**IN THE UNITED STATES DISTRICT COURT**
**FOR THE NORTHERN DISTRICT OF OHIO**
**EASTERN DIVISION**

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| ROSS GREENWOOD, individually and on behalf of all others similarly situated,<br><br>Plaintiff,<br><br>v.<br><br>CIGNA HEALTH AND LIFE INSURANCE COMPANY and EVERNORTH BEHAVIORAL HEALTH, INC.,<br><br>Defendants. | Case No. 4:25-cv-01759 |

# CLASS ACTION COMPLAINT

Plaintiff Ross Greenwood, individually and on behalf of all others similarly situated, alleges as follows against Defendants Cigna Health and Life Insurance Company ("Cigna") and Evernorth Behavioral Health, Inc. ("Evernorth") (collectively, "Defendants").

## INTRODUCTION

1. This case arises from Defendants' development, adoption, and use of certain clinical coverage criteria, including coverage criteria licensed from MCG Health LLC ("MCG"), for determining whether residential treatment of mental-health conditions is medically necessary, and, thus, covered by the welfare benefit plans Defendants administer. Although purporting to be consistent with generally accepted standards of medical practice, the criteria Defendants applied for determining the medical necessity of residential mental-health treatment, and used to administer employer-sponsored benefit plans, are far more restrictive than generally accepted standards of medical practice. As such, they contradict the benefit plans' written terms and violate the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq*. ("ERISA").

2. Defendants' development, adoption, and use of these criteria also violated their duties under the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 ("MHPAEA"), which was incorporated into ERISA. By applying more restrictive coverage criteria to behavioral-health insurance claims, such as Plaintiff's, than they apply to comparable medical/surgical insurance claims, Defendants also violated their duty to comply with MHPAEA.

## PARTIES

3. Plaintiff Ross Greenwood ("Plaintiff") was a beneficiary and participant of a self-insured health plan sponsored by Vista Equity Partners Management, LLC (the "Plan"), and administered by Defendants Cigna and Evernorth. Plaintiff, a resident of Howland Township, Ohio, was covered by the self-funded health plan sponsored by his spouse's employer.

4. Defendant Cigna Health and Life Insurance Company ("Cigna") is a subsidiary of The Cigna Group, Inc. and is headquartered in Bloomfield, Connecticut. Among other things, it administers health benefit plans such as the one that covered Plaintiff.

5. Defendant Evernorth Behavioral Health, Inc. ("Evernorth") is a subsidiary of The Cigna Group, Inc. and headquartered in Bloomington, Minnesota. Evernorth makes final and binding coverage determinations, including medical-necessity determinations, for Cigna's commercial health plans, including the Plan that covered Plaintiff, based on the coverage and utilization management guidelines developed and authorized by Cigna.

6. Evernorth systematically applies Cigna's guidelines to make medical-necessity determinations for residential mental-health treatment. Cigna's guidelines applicable to this case are licensed from a for-profit publisher, MCG. Evernorth systematically applies the MCG Guidelines for Residential Behavioral Health Level of Care (the "MCG Residential Behavioral Health Guidelines") to render the medical-necessity determinations at issue in this case.

## JURISDICTION AND VENUE

7. Subject matter jurisdiction exists under 28 U.S.C. § 1331.

8. This Court has personal jurisdiction over Defendants, who operate and administer health benefit plans in Ohio and in this District, and process claims that originate here, including Plaintiff's claim.

9. Venue is proper in this District as Plaintiff resides in this District. Under 29 U.S.C. § 1132(e)(2), venue is proper in an ERISA lawsuit in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found. Here, suit is brought in the district where Plaintiff's plan is administered and where the breach took place. Further, Cigna authorizes the use of the MCG Residential Behavioral Health Guidelines by Evernorth, which routinely conducts final and binding utilization reviews of mental-health claims submitted by Cigna insureds who reside in this District and nationwide.

## FACTUAL BACKGROUND

### I. Plaintiff's Health Plan

10. Plaintiff's Plan was issued by the employer of Plaintiff's spouse, a private company. As such, the Plan is governed by ERISA.

11. Plaintiff Ross Greenwood was a beneficiary of the Plan from on or around June 20, 2023 to on or around July 31, 2024.

12. Plaintiff's Plan covers services for mental-health and substance-use disorders, including residential treatment. The Plan does not limit residential treatment to acute or emergency care or to short-term crisis intervention.

13. Under the terms of the Plan, a condition of coverage is that services for which coverage is sought are "medically necessary."

14. The Plan defines "medically necessary" to mean services that are, among other things, provided "in accordance with generally accepted standards of medical practice," and "rendered in the least intensive setting that is appropriate for the delivery of the services … Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting."

## II. Defendants' Fiduciary Roles

15. Cigna is the designated third-party administrator that provided claim-administration services to Plaintiff's Plan, as a fiduciary to the Plan.

16. Third-party administrators that make binding coverage decisions are functional fiduciaries.

17. In addition to creating rights for plan participants, ERISA imposes duties upon the people and entities responsible for the operation of the plan. Those who operate the plan are "fiduciaries" of the Plan, and have a duty to do so prudently and in the interest of plan participants and beneficiaries. If a claim for a plan benefit is denied or ignored, a plan participant has the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial.

18. Because Cigna was responsible for making binding determinations on claims and appeals, and because Cigna is responsible for operating other aspects of the Plan, including, without limitation, utilization management and other related Plan-administration decisions, Cigna is a functional fiduciary and legal fiduciary as defined in ERISA.

19. Because it was delegated to handle certain duties by Cigna in administering Plaintiff's Plan, Evernorth is a functional fiduciary and legal fiduciary as defined in ERISA.

20. As the functional fiduciary responsible for the development and approval of clinical policies and coverage guidelines that interpret the terms of the health plans that it and its affiliates, including Defendant Evernorth, administer, Cigna adopted a coverage guideline entitled "Medical Necessity for Physicians," which operationalized a company-wide definition of "medically necessary" to mean healthcare services that are, among other things, "in accordance with generally accepted standards of medical practice."[1]

21. Cigna's coverage guidelines state that "'generally accepted standards of medical practice' means: (1) Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, (2) Physician Specialty Society recommendations; (3) The views of physicians practicing in the relevant clinical area; [and] (4) Any other relevant factors."[2]

22. The "Cigna Standards and Guidelines/Medical Necessity Criteria For Treatment of Mental Health Disorders" ("Behavioral Health Guidelines"), which has been in effect since at least 2020, state that "[i]n considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents."[3] While specific plan definitions of "medical necessity" can "vary to some degree," plans "commonly require the service or supply to be:

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[1] Cigna Healthcare, *Coverage Policies*, https://www.cigna.com/health-care-providers/coverage-and-claims/policies (last accessed Aug. 21, 2025). As to any documents or websites referenced or cited in this Complaint, Plaintiff does not allege the truth of the statements contained therein other than as specifically alleged in this Complaint, and does not otherwise incorporate any aspect of the referenced or cited materials beyond the specific allegations of this Complaint.

[2] *Id*.

[3] Cigna, *Cigna Standards and Guidelines/Medical Necessity Criteria: For Treatment of Mental Health and Substance Use Disorders*, https://static.evernorth.com/assets/evernorth/provider/pdf/resourceLibrary/behavioral/cigna-standards-and-guidelines-medical-necessity-criteria-2020-Edition.pdf (effective Jan. 2020) (last accessed Aug. 22, 2025).

- In accordance with the generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease."[4]

23. Cigna has adopted the MCG Residential Behavioral Health Guidelines as its "criteria … for guidance in conducting medical necessity reviews of mental[-]health levels of care for all health plan business, unless contractual requirements, federal or state law require use of other clinical criteria."[5]

24. As detailed herein, Cigna's Behavioral Health Guidelines and the MCG Residential Behavioral Health Guidelines' criteria are inconsistent with generally accepted standards of medical practice.

25. Utilization management of mental-health claims under Plaintiff's health plan has been delegated to Defendant Evernorth, which makes final and binding medical-necessity determinations for health plans Defendants administer, including Plaintiff's Plan.

26. In doing so, Evernorth systemically applies the coverage guidelines and medical policies developed and approved by Cigna, including the coverage guidelines regarding medical necessity.

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[4] *Id*.

[5] Cigna Healthcare, *Coverage Policies*, https://static.cigna.com/assets/chcp/resourceLibrary/coveragePolicies/index.html?_gl=1*10nj7a9*_gcl_au*MjEzOTE0OTUyMC4xNzU0NTkzNjcz (last accessed Aug. 7, 2025).

27. Thus, when rendering medical-necessity determinations, Evernorth must necessarily evaluate whether services for which coverage is sought are consistent with generally accepted standards of medical practice. Because, however, it has systematically relied on defective medical-necessity criteria provided to it by Cigna that were and continue to be far more restrictive than generally accepted standards of medical practice with respect to residential mental-health treatment, Evernorth could not reasonably make such determinations and any benefit denials based on these flawed guidelines were, and continue to be, inherently unreasonable.

## III. Generally Accepted Standards of Medical Practice for Mental Health

28. Generally accepted standards of medical practice, in the context of mental-health and substance-use-disorder services, are standards that have achieved widespread acceptance among behavioral-health professionals. The generally accepted medical standards at issue in this case do not vary state-by-state and are applicable nationwide.

