the United States Department of Labor Employee Benefits Administration's Frequently Asked Questions About the Benefit Claims Procedure Regulation, ERISA does not apply to in-network provider's claims for reimbursement when the provider has no recourse against the claimant for the amount in whole or in part not paid by the insurer or managed care organization. *See* http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html. (ERISA "does not apply to requests by health care providers for payments due them – rather than due the claimant – in accordance with contractual arrangements between the provider and an insurer or managed care organization, where the provider has no recourse against the claimant for amounts, in whole or in part, not paid by the insurer or managed care organization.")

Plan. This also means that the patient may be pursued and held personally liable by the out-of-network provider for any amounts unpaid by the Plan.

23. Plaintiff is an out-of-network provider that has no contract with Cigna or the Plan. As a non-participating provider, Plaintiff is not subject to any limitations or agreements contained in any PPO contract.

24. CB&I is an employer that sponsors and administers the Chicago Bridge and Iron Medical Plan ("the Plan"), an ERISA governed, self-funded welfare benefit plan created to provide benefits to subscribed CB&I employees and their enrolled dependents (collectively "plan beneficiaries"). In its 2013 plan year, the Plan had approximately 3700 individual active plan beneficiaries.

25. Branded as an "Open Access Plus" "Premier Choice" medical plan, the Plan promises its beneficiaries the freedom to receive and obtain reimbursement for health care services from his or her provider of choice. That is, the medical benefits covered by the Plan includes coverage for health care services from in-network *and* out-of-network providers, permitting the Plan's beneficiaries to seek treatment from a doctor or facility of his or her choice.

26. Under the terms of the Plan, the Plan is required to promptly pay benefits for out-of-network services based upon the usual, customary and reasonable rate ("UCR") for that service in the same geographic area. Whenever the Plan pays less than 100% of an out-of-network provider's claim, the Plan's failure or refusal to pay the full amount of the out-of-network provider's charges is deemed an adverse benefit determination under ERISA.[3]

[3] *See* FAQ C-12 of the United States Department of Labor Employee Benefits Administration's Frequently Asked Questions About the Benefit Claims Procedure Regulation, published online at http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html. (Under ERISA, an adverse benefit determination generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In any instance where the plan pays less than

B. Together with Cigna Defendants Owe Fiduciary Duties to the Plan's Beneficiaries

27. Under ERISA, a self-funded health benefit plan must set forth in a written official plan document or plan instrument specific details regarding the Plan, such as the terms of eligibility for enrollees, the types of benefits covered, and more. Pursuant to the public policy set forth by ERISA, as a self-funded welfare benefit plan, the Plan shall be interpreted and implemented solely in the best interests of the Plan's beneficiaries *for the exclusive purpose of providing benefits for them.*[4]

28. CB&I serves as the Plan Sponsor and Plan Administrator for the Plan. Specifically, CB&I employs individual Dennis Fox ("Mr. Fox") who holds the position of Director of Compensation and Benefits for CB&I. Through his employment and position with CB&I, Mr. Fox is charged with the responsibilities and duties of a Plan Administrator for the Plan.

29. Thus, under ERISA, Defendants serve as trustee-like fiduciaries of the Plan's beneficiaries. As fiduciaries, Defendants must act in accordance with the Plan's governing plan documents and solely in the interests of the Plan's beneficiaries for the exclusive purpose of providing benefits to them. Importantly, a fiduciary of an ERISA plan is forbidden to "deal with the assets of the plan in his own interest" and "shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect" transfer or lending of plan assets benefitting a co-fiduciary or other party in interest.[5]

30. Together, Defendants and Cigna, the Plan's designated TPA and Defendants'

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the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses, and is treated as an adverse benefit determination.)

[4] *See* 29 U.S.C. § 1104(a)(1)(A).

[5] *See* 29 U.S.C. § 1106(a)(1).

agent, serve as co-fiduciaries for the Plan. Defendants knowingly empowered Cigna with discretionary authority and control over the claims administration of the Plan, which includes the adjudication of medical claims (along with full and fair review of appealed claims), determinations of coverage and reimbursements, and the disposition of the Plan's assets. Alarmingly, despite the broad power entrusted to Cigna, Defendants never provided Cigna with the master governing plan documents.

C. The Plan's Fiduciaries Together Engage in an Elaborate Scheme to Embezzle Plan Funds at the Expense of Beneficiaries

31. Upon information and belief, in breach of their fiduciary duties, Defendants knowingly encouraged, authorized, assisted, and enabled Cigna, Defendants' designated agent and co-fiduciary, to unjustly enrich itself by misappropriating the Plan's assets at the expense of the Plan's beneficiaries. Specifically, in breach of their fiduciary duties, Defendants and Cigna engaged in a course of conduct which allowed Cigna to conceal plan fund withdrawals as false "contractual obligation" benefits payments that, in truth, were never actually paid to the providers, but were actually embezzled and wrongfully retained by Cigna.

32. Together, Defendants and Cigna promulgated a system of misappropriating plan funds by engaging in the following scheme:

a. ONE: Defendants and Cigna fraudulently processed this out-of-network provider's claims as fake "contractual obligation" claims subject to in-network, PPO pricing or third party repricing agreements;

b. TWO: After falsely processing the out-of-network claims under an artificial contract that did not actually exist, Defendants and Cigna fraudulently transferred/withdrew plan funds under the guise that payment would be issued to the out-of-network provider;

c. THREE: Defendants and Cigna then implemented Cigna's fee-forgiveness protocol scam in order to wrongfully withhold payment to providers. Defendants and Cigna falsely denied and withheld valid benefits claims under the flawed premise that the provider had to first prove that the patient's deductible and coinsurance amounts were collected in full, even when Cigna instructed Plaintiff not to bill the patient any of the charged amounts, and calculated the amounts owed by the patients to be zero; and

d. FOUR: Following the wrongful denials of valid benefits claims, Cigna kept, converted, and embezzled the withdrawn plan funds, claiming the amounts that were never paid to the providers as a form of nebulous, ASO managed care TPA or other "savings" fees owed to Cigna under its unlawful self-dealing ASO contract. These fees Cigna paid to itself were grossly excessive in amount.

33. Specifically, from the time period of November 2013 forward, every claim submitted by this out-of-network provider on behalf of a participant or beneficiary of the Plan was falsely labeled and processed by Cigna under a fabricated, non-existent Preferred Provider Organization (PPO) contract. That is, as evidenced by the Electronic Provider Remittance Advice ("EPRA") records generated for the submitted claims, Cigna systematically categorized and processed out-of-network claims as being subject to a phony "contractual obligation" when, in fact, no such contract ever applied to those claims.

