UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN JOSE DIVISION

CHARLES DES ROCHES, on his own behalf and on behalf of his beneficiary son, R.D., and all others similarly situated, SYLVIA MEYER, on her own behalf and all others similarly situated, and GAYLE TAMLER GRECO, on her own behalf and on behalf of all others similarly situated, Plaintiffs, v. CALIFORNIA PHYSICIANS' SERVICE d/b/a BLUE SHIELD OF CALIFORNIA; BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY; and HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA, Defendants.	Case No. 5:16-cv-2848 (LHK) Hon. Lucy H. Koh

LEGAL NOTICE BY ORDER OF
THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF CALIFORNIA

If you sought health insurance coverage or benefits from BLUE SHIELD OF CALIFORNIA or BLUE SHIELD OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANY for RESIDENTIAL TREATMENT OR INTENSIVE OUTPATIENT TREATMENT for PSYCHIATRIC OR SUBSTANCE USE DISORDERS on or after January 1, 2012 through March 5, 2017, you could get a payment from the proposed settlement of a class action lawsuit.

READ THIS NOTICE CAREFULLY.

A federal court authorized this notice. This is not a solicitation from a lawyer.

- **There is a proposed settlement ("Settlement") with California Physicians' Service d/b/a Blue Shield of California, Blue Shield of California Life & Health Insurance Co. (together, "Blue Shield"), and Human Affairs International of California ("HAI," and together with Blue Shield, "Defendants") in a class action lawsuit, *Des Roches, et al. v. California Physicians' Service, et al.*, Case No. 16-cv-2848-LHK (N.D. Cal.).**

- The Settlement will resolve a lawsuit over whether Defendants violated their obligations to members of health plans that Blue Shield administers under the Employee Retirement Income Security Act of 1974 ("ERISA") ("Blue Shield ERISA members") by developing, adopting, and applying a set of medical necessity criteria (the "Magellan Medical Necessity Criteria Guidelines," "MNCGs," "Guidelines," or "Challenged Guidelines")[1] that Plaintiffs allege were more restrictive than generally accepted professional standards, which were used to determine whether coverage requests for treatment at the Residential or Intensive Outpatient levels of care for psychiatric or substance use disorders were medically necessary.
- Defendants deny all of the Plaintiffs' claims, but have agreed to the Settlement to resolve the class action case. The Settlement provides two main types of relief to the Class:
    - (1) Defendants, who stopped using the Challenged Guidelines for Blue Shield ERISA members during the pendency of the lawsuit, will not return to using the Challenged Guidelines for Blue Shield ERISA members and will issue a bulletin to personnel conducting medical necessity reviews for members of Blue Shield health benefit plans, confirming that denials of Class members' coverage requests using the Challenged Guidelines should not be relied upon in future coverage request denials based on medical necessity; and
    - (2) Defendants will make a Settlement Payment of $7 million for the benefit of the Class. The amount of this Settlement Payment that remains after payment of the costs of providing notice and administering the Settlement, and any attorneys' fees, litigation costs, and Plaintiff incentive amounts authorized by the Court, will be used to make monetary payments to Class members according to a Plan of Allocation, which is summarized on pages 6-7, below, and attached to this Notice as Exhibit A.
- THIS SETTLEMENT APPLIES **ONLY** TO PEOPLE WHO SOUGHT INSURANCE COVERAGE FOR TREATMENT OF PSYCHIATRIC OR SUBSTANCE USE DISORDERS AT THE RESIDENTIAL OR INTENSIVE OUTPATIENT LEVELS OF CARE, AND WHOSE CLAIMS WERE DENIED ON THE GROUND THAT THE CLAIMS WERE NOT MEDICALLY NECESSARY UNDER THE CHALLENGED GUIDELINES.
- THE SETTLEMENT **DOES NOT** APPLY TO PEOPLE WHO SOUGHT COVERAGE FOR TREATMENT FOR EATING DISORDERS OR TREATMENT FOR SEXUAL DISORDERS.
- NOTE REGARDING THE PRIVACY OF YOUR INFORMATION: If you sought insurance coverage for treatment of substance use disorders (at either the residential or intensive outpatient levels of care), you may enjoy enhanced privacy protections under federal law (42 C.F.R. Part 2). At this time, information sufficient to identify the nature of the treatment you (or your insured) received, whether substance use disorder treatment or psychiatric treatment, has **not** been provided to Class Counsel or the Settlement Administrator. **Any member of the Class, no matter which treatment you sought or received, can object to disclosure of information or data relating to your request for coverage for treatment to Class Counsel and the Settlement Administrator. If you wish to object to disclosure of this information, you must notify the Settlement Administrator no later than May 11, 2018.** Contact information for the Settlement Administrator and instructions appear below in Question 7, entitled "How Do I Object to Disclosure of My Personal Treatment Data and Information?" However, in order to compute the individualized monetary recovery to which you may be entitled under the Plan of Allocation, based on a "Treatment Amount" (see page 6, footnote 3, below and Exhibit A), information about the specific treatment you received is necessary. This information is referred to as "Class Claims Data" in the Settlement. This information will be disclosed ONLY to Class Counsel and the Settlement Administrator. You have the right to keep this information private. If you have no objection to the disclosure of such information to Class Counsel and the Settlement Administrator, you need not take any action.

[1] The definition of Challenged Guidelines is contained in the Stipulation of Settlement, dated January 15, 2018.

