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Superior Court Of California
County Of Los Angeles

JUL 08 2014

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SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

BETSY FELSER, PATRICIA GRIFFIN, FELICIA MOGHADAM, STEVEN MOORE, JOSH WORTH & DEBORAH NITASAKA, individually and on behalf of all others similarly situated;

Plaintiffs,

v.

BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; and DOES 1 through 100 inclusive,

Defendants.

Case No.: BC 550739

CLASS ACTION COMPLAINT AND DEMAND FOR JURY TRIAL

Individual Claims

1. Fraud (Intentional Misrepresentation)
2. Fraud (Concealment)

Class Action Claims

3. Violation of Business & Professions Code § 17200, et seq. (Unlawful)
4. Violation of Business & Professions Code § 17200, et seq. (Unfair)
5. Violation of Business & Professions Code § 17200, et seq. (Fraudulent)
6. Violation of False Advertising Law, Business & Professions Code § 17500, et seq.
7. Violation of the Consumers Legal Remedies Act, Civil Code § 1750, et seq.
8. Declaratory Relief

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Plaintiffs Betsy Felser, Patricia Griffin, Felicia Moghadam, Steven Moore, Josh Worth, and Deborah Nitasaka (collectively, "Plaintiffs"), on behalf of themselves and all others similarly situated, bring this action against defendant Blue Cross of California dba Anthem Blue Cross (hereafter, "Blue Cross"). Plaintiffs allege the following on information and belief, except as to those allegations which pertain to the named Plaintiffs, which are alleged on personal knowledge:

NATURE OF THE ACTION

1. Plaintiffs bring this action to challenge Blue Cross's deceptive "bait and switch" misrepresentations, inadequate physician and hospital networks, and grossly mishandled administration of individual health service plans. In violation of California law, Blue Cross:

- Misrepresented to consumers that their physicians and hospitals were participating in Blue Cross health service plans;
- Misrepresented Exclusive Provider Organization ("EPO") health service plans, with no out-of-network coverage and benefits, as Preferred Provider Organization ("PPO") health service plans, which provide out-of-network coverage and benefits;
- Misrepresented and concealed that its new PPO health service plans imposed much higher deductibles for out-of-network providers than advertised for the plans;
- Subjected Plaintiffs and Class Members to inadequate networks of physicians and hospitals, causing delays and interruptions in accessing needed health care;
- Delayed Class Members' enrollment in new health service plans for months, effectively blocking access to physician and hospital services, even though Blue Cross collected consumers' premiums; and,
- Subjected consumers to exceedingly long wait times, regularly lasting several hours, on customer service telephone lines when consumers called to address these problems and misrepresentations.

2. In late 2013, Blue Cross notified consumers enrolled in individual Blue Cross

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health service plans that as of December 31, 2013, their existing health service plans would be cancelled and new health service plans would be made available as of January 1, 2014 to coincide with the commencement of federal health reform, the Affordable Care Act ("ACA").

3. The new ACA-compliant plans were made available to consumers during a designated enrollment period between October 1, 2013 and March 31, 2014 (hereafter, "Open Enrollment Period"). Blue Cross consumers whose older health service plans were cancelled were automatically enrolled in ACA-compliant health service plans of Blue Cross's choosing unless consumers affirmatively notified Blue Cross.

4. Blue Cross represented and marketed its health service plans as having specific physicians and hospitals ("providers") available to consumers enrolled in those plans (hereafter, "provider networks"). Prior to purchasing new EPO and PPO plans on the Covered California exchange or directly from Blue Cross, Plaintiffs and Class Members checked with Blue Cross over the phone, on Blue Cross's website, and with their providers to make sure that their providers were in-network under the Blue Cross plan they were considering purchasing. Plaintiffs and Class Members purchased plans in response to Blue Cross's representations and omissions regarding provider networks, deductible levels, and out-of-network coverage and benefits.

