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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF UTAH, CENTRAL DIVISION

IHC HEALTH SERVICES, INC., dba PRIMARY CHILDREN'S HOSPITAL, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., Defendant.	**COMPLAINT** Case No. 2:15-cv-00039-CW Judge Clark Waddoups

Plaintiff, through its undersigned counsel, complains and alleges as follows:

PARTIES, JURISDICTION AND VENUE

1. Plaintiff, IHC HEALTH SERVICES, INC. ("IHC"), operates several hospitals in the Intermountain Area, including PRIMARY CHILDREN'S HOSPITAL (the "Hospital"), in Salt Lake City, Utah.

2. IHC and the Hospital may be referred to collectively herein as "Plaintiff."

3. KAISER FOUNDATION HEALTH PLAN, INC. (the "Plan" or "Defendant") is a foreign corporation.

4. Defendant was, at all relevant times herein, the health insurer, plan sponsor, plan administrator, and/or claim administrator for K.R., who was a minor at the time of treatment.

5. The Plaintiff provided medical services to K.R. at the Hospital on the following dates of service: January 15, 2012, to January 22, 2012.

6. The claim for these dates of service may collectively be referred to herein as the "Disputed Claim."

7. K.R.'s mother signed an Assignment of Benefits ("AOB") in favor of the Plaintiff for the Disputed Claim.

8. The Plan is an employee welfare benefits plan established and operated under the Employee Retirement Income Security Act of 1974 ("ERISA").

9. This is an action brought under ERISA. This Court has jurisdiction of this case under 29 U.S.C. §1132(e)(1). Venue is appropriate under 29 U.S.C. §1132(e)(2) and 28 U.S.C. §1391(c) because the communications during the administrative appeal process took place between the Plaintiff and the Defendant in the State of Utah, and the breaches of ERISA and the Plan occurred in the State of Utah. Moreover, based on ERISA's nationwide service of process provision and 28 U.S.C. §1391, jurisdiction and venue are appropriate in the District of Utah.

10. The remedies Plaintiff seeks under the terms of ERISA are for the benefits due under 29 U.S.C. §1132(a)(1)(B), for interest and attorneys' fees under 29 U.S.C. §1132(g), and for other appropriate equitable relief under 29 U.S.C. §1132(a)(3).

FACTUAL BACKGROUND

A. Medical Treatment

11. Plaintiff realleges and incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

12. K.R., a 14-year-old minor at the time of treatment, went to the Hospital on January 15, 2012, presenting with possible SMA Syndrome.

13. K.R. remained in the Hospital until January 22, 2012.

14. The Plaintiff's billed charges for the Disputed Claim totaled $25,510.58.

B. Claim and Claim Processing

15. The Hospital submitted a claim to the Defendant and to the Primary Insurer, BlueCross and BlueShield, for the Disputed Claim in a timely manner.

16. BlueCross and BlueShield paid a total of $14,120.23 toward this claim.

17. The Defendant paid $0.00.

18. The Defendant denied this claim, contending that Plaintiff failed to send medical records.

19. The Plaintiff sent an appeal letter on August 31, 2012, indicating that medical records had already been sent to them on several previous occasions, but nonetheless, they were enclosed once again with this appeal letter.

20. The Defendant then denied the claim for lack of an itemized billing statement.

21. The Plaintiff indicated to the Defendant that it was their corporate policy not to provide itemized billing statements to insurers because they are confidential and proprietary.

22. In its appeal letter, the Plaintiff requested a copy of the Plan Document and Summary Plan Description ("SPD") which the Defendant believed governed the Disputed Claim.

23. The Plaintiff received no response to this letter.

24. On September 11, 2014, Plaintiff's attorney, Marcie E. Schaap, sent a final appeal letter to the Defendant indicating the reasons the claim should be paid. Ms. Schaap enclosed with this letter a copy of the Account Inquiry Notes (computer notes) which had been kept by the Plaintiff memorializing its phone calls, etc., during the administrative appeal of the claim for K.R. She also requested a copy of the Plan Document and Summary Plan Description which applied to the Disputed Claim.

25. Ms. Schaap requested a response to her letter within 15 days.

26. To date, the Defendant has not responded to this letter.

27. The Defendant has denied the Disputed Claim based on the following rationale:

A. The Defendant required an itemization from the Plaintiff before it would process the claim.

28. The Defendant has not paid the outstanding balance due to the Hospital for the Disputed Claim.

29. A balance of $11,380.35, plus interest, remains due to the Plaintiff from the Defendant for the treatment the Hospital rendered to K.R.

FIRST CAUSE OF ACTION

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

30. Plaintiff realleges and incorporates by reference all paragraphs of this Complaint as though fully stated herein.

31. The Plaintiff is a beneficiary of the Plan and stands in the shoes of K.R. pursuant to the AOB.

32. The Plaintiff has submitted all proof necessary to the Defendant to support its claim for payment.

33. The Defendant has failed to provide evidence to the Plaintiff to support its rationale for denial.

34. The Defendant has denied the Plaintiff's claim for the medical expenses it incurred in its treatment of K.R. without support for its position.

35. The Defendant has not fully reviewed or investigated all information sent to it by the Plaintiff, or available to it, which has caused the Defendant to deny this claim.

36. The Defendant has failed to bear its burden of proof that an exclusion or requirement in the SPD supports its denial of the Disputed Claim.

37. The Defendant failed to offer the Plaintiff a "full and fair review" as required by ERISA.

38. The Defendant failed to offer the Plaintiff "higher than marketplace quality standards," as required by ERISA. MetLife v. Glenn, 554 U.S. 105, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008).