- PLEASE NOTE: EVEN IF YOU OBJECT TO DISCLOSURE OF YOUR PERSONAL TREATMENT INFORMATION AND DATA, YOU STILL ARE A MEMBER OF THE CLASS AND WILL RECEIVE A SHARE OF THE SETTLEMENT FUND. However, your share will only be from the portion of the Settlement Fund that does not require use of the personal treatment data and information that you have decided not to disclose. *See* Question 5, "What Does the Settlement Do?" below. The only way to exclude yourself from the Class and the Settlement is to opt-out, as described below on page 8 (Question 9, "How Do I Opt Out of the Class?").
- Under the Settlement, Class members will release any individual legal claims they may have against Defendants arising out of Defendants' development, adoption, and application of the Challenged Guidelines and Defendants' decisions concerning coverage of the treatment of psychiatric or substance use disorders at the Residential or Intensive Outpatient levels of care that were made on medical necessity grounds under the Challenged Guidelines.
- Class Counsel has prosecuted this lawsuit on a wholly contingent basis since its inception in May 2016. Class Counsel will apply to the Court for an award of attorneys' fees and reimbursement of litigation costs. Class Counsel will also apply for reimbursement of litigation costs paid or incurred in connection with the prosecution and resolution of the lawsuit not to exceed $850,000, as well as payment of notice and administration costs not to exceed $150,000, and incentive awards to each of the three named Plaintiffs in a total amount of $60,000 ($20,000 for each named Plaintiff). In total, Class Counsel will apply for costs and expenses (including litigation costs, notice and administration costs, and incentive awards) of $1,060,000. In addition, Class Counsel will seek an award of attorneys' fees in an amount not to exceed one-third (33.3%) of the amount that remains of the $7 million Settlement Payment after deduction of the total costs and expenses; that is, Class Counsel will apply for attorneys' fees of $1,980,000. Any attorneys' fees, costs and expenses authorized by the Court will be paid from the $7 million Settlement Payment.
- Plaintiffs and the Class are being represented by Daniel L. Berger, Esq. of Grant & Eisenhofer P.A., Jason S. Cowart, Esq. of Zuckerman Spaeder LLP, and Meiram Bendat, Esq. of Psych-Appeal, Inc., who are Court-appointed Class Counsel.
- Your rights and options—and the deadlines to exercise them—are explained in this Notice. **If you are a member of the Class and the Settlement is approved, your legal rights will be affected whether you act or do not act. Read this Notice carefully and in its entirety to see what your options are in connection with the Settlement.**
- If you have questions about the Settlement, go to www.ChallengedGuidelinesSettlement.com, call 1-866-573-6825, or email ChallengedGuidelinesSettlement@AdministratorClassAction.com. You can also write to Challenged Guidelines Settlement, PO Box 30352, Philadelphia PA 19103, or contact Mr. Berger at Grant & Eisenhofer P.A., 485 Lexington Ave., New York, New York 10017, (646) 722-8500, or Mr. Cowart at Zuckerman Spaeder LLP, 485 Madison Ave., New York, New York 10022, (212) 704-9600.

SUMMARY OF YOUR LEGAL RIGHTS AND OPTIONS FOR THE SETTLEMENT	
REMAIN A MEMBER OF THE CLASS	To remain a Class member for the Settlement, you do not need to do anything. You automatically will be included in the Class and your portion of the Settlement Fund will be calculated based on Defendants' records. If you believe that those records understate the Allowed Amount for Services Received or Treatment Day(s)[2] for treatment for psychiatric or substance use disorders at the Residential or Intensive Outpatient levels for which you were denied coverage, you may submit additional documentation, which may affect the amount of money you are eligible to receive. Information about how to submit additional documentation is provided in response to Question 5 below. If you remain in the Class, you will give up your right to sue Defendants for claims arising out of the subject matter of the lawsuit.
OBJECT TO DISCLOSURE OF YOUR DATA RELATING TO YOUR REQUEST FOR COVERAGE	You may object to the disclosure to Class Counsel and the Settlement Administrator of data relating to your request for coverage, whether it was for substance use treatment, psychiatric treatment, or both. You may do so by **notifying the Settlement Administrator**. The procedures for how to object are discussed below in response to Question 7. **Your objection must be submitted electronically or postmarked no later than May 11, 2018.** NOTE. If you object to the disclosure of data relating to your request for coverage, you still will remain a member of the Class. You will be entitled to a share of the Settlement Fund, but not from that portion of the Settlement Fund that requires disclosure of personal treatment data and information.
EXCLUDE YOURSELF FROM THE CLASS	You may request exclusion from the Class (also known as "opting out") by notifying the Settlement Administrator of your request to be excluded from the Class. The procedures for how to opt out are discussed below in response to Question 9. **The request(s) for exclusion must be submitted electronically or received no later than June 5, 2018.** If you exclude yourself from the Settlement, you will not release your claims against Defendants, and you will not be bound by any judgments or orders of the Court as to the Settlement, but neither will you be eligible for any payment from the Settlement, nor will you be able to object to the Settlement.
OBJECT TO THE SETTLEMENT	To object to or comment on the Settlement, or to Class Counsel's request for an award of attorneys' fees or costs and expenses, you must send a copy of the appropriate papers via mail to the Court, Class Counsel, and counsel for Defendants. The procedures for how to object to the Settlement are discussed below in response to Question 11. **Your written objection must be received no later than June 5, 2018.** If you object to the Settlement, you will remain a member of the Class.
GO TO A HEARING	The Court will hold a Fairness Hearing on **June 28, 2018**, at 1:30 p.m., at the Robert F. Peckham Federal Building & United States Courthouse, Courtroom 8 – 4th Floor, 280 South 1st Street, San Jose, California 95113, to consider whether the Settlement is fair, reasonable, and adequate. The Court may also consider the motion for Class Counsel's attorneys' fees, costs, and expenses, and for an incentive amount for the class representatives. If you want to speak at the Fairness Hearing on **June 28, 2018**, you must let the Court and the Parties know by **June 5, 2018** and provide the Court and the Parties with a letter stating that you intend to appear at the hearing. You cannot speak at the hearing if you opt out of the Settlement.

[2] The definitions of Allowed Amount for Services Received and Treatment Day(s) are contained in the Plan of Allocation.

BASIC INFORMATION

1. WHAT IS THIS LAWSUIT ABOUT?

This lawsuit is about whether Blue Shield and HAI, in violation of ERISA and the plans that Blue Shield administers, developed, implemented, and applied overly restrictive medical necessity criteria guidelines, leading to denials of claims or requests for coverage of treatment that otherwise may have been approved. Plaintiffs allege that Defendants developed, adopted, and applied Guidelines for coverage of treatment for psychiatric and substance use disorders at the Residential and Intensive Outpatient levels of care that are more restrictive than generally accepted professional standards. Plaintiffs claim that Class members' ERISA plans provide, as one condition of coverage, that the services in question be consistent with generally accepted professional standards.