29. In the area of mental-health and substance-use-disorder treatment, there is a continuum of intensity at which services are delivered. There are generally accepted standards of medical practice for matching patients with the level of care that is most appropriate and effective for treating patients' conditions. These generally accepted standards of medical practice are described in multiple sources, including consensus guidelines from professional organizations and guidelines and materials distributed by government agencies, such as: (a) the American Association of Community Psychiatrists' ("AACP's") Level of Care Utilization System ("LOCUS"); (b) the Child and Adolescent Level of Care Utilization System ("CALOCUS") developed by AACP and the American Academy of Child and Adolescent Psychiatry ("AACAP"), and the Child and Adolescent Service Intensity Instrument ("CASII"), which was developed by AACAP in 2001 as a refinement of CALOCUS; (c) AACAP's Principles of Care for Treatment of

Children and Adolescents with Mental Illnesses in Residential Treatment Centers; (d) the Medicare Benefit Policy Manual issued by the Centers for Medicare and Medicaid Services; (e) the American Psychiatric Association ("APA")'s Practice Guidelines for the Treatment of Patients with Eating Disorders, Third Edition; (f) the American Society of Addiction Medicine ("ASAM") Criteria; (g) the APA Practice Guidelines for the Treatment of Patients with Substance Use Disorders, Second Edition; and (h) the New York Office of Mental Health Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services.

30. Generally accepted standards of medical practice for matching patients with the level of care that is most appropriate and effective for treating patients' mental-health conditions and substance-use disorders include the following:

(a) **First**, many mental-health and substance-use disorders are long-term and chronic. While current or acute symptoms are typically related to a patient's chronic condition, it is generally accepted in the behavioral-health community that effective treatment of individuals with mental-health or substance-use disorders is not limited to the alleviation of the current or acute symptoms. Rather, effective treatment requires treatment of the chronic underlying condition as well.

(b) **Second**, many individuals with behavioral health diagnoses have multiple, co-occurring disorders. Because co-occurring disorders can aggravate each other, treating any of them effectively requires a comprehensive, coordinated approach to all of the patient's conditions. Similarly, the presence of a co-occurring medical condition is an aggravating factor that may necessitate a more intensive level of care for the patient to be effectively treated.

(c) **Third**, to treat patients with mental-health or substance-use disorders effectively, it is important to "match" them to the appropriate level of care. The driving factors in

determining the appropriate treatment level should be safety and effectiveness. Placement in a less-restrictive environment is appropriate only if it is likely to be safe and *just as effective* as treatment at a higher level of care.

(d) **Fourth**, when there is ambiguity as to the appropriate level of care, generally accepted standards call for erring on the side of caution by placing the patient in a higher level of care. Research has demonstrated that patients who receive treatment at a lower level of care than is clinically appropriate face worse outcomes than those who are treated at the appropriate level of care. Conversely, there is no research establishing that placement at a higher level of care than clinically indicated results in an increase in adverse outcomes.

(e) **Fifth**, while effective treatment may result in improvement in the patient's level of functioning, it is well-established that effective treatment also includes treatment aimed at preventing relapse or deterioration of the patient's condition and maintaining the patient's level of functioning.

(f) **Sixth**, the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment. Similarly, it is inconsistent with generally accepted standards of medical practice to require discharge as soon as a patient becomes unwilling or unable to participate in treatment.

(g) **Seventh**, the needs of children and adolescents must be considered when making level-of-care decisions involving their treatment for mental-health or substance-use disorders. One of the ways practitioners should take into account the developmental level of a child or adolescent in making treatment decisions is by relaxing the threshold requirements for admission and continued service at a given level of care.

(h) **Eighth**, the determination of the appropriate level of care for patients with mental-health disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient. Except in acute situations that require hospitalization, where safety alone may necessitate the highest level of care, decisions about the level of care at which a patient should receive treatment should be made based on a holistic, biopsychosocial assessment that involves consideration of multiple dimensions.

31. As functional ERISA fiduciaries, one of Defendants' fiduciary duties is to apply due care in interpreting benefit plans, including when developing and/or selecting the criteria to use in making determinations about whether requested services are consistent with generally accepted standards of medical practice and thus medically necessary.

32. When Cigna developed its Behavioral Health Guidelines and adopted the MCG Residential Behavioral Health Guidelines to be utilized by its affiliate, Evernorth, in making medical-necessity decisions under Plaintiff's and Class members' benefit plans, Cigna had access to the independent, publicly available sources referenced above, which describe generally accepted standards of medical practice for behavioral healthcare. In the exercise of due care, Defendants thus knew, or should have known, what the generally accepted standards of medical practice actually were and continue to be. Likewise, in making discretionary determinations about medical necessity under Plaintiff's and Class members' benefit plans, Evernorth knew or should have known what the generally accepted standards of medical practice for behavioral healthcare actually were and continue to be.

## IV. Defendants' Adoption of the MCG Behavioral Health Guidelines for Making Medica-Necessity Decisions Relating to Residential Treatment for Mental Health

33. Prior to November 27, 2020, Cigna used its own Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders. As of that date, however, Cigna

adopted the MCG Behavioral Health Guidelines for making medical-necessity determinations relating to behavioral-health services. As stated in a CIGNA statement, entitled: "Cigna to Adopt MCG Behavioral Health Guidelines; Effective November 27, 2020":

> **What's changing:**
> - On November 27, 2020, Cigna will terminate use of the Cigna Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders and transition to MCG Behavioral Health Guidelines built on externally developed evidence-based guidelines.
> - Behavioral clinical criteria will remain on the Cigna for Health Care Professionals website, but at the end of November 2020, it will all be accessible in one location:
>   - Cigna for Health Care Professionals website (CignaforHCP.com) > Coverage Policies, See Supporting Behavioral Websites.
>   - **Please note:** Minimal login information will be required to access the MCG Behavioral Health Guidelines.
> - The new guidelines will present a change in how you access clinical criteria for treating patients with Cigna coverage. We are committed to supporting you through this transition and will strive to minimize any disruption to you and your patients.
>
> **What's staying the same?**
> - The MCG Behavioral Health Guidelines do not replace clinical judgment, and we recognize that they require adaptation to the unique situations of each individual patient, as well as to relevant state and federal regulations and licensing standards.
> - Our goal has always been to use the latest evidence-based literature to provide the most appropriate and effective patient care.
> - We will continue to use:
>   - The ASAM criteria, developed by the American Society of Addiction Medicine . . .
>   - Cigna Medical Coverage Policies for Autism Spectrum Disorders/Pervasive Developmental Disorders, Transcranial Magnetic Stimulation (TMS), Neuropsychology Testing, and Complementary and Alternative Medicine.[6]

34. The ASAM criteria apply only to medical-necessity and levels-of-care determinations relating to substance-use disorders, while the Cigna Medical Coverage Policies are limited to certain specific conditions and treatment. The MCG Behavioral Health Guidelines, which Cigna used as of the effective date of this policy change, was therefore the source for Cigna

[6] Cigna, *Cigna to Adopt MCG Behavioral Health Guidelines*, https://centercare.com/_uploads/Cigna-MCG-Behavioral-Health-Guidlines-09-2020.docx (effective Nov. 27, 2020) (last accessed Aug. 22, 2025).

to determine medical necessity for residential treatment for behavioral-health services, among other treatments.

35. Upon instruction from Cigna, Evernorth similarly transitioned to rely on the MCG Behavioral Health Guidelines for its medical-necessity decisions relating to behavioral healthcare. This is confirmed in the Evernorth Behavioral Administrative Guidelines, issued for contracted behavioral health providers, which state:

> All appeals are reviewed and determinations made by board certified psychiatrists or board certified PhD-level psychologists. If an appeal subsequently overturns an earlier decision, Evernorth Behavioral Health will implement the appeal decision and/or process the authorization or claim for payment of services. Decisions are communicated in writing with all adverse determinations and contain the following information:
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> - The specific guideline on which the determination is based, including the MCG Behavioral Health Guidelines, The ASAM Criteria, and/or the plan coverage policy;
> - The facts and evidence considered; and
> - The clinical rationale for the determination.[7]

36. Additionally, in summarizing the "Medical necessity criteria," Evernorth states:

> Cigna uses the **MCG Behavioral Health Guidelines** for guidance in conducting mental health level of care medical necessity reviews for all health plan business unless contractual requirements, federal or state law require use of other clinical criteria. The MCG guidelines have wide acceptance as an evidence-based standard for mental health care, are developed and maintained in compliance with state and federal regulations, including mental health parity laws, and are informed by consideration of guidance issued by at least ten (10) professional organizations.
>
> In addition to the MCG Behavioral Health Guidelines, the following resources are currently being used to make medical necessity determinations:
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> - The ASAM Criteria® Cigna uses this criteria, developed by the American Society of Addiction Medicine, for guidance in conducting medical necessity reviews of substance use disorder levels of care for all health plan business, unless contractual requirements, federal or state law require use of other clinical criteria.
> - Cigna Medical Coverage Policies

[7] Evernorth, *Evernorth Behavioral Administrative Guidelines*, https://static.cigna.com/assets/chcp/pdf/resourceLibrary/behavioral/ebh-provider-admin-guide.pdf, at 72 (last accessed Aug. 7, 2025).

- Cigna Authorization and Billing Resource
- State and federal regulations and licensing standards.[8]

37. The Evernorth report added: "On November 27, 2020, Cigna terminated use of its Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders and transitioned to the MCG Behavioral Health Guidelines referenced above."[9]

38. Thus, Defendants use the MCG Behavioral Health Guidelines on a company-wide basis, which Evernorth has systematically applied since November 28, 2020, to make medical-necessity determinations under Plaintiff's and the Class members' benefit plans, including with respect to claims for residential treatment.

## V. The MCG Residential Behavioral Health Guidelines are Inconsistent with Generally Accepted Standards of Medical Practice

39. MCG, a for-profit publisher, develops behavioral-health guidelines that it licenses to benefit administrators, including Defendants, with the express purpose and intention that benefit administrators will rely on them to make medical-necessity determinations under welfare benefit plans, including plans governed by ERISA.