34. Whenever a claim is processed by an insurance company, the insurance company issues an Explanation of Benefits (EOB) to the Provider, which is sometimes also called the

Provider Remittance Advice (PRA).[6] The EPRA is an electronic version of the EOB/PRA that is created from the data transmitted with the Electronic Remittance Advice (ERA or HIPAA 835) transaction.[7] The ERA or HIPAA 835 is the standard transaction mandated by the Health Insurance Portability and Accountability Act (HIPAA) which utilizes various claim adjustment reason codes (CARC) or remittance advice remark codes (RARC) to communicate information relating to the insurance carrier's processing and payment of the claim. In industry practice, the EPRA serves as an electronic version of the Provider Explanation of Benefits that can be promptly accessed to obtain details of a particular claim in order to trace, record, and auto-post claim payments into the provider's system.

35. Critically, the EPRAs readily show that Cigna mislabeled the claims submitted by Plaintiff under claim adjustment reason code (CARC)/remittance advice remark code (RARC) "CO: Contractual Obligation." This means that the claims had been falsely processed by Cigna as if they fell under a PPO contract, or re-pricing agreement, when in truth, this out-of-network provider never entered into any such agreement. Then, rather than issuing payment of plan funds, Cigna implemented its "fee-forgiveness" scam to wrongfully refuse payment to the providers under a false plan exclusion, reprehensively leaving the Plan's beneficiaries exposed to personal liability for the full amount of their medical bills. Cigna then embezzled and took the plan funds as its own by deceptively claiming that the funds were now owed to Cigna by the Plan as nebulous TPA "savings" fees.

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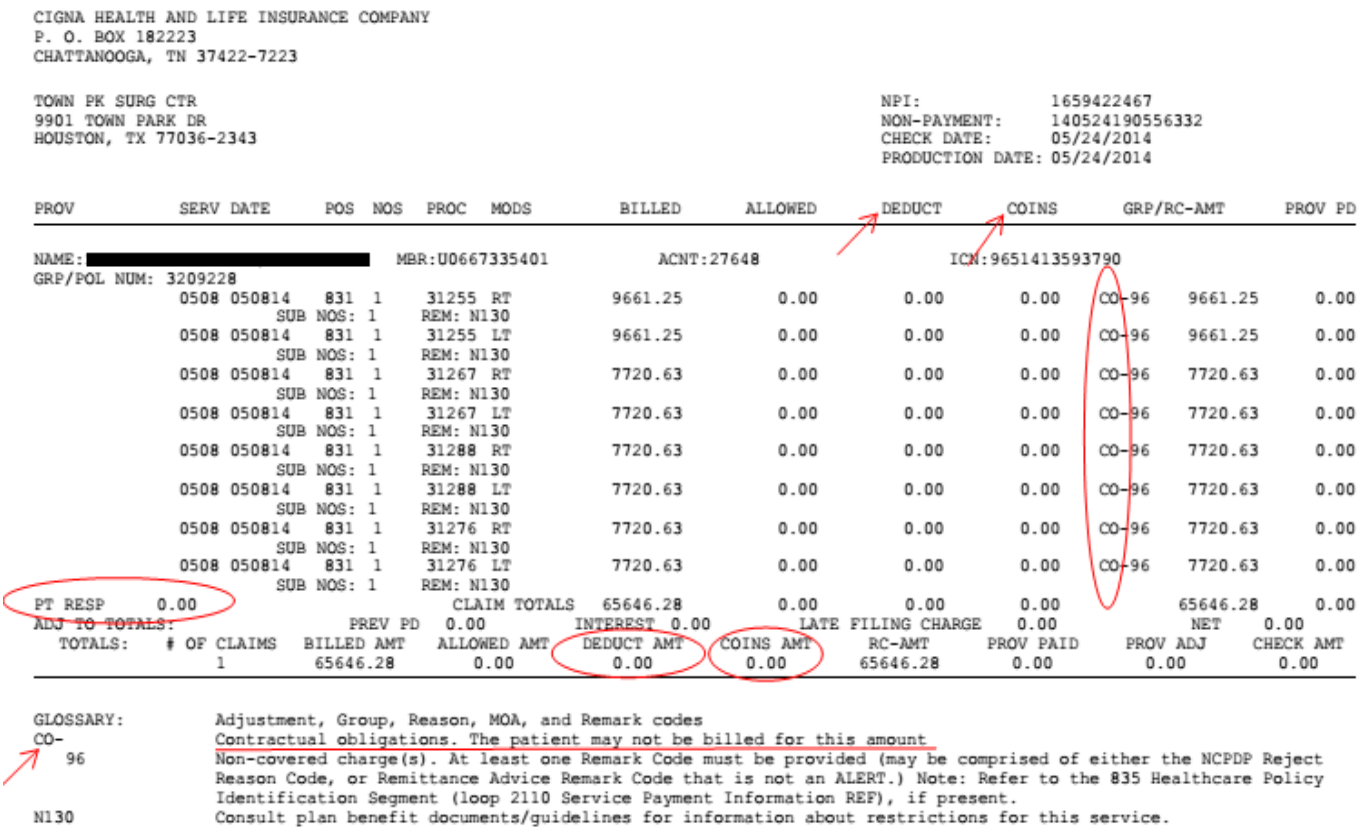
[6] *See* United Healthcare's "835 Definitions & Acronyms" available online at https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=5f885cfb4ee3c310VgnVCM2000002a4ab10a____.

[7] *Id.,* ("The 835 returns payment information that is reported on paper EOB/PRAs (Explanation of Benefits/Provider Remittance Advice) to the provider (or clearinghouse), in an electronic format. The ERA/835 uses claim adjustment reason codes mandated by HIPAA.)