Defendants deny all of Plaintiffs' allegations of wrongdoing and contend that they have fully complied with the law.

2. WHAT IS A CLASS ACTION AND WHO IS INVOLVED?

In a class action lawsuit, a "class representative" sues on behalf of herself and other people who have similar claims. Together, the class representatives and the others with similar claims are called a "Class" or "Class members." The Court-appointed class representatives in this case are the three Plaintiffs Charles Des Roches, Sylvia Meyer, and Gayle Tamler Greco, whose children were denied coverage and benefits by Defendants for treatment of psychiatric or substance use disorders at the Residential or Intensive Outpatient levels of care on the ground that they did not meet medical necessity under the Challenged Guidelines, and whose appeals of HAI's initial denial decisions were rejected by Blue Shield.

WHO IS IN THE SETTLEMENT

3. WHO IS A CLASS MEMBER?

The following Class was certified by the Court on June 15, 2017 (ECF No. 123 at 39):

> All participants or beneficiaries of a health benefit plan administered by either Blue Shield defendant and governed by ERISA whose request for coverage (whether pre-authorization, concurrent, post-service, or retrospective) was denied, in whole or in part, between January 1, 2012 and the present, based upon the Magellan Medical Necessity Criteria Guidelines for any of the following levels of care: (i) Residential Treatment, Psychiatric; (ii) Residential Treatment, Substance Use Disorders, Rehabilitation; (iii) Intensive Outpatient Treatment, Psychiatric; or (iv) Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation. Excluded from the Class are Defendants, their parents, subsidiaries, and affiliates, their directors and officers and members of their immediate families; also excluded are any federal, state, or local governmental entities, any judicial officers presiding over this action and the members of their immediate families, and judicial staff.

The period of time covered by this definition is the "Class Period." Because Defendants stopped using the Challenged Guidelines for Blue Shield members on March 5, 2017, any coverage denials issued after that date are not covered by the definition of the Class.

Excluded from the Class are the federal judge who has presided over the case and individuals who timely and validly request exclusion ("opt out") from the Class.

If you are not sure whether you are a member of the Class, you can write to the lawyers in this case at the addresses listed in Question 11.

4. DID THE COURT DECIDE WHO IS RIGHT?

No, the parties entered into the Settlement before the lawsuit reached a trial or court decision, so if the Court approves the Settlement there will not be a trial or decision about which side was right.

5. WHAT DOES THE SETTLEMENT DO?

The Settlement has three major parts: (1) an agreement by Defendants not to use the Challenged Guidelines going forward for Blue Shield ERISA members and to issue a bulletin to all personnel conducting medical necessity reviews for members of Blue Shield health benefit plans confirming that denials of Class members' coverage requests using the Challenged Guidelines should not be relied upon in future coverage request denials based on medical necessity; (2) payments to Class members; and (3) a release by Class members of any legal claims arising out of Defendants' development, adoption, and application of the Challenged Guidelines and Defendants' decisions concerning coverage of treatment of psychiatric or substance use disorders at the Residential or Intensive Outpatient levels of care that were made on medical necessity grounds under the Challenged Guidelines.

(1) Defendants' Agreements to Refrain from Using the Challenged Guidelines and to Issue a Bulletin

Under the Settlement, Defendants agree that they shall not apply the Challenged Guidelines to coverage decisions going forward for Blue Shield ERISA members. Defendants also agree that they shall issue a bulletin to all personnel conducting medical necessity reviews for members of Blue Shield health benefit plans confirming that denials of Class members' coverage requests using the Challenged Guidelines should not be relied upon in future coverage request denials based on medical necessity.

(2) Payments to Class Members

Under the Settlement, Defendants will also make a lump sum payment of $7 million (as referenced above, the "Settlement Payment"). This Settlement Payment, after subtracting settlement administration costs, attorneys' fees and litigation expenses, and any Plaintiff incentive amount, will make up the "Settlement Fund." A Settlement Administrator will oversee the distribution of payments from the Settlement Fund to Class members. The plan for allocation of the Settlement Fund to Class members (the "Plan of Allocation") in its entirety is attached as Exhibit A.

The Plan of Allocation divides the Settlement Fund into two parts. The first part is composed of 75% of the Settlement Fund and will be used for payments to Class members who received the treatment for which Defendants denied coverage. The second part is composed of 25% of the Settlement Fund, plus any residual funds remaining from the first part after all payments to Class members who received treatment are made (i.e., Class members with Treatment Amount(s)). All Class members, including those who received a payment from the first part of the Settlement Fund, will receive a payment from the second part of the Settlement Fund.

More specifically, the Plan of Allocation provides for the following payments to Class members:

- Each Class member with a Treatment Amount[3] will receive his or her Total Treatment Amount from the Settlement Fund so long as the Class's Total Treatment Amount does not exceed 75% of the Settlement Fund. In the event that the Class's Total Treatment Amount exceeds 75% of the Settlement Fund, each Class member with a Treatment Amount will receive his Pro Rata Share of 75% of the Settlement Fund. The Plan of Allocation discusses in greater detail how a Class member's Pro Rata Share would be calculated.
- After each Class member with a Treatment Amount receives a payment, as discussed in the preceding bullet, the remaining portion of the Settlement Fund will be distributed to the Class with every Class member receiving an equal share of the remaining 25% (or more) of the Settlement Fund.

Each Class member will receive, at a minimum, an equal share of 25% of the Settlement Fund. Class members with a Treatment Amount, as discussed above, will receive more (*i.e.*, payment of the Class member's Total Treatment Amount plus the minimum amount). These calculations, however, are subject to a number of unknown variables. For example, the opportunity of Class members to submit documentation could increase both the number of Class members with a Treatment Amount, and the amount of the Class's Total Treatment Amount. In fact, individuals with a Treatment

[3] Treatment Amount is defined in the Plan of Allocation, and that definition will control. However, it generally means the greater of (a) the amount that Defendants' records reflect would have been used to calculate the benefit payments if a post-service claim had been approved, or (b) an amount calculated by multiplying the Class member's Treatment Day(s) or Revised Treatment Day(s) number by the rate agreed to by Plaintiffs and Defendants based on Defendants' claims and reimbursement data for the level of care for the year in which the denial occurred.

