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.