36. The following exemplar EPRA issued by Cigna on behalf of the Plan (which nearly mirrors all claims submitted to the Plan that are subject to this dispute) depicts the false claim adjustment reason codes (CARC)/remittance advice remark codes (RARC) utilized:



CIGNA HEALTH AND LIFE INSURANCE COMPANY
P. O. BOX 182223
CHATTANOOGA, TN 37422-7223

TOWN PK SURG CTR
9901 TOWN PARK DR
HOUSTON, TX 77036-2343

NPI: 1659422467
NON-PAYMENT: 140524190556332
CHECK DATE: 05/24/2014
PRODUCTION DATE: 05/24/2014

PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: [redacted]	MBR:U0667335401					ACNT:27648			ICN:9651413593790		
GRP/POL NUM: 3209228											
	0508 050814	831	1	31255 RT		9661.25	0.00	0.00	0.00	CO-96 9661.25	0.00
	SUB NOS: 1			REM: N130							
	0508 050814	831	1	31255 LT		9661.25	0.00	0.00	0.00	CO-96 9661.25	0.00
	SUB NOS: 1			REM: N130							
	0508 050814	831	1	31267 RT		7720.63	0.00	0.00	0.00	CO-96 7720.63	0.00
	SUB NOS: 1			REM: N130							
	0508 050814	831	1	31267 LT		7720.63	0.00	0.00	0.00	CO-96 7720.63	0.00
	SUB NOS: 1			REM: N130							
	0508 050814	831	1	31288 RT		7720.63	0.00	0.00	0.00	CO-96 7720.63	0.00
	SUB NOS: 1			REM: N130							
	0508 050814	831	1	31288 LT		7720.63	0.00	0.00	0.00	CO-96 7720.63	0.00
	SUB NOS: 1			REM: N130							
	0508 050814	831	1	31276 RT		7720.63	0.00	0.00	0.00	CO-96 7720.63	0.00
	SUB NOS: 1			REM: N130							
	0508 050814	831	1	31276 LT		7720.63	0.00	0.00	0.00	CO-96 7720.63	0.00
	SUB NOS: 1			REM: N130							
PT RESP 0.00					CLAIM TOTALS	65646.28	0.00	0.00	0.00	65646.28	0.00
ADJ TO TOTALS:					PREV PD 0.00		INTEREST 0.00		LATE FILING CHARGE 0.00	NET	0.00

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	RC-AMT	PROV PAID	PROV ADJ	CHECK AMT
	1	65646.28	0.00	0.00	0.00	65646.28	0.00	0.00	0.00

GLOSSARY:
CO-96 — Contractual obligations. The patient may not be billed for this amount. Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N130 — Consult plan benefit documents/guidelines for information about restrictions for this service.

37. As depicted in the exemplar EPRA above, in processing any claim submitted by Plaintiff, an out-of-network, non-participating provider, Cigna utilized particular CARC/RARC codes to mask each submitted out-of-network claim as being subject to a false, sham Preferred Provider Organization ("PPO") type contract. In fact, Cigna mischaracterized each billed charge submitted by Plaintiff as being subject to a "CO" "Contractual Obligation," even though it is indisputable that no such contract between this provider and Cigna exists.

38. The deception of processing the claim as subject to a fake PPO contract is further shown by Cigna's calculation of the patient's responsibility ("PT RESP") at "0.00" and the declaration that "the patient may not be billed" for any of the amounts charged. These

representations falsely suggest that either: 1) 100% of the billed charges were paid by the plan to the provider, or 2) the charges were subject to some contractual discount (i.e. PPO contract or repricing discount). Neither is true.

39. Importantly, for every billed charge submitted, Cigna calculated the patients' deductible amounts – noted as "DEDUCT" in the EPRAs – as "0.00." Likewise, for every billed charge, Cigna calculated the patients' coinsurance amounts – under "COINS" – as "0.00."

40. Collectively, all of these codes deliver the false message that the patient's claim was governed by a PPO contract that prohibited this provider from balance-billing the patient, when in truth, the patient remains personally liable for any amounts charged but not paid by the Plan. These codes serve as trick signals meant to conceal this out-of-network provider's claim under a fabricated PPO "contractual obligation" in order to allow Cigna to withdraw the billed amounts from the Plan's benefits account, hiding the transfer of plan funds among the other withdrawals from the Plan that were truly subject to a PPO or re-pricing agreement.

41. Then, in order to proceed with its scheme to embezzle the withdrawn plan funds, rather than paying the withdrawn amounts to the provider, Cigna implemented its "fee-forgiving" scam, whereby Cigna unjustly demands proof from the provider that the patients' deductibles and co-insurance amounts were collected in full as a contrived precondition of payment of benefits.[8] Cigna claimed that "the Plan has no obligation to pay" until it receives proof from the provider that in advance of providing services to the patients, the patients' deductibles and co-insurance amounts were satisfied in full. In practice, unless an out-of-network provider submitted proof that

[8] For a detailed background as to Cigna's "fee-forgiving protocol," please *see North Cypress v. Cigna,* 781 F.3d 182, 189-190 (5th Cir. 2015)(explaining that Cigna's position was that patients were not insured for medical costs unless the out of network provider billed them for their co-insurance responsibility and that there were strong arguments that Cigna's interpretation is "not legally correct").

it collected 100% of a patient's deductible and coinsurance amounts prior to providing health care services, Cigna withheld the entire claims amount it withdrew from the Plan's benefits account when it processed the claim as being subject to a fake PPO contractual obligation.

42. Cigna's disingenuous basis for demanding this proof stems from an extraneous clause drafted by Cigna and contained in Cigna's ASO form document (a non-plan document), which states: "[c]harges which you are not obligated to pay or for which you would not have been billed except they were covered under the plan are not covered." Based upon Cigna's strained misinterpretation of the clause, Cigna unfairly demands proof that the patients' deductibles and co-insurance amounts were paid in full in advance of the services, despite the fact that the actual Plan documents do not contain any plan language which discloses or otherwise notifies the average plan participant that his or her coverage under the plan is conditioned upon the provider's full collection of deductible or coinsurance from those participants. In other words, there are no Plan documents that contain any language that clearly communicates to a regular plan member that there is no insurance coverage for services unless he or she is charged co-insurance by the provider. Nor is there any language in the Plan documents that clearly communicates to an average plan participant that the provider must collect all applicable deductible or co-insurance before triggering any benefit coverage for the service.

43. The self-dealing embezzlement scheme perpetrated by Cigna and Defendants is even more repugnant because Cigna duplicitously demands proof from the provider that it collected the patient's co-insurance and deductibles in full *when it explicitly instructed the provider not to bill the patient.* As depicted above, in Cigna's contradicting EPRA, Cigna calculates patient responsibility at "0.00" and brazenly declares that "the patient may not be billed" for any of the billed charges. Further, for every billed charge submitted, Cigna calculated the Patients'

deductible and coinsurance amounts as "0.00," suggesting that the patients already satisfied their annual deductible and maximum annual out-of-pocket amounts, which means that 100% of the patients' claims were covered and owed by the Plan.