Amount might receive less than their Treatment Amount (*i.e.*, the Class Member's Pro Rata Share), if the Treatment Amount increased substantially from the amount reflected in Defendants' data.

How to Submit Additional Documentation: Each Class member may call the Settlement Administrator at 1-866-573-6825 to request information reflected in the Class Claims Data about the Class member. A Class member may then submit additional documentation, if he or she desires to do so, related to each denial. ANY SUCH ADDITIONAL DOCUMENTATION MUST BE SUBMITTED NO LATER THAN **JUNE 30, 2018** TO BE CONSIDERED. The form of documentation that a Class member must submit, if he or she desires to do so, is not limited to any particular category, but must reflect: (a) the date(s) of the treatment; (b) the number of Treatment Days;[4] and (c) the level of care at which the treatment was received. Exemplary forms of documentation include invoices or bills from the provider who provided the treatment; explanation of benefit documentation from Defendants; and medical records, such as treatment notes from the provider. However, documentation such as a letter created by a Class member or other similar documentation created for purposes of submission in connection with this Settlement will not be accepted as valid documentation. The new documentation will be used, as explained in the Plan of Allocation, in certain circumstances,[5] to calculate the Class member's Treatment Amount and, in turn, the Class member's distribution. By submitting any such additional documentation, you agree to be contacted by the Settlement Administrator and Class Counsel to discuss the documentation submitted.

If you choose to submit documentation, you have until **June 30, 2018** to submit that evidence to the Settlement Administrator. Documentation should be sent to the Settlement Administrator at: Challenged Guidelines Settlement, PO Box 30352, Philadelphia PA 19103. You can also transmit an electronic copy of the documentation to the Settlement Administrator. Please contact the Settlement Administrator at the following address to arrange for secure transmittal: ChallengedGuidelinesSettlement@AdministratorClassAction.com.

NOTE: To allow efficient, cost-effective administration of the Settlement and thereby maximize the distribution to Class members, all evidence that a Class member wants considered must be submitted together, at the same time, in a single communication or parcel.

(3) Release of Claims Against Defendants

If you do not opt out of the Class, you, your current and former employees, attorneys, heirs, executors, administrators, agents, legal representatives, conservators, professional corporations, partnerships, assigns, successors, and with respect to minors, parents and guardians, will fully, finally, and forever release, relinquish, and discharge all of the Defendants and their Affiliated Entities from, and shall forever be enjoined from prosecution of Defendants and their Affiliated Entities for, any and all Released Claims.

"Released Claims" means any claims, rights, and liabilities of any nature, including but not limited to, actions, claims, demands, causes of action, obligations, damages, debts, charges, attorneys' fees, costs, arbitrations, forfeitures, judgments, indebtedness, liens and losses of any kind, source or character, whether arising out of federal or state law, whether known or unknown, whether asserted or unasserted, arising on or before the Effective Date, whether in contract, express or implied, tort, at law or in equity or arising under or by virtue of any statute or regulation, by reason of, or arising out of Defendants' development, adoption, and application of the Challenged Guidelines during the Class Period (including "Unknown Claims" as defined in the Settlement). For avoidance of doubt, "Released Claims" include all claims by the Class members relating to the coverage decisions and denials reflected in Class Claims Data and all claims arising out of the facts alleged in the operative complaint.

[4] The definition of Treatment Day(s) is contained in the Plan of Allocation, and that definition will control. However, it generally means the days of treatment a Class member received, following a denial, at the level of care for which coverage was denied. The treatment must be connected to the denial, so there is a temporal component that requires the treatment to have been received within fourteen (14) days of the denial.

[5] For example, the new documentation would not be used if it results in a lower Treatment Amount than the Treatment Amount based on information already contained in the Class Claims Data.

IF YOU DO NOTHING

6. WHAT HAPPENS IF I DO NOTHING?

If you do nothing, you will be included in the Class. Information about your claims for coverage for Residential or Intensive Outpatient treatment of psychiatric or substance use disorders will be supplied by Defendants to Class Counsel and the Settlement Administrator to facilitate implementation of the Plan of Allocation, and you will get a payment according to the Plan of Allocation. And you will be bound by the Settlement if it is finally approved by the Court. If you do nothing, you will not be able to sue Defendants (or other released entities) on your own for the Released Claims as described in the part of Question 5 titled "Release of Claims Against Defendants."

If you do not wish Defendants to disclose data relating to your request for coverage to Class Counsel and the Settlement Administrator, you must notify the Settlement Administrator no later than **May 11, 2018**. Contact information for the Settlement Administrator and a description of how to notify the Settlement Administrator appears in the table in Question 7 titled "How Do I Object to Disclosure of My Personal Treatment Data and Information?"

If you want to pursue any claim related to the issues in this case on your own and at your own expense, you should opt out of the Settlement.

OBJECTING TO DISCLOSURE OF PERSONAL TREATMENT DATA AND INFORMATION

7. HOW DO I OBJECT TO DISCLOSURE OF MY PERSONAL TREATMENT DATA AND INFORMATION?

If you wish to object to the disclosure by Defendants of your personal treatment data and information relating to your request for coverage to Class Counsel and the Settlement Administrator, you must notify the Settlement Administrator of this objection no later than **May 11, 2018**.

You may submit this statement to the Settlement Administrator electronically or by U.S. mail at the following addresses:

Email: ChallengedGuidelinesSettlement@AdministratorClassAction.com
U.S. mail: Challenged Guidelines Settlement, Attn: Data Release Objection,
PO Box 30352, Philadelphia, PA 19103.

OBJECTIONS THAT ARE NOT POSTMARKED ON OR BEFORE MAY 11, 2018 OR ARE NOT SUBMITTED ELECTRONICALLY ON OR BEFORE 11:59 P.M. PACIFIC TIME ON MAY 11, 2018 WILL NOT BE HONORED.