39. The actions of the Defendant, as outlined above, are a violation of ERISA, a breach of fiduciary duty, and a breach of the terms and provisions of the Plan.

40. The actions of the Defendant have caused damage to the Plaintiff in the form of a denial of ERISA medical benefits.

41. The Defendant is responsible to pay the claim for K.R.'s medical expenses pursuant to the terms of the Plan, and to pay Plaintiff's attorneys' fees and costs pursuant to 29 U.S.C. §1132(g), plus pre- and post-judgment interest to the date of payment of the unpaid benefits.

SECOND CAUSE OF ACTION

(Breach of Fiduciary Duties Under 29 U.S.C. §§1104, 1109, and 1132(a)(2) and (3))

42. Plaintiff realleges and incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

43. Defendant has breached its fiduciary duties under ERISA in the following ways:

A. Defendant has failed to discharge its duties with respect to the Plan:

1. Solely in the interest of the participants and beneficiaries of the Plan and

2. For the exclusive purpose of:

a. Providing benefits to participants and their beneficiaries; and

b. Defraying reasonable expenses of administering the Plan.

3. With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

4. By failing to fully investigate the Plaintiff's claim.

6. And in other ways to be determined as additional facts are discovered.

44. The actions of the Defendant in breaching its fiduciary duties under ERISA has caused damage to the Plaintiff in the form of denied medical benefits.

45. In addition, as a consequence of the breach of fiduciary duties of the Defendant, the Plaintiff has been required to obtain legal counsel and file this action.

46. Pursuant to ERISA and to the U.S. Supreme Court's recent ruling in CIGNA Corp. v. Amara, 131 S. Ct. 1866, 179 L.Ed. 2d 843 (2011), the Plaintiff's "make-whole relief" constitutes "appropriate equitable relief" under Section 1132(a)(3).

47. Therefore, the Plaintiff is entitled to payment of the medical expenses it incurred in treating K.R., as well as an award of interest, attorney's fees and costs incurred in bringing this action pursuant to the provisions of 29 U.S.C. §1132(g).

THIRD CAUSE OF ACTION

(Failure to Produce Plan Documents - 29 U.S.C. §§1024(b)(4) and 1132(c)(1))

48. Plaintiff realleges and incorporates by reference all previous paragraphs as though fully set forth herein.

49. The Plaintiff has requested the SPD and Plan Document in writing from the Defendant on two separate occasions.

50. The Defendant has failed to produce to the Plaintiff the SPD and Plan Document on which it relied to deny this claim.

51. The actions of the Defendant in failing to provide, within thirty (30) days after written requests were made, a copy of relevant Plan documents, as requested on numerous occasions by the Plaintiff, is a violation of the provisions of 29 U.S.C. §1024(b)(4).

52. The violations of 29 U.S.C. §1024(b)(4) have damaged the Plaintiff by impeding its ability to determine the extent and scope of coverage under the Plan, hindering verification of the degree to which exclusions or limitations on coverage exist, impairing the Plaintiff's ability to pursue administrative appeal of the Plan's denial of payment, and hindering the Plaintiff's ability to determine whether the Defendant's denial was meritorious.

53. In addition, as a consequence of the failure of the Defendant to provide the requested information in a timely manner, the Plaintiff has been required to obtain legal counsel and file this action.

54. Pursuant to 29 U.S.C. §1132(c)(1) and 29 C.F.R. §2575.502c-3, the Plaintiff is entitled to payment of statutory damages of a maximum of $110.00 per day from thirty days after the date the information was requested to the date of the production of the requested documents, as well as an award of attorney's fees and costs incurred in bringing this action

pursuant to the provisions of 29 U.S.C. §1132(g). Each new request begins a new and separate calculation.

55. The maximum statutory damages which have accrued to date for the two written requests which Plaintiff has made for the SPD and Plan Document, which have gone unanswered, is $104,170.00. Statutory damages continue to accrue until the relevant SPD and Plan Document are produced to the Plaintiff.

WHEREFORE, Plaintiff prays for judgment against Defendant as follows:

1. For judgment on Plaintiff's First Cause of Action in favor of the Plaintiff and against the Defendant pursuant to 29 U.S.C. §1132(a)(1)(B), for unpaid medical benefits in the amount of $11,380.35, for attorneys' fees and costs incurred pursuant to 29 U.S.C. §1132(g), and for an award of pre- and post-judgment interest to the date of the payment of the interest claimed.

2. For judgment on Plaintiff's Second Cause of Action in favor of the Plaintiff and against the Defendant pursuant to 29 U.S.C. §1132(a)(1)(B), for unpaid medical benefits in the amount of $11,380.35, for attorneys' fees and costs incurred pursuant to 29 U.S.C. §1132(g), and for an award of pre- and post-judgment interest to the date of the payment of the interest claimed.

3. Upon Plaintiffs' Third Cause of Action, in the amount of $110.00 per day from 30 days following the date of each written request for plan documents, to the date of production of the requested documents against the Defendant, attorney's fees and costs incurred pursuant to 29 U.S.C. §1132(g), and post-judgment interest incurred to date of payment of the judgment.

4. For such other equitable relief under 29 U.S.C. §1132(a)(3) as the Court deems appropriate.

DATED this 22nd day of January, 2015.

MARCIE E. SCHAAP
ATTORNEY AT LAW, P.C.

By: /s/ Marcie E. Schaap
Marcie E. Schaap
Attorney for Plaintiff