44. In other words, while on one hand Cigna informs the provider that the patient's coinsurance and deductible amounts equate to zero and directs the provider "not" to bill the patient for any amount, on the other hand, Cigna denies payment to the provider for exactly the reverse - because the provider somehow lacks proof that it billed and collected the patient's coinsurance and deductible amounts in full.

45. Critically, Cigna does not equally require the same proof that deductibles and co-insurance amounts were collected in full from its in-network providers. That is, Cigna has never enforced a similar "fee forgiveness protocol" against its in-network providers or patients. Further, even under Cigna's tenuous reading that the "not obligated to pay" clause requires proof that deductibles and co-insurance amounts were collected in full, which was rejected by the United States Fifth Circuit Court of Appeals as being not "legally correct,"[9] the exclusion cannot apply when the patient already satisfied his or her maximum out of pocket amounts under the plan.

46. Importantly, even though the amounts taken by Cigna were never actually paid to the provider, Cigna failed to return the withdrawn funds to the Plan within the sixty day time period mandated by the Department of Labor. Rather, Cigna ultimately embezzled and kept the funds by claiming the amounts as its own compensation for generating "savings" through provider negotiations - negotiations that never actually occurred. All in all, Defendants' and Cigna's joint scheme of masking plan fund withdrawals under a fabricated PPO contract, then profiting through "savings" generated by false denials of valid claims, has potentially resulted in an even grander

[9] *Id.*

web of tax fraud, as it is probable that the amounts reported by Defendants as non-taxable paid "benefits claims" in their Form 5500 Tax Filings were inaccurate.

47. Together with Cigna, Defendants knowingly and systematically violated ERISA regulations that statutorily forbid self-dealing transactions of a fiduciary. In addition to the EPRAs that plainly expose their embezzlement scheme, the ASO contract between Defendants and Cigna alone reveals indisputable self-dealing misconduct. Indeed, despite the obvious conflict of interest, Defendants agreed to compensate Cigna based upon savings or recovery that Cigna generates for the Plan by either denying or underpaying the claims submitted by providers. Thus, while Defendants endow Cigna with discretionary authority over the Plan, they also foolishly empower Cigna with a compensation structure that rewards Cigna for denying or underpaying claims. In other words, contrary to their fiduciary duties owed to the Plan's beneficiaries, Defendants contracted with Cigna in a manner that incentivizes Cigna to make benefits determinations not based upon the true terms of the Plan, but rather, based upon keeping the "savings" as high as possible, in order to maximize profit to Cigna. The harm to plan beneficiaries is even further compounded by Defendants' failure to track or confirm the legitimacy of the vague and mysterious "savings" declared by Cigna when Cigna pays itself with plan funds.

D. Relying Upon Defendants' Representations as to Coverage, Plaintiff Provided Medically Necessary Services to Beneficiaries of the Plan

48. The Plan purports to provide out-of-network benefits to its beneficiaries. Branded as an "Open Access Plus" "Premier Choice" medical plan, the Plan promises its beneficiaries the freedom to receive and obtain reimbursement for health care services from his or her provider of choice, including services obtained from out-of-network providers. Under the terms of the Plan, the Plan must promptly pay benefits for out-of-network services based upon the usual, customary and reasonable rate ("UCR") for that service in the same geographic area.

49. Plaintiff is a non-participating, out-of-network health care provider. Plaintiff has no contract with Cigna, or with the Plan.

50. Plaintiff provided health care services to several beneficiaries of the Plan. Specifically, Plaintiff rendered surgical services to the following beneficiaries of the Plan (hereinafter collectively the "Assignor-Patients"):

- Patient C.B. #44061 on March 27, 2014;
- Patient A.Z. #27648 on May 8, 2014;
- Patient W.W. #46735 on June 16, 2014;
- Patient J.C. #30020 on October 31, 2014;
- Patient B.G. #47892 on November 18, 2013;
- Patient T.N. #37458 on December 17, 2014;
- Patient T.L. #47585 on February 26, 2015;
- Patient K.C. #48621 on February 26, 2015; and
- Patient K.N. #49034 on June 17, 2015.

51. During the patient registration process, prior to receiving health care services from Plaintiff, each of the Assignor-Patients signed various forms acknowledging his or her understanding of personal financial responsibility for the amounts charged by Plaintiff, and that he or she remained fully obligated for all uncovered portions of the claims. By signing the forms, each Assignor-Patient acknowledged and agreed to the following terms: *"I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments;"* and that *"[Patient] will be personally responsible for [Patient's] account balance regardless whether or not if your insurance will pay for your total balance of your claims."* The Assignor-Patients did not know or otherwise bear an

understanding that their out-of-network coverage under the Plan was conditioned upon Plaintiff's upfront collection of their deductibles and co-insurance amounts in full.

52. Each Assignor-Patient also signed an Assignment of Benefits and Designation of Authorized Benefits ("AOB") stating:

> *In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.*
>
> *I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan*

> *in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.*

53. Through the AOB's, each of the Assignor-Patients assigned to Plaintiff all relevant rights hereunder, including: the right to be paid directly by the Plan, the right to challenge and appeal the amount of reimbursement, the right to pursue litigation including all ERISA causes of action (including breach of fiduciary claims), and the right to receive all relevant plan documents (Summary Plan Descriptions, Master Plan Documents, Claim Files, Administrative Files, Financial Reports, among other documents and information) as if Plaintiff was the member, participant, or beneficiary of the Plan. These assignments are unrestricted and unrevoked and it serves to place Plaintiff in the same position as the Assignor-Patients. Through these AOB's, Plaintiff serves as the Assignor-Patients' authorized representative, and therefore qualifies as a claimant under the Patient Protection and Affordable Care Act, 29 CFR § 2590.715.

54. Additionally, before providing any medically necessary healthcare services to the Assignor-Patients, as part of Plaintiff's routine and usual practice, Plaintiff verified that the services to be provided were covered under the Plan. Plaintiff followed the specific instructions indicated on the Assignor-Patients' insurance cards regarding insurance verification and claims submission. Through the verification process, Defendants affirmatively represented to Plaintiff that each of the Assignor-Patients were covered under the Plan, had applicable out-of-network benefits, and that the expected medical procedures were covered services. At that time, Defendants did not notify Plaintiff that the Assignor-Patients' out-of-network benefits under the Plan would

be conditioned upon proof that Plaintiff collected their respective deductibles and co-insurance in full in advance of the services rendered.