EXCLUDING YOURSELF FROM THE SETTLEMENT

8. WHY WOULD I ASK TO BE EXCLUDED (OPT OUT)?

You should ask to be excluded if you want to keep your right to pursue your own individual lawsuit against Defendants (or other released entities) arising out of the subject matter of the lawsuit. If you choose to opt out, you will not receive any payment from the Settlement Fund, but you also will not be bound by the Settlement, including the release.

9. HOW DO I OPT OUT OF THE CLASS?

To exclude yourself from the Class, you must send to the Settlement Administrator a statement identifying yourself by name and residential address, and declaring, "I request that I be excluded from the Class in *Des Roches v. California Physicians' Service*, No. 16-cv-2848-LHK (N.D. Cal.)." You may submit this statement to the Settlement Administrator electronically or by U.S. mail at the following addresses:

Email: ChallengedGuidelinesSettlement@AdministratorClassAction.com
U.S. mail: Challenged Guidelines Settlement, Attn: Opt Out Request,
PO Box 30352, Philadelphia, PA 19103.

REQUESTS FOR EXCLUSION THAT ARE NOT RECEIVED ON OR BEFORE JUNE 5, 2018, OR ARE NOT SUBMITTED ELECTRONICALLY ON OR BEFORE 11:59 PM PACIFIC TIME ON JUNE 5, 2018, WILL NOT BE HONORED.

10. IF I DO NOT EXCLUDE MYSELF, CAN I SUE FOR THE SAME THING LATER?

No. If the Court approves the Settlement and you do not opt-out by the deadline, you will be subject to the release of claims described in Question 5 above, and will lose your right to separately sue Defendants for relief arising from the Released Claims. You will receive a monetary payment from the Settlement only if you do not exclude yourself.

After the opt-out deadline, Class members will be permanently enjoined from asserting Released Claims.

OBJECTING TO THE SETTLEMENT

11. HOW DO I OBJECT TO THE SETTLEMENT?

You can object to the Settlement, the proposed Plan of Allocation, the attorneys' fees and expenses requested, or the class representative incentive amount. Submitting an objection gives you the chance to tell the Court why you think the Court should not approve any of these things, but will not exclude you from the Settlement. To object, you must send a statement identifying yourself by name and residential address, and setting forth all bases for objection and providing all documentation in support of the objection, to these four different groups identified below (i.e., the Court, Blue Shield Counsel, Class Counsel, and HAI Counsel), which must be received no later than **June 5, 2018:**

Court	**Class Counsel**	**Blue Shield Counsel**	**HAI Counsel**
Clerk of the Court United States District Court for the Northern District of California Robert F. Peckham Federal Building & United States Courthouse 280 South 1st Street Room 2112 San Jose, CA 95113	Daniel L. Berger Grant & Eisenhofer P.A. 485 Lexington Avenue New York, New York 10017 Jason S. Cowart Zuckerman Spaeder LLP 485 Madison Avenue New York, New York 10022 Meiram Bendat Psych-Appeal, Inc. 8560 Sunset Boulevard Suite 500 West Hollywood, CA 90069	Joseph E. Laska Manatt, Phelps & Phillips, LLP One Embarcadero Center 30th Floor San Francisco, CA 94111	Jennifer S. Romano Crowell & Moring LLP 515 South Flower St., 40th Floor Los Angeles, CA 90071-2201

OBJECTIONS THAT ARE NOT RECEIVED ON OR BEFORE JUNE 5, 2018 WILL NOT BE HONORED.

THE LAWYERS REPRESENTING YOU

12. DO I HAVE A LAWYER IN THE CASE?

Yes, unless you exclude yourself from the Class. The Court decided that Grant & Eisenhofer, P.A., Zuckerman Spaeder LLP, and Psych Appeal, Inc. are qualified to represent the members of the Class. Together, the lawyers are called "Class Counsel."

13. WILL THE LAWYERS AND CLASS REPRESENTATIVES BE PAID, AND IF SO HOW?

Class Counsel will ask the Court to approve payment of attorneys' fees and litigation costs from the Settlement Payment. This payment will compensate Class Counsel for their work investigating the facts, litigating the case, and negotiating the Settlement. The Court must approve the amount of fees and costs awarded to Class Counsel. Class Counsel will file a motion requesting attorneys' fees and litigation costs no later than May 15, 2018 so you will have time to review that motion prior to deciding whether you want to object or opt-out.

The amount that the class representatives (who brought the lawsuit and who served as the named Plaintiffs) receive for their coverage requests that were denied will be determined by the same Plan of Allocation used for all Class members. In addition, Class Counsel will ask the Court for an "incentive amount" of up to $20,000 for each of the three class representatives (a total of $60,000) to acknowledge their service in coming forward to prosecute their claims. That motion will be filed no later than May 15, 2018. Any such incentive amount must be approved by the Court.

Class Counsel intends to seek reimbursement of their out of pocket litigation costs of $850,000, and up to $150,000 for costs to conduct notice and administer the Settlement by the Settlement Administrator.

Class Counsel will seek an award of attorneys' fees of $1,980,000, which represents one-third of the Settlement Payment remaining after deduction of litigation costs, notice and administration costs, and any class representative incentive amount.

Class Counsel's motion for attorneys' fees and costs, and an incentive amount to the class representatives, will be available on the website (www.ChallengedGuidelinesSettlement.com), or you can call the Settlement Administrator to obtain these materials.

14. HOW IS THE COST OF PROVIDING NOTICE TO CLASS MEMBERS PAID FOR?

The costs of providing notice about the Settlement to Class members will be paid out of the Settlement Payment.

THE FAIRNESS HEARING

15. WHEN AND WHERE WILL THE COURT DECIDE WHETHER TO APPROVE THE SETTLEMENT?

The Court will hold a Fairness Hearing on June 28, 2018, at 1:30 p.m., at the Robert F. Peckham Federal Building & United States Courthouse, 280 South 1st Street, Courtroom 8 – 4th Floor, San Jose, CA 95113. At this hearing the Court will consider whether the Settlement is fair, reasonable, and adequate. If there are objections, the Court will consider them. The judge in the case, Judge Lucy H. Koh, will listen to people who have asked in advance to speak at the hearing. The Court may also decide how much Class Counsel may receive in attorneys' fees and expenses. The Court will also decide how much the class representatives should receive as an incentive amount. After the hearing, the Court will decide whether to approve the Settlement. It is not known how long these decisions will take.

