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TOBY SIDLO

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAII

TOBY SIDLO, Plaintiff, on behalf of himself and all others similarly situated, vs. KAISER PERMANENTE INSURANCE COMPANY, a California non-profit corporation, KAISER FOUNDATION HEALTH PLAN, INC., a foreign non-profit corporation, and DOE DEFENDANTS 1-50 Defendants.	CIVIL NO: _____ PLAINTIFF TOBY SIDLO'S CLASS ACTION COMPLAINT; EXHIBITS 1-2

PLAINTIFF TOBY SIDLO'S CLASS ACTION COMPLAINT

Plaintiff Toby Sidlo, on behalf of himself, and all others similarly situated, by their attorneys, Ning, Lilly & Jones, and for their Class Action Complaint against

Defendants, states as follows:

I. NATURE OF THE ACTION AND JURISDICTION

1. This civil action is brought under the Employee Retirement Income Security Act of 1974 ("ERISA") 29 U.S.C. §1001 et seq. for the purpose of compelling Defendants to provide certain healthcare benefits to ERISA plan participants in the amounts and at the coverage levels promised, for injunctive relief, recovery of damages, costs, and attorney fees incurred as a consequence of the Defendant's failure to do so.

2. Plaintiff Toby Sidlo is a resident of the State of Hawaii, and he resides in this District.

3. Plaintiff is a "participant" in an employee welfare benefit plan insured and/or administered by Defendant Kaiser Permanente Insurance Company and/or Defendant Kaiser Foundation Health Plan, Inc.

4. Defendant Kaiser Permanente Insurance Company ("Kaiser Permanente," or "Kaiser") is a California non-profit insurance corporation that was, at all relevant times, doing business within this District, and acted as an insurer and/or third-party claims administrator that determined the coverage level and reimbursement rate for Plaintiff and those similarly situated to his for certain out-of-network emergency medical transportation health insurance benefits during the periods for which these claims for benefits accrued.

5. Doe Defendants 1-50 are persons, partnerships, associations, companies, corporations, or entities whose names, identities, capacities, activities and/or responsibilities are presently unknown to Plaintiff or his attorneys, except that Doe Defendants 1-50 were and/or are subsidiaries, servants, employees, representatives, co-venturers, associates, consultants, owners, lessees, lessors, guarantors, assignees, assignors, licensees, and/or licensors of Defendants and were or are in some manner presently unknown to Plaintiff or his attorneys engaged or involved in the activities alleged herein or responsible for the activities of which Plaintiff complains, or should be subject to the relief Plaintiff seeks. Plaintiff prays for leave to certify the true names, identities, capacities, activities and/or responsibilities of Doe Defendants 1-50 when, through further discovery in this case, the same are ascertained. Plaintiff has made a good faith effort to identify said Doe Defendants prior to filing this Complaint, including interviewing witnesses and reviewing documents on file with the Department of Consumer Affairs and the Circuit Court of the First Circuit.

6. All or a part of the wrongful conduct and/or transactions described herein occurred in the State of Hawaii, and more specifically, in this District, where Defendants are regularly engaged in commerce and conduct business with a number of employee welfare benefit plans.

7. Jurisdiction is proper in this Court under 29 U.S.C. § 1132(e)(1) and (f).

8. Venue is proper in this District under 29 U.S.C. § 1132(e)(2).

9. All documents referenced herein are in the possession of Defendants.

II. THE PARTIES

A. Plaintiff

10. Plaintiff, and the putative class, are and were, at all relevant times, "participants" or "beneficiaries," within the meaning of The Employment Income Security Act of 1974 ("ERISA").

11. Plaintiff Toby Sidlo is insured as a participants or a beneficiary under a Kaiser Health plan who required emergency medical transportation services during the putative class period.

12. Plaintiff's health insurance coverage is provided by virtue of his employment with Kauai Sea Tours and its predecessor corporations.

13. On or about July 17, 2014, Plaintiff was badly injured during an accident in which he suffered serious and potentially life-threatening burns over large portions of his body.