55. Reasonably relying upon Defendants' representations, Plaintiff provided the medically necessary health care services to the Assignor-Patients and then timely submitted claims for payment in accordance with the procedures established in the Plan. Collectively, the submitted claims reflected billed charges incurred by the nine Assignor-Patients totaled to $315,848.01.[10]

E. Defendants' Wrongful Denial of Plaintiff's Claims.

56. Following Plaintiff's submission of the Assignor-Patients' claims, Defendants refused to pay any amounts to Plaintiff. Rather than issue payment for the benefits owed, Defendants proceeded to enable, authorize, ratify, or otherwise engage in, Cigna's scheme to conceal misappropriation of plan funds and other prohibited self-dealing misconduct.

57. As evidenced by the EPRAs generated from each of the Assignor-Patients' claims submitted by Plaintiff, Cigna, Defendants' agent and co-fiduciary, applied the same "CO" "Contractual Obligation" codes to mask each claim as being subject to a false, phantom Preferred Provider Organization ("PPO") type contract, even though no such contract truly exists. Further, for each and every claim submitted on behalf of the Assignor-Patients, Cigna affirmatively calculated the patient's responsibility ("PT RESP"), deductible ("DEDUCT"), and coinsurance ("COINS") amounts as "0.00" and declared that "the patient may not be billed" for any of the amounts billed by Plaintiff.

58. Notably, the EPRAs never disputed the reasonableness of the amounts charged by Plaintiff for the medical services, signifying Defendants' acceptance of the fees charged for each

[10] *See* List of Claims, attached hereto as Exhibit A. *See also* Redacted Versions of EPRAs, attached hereto as Exhibit B.

procedure. In other words, Defendants did not apply any price reductions or discounts, affirmatively agreeing to 100% of the billed charges. Thus, rather than withdrawing a discounted amount, Cigna withdrew the total amounts, an approximate sum of $315,848.01, from the Plan's benefits account under the guise that it would issue payment to this provider.

59. Following Cigna's withdrawals of the amounts from the Plan's benefits account, Defendants implemented Cigna's "fee-forgiving" scam in order to falsely deny valid benefits claims, and issued misleading EOBs that directly contradicted the EPRAs. Defendants refused to issue payment to Plaintiff, demanding Plaintiff to prove that it billed and collected from each of the Assignor-Patients all unmet deductible amounts and co-insurance portions.

60. Critically, Defendants refused payment and demanded this proof even though the EPRAs issued by them duplicitously:

- Instructed the provider *not* to bill the patient (declaring that "the patient may not be billed" for any of the billed charges);
- Calculated each patient's responsibility at "0.00";
- Calculated each patient's deductible amount at "0.00"; and
- Calculated each patient's coinsurance amount at "0.00."

In other words, while Defendants refused payment because of "missing" proof that deductible and coinsurance amounts were collected in full, Defendants simultaneously declared that the patient's deductible and coinsurance amounts were "0.00" and specifically instructed the provider not to bill the patient.

F. Defendants Ignored Plaintiff's Numerous ERISA Appeals Alerting Them of Cigna's Misconduct, and Improperly Denied Plaintiff's Repeated Requests for Plan Documents and Full and Fair Review.

61. Following receipt of the wrongful blanket denials of benefits issued by Defendants, Plaintiff timely lodged ERISA appeals challenging each of the adverse benefit determinations. In fact, Plaintiff sent Level 1 Appeals by certified mail to Cigna *and* CB&I/Dennis Fox on:

- August 21, 2014 for Patients C.B. #44061 and A.Z. #27648,
- December 30, 2014 for Patient W.W. #46735,
- January 23, 2015 for Patient J.C. #30020,
- February 6, 2015 for Patients B.G. #47892 and T.N. #37458,
- April 7, 2015 for Patients T.L. #47585 and K.C. #48621, and
- July 10, 2015 for Patient K.N. #49034.

62. In all of the Level 1 Appeals submitted, Plaintiff challenged Defendants' bogus denial bases, showing that the Assignor-Patients were, in fact, "obligated to pay" the charges in question. Plaintiff's Level 1 Appeals also noted that the denials of benefits based upon a supposed need for more information were fatally flawed because Cigna failed to precisely identify the information needed for each specific patient.

63. Additionally, time and time again, with each Level 1 Appeal, Plaintiff requested plan documents, including the Plan's Summary Plan Description (SPD), the Summary of Benefits and Coverage (SBC), the final or master governing documents, the Plan's Form 5500, the complete administrative file, *and* certification of PPACA grandfathered status.

64. Critically, every Level 1 Appeal submitted on behalf of the Assignor-Patients directly notified Defendants of the self-dealing misconduct raised in this Complaint:

> *Breach of Fiduciary Duty.* The Plan Administrator is, by statute, a fiduciary of the Plan.[9] As a fiduciary, you have a strict obligation to discharge your duties with respect to the Plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries. Cigna is also acting as a fiduciary

> by exercising discretion in whether to pay our claim and what amount of our claim to pay. This exercise of discretion is an inherent function of a fiduciary and you must discharge it, too, in strict accordance with the Plan and the statute. *Cigna has made a determination to deny benefits without valid data to substantiate its determination, by acting in an arbitrary and capricious manner, by omitting and/or misstating material information about its determination, and by making misrepresentations about coverage and the adverse benefit determinations. This conduct demonstrates a failure to act with the care, skill, prudence, and diligence that a reasonable and prudent plan administrator would in a like or similar circumstance, and it demonstrates a failure to act in accordance with the documents and instruments governing the Plan, which you must do. This arbitrary decision to deny benefits in our claim maximizes Cigna's profits at the expense of the Plan's participants and beneficiaries, of whom [PATIENT] is one and we, by virtue of the assignments to us, are another.* Therefore, continued refusal to deny the benefits will entitle us to seek damages, including a surcharge. [Emphasis added.]

65. Defendants refused to directly respond to the Level 1 appeals and wholly failed to provide Plaintiff with any of the documents requested. Instead, through silence and inaction, Defendants simply deferred to their agent and co-fiduciary Cigna, and ratified Cigna's denials of benefits based upon the fee-forgiveness "not obligated to pay" clause contained within the document marked "ASO79" "CB&I" "Open Access Plus Medical Benefits" booklet (hereinafter "Cigna's ASO 79 Booklet").

66. Critically, Cigna's ASO 79 Booklet, which was not received by Plaintiff until February 16, 2015, fails to satisfy the statutory requirements outlined for a Summary Plan Description, as defined in 29 U.S.C. §1022. Further, Defendants refused to supply Plaintiff with any governing or master plan document, prejudicially leaving Plaintiff with no means to even determine or confirm whether Cigna's ASO 79 Booklet was ever officially or properly adopted by the Plan.