40. MCG describes its service as creating "care guidelines" to "provide fast access to evidence-based medicine's best practices and care plan tools across the continuum of treatment, providing clinical decision support and documentation which enables efficient transitions between care settings."[10] The MCG Behavioral Health Guidelines themselves, however, are not publicly accessible.

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[8] *Id*. at 108.

[9] *Id*. at 109.

[10] MCG, *Company Overview*, https://www.mcg.com/about/company-overview/ (last accessed Aug. 7, 2025).

41. The MCG Behavioral Health Guidelines include footnote citations to peer-reviewed medical literature and physician-specialty-society recommendations that purportedly "support" their criteria. The annually revised MCG Behavioral Health Guidelines, however, have been inconsistent with the primary sources on which they purport to rely and have distorted the generally accepted standards of medical practice for the treatment of behavioral-health disorders, as explained below.

42. In various statements and publications concerning their use of MCG, Defendants conspicuously failed to consider and reference far more contemporaneous and relevant sources – such as LOCUS and CASII/CALOCUS – that specifically reflect generally accepted standards of medical practice for patient placement selection. Unsurprisingly, therefore, the residential mental-health criteria in the MCG guidelines that Defendants licensed and relied on, are inconsistent with generally accepted standards of medical practice for the treatment of behavioral-health disorders.

43. In particular, MCG devised medical necessity criteria for evaluating residential mental-health treatment that improperly heightened the relevance of acute behavioral-health symptoms, while minimizing the relevance of non-acute behavioral-health symptoms and conditions—that is, chronic mental-health conditions that are persistent and/or pervasive and could not necessarily be effectively treated with short-term doses/treatment.

44. At all times relevant to this Complaint, the applicable version of the MCG Behavioral Health Guidelines was inconsistent with generally accepted standards of medical practice.

45. As a threshold matter, the MCG Behavioral Health Guidelines explained that symptoms or conditions used to determine the appropriate treatment intensity should be due to the underlying behavioral-health diagnosis or represent factors that contribute to destabilization of the

underlying diagnosis, and are acute in nature or represent a significant worsening over baseline. Thereafter, the MCG Behavioral Health Guidelines specify that, to be medically necessary upon admission, *residential treatment* must satisfy a number of threshold conditions, all of which must be met:

> (a) First, patient risk or severity of behavioral health disorder is appropriate to proposed level of care as indicated by 1 or more of the following: (1) danger to self; (2) danger to others; or (3) a behavioral health disorder is present and appropriate for residential care with ALL of the following: (a) moderately severe psychiatric, behavioral, or other comorbid conditions for adult and (b) serious dysfunction in daily living.
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> (b) Second, ***all*** of the following must be true (in addition to other requirements): (1) treatment at a lower level of care is not "feasible"; (2) *"[v]ery short-term* crisis intervention and resource planning for continued treatment at a nonresidential level is unavailable or inappropriate"; (3) "[p]atient is *willing* to participate in treatment within highly structured setting voluntarily"; *and* (4) "biopsychosocial stressors have been assessed and are absent or *manageable* at proposed level of care" (emphasis added).[11]

46. These requirements are objectively far more restrictive than generally accepted standards of medical practice and are contradicted by the primary sources on which the MCG Behavioral Health Guidelines purport to rely (*i.e.*, LOCUS).[12]

47. For example, contrary to generally accepted standards of medical practice, the MCG Behavioral Health Guidelines necessitate that risk of harm and/or functional impairment be "acute" and/or "represent significant worsening over baseline," thus drawing a red line and ruling out coverage for residential treatment for anyone with long-standing risk of harm and/or chronic

[11] MCG, *B-901-RES – Residential Behavioral Health Level of Care, Adult*, https://behavioralguidelines.access.mcg.com/Index/Guideline (2025).

[12] MCG, *MCG Releases 27th Edition of Care Guidelines with Updates for COVID-19 and Specialty Medications*, https://www.mcg.com/client-resources/news-item/mcg-27th-edition-care-guidelines/ (Feb. 28, 2023) (last accessed Aug. 22, 2025).

functional impairments that would benefit from such care and not be expected to improve with outpatient treatment.

48. Even if patients meet the unjustifiably stringent acuity thresholds, the MCG Behavioral Health Guidelines provide that residential treatment is not medically necessary if treatment at a lower level of care is "feasible." As described above, however, under generally accepted standards of medical practice, treatment at a less-intensive level of care must be "as effective" as the more intensive level of care—not merely "feasible."

49. The MCG Behavioral Health Guidelines' stringent criteria also require that "very short-term crisis intervention" at a non-residential level be unavailable or inappropriate—thus cementing that care at a residential level is expected to be for "very short-term crisis intervention."[13] This requirement is inconsistent with generally accepted standards of medical practice, which do not restrict residential treatment to "crisis intervention" and which do not limit residential treatment to artificially predetermined durations, let alone to "very short-term" stays.

50. The MCG Behavioral Health Guidelines also improperly limit the scope and duration of residential treatment by providing that biopsychosocial stressors—which, according to MCG, include comorbid conditions—need only be "manageable" at the proposed level of care,[14] thus setting the expectation that "management" of comorbid conditions is all that is required. Accepted standards of medical practice, however, recognize that biopsychosocial stressors, if present, must be "effectively treated"—not merely "managed."

[13] MCG, *B-901-RES – Residential Behavioral Health Level of Care, Adult*, https://behavioralguidelines.access.mcg.com/Index/Guideline (2025).

[14] *Id*.

51. Further, to meet medical necessity under the MCG Behavioral Health Guidelines, patients must be "willing" to participate in treatment in a highly structured setting "voluntarily."[15] This criterion, too, is inconsistent with generally accepted standards of medical practice, which recognize that a lack of motivation for treatment may necessitate ***higher*** levels of care and that treatment might not be sought at one's own initiative, *e.g.*, a court, conservator, or guardian may demand or require it.

52. At the same time as the MCG Behavioral Health Guidelines unjustifiably restrict admission to residential treatment for mental health, they generously allow for discontinuation of such care as soon as risk of harm, functional impairments, and comorbidities can be "managed"—rather than "effectively treated"—at lower levels.[16]

53. As discussed above, under generally accepted standards of medical practice, treatment at a less-intensive level of care is warranted only if it is just as effective as the more intensive level of care. Superficially "managing" a patient's condition is not sufficient.

54. In sum, the MCG Behavioral Health Guidelines as utilized by Defendants provide that residential behavioral health treatment is only medically necessary for crisis stabilization or other circumstances in which a patient is suffering from acute symptoms. As such, those Guidelines are much more restrictive than generally accepted standards of medical practice, which recognize that persistent and/or pervasive behavioral-health disorders cannot necessarily be as effectively treated on a short-term and/or outpatient basis as they could be in residential care.

[15] *Id.*

[16] *Id.*

## VI. DEFENDANTS' ADOPTION AND USE OF THE MCG RTC GUIDELINES VIOLATE MHPAEA

55. MHPAEA, codified at 29 U.S.C. § 1185a, amended ERISA to prohibit discrimination with respect to mental-health and substance-use-disorder benefits. Because the parity provisions were inserted into ERISA, they are enforceable through ERISA's enforcement provision, 29 U.S.C. § 1132.

56. Since the addition of the parity provisions, ERISA requires any group health plan (like the Plaintiff's Plan), which "provides both medical and surgical benefits and mental health or substance use disorder benefits," to ensure that, among other things:

> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

57. MHPAEA's implementing regulations explain that "treatment limitations," which limit the scope or duration of benefits for treatment, may be quantitative (a "QTL"), *i.e.*, expressed numerically, or non-quantitative (an "NQTL"). The regulations prohibit the imposition of an NQTL on behavioral-health benefits unless, as written and in operation, the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to behavioral benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL with respect to medical/surgical benefits in the same classification. The regulations expressly provide that medical-necessity standards are NQTLs. The MCG RTC Guidelines, therefore, constitute an NQTL, as defined by the regulations.

58. MCG's decision to develop guidelines ***only*** for "acute" residential care, and not for treatment of chronic conditions at the residential level of care, is an illegal NQTL, as it violates the parity rules. As MCG admitted in a 2017 white paper, MCG views intermediate levels of care

(including residential treatment) for behavioral-health conditions very differently from intermediate levels of care for medical/surgical conditions:

> While inpatient and outpatient levels of care are common to both [mental health and substance use disorder ("MHSUD") benefits] and physical health conditions, there is a divergence in how intermediate levels of care (*e.g.*, services less intensive than would be available in an inpatient hospital setting, but more expansive than care that could be provided in most outpatient clinics) are managed.
>
> . . . Intermediate levels of care for ***medical/surgical conditions are designed to improve functional status among people with impairments that, while potentially significant, generally are not acute, and are not offered as alternatives to inpatient admission.*** As an example, the presence of an acute pulmonary infection, such as pneumonia, likely would lead to a denial of admission to a pulmonary rehabilitation program [an intermediate level of care].
>
> In contrast***, intermediate levels of care for MHSUDs are designed to support acute management of patients with MHSUDs. They often service as alternative to inpatient care, and are intended to have the ability to address acute symptoms or provide crisis stabilization*** . . . (emphasis added).[17]

59. As the MCG white paper demonstrates, MCG takes the position that while intermediate care for medical/surgical services is designed to address sub-acute conditions in order to improve functional status, intermediate care for behavioral-health services is available only "to support acute management" and to "address acute symptoms or provide crisis stabilization."[18]

60. For many years, MCG's website reflected its view that residential treatment is only available for "acute" behavioral-health conditions. MCG offered a set of "Level of Care Comparison Charts" that "allow[] a side by side comparison of behavioral health level of care criteria" to "facilitate placement decisions for behavioral health levels of care." As MCG's own description of its chart made clear, MCG recognizes only "5 levels of care" for behavioral-health

[17] MCG, "Mental Health Parity: Where Have We Come From? Where Are We Now?" (2017) (attached as Exhibit 1).