14. At the time of his accident, Plaintiff was located in Kauai, Hawaii.

15. Unable to adequately treat Plaintiff's serious burn injuries, a decision

was made by treating health professionals to transport Plaintiff to Oahu, Hawaii to be treated in a suitable burn center and trauma unit.

16. Plaintiff was transported by emergency medical air ambulance service to Oahu, Hawaii by Hawaii Life Flight, Inc., an emergency medical transport provider.

17. By air ambulance, Plaintiff was transported to the Straub Medical Center and admitted to the center's Intensive Care Burn Unit where he received skin graft treatments over a one month period.

18. To this day, Plaintiff remains badly scarred over 30% of his body.

19. Following his discharge, Plaintiff began receiving Explanation of Benefit (EOB) forms from the Defendants which indicated that nearly his entire claim for reimbursement was denied.

20. Plaintiff protested the denials which, in his infirm state, left him with a balance due of approximately $36,000.00.

21. Despite multiple phone calls and written appeals, Defendants refused to pay for the emergency services and impermissibly shifted the risk under its health contracts to the Plaintiff.

22. As set forth herein, the Plaintiff is one of hundreds of victims of the Defendants' wrongful refusal to provide medical coverage and/or reimbursement rates in accordance with its universal Plan documents for the emergency medical

transportation costs for its seriously ill participants in those ERISA welfare benefit plans that they insure or administer.

23. Plaintiff has standing to bring these claims. Defendants have denied Plaintiff's claim for full reimbursement, and Plaintiff is deemed to have exhausted all administrative remedies pursuant to relevant Department of Labor regulations, and this case is ripe for adjudication. Alternatively, given Defendants' widespread, systemic practice, pursuing administrative remedies is futile.

B. The Kaiser Defendants

24. Defendant Kaiser Permanente is a California non-profit corporation with its corporate headquarters located in Oakland, California.

25. Defendant Kaiser Foundation Health Plan, Inc. is a foreign non-profit corporation which provides insurance and administrative services to health plans throughout this District. ("Kaiser Foundation" together with Kaiser Permanente will be collectively referred to as "the Defendants.")

26. At all relevant times, Defendants acted as the insurers and third-party claims administrators for various insured and self-funded employee welfare benefit plans providing health insurance coverage ("the Plans.")

27. At all relevant times, Defendants also acted as the insurance providers and claims administrators providing health insurance benefits to various employee welfare benefit plans.

28. Defendants are "fiduciaries," as defined by ERISA, as it was responsible for determining the eligibility of participants and beneficiaries for benefits under the Plans under 29 U.S.C. § 1002(21)(A).

29. In a manner common to all of the class members, Defendants, individually and collectively, have refused to provide the full and proper reimbursement levels under the Plans for emergency medical transportation services, in particular, for claims arising out of air ambulance services provided by Hawaii Life Flight, Inc. which is located in Honolulu, Hawaii.

30. Defendants and their related entities have established and carried out a deliberate and systemic policy to deny all claims for proper emergency transport reimbursement, even though it knows that the terms of its own Plan documents purport to provide full reimbursement coverage for the medical services minus a standard 20% co-pay applicable to the class.

31. Defendants' refusal to provide full reimbursement coverage for emergency medical transportation services under the Plans is in violation of the Plans standardized, uniform, and governing documents.

32. Defendants' actions also constitute a violation of their fiduciary duties owed to Plaintiff and a class of persons similarly situated to fairly and properly construe and interpret the Plans' language for the "exclusive purpose of providing benefits to participants and beneficiaries" as is required of claims administrators,

insurers, and fiduciaries under ERISA, 29 U.S.C. §1104(A).

III. OVERVIEW OF EMERGENCY AIR MEDICAL TRANSPORTATION SERVICES

A. Medically Necessary Emergency Air Ambulance Services

33. A significant segment of the American population resides in areas that may be described as either rural or remote local communities.