5. Blue Cross offered HMO, EPO, and PPO plans inside and outside Covered California during the Open Enrollment Period. An EPO plan, like an HMO, only covers the cost of a visit with a pre-specified provider within the plan's network and provides no coverage for out-of-network, non-emergency services. A PPO plan allows enrollees to visit pre-specified, in-network providers at a discount, but also covers some portion of out-of-network provider services. Under the terms of EPO and PPO plans, once consumers meet their plans' annual deductible, Blue Cross reimburses providers for services and treatments. Prior to meeting their annual deductible, patients seeking services from in-network providers would benefit from reduced costs for services as a result of negotiated fee schedules resulting from agreements entered into between Blue Cross and in-network providers. Unlike PPO

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plans, in EPO plans, payments to out-of-network providers do not accrue toward an enrollee's annual deductible.

6. Once Plaintiffs and Class Members enrolled in the new Blue Cross plans, they soon found out that their provider networks did not include the providers Blue Cross had represented as in-network. By changing the providers who were in-network after Plaintiffs and Class Members purchased the health service plans, Blue Cross deprived these enrollees of providers that Blue Cross had represented as in-network. Due to Blue Cross's actions and misrepresentations, Plaintiffs and Class Members are not able to fully access plan benefits:

- Promised providers are not in-network;
- Negotiated fee schedules are not available;
- Payments made to out-of-network providers in EPO plans do not accrue toward Plaintiffs' and Class Members' annual deductibles; and,
- PPO plans impose much higher deductibles for out-of-network providers than advertised for the plans.

7. Blue Cross had a clear incentive to conceal its reduced network during the Open Enrollment Period in order to increase sales of its health service plans. Plaintiffs and Class Members did not find out about the reduced networks until after the Open Enrollment Period ended, thus locking Plaintiffs and Class Members into the plans until the next open enrollment period. As a result of these practices, Blue Cross significantly increased its share of the California individual health service plan market, while offering inferior products.

8. Additionally, many consumers who paid for coverage never received proof of insurance in the form of health service plan enrollment cards ("ID cards") for two to three months, preventing them from using their health service plans or forcing them to pay out-of-pocket for covered services.

9. By selling health service plans that do not provide benefits or access to physicians and hospitals as advertised and by not delivering ID cards upon consumers' payment of premium, Blue Cross's deceptive business practices resulted in mass confusion.

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Plaintiffs and Class Members who call Blue Cross's customer service telephone line seeking information about the loss of benefits and limited provider networks spend hours navigating through a labyrinth of automated phone trees, multiple transfers, average hold times of two to three hours, and disconnections.

10. Plaintiffs were each fraudulently induced into purchasing a health service plan from Blue Cross based on misrepresentations and omissions regarding the extent and timing of benefits and provider networks. Plaintiffs, in their individual capacity, bring claims seeking damages caused by Blue Cross's intentional misrepresentation and concealment of material facts about Blue Cross's new ACA-compliant health service plans during the Open Enrollment Period.

11. Plaintiffs bring additional claims on behalf of themselves and on behalf of a class of current California residents who are currently enrolled in, or who were enrolled in, a Blue Cross individual health service plan contract purchased between October 1, 2013 and March 31, 2014 (the "Class").

12. Blue Cross's misrepresentations violate Health and Safety Code section 1360, which bars Blue Cross from: (i) using any advertising or solicitation which is "untrue or misleading," or (ii) making any statement or representation about coverage that is untrue, misleading, or deceptive. Blue Cross's limited provider network and failure to provide coverage violates other provisions of the Health and Safety Code designed to ensure adequate access to care and continuity of treatments.

13. Blue Cross's unlawful, unfair, and fraudulent conduct violates California Business and Professions Code sections 17200, et seq. and 17500, et seq.

14. Blue Cross's bait and switch tactics of representing and advertising that its health service plans have certain providers in the plans' networks when those providers are not actually in the plans' networks violates the Consumers Legal Remedies Act ("CLRA"), California Civil Code section 1750, et seq.