The Court can change the date of the hearing without further notice, so please check the docket for the case if you want to appear to make sure that the date and time have not changed. You may also confirm the date, time, and location of the Fairness Hearing with Class Counsel.

16. DO I HAVE TO COME TO THE HEARING?

No. Class Counsel will answer questions the Court may have. But you are welcome to come at your own expense. If you send an objection, you do not have to come to Court to talk about it. As long as you mailed your written objection on time, the Court will consider it. If you retain your own lawyer, your lawyer can attend on your behalf.

17. MAY I SPEAK AT THE HEARING?

You may ask the Court for permission to speak at the Fairness Hearing. To do so, you must send a letter saying that it is your "Notice of Intention to Appear in *Des Roches v. California Physicians' Service*, No. 16-cv-2848-LHK (N.D. Cal.)." Be sure to include your name, address, telephone number, and signature. Your Notice of Intention to Appear must be received no later than June 5, 2018 and must be sent to the Clerk of the Court, Class Counsel, and Defense Counsel, at the addresses in Question 11. You cannot speak at the hearing if you opted out of the Settlement.

GETTING MORE INFORMATION

18. ARE THERE MORE DETAILS ABOUT THIS LAWSUIT?

Yes. Additional information regarding the lawsuit and the Settlement is also available at www.ChallengedGuidelinesSettlement.com. The information includes the complaint filed in the case; the Settlement Agreement and its attachments; the Plan of Allocation; and the motion for preliminary approval of the Settlement, along with the exhibits to the motion. In addition, the motion for attorneys' fees and expenses will be posted to the website after it is filed on or before May 15, 2018.

19. HOW CAN I LEARN MORE?

If you have additional questions about the Settlement or the case, you can go to www.ChallengedGuidelinesSettlement.com, call 1-866-573-6825, or email ChallengedGuidelinesSettlement@AdministratorClassAction.com. You can also write to: Challenged Guidelines Settlement, PO Box 30352, Philadelphia, PA 19103.

PLAN OF ALLOCATION

Des Roches, et al. v. California Physicians' Service d/b/a Blue Shield of California, et al., No. 5:16-cv-2848-LHK

Objective: The goal of this Plan of Allocation is to distribute the Settlement Fund in a way that prioritizes reimbursement for those Class members who actually received treatment at a Relevant Level of Care for which coverage was sought and denied, while also ensuring that all Class members receive equal compensation for their pre-authorization and concurrent review claims that were denied.

A. Definitions

1. Class Definition: "All participants or beneficiaries of a health benefit plan administered by either Blue Shield defendant and governed by ERISA whose request for coverage (whether pre-authorization, concurrent, post-service, or retrospective) was denied, in whole or in part, between January 1, 2012 and the present, based upon the Magellan Medical Necessity Criteria Guidelines for any of the following levels of care: (i) Residential Treatment, Psychiatric; (ii) Residential Treatment, Substance Use Disorder Rehabilitation; (iii) Intensive Outpatient Treatment, Psychiatric; or (iv) Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation. Excluded from the Class are Defendants, their parents, subsidiaries, and affiliates, their directors and officers and members of their immediate families; also excluded are any federal, state, or local governmental entities, any judicial officers presiding over this action and the members of their immediate families, and judicial staff."

2. "Class List" means the list of names and last-known mailing addresses of all Class members whom Defendants are reasonably able to identify as of twenty (20) days after the date on which the Preliminary Approval Order is entered by the Court.

3. "Class Period" means January 1, 2012 to March 5, 2017.

4. "Class Claims Data" means a spreadsheet provided to the Settlement Administrator and Class Counsel by Defendants that, to the extent Defendants possess the information,[1] lists, for each Class member denial, the following fields:

♦ **a.** name of Class member; ♦ **b.** last-known address of Class member; ♦ **c.** the level of care requested; ♦ **d.** the date of the denial; ♦ **e.** the Billed Amount(s) of Denied Claims for Services Received (i.e., post-service claims), if any[2]; ♦ **f.** the Allowed Amount(s) for Services Received (i.e., post-service claims), if any[3] and ♦ **g.** the Treatment Day(s), if any, in connection with the request that was denied[4]

5. A Class member's "Allowed Amount(s) for Services Received" means, for each Class member with respect to each denial of coverage for services received (i.e., post-service claims) at a Relevant Level of Care during the Class Period, the amount that the Class Claims Data indicates that Defendants would have used to calculate benefit payments if the claim(s) had been approved; however, in most cases, the Allowed Amount is greater than the amount that would have been paid by Defendants under the health benefit plan for the services. The sum of these amounts for a particular Class member is referred to herein as that Class member's "Total Allowed Amount for Services Received." The sum of all Class members' Total Allowed Amount for Services Received is referred to herein as the "Class's Total Allowed Amount for Services Received."

6. A Class member's "Billed Amount(s) of Denied Claims for Services Received" means, for each Class member with respect to each denial of coverage for services received (i.e., post-service claims) at a Relevant Level of Care during the Class Period, the amount that the Class Claims Data indicates as the billed charge submitted by the Class member and/or provider for such service. The sum of these amounts for a particular Class member is referred to herein as that Class member's "Total Billed Amount of Denied Claims for Services Received." The sum of all Class members' Total Billed

[1] Defendants may not have information for all Class members regarding A(4)(b)-(g); for those Class members the fields for the missing information will be left blank. In the event Defendants cannot provide a last-known address of a Class member, Defendants will work cooperatively with the Settlement Administrator and/or Class Counsel to attempt to provide information by which notice may be provided to the Class member.

[2] This information will only be available for individuals who submitted post-service claims or for whom data exists and is reasonably accessible, as discussed in footnote 5. For all other Class members, this field will have a zero.

[3] This information will only be available for individuals who submitted post-service claims or for whom data exists and is reasonably accessible, as discussed in footnote 5. For all other Class members, this field will have a zero.