34. In certain cases, when an individual's health needs, or prescribed medical care, cannot be properly medically addressed, a person residing in (or located in) rural markets must be transported to a medical facility able to adequately manage the person's healthcare.

35. A patient's attending physician is responsible for making the determination to relocate a patient and for selecting the safest and medically necessary form of transportation.

36. Often times, these decisions are made on a life and death basis, and the urgency of the patient's medical condition necessitates the prompt and safe transport from a local medical facility to a major medical center equipped with the type of life saving equipment and specialists to adequately address the patient's symptoms.

37. In order to safely transport a patient between the two locations, a team consisting of trained pilots, emergency medical technicians, emergency nursing professionals, and properly equipped medical transport aircraft is required.

38. The costs alone for air medical transportation services can run into the millions of dollars to properly equip each individual aircraft.

39. Additionally, the cost of having an emergency medical transport team on "standby" runs millions of dollars annually as well.

40. The average cost of an emergency air medical flight is $40,000.

41. The cost is reflective of the actual operating costs of having a fleet of such emergency medical transportation aircraft at the ready, twenty-four hours per day, seven-days per week.

42. Reimbursement rates for emergency aircraft carriers are governed, in part, by the Airline Deregulation Act of 1978, 49 U.S.C.§1371 *et seq*.

43. Reimbursement rates are governed, in part, by rates set forth in the Patient Protection and Affordable Health Care Act of 2010, P.L. 111-148 (2010).

44. Under its own contracts, however, Defendants have represented to ERISA plan participants, like Plaintiff, that those plans insured and/or administered by Defendants will provide reimbursement for "Ambulance Services" at the "Actual Billed Charge" minus a co-pay of 20% born by the participants. (Ex. 1, Kaiser 2015 Benefits Summary).

45. Under its own administrative service contracts, Defendants have represented to ERISA plan participants, like Plaintiff, that the only coverage limitations imposed is that the service be medically necessary and that death or

serious impairment may result in the event the transport service is not provided.

46. Under Defendants' own uniform administrative service agreements which govern those benefit plans in the Hawaii Region which it administers or insures, Defendants have promised, that for "Ambulance Services," Defendants:

> . . . *will pay* 80% of Applicable Charges for ground or air ambulance services received within or outside the Service Area when deemed medically necessary by a Physician. Ambulance service is medically necessary if use of any other means of transport, regardless of the availability of such other means, would result in death or serious impairment of the Member's health. Air ambulance must be for the purpose of transporting the Member to the nearest medical facility designated by Health Plan for receipt of medically necessary acute care, and the Member's condition must require the services of an air ambulance for safe transport. (Ex. 2, Kaiser Administrative Services Agreement)(emphasis added).

47. Further, Defendants have promised under their governing documents that the term "Applicable Charges" means the following:

> (1) For professional services, Applicable Charges mean:
>
> (a) When Medical Group or Health Plan Hospital provides medical services to a Member, then Member Rates are used, (b) When a contracted non-Medical Group practitioner or a contracted non Health Plan facility provides medical services to a Member, the Applicable Charge is the negotiated rate, c) When a non-contracted non-Medical Group practitioner or a non-contracted non Health Plan facility provides medical services to a Member, the Applicable Charge is the actual billed charge.
>
> (2) For other medical services or items, Applicable Charges mean:
>
> (a) when Kaiser Permanente provides medical services or items to a Member, then Member Rates are used,

(b) when medical services or items are not provided by Kaiser Permanente, then Applicable Charges mean the negotiated rate, *or the actual billed charge*. (*Id.*)(Emphasis added).

48. Despite this express language written into every health plan administered by Defendants in the Hawaii Region, Defendants refuse to reimburse claims in compliance with this express language.

B. The Kaiser Defendants Routinely Underpay Reimbursement Claims for Participants In Their Employee Welfare Benefit Plans

49. It is believed that the cost of emergency transportation services has been an easy target for Defendants to under-reimburse healthcare claims based on artificially reduced reimbursement rates that do not comply with the Defendants' contracts.