15. Plaintiffs seek an order of this Court enjoining Blue Cross's continued

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violations. Plaintiffs also seek an order for restitution of all monies paid for Blue Cross health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the networks of providers that were listed during the Open Enrollment Period and the value of the health service plans now that the network is narrowed, including the difference in value between PPO and EPO coverage, and (ii) premium payments made by consumers for the period for which consumers had not received ID cards.

PARTIES

16. Plaintiff Betsy Felser (Felser) is a citizen of California and resides in Los Angeles County.

17. Plaintiff Patricia Griffin (Griffin) is a citizen of California and resides in Orange County.

18. Plaintiff Felicia Moghadam (Moghadam) is a citizen of California and resides in Los Angeles County.

19. Plaintiff Steven Moore (Moore) is a citizen of California and resides in Santa Clara County.

20. Plaintiff Josh Worth (Worth) is a citizen of California and resides in Los Angeles County.

21. Plaintiff Deborah Nitasaka (Nitasaka) is a citizen of California and resides in Sonoma County.

22. Defendant Blue Cross of California is a corporation duly organized and existing under the laws of California with its principal place of business located in Woodland Hills, California and is authorized to transact, and is transacting, the business of providing health service plans in California.

23. The true names and capacities, whether individual, corporate, associate or otherwise, of defendants Does 1 through 100 are unknown to Plaintiffs, who therefore sue these defendants by such fictitious names. Plaintiffs allege upon information and belief that

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each of the Doe defendants is legally responsible in some manner for the events and happenings referred to herein and will ask leave of this court to amend this complaint to insert their true names and capacities when they become known.

24. At all relevant times, Blue Cross and the Doe defendants were the agents and employees of each other and were at all times acting within the purpose and scope of said agency and employment, and each defendant ratified and approved the acts of its agent.

JURISDICTION AND VENUE

25. This Court has jurisdiction over this action under Article VI, section 10 of the California Constitution and section 410.10 of the Code of Civil Procedure. Jurisdiction is also proper under Business and Professions Code section 17200, et seq. and Civil Code section 1750, et seq.

26. This Court has jurisdiction over Blue Cross, a resident of the State of California.

27. Jurisdiction over Blue Cross is also proper because Blue Cross has purposely availed itself of the privilege of conducting business activities in California and because Blue Cross currently maintains systematic and continuous business contacts with this State, and has many thousands of policyholders who are residents of this State and who do business with Blue Cross.

28. Plaintiffs do not assert any claims arising under the laws of the United States of America. The amount in controversy in this action does not exceed $74,999 with respect to each Plaintiff's claim and the claim of each Class Member. Moreover, all Class Members are currently residents of the State of California.

29. Venue is proper in this Court because, inter alia, Blue Cross's principle place of business is in the County of Los Angeles, and because Blue Cross engages and performs business activities in the County of Los Angeles. Many of the Plaintiffs also entered into agreements to purchase Blue Cross's health service plans while in the County of Los Angeles.

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STATUTORY AND REGULATORY SCHEME

30. Enacted in March 2010, the federal Patient Protection and Affordable Care Act ("ACA") created new rules applicable to health service plans in the United States. (PL 111-148, March 23, 2010, 124 Stat 119.) Under the ACA, states may operate a marketplace, known as an exchange, through which private health service plans are sold to consumers. (42 U.S.C. § 18031(b).)

31. Individuals could purchase health service plans through their state's exchange during the six-month Open Enrollment Period between October 1, 2013 and March 31, 2014. (45 C.F.R. § 155.410.) After the Open Enrollment Period, individuals cannot purchase health service plans until the next enrollment period, beginning November 15, 2014. (45 C.F.R § 155.410(e).) [Trigger Events - Temporary Plans]

32. The ACA expressly preserves state laws that offer additional consumer protections that do not "prevent the application" of any ACA requirement. (42 U.S.C. § 18041(d).) State laws that impose stricter requirements on health service plan issuers than those imposed by the ACA are also not superseded by the ACA.