[18] *Id*.

treatment: "inpatient, ***acute*** residential, partial hospital, intensive outpatient, and ***acute*** outpatient care."[19]

61. After being named in a lawsuit challenging its acute-focused guidelines, MCG scrubbed its website to remove references to "acute" residential behavioral health and "acute" outpatient services. That cosmetic change, however, does not alter the fact that the MCG Guidelines themselves are improperly acute-focused and otherwise in conflict with generally accepted standards of care, as detailed herein.

62. Evidence will show that the MCG Guidelines for intermediate care of medical and surgical conditions, including its guidelines for "Recovery Facility Care," similarly reflect MCG's stated view that intermediate care for medical/surgical services is designed to address *sub-acute* conditions in order to improve functional status—meaning that, unlike the MCG RTC Guidelines, the medical/surgical guidelines do not condition coverage on the presence of acute factors.

63. Defendants' adoption and use of the MCG RTC Guidelines thus constitute the application of treatment limitation(s) to inpatient (intermediate) mental-health and substance-use-disorder benefits that are "separate" and/or "more restrictive" than Defendants' treatment limitation(s) for inpatient (intermediate) medical/surgical benefits. Under the MCG RTC Guidelines, moreover, medical-necessity determinations for inpatient (intermediate) mental-health and substance-use-disorder services use factors that are not comparable to, or used the same way as, factors in determining medical necessity for inpatient (intermediate) medical/surgical services, including acuity. For these reasons, Defendants' adoption and use of the MCG RTC Guidelines violate MHPAEA.[20]

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[19] MCG Behavioral Health Care Guidelines, https://www.mcg.com/care-guidelines/behavioral-healthcare/ (emphasis added) (last accessed Aug. 21, 2025).

[20] *See* ERISA, 29 U.S.C. § 1185a.

## VII. Financial Considerations Impacted Defendants' Decision to License, Use, and Apply the MCG Residential Behavioral Health Guidelines

64. Defendants have significant financial incentives to artificially suppress behavioral-health costs by restricting coverage for residential treatment of behavioral-health conditions.

65. Cigna and its subsidiaries make money by charging fees for their services, including behavioral-health-claims administration.

66. For fully insured plans, Cigna's subsidiaries charge a premium, from which all benefits approved by Evernorth are paid. Cigna and its subsidiaries, therefore, bear the risk that benefit reimbursements will exceed the fixed premiums and/or any per-member, per-month rates that they allocate for behavioral-health expenditures.

67. For self-funded plans, Cigna's subsidiaries are paid an administrative fee and the employers, as the plan sponsors, pay the medical expenses Evernorth approves. Defendants have an incentive to reduce such expenses to retain business and market their services as "cost-effective." Further, because the same guidelines are applied to fully insured and self-funded plans, Cigna has the incentive to use the more restrictive guidelines for self-funded plans so that it can use the same guidelines for fully insured plans, when it is paying for the expenses out of its own assets.

68. Cigna also may have financial motivations with respect to denying *out-of-network* claims when administering self-funded health plans such as the claim at issue here, as it has been reported that Cigna may obtain a "shared savings fee" (or other fees) of a substantial percentage of the billed charges when it denies coverage for non-network claims. Discovery in this litigation will ascertain whether, in addition to the other claims alleged herein, Cigna profited by denying Plaintiff's out-of-network claim here by taking a fee for itself.

69. By developing, adopting, and applying the MCG Residential Behavioral Health Guidelines as their interpretations of the terms of the plans it issues and administers, Defendants significantly narrowed the scope of coverage available under the terms of the plans, and decreased the number and value of covered claims by shifting some of the risk from themselves and their employer-customers to the participants and beneficiaries of the plans.

70. Residential treatment, though widely recognized as a critical component in the behavioral-health continuum of care, can be quite expensive. Avoiding benefit expense associated with providing coverage for residential treatment, therefore, directly benefitted Defendants' bottom line.

71. These self-motivated financial incentives infected Defendants' adoption of the MCG Residential Behavioral Health Guidelines, since these guidelines are the primary clinical tools that Defendants use to ration access to behavioral healthcare, including expensive residential treatment, and thereby artificially reduce medical expense.

## VIII. Defendants Used the MCG Guidelines to Improperly Deny Benefits to Plaintiff in Contravention of His Plan's Terms.

72. As Defendants' denial letters to Plaintiff detailed below reflect, Cigna and its affiliate, Evernorth, denied residential mental-health-treatment coverage for Plaintiff based on the MCG Residential Behavioral Health Guidelines, and applied requirements for determining medical necessity that are inconsistent with the "generally accepted standards of medical practice" required by Plaintiff's Plan.

73. Prior to issuing their denial letters, while Plaintiff was a beneficiary and participant of the Plan, Defendants licensed and used the MCG Residential Behavioral Health Guidelines, for their interpretation of the terms of Plaintiff's Plan, through their final denials of Plaintiff's requests for coverage of residential mental-health treatment.

74. Defendants' use of the MCG Residential Behavioral Health Guidelines thus shifted risk that otherwise would have been borne by Plaintiff's Plan directly to Plaintiff, thereby making his benefits less valuable. Plaintiff incurred thousands of dollars in direct economic expenses and harm as a result of the improper denial of his claim by Defendants, and thus has Article III standing to bring this lawsuit individually and on behalf of the Class as defined below.

75. Plaintiff suffers from major depression. On January 29, 2024, Plaintiff was admitted for residential treatment of his mental-health conditions at a well-known and reputable facility, the Austen Riggs Center ("Austen Riggs"), an out-of-network facility.

76. Plaintiff remained in residential treatment and incurred unreimbursed expenses from the date of his admission to until April 23, 2024, a period just short of three months. Through Austen Riggs, Plaintiff timely requested coverage for his residential treatment.

77. In a letter dated August 23, 2024, Evernorth wrote to Plaintiff that his claim was reviewed by Evernorth "for medical necessity for Cigna Health and Life Insurance Company." The letter provided, in pertinent part:

> Evernorth Behavioral Health, Inc., a licensed utilization review agent, reviews certain health care services for medical necessity for Cigna Health and Life Insurance Company… We received a coverage request on 05/21/2024 for Ross Greenwood for the following service/procedure: Residential Behavioral Health Level of Care, Adult from 01/29/2024 to 04/23/24 rendered by Austen Riggs Center Inc. After a review of the information submitted by your provider and the terms of your benefit plan, our peer reviewer, Amanda Rizzari, MD, (AZ:67149), a board certified psychiatrist, has determined that the requested services are not covered. The decision was based on the following:
>
> The clinical basis for this decision is: ***Based upon my review of the available clinical information and the MCG Behavioral Health Guidelines, medical necessity was not met for admission and continued stay at Residential Behavioral Health Level of Care, Adult***…. [emphasis added]

78. By its own admission, Evernorth based its determination on the MCG Residential Behavioral Health Guidelines.

79. Following receipt of this letter, Plaintiff, through his counsel, submitted a timely appeal to Defendants, addressed, as called for in the denial, to Evernorth Behavioral Health, Inc., dated November 11, 2024. Pursuant to the ERISA Claims Procedure regulations, it had 30 days to respond to the appeal.

80. After a response was not provided, Plaintiff's counsel sent a second letter to Defendants, again addressed to Evernorth, attaching another copy of the appeal letter, dated January 15, 2025.

81. After that letter was similarly ignored, Plaintiff's counsel sent a third letter, attaching copies of the first two letters, this time addressed both to Evernorth Behavioral Health, Inc. and Cigna Healthcare Inc.

82. Finally, by letter dated June 3, 2025, *nearly seven months after the initial appeal letter was submitted*, Defendants responded, denying the appeal. Notably, the letter was addressed directly to Plaintiff, even though each of the three letters had been submitted by Plaintiff's counsel, who had informed Defendants that counsel represented Plaintiff and was submitting the appeal on Plaintiff's behalf.

83. In the letter, on Cigna letterhead, but with an Evernorth Health Services address out of Chattanooga, Tennessee, Defendants reported that Plaintiff's appeal was denied on the ground that residential treatment was not medically necessary, citing the determination of "a Cigna HealthCare Medical Director" The letter once again confirmed that Defendants had relied in its denial on the MCG Residential Behavioral Health Guidelines.

84. As Plaintiff's Plan mandated one level of internal appeal, Plaintiff exhausted his administrative remedies, such that he now has the right to pursue his claims in federal court.

85. Plaintiff has alleged an injury in fact sufficient to support Article III standing for himself and the proposed Class members. At least five federal courts of appeal, including the United States Court of Appeals for the Sixth Circuit, have held that the denial of plan benefits is a concrete injury for Article III standing even when patients were not directly billed for their medical services (let alone when they are). *See Springer v. Cleveland Clinic Emp. Health Plan Total Care*, 900 F.3d 284, 287 (6th Cir. 2018); *Mitchell v. Blue Cross Blue Shield of N.D.*, 953 F.3d 529, 536 (8th Cir. 2020), *North Cypress Med. Ctr., Operating Co., Ltd. v. Cigna Healthcare*, 781 F.3d 182, 193 (5th Cir. 2015); *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1291 (9th Cir. 2014); *HCA Health Servs. of Ga., Inc. v. Emp'rs Health Ins. Co.*, 240 F.3d 982, 991 (11th Cir. 2001), overruled on other grounds by *Doyle v. Liberty Life Assurance Co. of Bos.*, 542 F.3d 1352 (11th Cir. 2008).