50. Defendants are denying claims for plan participants who are seriously ill or even impaired from an occupational standpoint as a result of their medical conditions and cannot physically or financially challenge the Kaiser Under-reimbursement program.

51. Upon information and belief, Defendants have systematically implemented a program designed to specifically under-reimburse emergency medical transportation claims.

52. In Hawaii alone, Defendants have under-reimbursed nearly 100 claims since 2013 for air medical transportation services for one provider of such services, Hawaii Life Flight, Inc.

53. Those plan participants unfortunate enough to have Defendants serving as their claims administrators have suffered reimbursement rates as low as 10% to 20%.

54. By applying invalid or inoperative payment guidelines to the claims of these participants, Defendants are wrongfully under-reimbursing health care claims totaling tens of millions of dollars, as well as dissuading participants from seeking full reimbursement for these claims.

55. Defendants' refusal to provide certain healthcare benefits at the correct and proper reimbursement levels impermissibly shifts the risk of emergency care to plan participants and leaves them facing financial devastation.

56. Few, if any participants, are financially able to pay the balance due and owing on for a claim which is under-reimbursed by Defendants.

57. Defendants' actions have also led to an identifiable disparity of care.

58. Defendants' refusal to provide coverage is affecting hundreds of participants in like circumstances.

59. Defendants' wrongful refusal to provide coverage has caused financial damages to members of the class who have either had to pay for the care themselves or have substantial unpaid balances for which they are personally liable.

60. Further, Defendants' have orchestrated a system-wide policy to unduly hamper the processing of claims in violation of its fiduciary obligations and those

regulations promulgated by the Department of Labor. Specifically, Defendants:

a. Use a host of improper procedural denials to initially deny underpaid claims such as telling participants that the reimbursement rates are set by Medicare or Medicaid;

b. Routinely provide incorrect and invalid reasons for denying full coverage before settling a "final and binding determination" and after the participants have rebutted the prior reasons for the claims denials; and

c. Eliminate from consideration any favorable evidence rebutting their self-serving and self-generated opinions on the proper level of reimbursement even where its own contracts state that 80% of the actual billed charge will be provided for emergency medical transport providers of the actual transport cost.

61. Defendants have implemented these policies knowing full well that their participants cannot fight the bureaucracy and are likely to simply drop their claims rather than exercise their rights under ERISA.

62. Moreover, Defendants have deliberately excluded from any consideration of the claimant's administrative appeals the law and regulations applicable to air ambulance or emergency medical air transportation services.

63. The class for which Plaintiff seeks recovery includes all plan

participants who received air medical transportation services provided by Hawaii Life Flight, Inc. and had their claims underpaid by Defendants.

IV. CLASS ACTION ALLEGATIONS

64. Plaintiff brings this action as a class action against Defendants pursuant to Rule 23 of the Federal Rule of Civil Procedure, individually and on behalf of a class consisting of all persons who are participants in or beneficiaries of an employee benefit plan administered by or provided by Defendants and who have been had their claims coverage for air medical transportation services provided by Hawaii Life Flight, Inc. underpaid or under-reimbursed by Defendants.

65. The class period commences six years prior to the filing of the original Complaint in this matter, through the date of the entry of a final judgment.

66. Plaintiff is a member of the class and will fairly and adequately assert and protect the interests of the class.

67. The interests of the Plaintiff are consistent with, and not antagonistic to, those of the other members of the class.

68. Plaintiff has retained attorneys who are experienced in class action litigation, and who will provide adequate representation.

69. Members of the class are so numerous that joinder of all members of the class is impracticable.

70. Upon information and belief, there are numerous members of the class

whose identities can be ascertained from the records and files of Defendants and from other sources.

71. Common questions of law or fact as to the violations by Defendants of ERISA that have caused and will continue to cause harm to the class predominate over any question affecting only individual members of the class.

72. The prosecution of separate actions by individual members of the class would create a risk of, among the other things, the following:

a. Inconsistent or varying adjudications with respect to individual members of the class; and

b. Adjudication with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of other members not parties to the adjudication or substantially impair or impede their ability to protect their interests.