33. The individual health service plans at issue here are subject to the requirements of California Health and Safety Code sections 1340 through 1399.99 (the "Knox-Keene Act").

34. In adopting the Knox-Keene Act, it was the "intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California" by:

a. "Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace." (Health & Saf. Code § 1342(b).)

b. "Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public." (*Id.* at (c).)

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c. "Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers." (*Id.* at (d).)

35. Health and Safety Code section 1367, subdivision (h)(1), provides that "contracts with subscribers and enrollees . . . shall be *fair, reasonable, and consistent with the objectives of [the Knox-Keene Act].*" (Emphasis added.)

36. To further the goals of ensuring that consumers are educated and informed about the coverage and benefits and enabling consumer choice in the market place, the Knox-Keene Act bars health care service plans from using "any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive." (Health & Saf. Code § 1360(a).) Under this statute, no health care service plan "shall use or permit the use of any verbal statement which is untrue, misleading, or deceptive or make any representations about coverage offered by the plan or its cost that does not conform to fact." (*Id.* at (b).) For the purposes of this statute:

a. "A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an enrollee or subscriber, or potential enrollee or subscriber in a plan." (*Id.* at (a)(1).)

b. "A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee, or potential enrollee or subscriber, in a plan, and such is not the case." (*Id.* at (a)(2).)

37. The Knox-Keene Act also requires a health care service plan to "provide, upon request, a list of ... contracting providers, within the enrollee's or prospective enrollee's general geographic area" including a list of "[p]rimary care providers." (Health & Saf. Code §

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1367.26(a)(1).) "A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its Internet Web site . . . ." (*Id.* at (d).)

38. Additionally, the Knox-Keene Act required regulators to "develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner." (Health & Saf. Code § 1367.03(a).) Under these regulations (Title 28 of the California Code of Regulations ["28 CCR"] § 1300.67.2, et seq.):

a. "Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes." (28 CCR § 1300.67.2.2(c)(10).)

b. "Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard." (28 CCR § 1300.67.2.2(c)(1).)

c. "[E]ach plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet [certain] timeframes[.]" (28 CCR § 1300.67.2.2(c)(5).) For example, a contracted provider network must be able to offer enrollees "[n]on-urgent appointments for

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primary care[1] within ten business days of the request for appointment[.]" (*Id.* at (c)(5)(C).)

d. "Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by [28 CCR § 1300.67.2.2(c)]." (28 CCR § 1300.67.2.2(c)(7).)

39. "Contracts between health care service plans and health care providers shall assure compliance with the standards" set forth in 28 CCR § 1300.67.2 et seq., quoted above. (Health & Saf. Code § 1367.03(f)(1).) "These contracts shall require reporting by health care providers to health care service plans and by health care service plans to [regulators] to ensure compliance with the[se] standards." (*Ibid.*)

40. To further the goals of ensuring the best possible health care for the public at the lowest possible cost, the Knox-Keene Act provides that a health care service plan, at the request of an enrollee, must arrange the completion of covered services by a terminated provider or by a nonparticipating provider for an acute condition, serious chronic condition, pregnancies,[2] terminal illness, care of a newborn child,[3] or performance of surgery. (Health & Saf. Code § 1373.96(a)-(c), (l), (m)(2).) "A health care service plan … shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice." (Health & Saf. Code

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[1] A "primary care physician" is defined as "a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner." (28 CCR § 1300.45(m).)

[2] "A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy." (Health & Saf. Code, § 1373.96(c)(3).)

[3] Health care service plans must provide for completion of services for "[t]he care of a newborn child between birth and age 36 months. Completion of covered services … shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee." (Health & Saf. Code § 1373.96(c)(5).)