86. Moreover, in light of Defendants' violation of the ERISA claims procedure regulations by failing to submit a timely response, *i.e.*, within 30 days, there is "deemed exhaustion" under the regulations, pursuant to which Plaintiff is not required to pursue any further administrative remedies before filing his lawsuit. 29 CFR § 2560.503-1(l).

## CLASS ACTION ALLEGATIONS

87. Defendants' policies and practices followed with respect to the benefit claim submitted by Plaintiff are the same as those that have been applied by Defendants to other similarly situated insureds seeking coverage under their health plans for residential behavioral-health treatment, including Defendants' admitted and systematic use of the MCG Residential Behavioral Health Guidelines that contained the same restrictive medical-necessity criteria.

88. Pursuant to Federal Rule of Civil Procedure 23(a), (b)(1), and (b)(2), Plaintiff brings each of his claims below individually and on behalf of the following class of similarly situated individuals:

> All members of a health benefit plan governed by ERISA, the terms of which require that covered services must be provided in accordance with generally accepted standards of medical practice: (a) whose request for coverage of residential treatment services for a behavioral-health disorder was denied for lack of medical necessity by either or both Defendants at any time on or after August 22, 2019; where (b) such denial was based on Cigna's Behavioral Health Guidelines or the MCG Residential Behavioral Health Guidelines; and (c) such denial was not reversed on administrative appeal (the "Class").

89. The Class members can be objectively ascertained through the use of information that is readily available in Defendants' own files because Defendants know who their insureds are, which plans they are insured by, what type of claims they filed, and how those claims were adjudicated and denied. This information will be requested by Plaintiffs as part of discovery.

90. The Class is sufficiently numerous, numbering in the thousands, such that joinder is impracticable. While Plaintiff does not currently have access to the identity of the Class members, that information is readily available and in Defendants' possession, custody, or control.

91. Certification of the Class is desirable and proper because there are questions of law and fact in this case that are common to all members of the Class. Such common questions of law and fact include, but are not limited to:

(a) whether Cigna's Behavioral Health Guidelines and/or the MCG Residential Behavioral Health Guidelines are consistent with generally accepted standards of medical practice;

(b) whether Defendants breached their fiduciary duties when they licensed and/or adopted the MCG Residential Behavioral Health Guidelines;

(c) whether Defendants violated MHPAEA by adopting and applying the MCG RTC Guidelines for making coverage decisions relating to behavioral-health conditions;

(d) whether Evernorth was directed by Cigna to use the MCG Residential Behavioral Health Guidelines;

(e) whether Defendants' breached their fiduciary duties when they applied the MCG Residential Behavioral Health Guidelines to deny requests for benefits for residential treatment;

(f) whether Defendants' use of the MCG Residential Behavioral Health Guidelines to deny requests for benefits for residential treatment of behavioral health disorders violated the terms of the Class members' plans;

(g) whether Defendants violated their duties as fiduciaries or co-fiduciaries under ERISA; and

(h) what remedies are available to the Class.

92. Class certification is desirable and proper because Plaintiff's claims are typical of the claims of the members of the Class that Plaintiff seeks to represent.

93. Class certification is also desirable and proper because Plaintiff will fairly and adequately protect the interests of the Class he seeks to represent. There are no conflicts between the interests of Plaintiff and those of other Class members, and Plaintiff is cognizant of his duties and responsibilities to the entire Class. Plaintiff's attorneys are qualified, experienced, and able to conduct the proposed class-action litigation and have obtained successful results in similar cases.

94. It is desirable to concentrate the litigation of these claims in this forum. The determination of the claims of all Class members in a single forum, and in a single proceeding is a fair and efficient means of resolving the issues in this litigation.

95. Class certification is proper pursuant to Rule 23(b)(1) of the Federal Rules of Civil Procedure because prosecuting separate actions by individual class members would create a risk of inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for Defendants.

96. Class certification is proper pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure because Defendants have acted or refused to act on grounds that apply generally to the

class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole.

97. This ERISA class action can be reasonably managed, especially when weighed against the virtual impossibility of affording adequate relief to the members of the Class through numerous separate actions.

**COUNT I**
**CLAIM FOR BREACH OF FIDUCIARY DUTY**
**(against all Defendants)**

98. Plaintiff incorporates by reference all preceding paragraphs as though such paragraphs were fully stated herein.

99. Plaintiff brings this Count I individually and on behalf of the Class pursuant to 29 U.S.C. § 1132(a)(1)(B) and/or § 1132(a)(3)(A) and (a)(3)(B).

100. As explained above, Defendants are responsible for interpreting the plans they administer and developing and/or adopting policies and guidelines interpreting plan terms, while Defendant Evernorth is also responsible for its delegated power in making final and binding decisions about whether to approve coverage requested by plan members. As such, Defendants exercise discretionary authority with respect to the administration of the plans and the payment of plan benefits. Defendants are therefore ERISA fiduciaries as defined by 29 U.S.C. §§ 1002(21)(A) and 1104(a).

101. As ERISA fiduciaries, and pursuant to 29 U.S.C. § 1104(a), Defendants have a duty of loyalty to plan participants and beneficiaries that requires them to discharge their duties "solely in the interests of the participants and beneficiaries" of the plans they administer and for the "exclusive purpose" of providing benefits to participants and beneficiaries and paying reasonable expenses of administering the plans. Defendants also owe plan participants and beneficiaries a

duty of care, which requires them to act with reasonable "care, skill, prudence, and diligence" and in accordance with the terms of the plans, so long as such terms are consistent with ERISA.

102. Defendants violated these duties by using the MCG Residential Behavioral Health Guidelines as Defendants' interpretation of terms in Plaintiff's and Class members' plans. Despite the fact that the health-insurance plans that insure Plaintiff and the Class members require medical-necessity determinations concerning residential behavioral-health treatment to be made consistent with generally accepted standards of medical practice, and the fact that generally accepted standards of medical practice are widely available and well-known to Defendants, Defendants selected and adopted clinical coverage criteria – the MCG Residential Behavioral Health Guidelines – that were more restrictive than generally accepted standards of medical practice. In doing so, Defendants did not act "solely in the interests of the participants and beneficiaries" for the "exclusive purpose" of "providing benefits." They did not use the "care, skill, prudence, and diligence" that ERISA demands of fiduciaries. They did not act in accordance with the terms of the Plaintiff's or the Class members' plans.

103. Instead, Defendants elevated their own interests above the interests of the plan participants and beneficiaries. By interpreting plan terms in this manner, Defendants artificially decreased the scope of coverage available under the plans, thereby transferring risk from themselves and their employer customers to the participants and beneficiaries of the plans and severely limiting the availability of residential treatment services to Plaintiff and the Class. In so doing, Defendants harmed Plaintiff and the Class.

104. In addition, Defendants breached their fiduciary duties by violating the mental-health parity provisions of ERISA, 29 U.S.C. § 1185a, by applying the MCG RTC Guidelines to claims for residential treatment of behavioral-health conditions, because the MCG RTC Guidelines

are more stringent than the MCG guidelines Defendants use for medical/surgical conditions in the same classification, both as written and in operation.

105. Plaintiff and the Class seek the relief identified below to remedy this claim.

**COUNT II**
**Violation of Plan Terms**
**(against all Defendants)**

106. Plaintiff incorporates by reference all preceding paragraphs as though such paragraphs were fully stated herein.

107. Plaintiff brings this count individually and on behalf of the Class pursuant to 29 U.S.C. § 1132(a)(1)(B).

108. Defendants denied the requests for coverage of residential treatment services submitted by Plaintiff and Class members in violation of the terms of the applicable plans. Defendant denied benefits to Plaintiff and the Class, at least in part, based on restrictive clinical coverage guidelines that it applied in violation of its fiduciary duties, as set forth above.

109. Given that the MCG Behavioral Health Guidelines relied upon by Defendants were contrary to generally accepted standards, in violation of plan terms, the denial should be reversed as arbitrary and capricious or pursuant to *de novo* review.

110. Plaintiff and the Class members were harmed by Defendant's improper benefit denials because Defendant denied their requests for benefits using clinical coverage criteria that were inconsistent with the applicable plan terms and in violation of ERISA.

111. Plaintiff and the Class seek the relief identified below to remedy this claim.

**COUNT III**
**Claim for Breach of Co-Fiduciary Duty**
**(against all Defendants)**

112. Plaintiff incorporates by reference all preceding paragraphs as though such paragraphs were fully stated herein.

113. Plaintiff brings this count individually and on behalf of the Class pursuant to 29 U.S.C. § 1132(a)(1)(B) and/or § 1132(a)(3)(A) and (a)(3)(B).

114. At all times, Defendants were co-fiduciaries in the administration of the Plan.

115. As explained above, Cigna licensed, adopted, and used the policies and guidelines interpreting plan terms, and thereby exercised discretionary authority with respect to the administration of the plans and the payment of plan benefits and served as a co-fiduciary under ERISA to the plans' named fiduciaries, for which it is liable under 29 U.S.C. § 1105(a).

116. Defendants were also delegated fiduciary responsibility for making final and binding decisions about whether to approve coverage requested by plan members based on the policies and guidelines developed and/or adopted by Cigna. As such, Defendants were actual and functional fiduciaries under ERISA.

117. As ERISA co-fiduciaries, Defendants are liable under 29 U.S.C. § 1105(a) for their breaches of fiduciary duty to the health plans for which they administer claims, arising from their knowing use of the flawed and overly restrictive coverage guidelines for making coverage determinations and their failure to make reasonable efforts to remedy the breach.