67. By March 10, 2015, in *North Cypress v. Cigna*, 781 F.3d 182 (5th Cir. 2015), a case brought against Cigna for denials of benefits based upon the same exact purported "obligated to pay" plan exclusion used in the fee-forgiveness scam described above, the United States Fifth Circuit of Appeals rendered its opinion directly notifying Cigna that there were "strong arguments"

that its interpretation of the clause was not "legally correct." Critically, the Fifth Circuit explained that the "ordinary plan members who read [the exclusion]" would be unlikely to "understand the language to condition coverage on the collection of coinsurance, rather than simply describing the fact that the insurance does not cover all of a patient's costs." Despite this, Cigna continued to stand behind its denials, and continued to demand proof that providers collected patients' deductibles and co-insurance amounts in full before paying benefits claims submitted by out-of-network providers.

68. As a result of Defendants' continuing arbitrary and wrongful denial of benefits, Plaintiff again lodged more appeals to Defendants and Cigna, again requesting a full and fair review of every claim, a copy of the entire claim file, a copy of the Summary Plan Description, the IRS Form 5500, and the master governing plan documents. Plaintiff sent Level 2 Appeals to both Cigna *and* CB&I/Dennis Fox on:

- March 6, 2015 for Patient J.C. #30020,
- April 10, 2015 for Patient W.W. #46735,
- May 4, 2015 for Patient T.N. #37458,
- May 8, 2015 for Patient C.B. #44061,
- May 4, 2015 for Patient A.Z. #27648,
- May 11, 2015 for Patient B.G. #47892,
- June 8, 2015 for Patient K.C. #48621,
- June 10, 2015 for Patient T.L. #47585, and
- August 17, 2015 for Patient K.N. #49034.

Once again, Plaintiff identified the fatal flaws in Defendants' adverse benefit determinations, and due to the inherent conflict of interest between Cigna and Defendants, encouraged Defendants to

seek independent legal counsel not appointed or otherwise engaged by Cigna to look into Plaintiff's concerns.

69. Following Plaintiff's Level 2 Appeals, Defendants still failed and refused to provide full and fair *de novo* reviews of the Assignor-Patients' claims. As they did before, Defendants did not directly respond to Plaintiff. Defendants continued to refuse to take any corrective action. Rather, Defendants continued to ratify Cigna's wrongful assertion that benefits payments by the Plan were conditioned upon proof that the Assignor-Patients' paid their deductible and co-insurance amounts in full. Defendants maintained and upheld their adverse benefits determinations arbitrarily and capriciously. Plaintiff again tried to obtain the precise, ERISA-compliant reasons for Defendants' denial of Plaintiff's claims, but to no avail. Meanwhile, Cigna misappropriated and paid to itself the amounts it withdrew from the Plan's benefits accounts for Plaintiff's claims.

70. On October 9, 2015, Plaintiff corresponded to Defendants lodging its final voluntary Level 3 appeal of the Assignor-Patients' claims. Specifically, Plaintiff pointedly notified Defendants of Cigna's embezzlement of plan funds and even identified the scheme employed to conceal same, as detailed herein. Plaintiff requested and encouraged Defendants to conduct their own investigation, and pleaded with Defendants to supply Plaintiff with evidence disproving its suspicions.

71. On October 14, 2015, under his capacity as Plan Administrator and Director of Benefits and Compensation for CB&I, Dennis Fox responded to Plaintiff's Level 3 Appeal, forwarding *for the first time* a document titled "2015 Summary Plan Description." On page "N-2" of the section "Benefit Rights," that document contained the following "Disclaimer" explicitly stating:

> *This handbook describes the health and welfare benefit plans available to eligible employees of Chicago Bridge & Iron Company (the "Company" or "CB&I").* ***It does not include all plan details.***
>
> *All sections of the handbook, when combined, form the Summary Plan Description (SPD). The SPD describes the major provisions of the plans.* ***It does not replace the official plan documents or insurance policies which govern each of the respective plan's operations. In the case of any conflict between the SPD and the official plan documents or insurance policies, the plan documents or insurance policies will govern.***
>
> *Copies of* ***official plan documents****, the latest annual reports and any other legally required materials under which a plan is operated, may be obtained free of charge by written request to the Plan Administrator. [Emphasis added].*

72. Even though master governing plan documents have been identified by the Plan (specifically referred to as "official plan documents" in the document sent to Plaintiff by Dennis Fox on October 14, 2015), Defendants have still never supplied Plaintiff with the governing master plan documents despite having received at least nineteen separate written requests (the earliest request having been sent to Defendants as far back as August of 2014).

73. Further, after having received at least nineteen appeal letters from Plaintiff, Defendants never raised or mentioned any anti-assignment clause. The only correspondence Plaintiff received directly from Defendants was the letter from Dennis Fox dated October 14, 2015, which failed to raise or mention any anti-assignment clause.

74. Even after Plaintiff's Level 3 voluntary appeal of all Assignor-Patients' claims, despite actual knowledge of details as to their co-fiduciary's embezzlement scheme that continues to harm their Plan beneficiaries through ongoing wrongful denials of benefits and usurping of plan funds, Defendants refused to independently conduct its own investigation. Alarmingly, despite explicit warnings as to their own co-fiduciary liability, Defendants imprudently forwarded Plaintiff's Level 3 letter to Cigna, the very perpetrator of the suspected misconduct. Defendants

continued to refuse to exercise their discretionary authority, and continued to woefully maintain deference to Cigna.

75. In fact, on October 22, 2015, in spite of the obvious conflict of interest between Cigna and Defendants, Defendants enlisted Cigna to issue a written response to Plaintiff's detailed Level 3 appeal *on behalf of the Plan*.[11] Critically, in that letter, Defendants and Cigna utterly failed to deny or dispute that Plaintiff's out-of-network claims were falsely processed as "CO" PPO or repricing claims. Further, Defendants and Cigna utterly failed to deny or dispute that Cigna paid itself with funds from the plan for Plaintiff's submitted but unpaid claims. Instead, Defendants and Cigna merely argued that the flatly incriminating EPRAs identified by Plaintiff were not actually EOBs but "835 Remittance Advice" statements issued to the provider. Tellingly, while Cigna's letter claimed to "reject" Plaintiff's contentions, Cigna wholly failed to present any facts or financial accounting records that challenged the suspicions of misconduct asserted.