73. The claims of the lead Plaintiff are typical of the claims of the class, and the class action method is appropriate for the fair and adequate prosecution of this action.

74. Individual litigation of claims which might be commenced by all class members would produce a multiplicity of cases such that the judicial system having jurisdiction over the claims would remain congested for years.

75. Class treatment, by contrast, provides manageable judicial treatment

calculated to bring a rapid conclusion to all litigation of all claims arising out of the conduct of Defendants.

76. The certification of a class would allow litigation of claims that, in view of the expense of litigation, may be insufficient in amount to support separate claims.

77. Accordingly, Plaintiff brings this action on behalf of himself and on behalf of all other members of the classes defined as follows:

Class 1:

All individuals who, on or after, July 15, 2009 were participants or beneficiaries in a health plan insured or administered by Kaiser Permanente or the Kaiser Foundation Health Plan, Inc. and who made or make a claim for the full reimbursement of air medical transportation provided by Hawaii Life Flight, Inc., and whose claim was not paid according to the actual billed charge and who paid the under-reimbursed charges in full.

Class 2:

All individuals who, on or after July 15, 2009 were participants or beneficiaries in a health plan insured or administered by Kaiser Permanente or the Kaiser Foundation Health Plan, Inc. and who made or make a claim for the full reimbursement of air medical transportation provided by Hawaii Life Flight, Inc., and whose claim was not paid according to the actual billed charge and whose under-reimbursed claims remain unpaid. (Hereinafter referred collectively to as Members in the "Kaiser Under-reimbursement Class.")

V. DEFENDANTS' VIOLATIONS OF ERISA

78. ERISA requires every employee benefit plan to provide for one or more named fiduciaries who will have the "authority to control and manage the operations and administration of the Plan" [29 U.S.C. § 1102(a)(1)].

79. The employers of the Plaintiff and class members delegated their fiduciary responsibilities for claims administration to Defendants.

80. At all relevant times, Defendants were fiduciaries within the scope of ERISA by virtue of its exercise of discretionary authority, control and responsibility over the design, implementation and administration of the Plans.

81. As a matter of policy, Defendants have wrongfully denied Plaintiff, the class members, and their dependents full reimbursement for emergency medical transportation provided by Hawaii Life Flight, Inc.

82. Defendants wrongfully underpay or under-reimburse coverage on the bad faith basis that despite overwhelming evidence showing, among other things, the proper reimbursement levels for emergency transportation services.

83. Defendants are intentionally misconstruing the terms of the Plans.

84. Defendants have failed to provide any explanation or evidence in support of its purported fair market reimbursement rates.

85. Defendants' failure to provide evidence in support of its position constitutes a failure to provide full and fair review of the decision to deny benefits, in

violation of ERISA [29 U.S.C. § 1133(2)].

86. By administering the Plans in the manner described in this Complaint, Defendants have failed to exercise the utmost loyalty and care of a prudent person engaged in similar activity under prevailing circumstances, in violation of ERISA.

87. Plaintiff has exhausted all of his administrative remedies, and, given Defendants' policy and practice of underpaying claims for air medical emergency transport, it would be futile for the remainder of the class to exhaust their administrative remedies.

COUNT I -
ACTION AGAINST DEFENDANTS UNDER
29 U.S.C. § 1132(a)(1)(B) TO RECOVER FULL HEALTH CARE BENEFITS

88. Plaintiff realleges all preceding allegations.

89. Plaintiff, the class and their dependents have been continuously covered under health insurance policies purporting to provide health care coverage for covered medical expenses under the Plans.

90. Plaintiff, the class and their dependents are entitled to benefits upon supplying proof of a claim incurred under a Plan.

91. Defendants have repeatedly denied proper coverage for covered medical expenses, specifically, emergency air medical transportation services to a specific provider, Hawaii Life Flight, Inc.