118. By elevating their own interests above the interests of the plan participants and beneficiaries and making no reasonable efforts to remedy the fiduciary breaches described herein, Defendants harmed Plaintiff and the Class.

119. Plaintiff and the Class seek the relief identified below to remedy this claim.

**COUNT IV**
**Claim for Injunctive Relief**
**(against all Defendants)**

120. Plaintiff incorporates by reference all preceding paragraphs as though such paragraphs were fully stated herein.

121. Plaintiff brings this count individually and on behalf of the Class pursuant to 29 U.S.C. § 1132(a)(3)(A) only to the extent that the Court finds that the injunctive relief available pursuant to 29 U.S.C. § 1132(a)(1)(B) is inadequate to remedy the violations alleged in Counts I and/or II.

122. Plaintiff and the Class have been harmed, and are likely to be harmed in the future, by Defendants' breaches of fiduciary duty and/or violations of ERISA described above.

123. To prevent Defendants' ongoing violations of ERISA and the applicable plans, and the harm those violations cause, Plaintiff and the Class are entitled to enjoin these acts and practices pursuant to 29 U.S.C. § 1132(a)(3)(A).

**COUNT V**
**Claim for Other Appropriate Equitable Relief**
**(against all Defendants)**

124. Plaintiff incorporates by reference all preceding paragraphs as though such paragraphs were fully stated herein.

125. Plaintiff brings this count individually and on behalf of the Class pursuant to 29 U.S.C. § 1132(a)(3)(B) only to the extent that the Court finds that the equitable relief available pursuant to 29 U.S.C. § 1132(a)(1)(B) is inadequate to remedy the violations alleged in Counts I and/or II.

126. Plaintiff and the Class have been harmed, and are likely to be harmed in the future, by Defendants' breaches of fiduciary duty and/or violations of ERISA described above.

127. To completely and adequately remedy these harms, Plaintiff and the Class are entitled to appropriate equitable relief pursuant to 29 U.S.C. § 1132(a)(3)(B).

## REQUESTED RELIEF

**WHEREFORE**, Plaintiff demands judgment in his favor against Defendants as follows:

A. Certifying the Class and their claims, as set forth above, for class treatment;

B. Appointing Plaintiff as the Class Representative;

C. Designating Plaintiff's undersigned counsel as Class Counsel;

D. Declaring that the MCG Residential Behavioral Health Guidelines used by Defendants were inconsistent with generally accepted standards of medical practice;

E. Declaring that Defendants' use of the MCG RTC Guidelines to make coverage determinations with respect to behavioral-health conditions violates MHPAEA;

F. Issuing a permanent injunction ordering Defendants to stop using the MCG Residential Behavioral Health Guidelines as complained of herein, and to instead adopt or develop and use clinical coverage guidelines that are consistent with generally accepted standards of medical practice;

G. Ordering Defendants to reprocess the claims for residential behavioral-health treatment that they previously denied in whole or in part under the MCG Residential Behavioral Health Guidelines, or any other MCG Guidelines containing the same restrictive criteria, and instead to apply new guidelines that are consistent with generally accepted standards of medical practice and ERISA;

H. Awarding other appropriate equitable relief, including but not necessarily limited to additional declaratory and injunctive relief;

I. Awarding Plaintiff's disbursements and expenses for this action, including reasonable attorneys' fees, costs, and expert fees, in amounts to be determined by the Court, pursuant to 29 U.S.C. § 1132(g); and

J. Granting such other and further relief as is just and proper.

Dated: August 22, 2025

Respectfully submitted,

*/s/ Ashlie Case Sletvold*

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# Mental Health Parity:
## Where Have We Come From? Where Are We Now?

by Monique Yohanan, MD, MPH

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### Introduction

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008[1] has an underlying premise that seems straightforward: If insurers choose to offer mental health and substance use disorder (MHSUD) benefits, this must be done in parity with medical and surgical benefits. Though several years have passed since MHPAEA was signed into law, equal coverage for MHSUDs is seen as lagging by many observers, and confusion regarding key elements of the law persists. This white paper reviews the background, timeline, and evolution of mental health parity. Challenges in attaining mental health parity also are discussed, including ways in which physical and mental health differ in terms of systems of care, diagnostic methods, and resources.

### The History of Mental Health Parity

While MHPAEA was signed into law on Oct. 3, 2008, federal efforts to address mental health parity have a much longer history. The Federal Mental Health Parity Act (FMHPA) of 1996[2] prohibited payers from having differences in annual and lifetime dollar limits for mental health and medical/surgical conditions, but did not address substance use disorder treatment. MHPAEA maintained the FMHPA prohibition on differences in annual and lifetime dollar limits, and though it applied only to large group health plans, it broadened parity efforts in many important ways.

MHPAEA required payers who offer mental health benefits to also provide coverage for substance use disorder treatment. It expanded restrictions on quantitative (numeric) limits to include other types of financial limitations (e.g., co-pays), as well as non-financial quantitative limitations (e.g., visit numbers). It also addressed the role of non-numeric, non-quantitative treatment limitations (NQTLs) and their potential impact on the duration and scope of MHSUD services. Finally, MHPAEA promoted greater transparency of factors used in making coverage determinations through increased disclosure requirements.

Since MHPAEA addressed parity in a more comprehensive way than FMHPA, which had focused on parity related to annual and lifetime dollar limits, direction on how to structure care to meet these new obligations was necessary. This led to the issuance of the 2010 Interim Final Rule (IFR)[3], the 2013 Final Rule[4], and numerous subsequent guidance statements from the Departments of Health and Human Services, Labor, and Treasury – all of which were designed to support appropriate implementation of MHPAEA. The expansion of the concept of parity, and the elements of care necessary to achieve this goal, required both a format to allow for comparison of medical/surgical and MHSUDs, as well as clarification as to what would constitute limitations on treatment. The IFR addressed these issues by defining 6 benefit classifications and providing further detail on treatment limitations, including guidance on limitations that potentially could represent parity violations.

The six benefit classifications described in the IFR – inpatient and outpatient care (in- and out-of-network), emergency care, and prescription drugs – provided a framework for determining if benefits were being provided in parity. Determinations were expected to be made by comparing care within the same benefit class for MHSUDs and medical/surgical care (e.g., inpatient, in-network care for an MHSUD would be compared to how inpatient, in-network care for medical/surgical benefits were handled by the organization).

**Levels of Care**

The levels of care described in the IFR were intended to facilitate evaluation of mental and physical health services, but the categories that were included highlighted one of the challenges involved in making these kinds of comparisons. While inpatient and outpatient levels of care are common to both MHSUDs and physical health conditions, there is a divergence in how intermediate levels of care (e.g., services less intensive than would be available in an inpatient hospital setting, but more expansive than care that could be provided in most outpatient clinics) are managed.

While intermediate levels of care, such as pulmonary rehabilitation, are available to treat physical conditions, acute care decisions for medical and surgical patients tend to be binary – admit to inpatient care or treat in an outpatient clinic. Intermediate levels of care for medical/surgical conditions are designed to improve functional status among people with impairments that, while potentially significant, generally are not acute, and are not offered as alternatives to inpatient admission. As an example, the presence of an acute pulmonary

infection, such as pneumonia, likely would lead to a denial of admission to a pulmonary rehabilitation program.

In contrast, intermediate levels of care for MHSUDs are designed to support acute management of patients with MHSUDs. They often serve as alternatives to inpatient care, and are intended to have the ability to address acute symptoms or provide crisis stabilization, and some instances may be preferable to inpatient care, in particular by allowing for maintenance of community-based psychosocial supports and structures (e.g., school attendance). Practice guidelines and standards for intermediate levels of care for MHSUDs have been issued by many professional organizations, including, but not limited to, the Association for Ambulatory Behavioral Healthcare (AABH), and the Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists (AACP). Best practices for MHSUD intermediate levels of care are specific, and address appropriate multidimensional admission assessment, number of days per week and hours per day of services, staffing models, and documentation.

**Treatment Limitations**

In addition to outlining benefit classifications, the IFR also addressed two types of treatment limitations: quantitative treatment limitations and NQTLs. Quantitative, or numeric, treatment limitations include a variety of financial limitations (e.g., annual and lifetime dollar caps on services, co-pays), as well as other types of quantifiable treatment limitations (e.g., limits on the number of days of coverage for a condition). The IFR did not mandate that quantifiable limitations for medical/surgical and MHSUDs had to be exactly the same, and instead provided 2 methods to allow systems to address parity as it related to quantitative limitations – “predominant” and “substantially all.”

“Predominant” refers to financial requirements within the same benefit classification (e.g., prescription drugs). If a financial requirement such as a co-pay was applied to an MHSUD, then the “predominant” standard generally would be met if it also applied to at least half of all covered medical/surgical conditions (within the same benefit classification). If this one-half threshold was not met, this could represent a potential parity violation.

“Substantially all” was used for other types of quantitative limitations, and was set as a two-thirds standard. Any quantitative, but non-financial, limitation on MHSUD coverage was required

to also apply to two-thirds of medical/surgical conditions (in the same benefit classification), or potentially run the risk of a parity violation.

While there were some structural challenges in making “predominant” and “substantially all” determinations, addressing NQTLs proved far more complicated. NQTLs are factors that limit the scope or duration of covered services. Just as the IFR did not require a one-to-one alignment for quantitative limitations (as indicated by the “predominant” and “substantially all” thresholds), it did not indicate that the presence of an NQTL should be seen as an automatic violation of MHPAEA. The IFR gave examples of NQTLs, such as differences in pre-authorization requirements, as well as other factors such as “fail-first” requirements (e.g., requiring that someone first “fail” a lower level of care or less expensive medication before being allowed to receive more intensive services or a costly drug therapy).