76. ERISA declares that the primary responsibility of fiduciaries is to run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses. Fiduciaries must act prudently and must follow the terms of plan documents to the extent that the plan terms are consistent with ERISA. They also must avoid conflicts of interest. In other words, fiduciaries may not engage in transactions on behalf of the plan that benefit parties related to the plan, such as other fiduciaries, services providers, or the plan sponsor.

77. Defendants have continuously ignored and breached their fiduciary duties. Despite actual knowledge of Cigna's misconduct, and the glaring conflict of interest between them as ERISA co-fiduciaries under 29 U.S.C. §1105, Defendants categorically rejected the standards of

[11] *See* Cigna's October 22, 2015 Letter, attached hereto as Exhibit C.

reason and prudence required of them, and instead, continued to enable, ratify and join Cigna in engaging in misconduct harmful to the plan beneficiaries. As a result of Defendants' utter failure to take any corrective actions and willful refusal to pay the benefits owed by the Plan, the Assignor-Patients (beneficiaries of the Plan) are left personally exposed to financial liability for their unpaid medical bills.

78. Defendants not only promised to provide out-of-network benefits to their employees and their dependents, Defendants charged and collected premiums from them. Unfortunately, the out-of-network benefits promised to beneficiaries of the Plan were apparently fictional, as Defendants have paid *nothing* to the Assignor-Patients' out-of-network provider. Instead of paying the providers who have medically treated their plan beneficiaries, Defendants enable and allow their agent and co-fiduciary Cigna to unlawfully use the plan funds to pay itself grossly excessive and fundamentally unfair amounts. Meanwhile, Defendants seek to unlawfully punish and penalize their plan beneficiaries for electing to use their promised out-of-network benefits by wrongfully refusing to pay for their out-of-network claims.

79. By knowingly and willfully making, approving and upholding these adverse benefit claims determinations without valid reasons to support them, and by failing to avoid self-dealing transactions prohibited by ERISA, Defendants violated their fiduciary obligations under ERISA.

80. Plaintiff has fully exhausted all administrative remedies under the Plan, having submitted numerous appeals to Defendants and Cigna, the Plan's TPA, by United States Mail, certified with return receipt requested. Additionally, through written correspondence from Cigna, Defendants confirmed that any further appeals from Plaintiff would be futile, and have expressly conceded that Plaintiff has exhausted all of its administrative remedies and has the right to institute judicial action to redress the wrongs complained of in this lawsuit.

V. COUNT ONE

Claims under § 502(a) of ERISA, 29 U.S.C.§ 1132(a)

81. Plaintiff incorporates and realleges the allegations set forth above.

82. Plaintiff has assignments of benefits from the Assignor-Patients who are covered under the Plan. The assignment of benefits that Plaintiff received from the Assignor-Patients confers upon Plaintiff the status of a "beneficiary" under § 502(a) of ERISA, 29 U.S.C. § 1132(a). As the beneficiary, Plaintiff is entitled to recover benefits due to it and/or to the patients under the terms of the Plan and applicable law, including (but not limited to) § 502(a)(1)(B) of ERISA; and to pursue equitable relief under applicable law, including (but not limited to) § 502(a)(3) of ERISA.

83. Plan Administrator(s) Dennis Fox, Director of Benefits and Compensation for CB&I, and his employer CB&I, are liable to Plaintiff under § 502(a) of ERISA, 29 U.S.C. § 1132(a), for violations of ERISA and the terms of the Plan, including (but not limited to) the following:

a. In violation of ERISA, Defendants knowingly and willfully failed to make payment of benefits to Plaintiff and/or to Assignor-Patients, as required under the terms of the Plan and applicable law, as described herein;

b. In violation of ERISA, Defendants knowingly and willfully failed to provide beneficiaries with a "full and fair review" concerning denial of claims, as required by 29 U.S.C. § 1133(2);

c. In violation of ERISA, Defendants wrongfully entered into unlawful arrangements with Cigna in a manner that encourages false denial of benefits based upon a compensation model that maximizes profit to Cigna resulting from vague "savings"

achieved through wrongful denial of claims rather than based upon the terms of the plans; and

d. In violation of ERISA, Defendants violated their fiduciary duties, and despite knowledge of Cigna's embezzlement of plan funds, Defendants refused to take corrective actions, and continued to authorize, encourage, enable, and empower Cigna to continue embezzling plan funds.

84. Plaintiff has suffered damage as a result of Defendants' violations of ERISA. Plaintiff is entitled to monetary damages and/or restitution from Defendants as well as other declaratory and injunctive relief related to the enforcement of the plan terms. Defendants are liable to Plaintiff for unpaid benefits, interest, attorneys' fees, and other penalties as this Court deems just, including the issuance of appropriate declaratory and injunctive relief against Defendants and Defendants' removal as fiduciaries.

VI. COUNT TWO

Breach of Fiduciary Duty and Co-fiduciary Liability

85. Plaintiff incorporates and realleges the allegations set forth above.

86. Pursuant to ERISA §502(a)(3) and 29 U.S.C. §1132(a)(3), Plaintiff, as assignee of the rights of the Assignor-Patients, avers that Defendants breached their fiduciary duties to the Plaintiff in connection with the subject claims.

87. In their capacity as Plan Administrator(s), CB&I and Dennis Fox are fiduciaries of Plaintiff's because Plaintiff, as a legitimate assignee of the Assignor-Patients' rights, stands in the same place as each patient in connection with the coverages and other benefits and rights under the Plan, as ERISA contemplates and defines such terms.

88. Defendants breached their fiduciary duties to Plaintiff, as assignee, by failing to act in accordance with the documents and instruments governing the Plan, by making and upholding wrongful invalid adverse benefit determinations and/or doing so in an arbitrary and capricious fashion, by omitting material information about their determinations and otherwise failing to provide beneficiaries with adequate notice concerning those claims determinations, by failing to provide ERISA mandated full and fair review of the claims appealed, and/or by making willful, knowing, repeated, and systematic misrepresentations about coverage and their adverse benefit determinations. These acts and omissions include, without limitation, Defendants' insistence that Plaintiff bill and collect from its patients all unmet deductibles and other uncovered amounts when the governing Plan documents do not contain such requirement, and despite contradicting information contained in their EPRAs declaring that all deductible and co-insurance amounts were "0.00."