92. Defendants have failed to properly interpret its own plan language and denied covered health care benefits, despite satisfaction of the Plans' eligibility requirements.

93. Plaintiff, the class, and their dependents are, and have always been, entitled to health care benefits under the Plans.

94. Defendants' underpayment or under-reimbursement of emergency air medical transportation services is not based on deliberate principled reasoning or substantial evidence in violation of the Plan and ERISA.

95. Defendants' denial for full reimbursement is not encompassed by the terms of the Plan is a violation of the Plan and ERISA.

96. Defendants' decision to deny full coverage is both incorrect and unreasonable.

97. Accordingly, Plaintiff and the class members are entitled to immediate payment of past due benefits, and they are also entitled to clarify and enforce their rights to payment of those amounts still due and owing benefits through the entry of an injunction.

WHEREFORE, Plaintiff and the class request judgment in their favor against Defendants in an amount to be determined, plus costs, interest, and attorney fees, declaratory and injunctive relief, and any other relief to which Plaintiff and the class are entitled.

COUNT II –
ACTION AGAINST DEFENDANTS UNDER
29 U.S.C. § 1132(a)(3) FOR EQUITABLE RELIEF

98. Plaintiff realleges all preceding paragraphs.

99. Plaintiff and his fellow class members have the right to full and fair review and proper notice of the reasons for the denial of their claimed benefits under ERISA §503, 29 U.S.C. §1133.

100. Plaintiff and his fellow class members were denied their right to a full and fair review of their claims for benefits in one or more of the following ways:

a. Defendants are operating with the inherent structural conflict of interest by acting as both administrators and insurers of certain Plan members' benefits and this has affected the unbiased decision making of the Defendants;

b. Defendants are operating under a conflict of interest when they administer self-funded Plans by denying the claims of those participants because of its steadfast refusal to properly pay reimbursement claims under its insured plans;

c. Defendants' internal file reviewers refuse to consider or credit any favorable documentation demonstrating the correct and proper reimbursement rates; and

d. Defendants repeatedly fail to abide by Department of Labor Regulations ("DOL") governing the administering of group healthcare claims by, among other things, creating numerous internal obstacles to frustrate its claimant's ability to purse their claims and unduly hamper the processing of claims.

101. Because ERISA requires Defendants to discharge its fiduciary duties with respect to a plan solely in the interest of the participants and beneficiaries and with utmost, undivided loyalty to their interests, equitable relief is required requiring, without limitation, the re-administration of denied claims and the enjoining of the further use of artificially lower reimbursement rates for participants requiring emergency air medical transportation services.

102. ERISA requires that Plaintiff and the class members be afforded a reasonable opportunity for a full and fair review of the decision denying their benefits.

103. Defendants' actions as set forth above are in violation of the ERISA statute and the relevant Plans.

104. Specifically, Defendants have implemented a plan-wide system of denying coverage, without providing beneficiaries and participants a full and fair review, in violation of those duties imposed by ERISA and has administered the Plan in such a manner as to unduly hamper the processing of valid claims.

105. Further, by failing to provide evidence or an explanation for its determination that reimbursement rates are set by either Medicare or Medicaid, Defendants are denying Plaintiff and the class members an opportunity for a full and fair review.

106. As a result of the breaches of their duties as described above, Plaintiff and the class members have been harmed, continue to be harmed, and will be harmed in the future, due to the acts or omissions detailed above.

107. Therefore, Plaintiff and the class members are entitled to (1) an order enjoining Defendants from denying full coverage based on artificially lowered reimbursement rates, and (2) other appropriate equitable relief necessary to redress Defendants' violations and to enforce the law and the Plan.

WHEREFORE, Plaintiff and the class request equitable relief, including injunctive relief, in their favor and against Defendants plus costs, interest, and attorney fees, equitable disgorgement, declaratory relief, and any other relief to which Plaintiff and the class are entitled.

DATED: Honolulu, Hawaii, July15, 2015.

/s/ Michael A. Lilly
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TOBY SIDLO