NQTLs are common in the management of both medical/surgical conditions and MHSUDs. As an example, a likelihood of clinical improvement would be a typical expectation for most inpatient medical admissions. Similarly, for patients who are not severely ill, a trial of outpatient antimicrobial therapy, as part of initial management of an infection, and admission only if outpatient therapy was deemed to have “failed” are common clinical practices (NB: A 2015 study of adults being treated as inpatients for pneumonia found that 22% had received a trial of outpatient antibiotics prior to admission[5]). Given this context, the IFR allowed for exceptions to NQTL requirements if these were made using “established clinical rationale.” These exceptions, while favored by some providers, were not without controversy, and were seen by some advocates as a loophole that would lead to restrictions on care.

**Disclosure Requirements**

Finally, the IFR addressed the issue of disclosure of medical necessity criteria. Two types of disclosures were mandated under the IFR. The IFR indicated that any current or prospective members of an insurance plan (or their proxies or providers) who wished to review the medical necessity criteria used for MHSUD coverage should be given this information. In addition, if a plan subscriber wished to receive information about a coverage determination (including, but not limited to, a denial of service), the IFR allowed for the subscriber to request not just the criteria that were used in the determination, but the reason for the determination as well. In cases in which an NQTL factored into the determination, the IFR specified that the “processes,

strategies, evidentiary standards, and other factors used to apply the non-quantitative treatment limitation" should also be provided.

Though the IFR expanded disclosure requirements, there was significant confusion as to what types of disclosures were required. While the IFR indicated that MHSUD medical necessity criteria had to be disclosed to both current and potential plan members, there was concern about the utility of only disclosing the MHSUD content vs providing the corresponding medical/surgical content as well (to allow for comparison of the criteria). At the time the IFR was issued, MHPAEA applied only to certain large group plans. Other types of insurance plans (e.g., plans subject to Employee Retirement Income Security Act (ERISA) rules) had different disclosure requirements (e.g., ERISA-covered plans were required to disclose both MHSUD and medical/surgical criteria within 30 days of any request by a participant or plan administrator), and these different models led to uncertainty as to how to apply disclosure policies in a general manner.

**The Final Rule for MHPAEA**

The IFR was followed by the Final Rule for MHPAEA, which was issued in 2013. While the Final Rule kept intact the key financial requirements and formulae for their application that had been established in the IFR ("predominant" and "substantially all"), it also included notable changes. The Final Rule clarified that in addition to inpatient and outpatient benefit classification levels, coverage for intermediate level-of-care services for MHSUDs (e.g., residential, partial hospital, and intensive outpatient) also was required (NB: intermediate levels of care had not been excluded from the IFR, but the Final Rule made the requirement to include them explicit).

The Final Rule expanded disclosure requirements, and the reason for any denial of service was required to be provided to the member automatically (rather than disclosure only to members who had requested this information). In addition, the Final Rule emphasized that disclosure requirements that were more expansive than those defined under MHPAEA (e.g., ERISA-covered plans, state laws), could supersede federal MHPAEA requirements.

The Final Rule also removed the "established clinical rationale" exception for NQTLs, ostensibly because this exception had created some confusion as to which sorts of NQTLs might represent a parity violation. The Final Rule, as well as subsequent guidance statements from the Departments of Health and Human Services, Labor, and Treasury, attempted to clarify this issue, albeit with little success. These documents provided numerous examples of "warning

signs" that were described as potential violations of parity. These "warning signs" were not absolute, nor were limitations on treatment described as inherently being in violation of parity. And while "warning signs" of potential violations were provided, positive models (e.g., examples of organizations whose utilization management practices were within the bounds of parity) were not provided.

**Key Differences Between Medical/Surgical Conditions and MSHUDs**

Why did understanding NQTLs prove to be so difficult? The way diagnoses are made for medical/surgical conditions vs MHSUDs is illustrative when considering the challenges in making these kinds of comparisons. As an example, diabetes is diagnosed based on blood sugar levels. Similarly, quality indicators for diabetes management are based on tests of blood sugar control. When determining the severity of a complication of diabetes, such as diabetic ketoacidosis, specific acid/base and electrolyte levels are used in making this assessment. By no means does this reliance on objective laboratory findings mean that other factors – motivation to participate in care, compliance with recommended therapies, or formation of a therapeutic alliance with a healthcare provider – are unimportant in diabetes management. But while these factors may impact the management of a medical condition, they are not intrinsic to the disease process itself. There are people with brittle diabetes who may develop severe complications of diabetes, despite optimal compliance with recommended therapies, and others who are relatively unengaged in care who have a disease course that is mild (and may even be completely asymptomatic).

Objective, widely accepted laboratory parameters available for the diagnosis and ongoing management of MHSUDs are not presently available. Instead, the Diagnostic and Statistical Manual of Mental Disorders, 5$^{th}$ Edition (DSM-5), provides a method in which diagnoses are made based on a combination of symptoms and functional impairment. Similarly, the American Society of Addiction Management (ASAM) does not describe grading the severity of addiction based on a blood test or imaging study; rather, ASAM provides a structure in which multiple dimensions of care are considered to determine the substance use severity and appropriate placement.

Federal and state guidance statements have indicated that consideration of factors such as "likelihood of improvement" or "compliance with recommended therapies" represent "warning signs" that a potential MHPAEA violation may be present. While acknowledging that many of

these “warning signs” represent typical standards of care for medical/surgical conditions, mental health advocates have made the case that these sorts of factors have been used in the past to discriminate against patients with MHSUDs. Providers are left balancing legitimate concerns related to past discrimination with efforts to align mental and physical healthcare in the context of evidence-based medicine.

Numerous best practice organizations, including ASAM, the AABH, the AACP, the American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry indicate that a multidimensional assessment is essential in determining the level of service intensity necessary to effectively manage MHSUDs. Factors such as evaluation of resistance to treatment and motivation to participate in care are standard elements of the evidence-based assessments recommended by these organizations. Put another way, many of the “warning signs” described by regulators may reflect features of the MHSUD disease process itself, and are required if the “right care, in the right place, at the right time” is to be delivered.

**The Impact of Other Important Legislation**

Along with the evolution of federal parity laws, other legislative efforts at the federal and state level also have helped shape the form in which parity efforts would be delivered. These include expansion of the types of plans subject to parity, an increase in the scope of services that plans are required to cover, and increased access to insurance coverage.

While MHPAEA originally only applied to large group health plans, the 2010 Patient Protection and Affordable Care Act (PPACA)[6] and subsequent Health Care and Education Reconciliation Act (which will be referred to going forward as the Affordable Care Act, or ACA), led to an application of MHPAEA to all new small group plans and individual market plans. In addition, qualified health plans offered through state health insurance marketplaces also had to comply with MHPAEA.

Prior to passage of the ACA, plans had significant discretion in the types of services they could choose to cover. This limitation on the scope of services was narrowed by the establishment of 10 Essential Health Benefits, including MHSUDs. But from a practical standpoint, the ACA Medicaid arguably has had the greatest impact on mental health parity efforts.

There is a strong association between severe mental illness and poverty[7], and social withdrawal and limited community supports are more common among patients with mental health disorders

than in patients with chronic medical conditions.[8] Medicaid serves as the single largest payer for behavioral healthcare services in the United States.[9] While the annual prevalence of serious mental illness among privately insured adults is less than 5%[10], 33% of Medicaid beneficiaries who qualify for services based on disability have a serious mental illness.[11] The impact on the treatment of MHSUDs that resulted from the expansion of Medicaid coverage in general, and more specifically, in terms of the application of MHPAEA to Medicaid beneficiaries participating in managed-care programs, cannot be overstated.

**Conclusion**

While differences in systems of care, diagnostic methods, and resources all have represented challenges in achieving the goals of the Mental Health Parity and Addiction Equity Act, an additional obstacle has been the difficulty of reconciling the terms “parity” and “equity.” Providing the same clinical services for people with medical/surgical and MHSUDs may be insufficient to address issues of fairness and injustice that too often impact healthcare. Discrimination, poverty, and disengagement from friends, family, and community are far too common among people with serious mental illness. For these people, even if the clinical services that are provided are objectively the same, it is unlikely that this will achieve equity in care. Despite these challenges there is hope. Integrated approaches for the management of behavioral health and medical services, such as collaborative care, are expanding, and are associated with improved outcomes. Ultimately, efforts to promote mental health parity stand to benefit the entire population by improving access to needed services and promoting a holistic model of care.

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5. van de Garde EM, Natsch S, Prins JM, van der Linden PD. Antibiotic prescribing on admission to patients with pneumonia and prior outpatient antibiotic treatment: A cohort study on clinical outcome. BMJ Open February 12, 2015;5(2):e006892. doi: 10.1136/bmjopen-2014-006892.