[4] This information will only be available for individuals who submitted post-service claims or for whom data exists and is reasonably accessible, as discussed in footnote 5. For all other Class members, this field will have a zero. Class members who believe they should have a greater number of Treatment Day(s) than reflected in the Class Claims Data will have an opportunity to submit information, pursuant to procedures described in the Notice of Settlement and Paragraph C(3).

Amount for Denied Claims for Services Received is referred to herein as the "Class's Total Billed Amount of Denied Claims for Services Received."

7. "Pre-Distribution Procedure" means the procedures to be followed by the Settlement Administrator in advance of calculating distribution amounts from the Settlement Fund. Because 42 C.F.R. Part 2 may apply to some Class members, there are specific procedures that will be followed before Defendants share certain information with the Settlement Administrator and/or Class Counsel.

8. "Relevant Level of Care" means (i) Residential Treatment, Psychiatric; (ii) Residential Treatment, Substance Use Disorder Rehabilitation; (iii) Intensive Outpatient Treatment, Psychiatric; or (iv) Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation.

9. "Settlement Administrator" means the court-approved Settlement Administrator. Plaintiffs have sought approval from the Court for Angeion Group to serve as the Settlement Administrator.

10. "Settlement Amount" means $7,000,000.

11. "Settlement Fund" means the Settlement Amount after the deduction of Class Counsel's litigation costs and expenses, attorneys' fees, notice and administration expenses, and any incentive award to the named Plaintiffs.

12. "Treatment Day(s)" shall mean the number of days for which a Class member received treatment at a Relevant Level of Care and either (a) a claim for such treatment was subject to a post-service clinical denial by Defendants or (b) such treatment was commenced within fourteen (14) days of a pre-authorization or concurrent review denial by Defendants at that same level of care. For a day to be counted as a Treatment Day, it either must be: (a) reflected on the Class Claims Data for the individual (i.e., it was submitted and denied as a post-service claim); or (b) reflected in information a Class member submits. If an individual voluntarily stopped treatment at the level of care, there is a break in treatment, or the individual was treated at a lower level of care than the one for which he or she requested coverage, the subsequent days of treatment will not count as Treatment Days. The purpose of allowing a Class member to submit information is to capture Treatment Days that may not be reflected in Defendants' data.[5]

B. Notice

1. Defendants will provide the Class List.

2. The Settlement Administrator will provide notice to each Class member in accordance with the Court's Preliminary Approval Order, and in the form approved by the Court.

3. The notice will inform Class members that: (a) they have the ability to prevent Defendants from sharing with the Settlement Administrator and Class Counsel certain personal information about them in the Class Claims Data; and (b) consistent with federal law (42 C.F.R. Part 2), they have thirty-five (35) days to inform the Settlement Administrator of their desire to exercise this right.

C. Pre-Distribution Procedure

1. After the expiration of the deadline for objections to sharing of Class Claims Data, Defendants will do the following:
   - For Class members on the Class List who stated they did not want information shared, Defendants will provide no additional information. The Class List's information about these Class members will be used to make a payment calculation pursuant to Paragraph D(5).
   - For all other Class members on the Class List, Defendants will provide Class Claims Data to the Settlement Administrator and Class Counsel within five (5) days of the Court's entry of the order authorizing Defendants to provide the Class Claims Data.

2. As set forth in the notice, after Defendants provide the Class Claims Data to the Settlement Administrator and Class Counsel, Class members may contact the Settlement Administrator to request, in the manner described in the notice, the information reflected in the Class Claims Data and to ask related questions.

3. Class members may submit additional information to demonstrate that the Class Claims Data is inaccurate or incomplete no later than forty-five (45) days after the Court issues an order authorizing the disclosure of Class Claims Data to Class Counsel and the Settlement Administrator. After that date, the Settlement Administrator and/or Class Counsel will, for individuals who submitted information, proceed as follows:

[5] Defendants' data could be inaccurate or incomplete for several reasons, including, but not limited to, that the Class member never submitted request for coverage for all Treatment Days, or that Defendants' internal data is not reasonably accessible or may not be retrieved despite best efforts.

- When individuals submit new information, the focus will be on the Treatment Day(s) and when they were received. A new calculation of the Class member's Allowed Amount(s) for Services Received will not be done. Therefore, the information submitted must be documentation that reflects: (a) the date of the treatment; (b) the number of Treatment Days; and (c) the level of care at which the treatment was received. The form of documentation is not limited to any particular category. Exemplary forms of documentation include: invoices or bills from the provider who provided the treatment; explanation of benefit documentation from Defendants; and medical records, such as treatment notes from the provider. However, documentation such as a letter created by a Class member or other similar documentation created for purposes of submission in connection with this Settlement will not be accepted as valid documentation.

- Next, the information submitted will be compared to the Class Claims Data to determine whether the information received reflects treatment received at the level of care requested within 14 days of Defendants' denial of coverage. By way of example, if a Class member submitted a request for coverage for Residential Treatment for substance use on August 1, 2012 and was denied coverage, and then the Class member, despite the denial, received Residential Treatment for substance use on August 15, 2012, any day of treatment starting on August 15, 2012 and continuing at the same level of care will count as a Treatment Day. If the individual started receiving treatment on August 16, 2012 (i.e., 15 days after the denial), neither that day nor any of the following days would count as a Treatment Day. For purposes of clarity, the goal is to capture instances where the Class member was denied coverage and sought treatment anyway, but those treatment days that are related to the denial are for some reason not reflected in the Class Claims Data.

- Next, the Class member's Treatment Day(s), based on information that he or she provided, will be compared to the data related to the same denial reflected on the Class Claims Data. If the Class member's information results in a higher number of Treatment Day(s), that number will be used. That number is referred to as a Class member's "Revised Treatment Day(s)." For example, if a Class member was denied coverage for Residential Treatment for substance use and the Class Claims Data shows one Treatment Day, but the individual submits information that shows that he or she actually received seven days of treatment, the Class member will receive a Revised Treatment Day(s) number of seven. Conversely, if the Class Claims Data shows that an individual received ten days of Residential Treatment for substance use, and the Class member submits data that shows that he or she received six days of Residential Treatment for substance use, the Class member would not receive a Revised Treatment Day(s) number.