89. Further, as fiduciaries, Defendants owe the beneficiaries of the Plan a duty of loyalty, defined by ERISA § 406, 29 U.S.C. §1106, as an obligation to make decisions in the interest of beneficiaries, and to avoid self-dealing or financial arrangements that benefit the fiduciary at the expense of beneficiaries. Contrary to their fiduciary duty of loyalty under ERISA, Defendants knowingly entered into an arrangement with Cigna which encourages and promotes co-fiduciary self-dealing misconduct by compensating Cigna based upon savings from reduced benefits payments. Such an arrangement results in an inherent conflict of interest between Cigna's desire to maximize profit by falsely denying otherwise claims and Defendants' fiduciary obligation to make payments in accordance with the terms of the Plan. Further, such an arrangement results in grossly excessive payments to Cigna that are fundamentally unfair.

90. Despite knowledge of Cigna's overall embezzlement of plan funds, self-dealing misconduct and invalid denials of benefits, Defendants enabled, approved, ratified, and otherwise failed to remedy the known breaches of duty by its co-fiduciary.

91. Defendants are liable to Plaintiff for the violations of fiduciary duty described herein and for violations of its duties as a co-fiduciary under 29 U.S.C. §1105. Plaintiff has been damaged and continues to suffer damage as a direct and proximate cause of Defendants' wrongful conduct described herein. Plaintiff is entitled to damages, equitable relief (including, but not limited to surcharge), and injunctive relief, including Defendants' removals as breaching fiduciaries and prohibition from ever serving as a plan fiduciary under ERISA §502(a)(2) and 29 U.S.C. §1132(a)(2).

VII. COUNT THREE

Failure to Provide Full and Fair Review

92. Plaintiff incorporates and realleges the allegations set forth above.

93. CB&I and its employee Dennis Fox each qualify as the "plan administrator" within the meaning of that term under ERISA. CB&I and Mr. Fox are designated as the plan administrator for the Plan, or otherwise act in the role of a plan administrator with the discretion generally accorded to a plan administrator. As such, Plaintiff is entitled to assert a claim for relief under 29 U.S.C. §1132(a)(3).

94. Although Defendants were obligated to do so, Defendants failed and refused to provide a "full and fair review" to Plaintiff, on their own and by and through their agent and co-fiduciary Cigna, and otherwise failed to make necessary disclosures pursuant to 29 U.S.C. §1133 and the regulations promulgated under ERISA. Plaintiff requested appeals at least twice for each submitted claim and exhausted all of its administrative remedies under the Plan before bringing

this lawsuit. Instead of providing Plaintiff a full and fair review as required by ERISA, Defendants responded through form letters issued by Cigna that merely reiterated the original adverse benefits determination.

95. Defendants' misconduct recited above was the direct and proximate cause of Plaintiff's harm.

VIII. COUNT FOUR

Failure to Provide Requested and Required Documentation

96. Plaintiff incorporates and realleges the allegations set forth above.

97. Defendants have not provided the following requested documents, which ERISA requires it to produce to Plaintiff upon request: a complete and accurate master governing plan document, a complete and accurate SPD, the complete administrative claim file, and all documents showing the actual basis for the adverse benefit determination and the methodology used in applying that basis and making that determination.

98. Defendants' failure to comply with Plaintiff's request for information pursuant to 29 U.S.C. §1132(c)(1)(B) provides a civil penalty/sanction in the amount of $110.00 per day for such failure or refusal to provide the requested documents and information and Plaintiff is entitled to receive this sanction against Defendants, in addition to an order from this Honorable Court compelling Defendants to produce the requested documents.

IX. COUNT FIVE

Negligent Misrepresentation

99. Plaintiff incorporates and realleges the allegations set forth above.

100. Defendants are liable for the negligent misrepresentations they made to Assignor-Patients and to Plaintiff.

101. Plaintiff reasonably and justifiably relied upon the representations Defendants made in the course of its business and in the transaction in which it had a pecuniary interest. Defendants' representations supplied false information for the guidance to Plaintiff in its business, and Defendants did not exercise reasonable care or competence in obtaining or communicating the information. The negligent misrepresentations included the representations by Defendants, or its agents, that the patients at issue were covered under healthcare policies or plans and further that the medical services to be provided by Plaintiff were likewise covered under the terms of the policy or Plan, as specifically represented by Defendants or its agents via telephone during the insurance verification process referenced in this complaint and as documented by Plaintiff.

102. In reliance on these false statements, Plaintiff provided health care services to the patients. It was only later, when the claims for services had been denied and not paid at all, that Plaintiff realized that Defendants misrepresented to Plaintiff that the patients were covered under the health care policy or Plan. Further, to the extent that the member/insured is not covered by the applicable health benefits policy or Plan as represented by Defendants to Plaintiff, Defendants made misrepresentations actionable under common law. Plaintiff has been damaged due to reasonable reliance on the negligent misrepresentations of Defendants.

X. COUNT SIX

Attorney's Fees

103. Plaintiff has presented claims to Defendants demanding payment for the value of the services described above. More than 30 days have passed since those demands were made, but Defendant has failed and refused to pay Plaintiff. As a result of Defendants' failures to pay these claims, Plaintiff was required to retain legal counsel to institute and prosecute this action. Plaintiff

is therefore entitled to recover reasonable attorney's fees for necessary services rendered in prosecuting this action and any subsequent appeals.

104. Plaintiff is also entitled to an award of attorney's fees on its ERISA claims. ERISA allows a court, in its discretion, to award "a reasonable attorney fee and costs of action to either party."[12]

105. Plaintiff demands a jury trial on all issues for which trial by jury is permitted.

WHEREFORE, PREMISES CONSIDERED, Plaintiff respectfully prays that this Honorable Court issue judgment against Defendants granting Plaintiff the following relief:

1. Plaintiff's actual damages;

2. Statutory penalties and surcharges permitted by law;

3. Attorney's fees, including attorney's fees in the event of an appeal of this lawsuit;

4. Prejudgment and post-judgment interest at the highest rates permitted by law;

5. An injunction and/or other equitable relief as appropriate to arrest, correct, and prevent acts and omissions by Defendants that violate the Plan and/or ERISA, including, but not limited to, removal of CB&I and Dennis Fox as plan fiduciaries;

6. Plaintiff's costs of court; and

[12] 29 U.S.C. §1132(g)(1). *See Hardt v. Reliance Std. Life Insurance. Co.*, 130 S.Ct. 2149, 2152 (2010); *see also Baptist Mem. Hosp. - Desoto, Inc. v. Crain Auto., Inc.*, 392 Fed. Appx. 289, 299 (5th Cir. Miss. 2010).

7. All other relief, legal and equitable, to which Plaintiff may be justly entitled.

Respectfully submitted,

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