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JS 44 (Rev. 10/20)

# CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

**I. (a) PLAINTIFFS**

ROSS GREENWOOD, individually and on behalf of all others similarly situated,

**(b)** County of Residence of First Listed Plaintiff Trumbull County, OH
*(EXCEPT IN U.S. PLAINTIFF CASES)*

**(c)** Attorneys *(Firm Name, Address, and Telephone Number)*
Ashlie Case Sletvold, Peiffer Wolf Carr Kane Conway & Wise LLP, 6370 SOM Center Road, Suite 108, Cleveland OH, 44139, (216) 260 0808; (see attachment A)

**DEFENDANTS**

CIGNA HEALTH AND LIFE INSURANCE COMPANY and EVERNORTH BEHAVIORAL HEALTH, INC.,

County of Residence of First Listed Defendant
*(IN U.S. PLAINTIFF CASES ONLY)*

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

**II. BASIS OF JURISDICTION** *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

**III. CITIZENSHIP OF PRINCIPAL PARTIES** *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
*(For Diversity Cases Only)*

| | PTF | DEF | | PTF | DEF |
|---|---|---|---|---|---|
| Citizen of This State | ☐ 1 | ☐ 1 | Incorporated *or* Principal Place of Business In This State | ☐ 4 | ☐ 4 |
| Citizen of Another State | ☐ 2 | ☐ 2 | Incorporated *and* Principal Place of Business In Another State | ☐ 5 | ☐ 5 |
| Citizen or Subject of a Foreign Country | ☐ 3 | ☐ 3 | Foreign Nation | ☐ 6 | ☐ 6 |

**IV. NATURE OF SUIT** *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

| CONTRACT | TORTS | | FORFEITURE/PENALTY | BANKRUPTCY | OTHER STATUTES |
|---|---|---|---|---|---|
| ☐ 110 Insurance | PERSONAL INJURY | PERSONAL INJURY | ☐ 625 Drug Related Seizure of Property 21 USC 881 | ☐ 422 Appeal 28 USC 158 | ☐ 375 False Claims Act |
| ☐ 120 Marine | ☐ 310 Airplane | ☐ 365 Personal Injury - Product Liability | ☐ 690 Other | ☐ 423 Withdrawal 28 USC 157 | ☐ 376 Qui Tam (31 USC 3729(a)) |
| ☐ 130 Miller Act | ☐ 315 Airplane Product Liability | ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability | | PROPERTY RIGHTS | ☐ 400 State Reapportionment |
| ☐ 140 Negotiable Instrument | ☐ 320 Assault, Libel & Slander | ☐ 368 Asbestos Personal Injury Product Liability | | ☐ 820 Copyrights | ☐ 410 Antitrust |
| ☐ 150 Recovery of Overpayment & Enforcement of Judgment | ☐ 330 Federal Employers' Liability | PERSONAL PROPERTY | LABOR | ☐ 830 Patent | ☐ 430 Banks and Banking |
| ☐ 151 Medicare Act | ☐ 340 Marine | ☐ 370 Other Fraud | ☐ 710 Fair Labor Standards Act | ☐ 835 Patent - Abbreviated New Drug Application | ☐ 450 Commerce |
| ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans) | ☐ 345 Marine Product Liability | ☐ 371 Truth in Lending | ☐ 720 Labor/Management Relations | ☐ 840 Trademark | ☐ 460 Deportation |
| ☐ 153 Recovery of Overpayment of Veteran's Benefits | ☐ 350 Motor Vehicle | ☐ 380 Other Personal Property Damage | ☐ 740 Railway Labor Act | ☐ 880 Defend Trade Secrets Act of 2016 | ☐ 470 Racketeer Influenced and Corrupt Organizations |
| ☐ 160 Stockholders' Suits | ☐ 355 Motor Vehicle Product Liability | ☐ 385 Property Damage Product Liability | ☐ 751 Family and Medical Leave Act | SOCIAL SECURITY | ☐ 480 Consumer Credit (15 USC 1681 or 1692) |
| ☐ 190 Other Contract | ☐ 360 Other Personal Injury | | ☐ 790 Other Labor Litigation | ☐ 861 HIA (1395ff) | ☐ 485 Telephone Consumer Protection Act |
| ☐ 195 Contract Product Liability | ☐ 362 Personal Injury - Medical Malpractice | | ☒ 791 Employee Retirement Income Security Act | ☐ 862 Black Lung (923) | ☐ 490 Cable/Sat TV |
| ☐ 196 Franchise | | | | ☐ 863 DIWC/DIWW (405(g)) | ☐ 850 Securities/Commodities/ Exchange |
| | | | | ☐ 864 SSID Title XVI | ☐ 890 Other Statutory Actions |
| | | | | ☐ 865 RSI (405(g)) | ☐ 891 Agricultural Acts |
| | | | | | ☐ 893 Environmental Matters |
| | | | | FEDERAL TAX SUITS | ☐ 895 Freedom of Information Act |
| | | | | ☐ 870 Taxes (U.S. Plaintiff or Defendant) | ☐ 896 Arbitration |
| | | | | ☐ 871 IRS—Third Party 26 USC 7609 | ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision |
| | | | IMMIGRATION | | ☐ 950 Constitutionality of State Statutes |
| | | | ☐ 462 Naturalization Application | | |
| | | | ☐ 465 Other Immigration Actions | | |

| REAL PROPERTY | CIVIL RIGHTS | PRISONER PETITIONS |
|---|---|---|
| ☐ 210 Land Condemnation | ☐ 440 Other Civil Rights | **Habeas Corpus:** |
| ☐ 220 Foreclosure | ☐ 441 Voting | ☐ 463 Alien Detainee |
| ☐ 230 Rent Lease & Ejectment | ☐ 442 Employment | ☐ 510 Motions to Vacate Sentence |
| ☐ 240 Torts to Land | ☐ 443 Housing/ Accommodations | ☐ 530 General |
| ☐ 245 Tort Product Liability | ☐ 445 Amer. w/Disabilities - Employment | ☐ 535 Death Penalty |
| ☐ 290 All Other Real Property | ☐ 446 Amer. w/Disabilities - Other | **Other:** |
| | ☐ 448 Education | ☐ 540 Mandamus & Other |
| | | ☐ 550 Civil Rights |
| | | ☐ 555 Prison Condition |
| | | ☐ 560 Civil Detainee - Conditions of Confinement |

**V. ORIGIN** *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

**VI. CAUSE OF ACTION**

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
ERISA 29 U.S.C. § 1132

Brief description of cause:
Breach of fiduciary duty; violation of federal Parity Act; and unreasonable denials of coverage for behavioral health

**VII. REQUESTED IN COMPLAINT:**

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

**DEMAND $**

CHECK YES only if demanded in complaint:
**JURY DEMAND:** ☐ Yes ☒ No

**VIII. RELATED CASE(S) IF ANY** *(See instructions)*:

JUDGE _____ DOCKET NUMBER _____

DATE
August 25, 2025

SIGNATURE OF ATTORNEY OF RECORD

**FOR OFFICE USE ONLY**

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

# UNITED STATES DISTRICT COURT
# NORTHERN DISTRICT OF OHIO

**I.** Civil Categories: (Please check one category only ).

1. ☑ General Civil
2. ☐ Administrative Review/Social Security
3. ☐ Habeas Corpus Death Penalty

*If under Title 28, §2255, name the SENTENCING JUDGE: _____

CASE NUMBER: _____

**II.** **RELATED OR REFILED CASES** See LR 3.1 which provides in pertinent part: "If an action is filed or removed to this Court and assigned to a District Judge after which it is discontinued, dismissed or remanded to a State court, and subsequently refiled, it shall be assigned to the same Judge who received the initial case assignment without regardfor the place of holding court in which the case was refiled. Counsel or a party without counsel shall be responsible for bringing such cases to the attention of the Court by responding to the questions included on the Civil Cover Sheet."

This action: ☐ is **RELATED** to another **PENDING** civil case ☐ is a **REFILED** case ☐ was **PREVIOUSLY REMANDED**

**If applicable, please indicate on page 1 in section VIII, the name of the Judge and case number.**

**III.** In accordance with Local Civil Rule **3.8**, actions involving counties in the Eastern Division shall be filed at any of the divisional offices therein. Actions involving counties in the Western Division shall be filed at the Toledo office. For the purpose of determining the proper division, and for statistical reasons, the following information is requested.

ANSWER ONE PARAGRAPH ONLY. ANSWER PARAGRAPHS 1 THRU 3 IN ORDER. UPON FINDING WHICH PARAGRAPH APPLIES TO YOUR CASE, ANSWER IT AND STOP.

(1) **Resident defendant**. If the defendant resides in a county within this district, please set forth the name of such county

**COUNTY:**

Corporation **For the purpose of answering the above, a corporation is deemed to be a resident of that county in which it has its principal place of business in that district.**

(2) **Non-Resident defendant**. If no defendant is a resident of a county in this district, please set forth the county wherein the cause of action arose or the event complained of occurred.

**COUNTY:** Trumbull County, OH

(3) **Other Cases**. If no defendant is a resident of this district, or if the defendant is a corporation not having a principle place of business within the district, and the cause of action arose or the event complained of occurred outside this district, please set forth the county of the plaintiff's residence.

**COUNTY:**

**IV.** The Counties in the Northern District of Ohio are divided into divisions as shown below. After the county is determined in Section **III**, please check the appropriate division.

**EASTERN DIVISION**

| | | |
|---|---|---|
| ☐ | **AKRON** | **(Counties: Carroll, Holmes, Portage, Stark, Summit, Tuscarawas and Wayne)** |
| ☐ | **CLEVELAND** | **(Counties: Ashland, Ashtabula, Crawford, Cuyahoga, Geauga, Lake, Lorain, Medina and Richland)** |
| ☑ | **YOUNGSTOWN** | **(Counties: Columbiana, Mahoning and Trumbull)** |

**WESTERN DIVISION**

| | | |
|---|---|---|
| ☐ | **TOLEDO** | **(Counties: Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Lucas, Marion, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca VanWert, Williams, Wood and Wyandot)** |

# INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

**I.(a)** **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

**(b)** **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

**(c)** **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

**II.** **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

**III.** **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

**IV.** **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

**V.** **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
**PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

**VI.** **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

**VII.** **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

**VIII.** **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

**Date and Attorney Signature.** Date and sign the civil cover sheet.

**ATTACHMENT A – ATTORNEYS**

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