- Next, the Settlement Administrator and/or Class Counsel will create a spreadsheet that will be referred to as the "Treatment Days Received Spreadsheet." The starting point will be the Class Claims Data. For individuals who did not submit information, nothing will be changed. For individuals who received a Revised Treatment Day(s) number, that number will be inserted into a column with that heading. Then, the corresponding number, in the Treatment Days from the Class Claims Data, will be removed from the Treatment Days Received Spreadsheet.

- The spreadsheet will be sorted by the Class members' names.

- The Settlement Administrator will then follow the procedure set forth in Paragraph D.

- The Settlement Administrator will treat the Class List and Class Claims Data consistent with the protections under HIPAA and 42 C.F.R. Part 2 and the terms of the Business Associate Agreement executed as part of this engagement.

D. Each Class member will receive payments as follows:

1. For each denial, a Class member – who has an Allowed Amount(s) for Services Received, and/or Treatment Day(s) and/or Revised Treatment Day(s) figure for that denial – will receive a "Treatment Amount." The Treatment Amount will be defined in the following manners: (a) If a Class member's denial has an Allowed Amount(s) for Services Received number and a Treatment Day(s) number, the Treatment Amount will be the Allowed Amount(s) for Services Received; (b) If a Class member's denial has an Allowed Amount(s) for Services Received number and a Revised Treatment Day(s) number, then the Treatment Amount will be the greater of the Allowed Amount(s) for Services Received, or the Revised Treatment Day(s) multiplied by the per diem value of the Allowed Amount(s) for Services Received using the Treatment Day(s) number from the Class Claims Data for that denial;[6] and (c) If the Class member's denial has no Allowed Amount(s) for Services Received, then the Treatment Amount will be the either the Treatment Day(s) or the Revised Treatment Day(s) number, if either exist, multiplied by the rate agreed to by Plaintiffs and Defendants based on Defendants' claims and reimbursement data for the level of care for the year in which the denial occurred.[7]

[6] The per diem value of the Allowed Amount(s) for Services Received will be calculated by dividing the Allowed Amount(s) for Services Received for the denial by the Treatment Day(s) number for the denial.

[7] The rate agreed to by Plaintiffs and Defendants based on Defendants' clams and reimbursement data has been designated as "highly confidential" pursuant to the Protective Order. That information will not be made public. Nor will it be shared with Class members. To the extent the data is used, it will be used by the Settlement Administrator and Class Counsel, when necessary in limited circumstances, for the calculations discussed above.

- Based on Defendants' data, a large portion of the Class will not have a Treatment Amount. The Plan of Allocation addresses this by allowing Class members to ask the Settlement Administrator for the information about the Class member reflected in the Class Claims Data (Paragraph C(2)), submit additional information (Paragraph C(3)), and receive a Treatment Amount based on either the Class Claims Data or the new information submitted, whichever results in a higher calculation.

2. The Treatment Amount calculation described in Paragraph D(1) will be done for each denial for which a Class member has a Treatment Day(s) number and/or a Revised Treatment Day(s) number, and/or an Allowed Amount(s) for Services Received number.

3. The Class members' Paragraph D(1) Treatment Amount(s) will then be added together to come up with a "Total Treatment Amount." The sum of the Treatment Amounts for all Class members with Treatment Amounts will be the "Class's Total Treatment Amount."

4. Each Class member with a Total Treatment Amount will receive his or her Total Treatment Amount from the Settlement Fund, unless the Class's Total Treatment Amount exceeds 75% of the Settlement Fund. In the event that the Class's Total Treatment Amount exceeds 75% of the Settlement Fund, each Class member with a Treatment Amount will receive his Pro Rata Share of 75% of the Settlement Fund, pursuant to the procedures discussed in Paragraph E.

5. After each Class member with a Treatment Amount receives a payment calculation in accordance with Paragraph D(4), the remaining portion of the Settlement Fund will be distributed to the Class with every Class member receiving an equal share. In other words, at a minimum, each Class member will receive an equal share of 25% of the Settlement Fund.

6. The Settlement distribution to each Class member with a Treatment Amount will be calculated by adding the amount the Class member will receive pursuant to Paragraph D(4) and the amount that the Class member will receive pursuant to Paragraph D(5).

7. The Settlement distribution to each Class member without a Treatment Amount will be the payment calculated pursuant to Paragraph D(5).

8. As discussed above, the objective of either paying individuals with Treatment Amounts their full Treatment Amounts or, at least paying those individuals their Pro Rata Share of 75% of the Settlement Fund, is to attempt to ensure that individuals who received and were billed for treatment are awarded compensation commensurate with what they likely would have received had their claim been approved by Defendants (i.e., their Allowed Amount(s) for Services Received).

E. <u>Determination of Pro Rata Payments from the Services-Received Portion of the Settlement Fund</u>

1. Calculate the Class's Total Treatment Amount. If the sum is greater than 75% of the Settlement Fund, then proceed to Paragraphs E(2)-(4) to calculate the Class member's Pro Rata Share.

2. Divide that Class member's Total Treatment Amount by the Class's Total Treatment Amount (the "Pro Rata Percentage").

3. Multiply the Settlement Fund by 75% to arrive at the "Treatment Amount Distribution Fund."

4. Multiply the Pro Rata Percentage by the Treatment Amount Distribution Fund to arrive at the Class member's "Pro Rata Share."

F. <u>Payment</u>

1. The Settlement Administrator shall issue a check (a "Settlement Check") to each Class member based on the methodology above.

2. Each Settlement Check issued pursuant to this Settlement shall be void if not negotiated within one hundred and twenty (120) calendar days after its date of issue ("Void Date"), and shall contain a legend to such effect. Settlement Checks that are not negotiated by the Void Date shall not be reissued unless otherwise directed by Class Counsel or ordered by the Court.

3. All payments that are unclaimed by Class members, including all returned Settlement Checks, all undeliverable Settlement Checks, and all Settlement Checks not cashed by the Void Date shall revert to the Settlement Fund.

G. The Settlement Administrator may exercise reasonable judgment to resolve questions concerning the allocation of the Settlement Fund. The Settlement Administrator must consult with Class Counsel concerning this Plan of Allocation to address such questions as they arise.