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§ 1367(d).)

FACTUAL ALLEGATIONS

A. Blue Cross engaged in a fraudulent and deceptive marketing scheme to increase its market share.

41. At the end of 2013, in anticipation of the changes required by the ACA, Blue Cross cancelled all "non-grandfathered" plans it offered in California. As a result, hundreds of thousands of existing Blue Cross enrollees had their individual health service plans canceled and were also looking for replacement coverage to purchase during the Open Enrollment Period, October 1, 2013 through March 31, 2014. [Didn't Covered CA Force it?]

42. In an effort to increase its share of the California individual health service plan market, Blue Cross engaged in a fraudulent and deceptive marketing scheme leading up to, and during, the Open Enrollment Period.

B. Blue Cross intentionally misrepresented EPO plans as PPO plans.

43. Following the enactment of the ACA, Blue Cross elected to no longer offer any PPO plans in California's four most populous counties: Los Angeles, San Francisco, San Diego, and Orange counties. That meant that after January 1, 2014, Blue Cross did not provide any out-of-network coverage or benefits on its new individual health service plans in California's four largest markets. But Blue Cross misrepresented, concealed, and failed to disclose this information to both existing health service plan enrollees searching for new ACA-compliant plans as well as new consumers shopping for coverage required under the ACA. [I posted this on MY website - page 14!]

44. Blue Cross's misrepresentations to existing enrollees began at the end of 2013. From September 2013 through December 31, 2013, Blue Cross sent cancelation notices to hundreds of thousands of its enrollees. The cancelation notices included a section that provided enrollees with a "new suggested Anthem plan." This section of the cancelation letters all included similar language as follows:

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> Your _____ health benefit plan can no longer be offered as of January 1, 2014. We have suggested a new health benefit plan for your consideration, _____ offered by Anthem Blue Cross. Although this plan is currently pending regulatory review and/or approval, we are suggesting it because it includes the requirements of the new ACA laws and provides you with the health benefits you have come to count on by being an Anthem member. This plan will include coverage for doctors' visits, prescription drug coverage, emergency care and more. You can check out a complete list of benefits at sbc.anthem.com/dps/CCD0RXQ.
>
> If the health benefit plan we've suggested above seems like a good fit, just pay your bill when it arrives and we'll send you a new ID card.

45. Blue Cross sent this same cancelation letter to Plaintiffs and Class Members in Los Angeles, San Francisco, San Diego, and Orange counties enrolled in PPO plans at the time. Each of these letters suggested a replacement plan with "health benefits you have come to count on," without disclosing that the suggested replacement plans were not PPO plans and did not include any out-of-network coverage or benefits. Rather, Blue Cross suggested EPO plans to Plaintiffs and Class Members in Los Angeles, San Francisco, San Diego, and Orange counties enrolled in PPO plans at the time, without disclosing this significant change in coverage. Blue Cross also deceptively did not label the replacement plans as EPO plans in the letters, thus further concealing and misrepresenting that what was actually being suggested as replacement coverage was not a PPO plan.

46. Blue Cross then furthered its deception by sending out ID cards on these new plans with a PPO symbol conspicuously placed on the cards. These health service plans were not PPO plans and there was no reason to include the PPO symbol on the ID cards. Nowhere on these new EPO plan ID cards did the term EPO even appear; only the PPO symbol appeared. It was not until after the end of the Open Enrollment Period that Blue Cross retracted all of these ID cards and issued corrected ID cards without the PPO symbol.

47. During the September 2013 through March 31, 2014 timeframe, Blue Cross's

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customer service agents also were trained to provide deceptive information to existing enrollees and new customers. The cancelation letters Blue Cross sent out directed existing enrollees to call one of Blue Cross's Health Plan Advisors to help answer any questions concerning the replacement plans. The Blue Cross agents were trained to suggest the same EPO plans to any existing PPO plan enrollees in Los Angeles, San Francisco, San Diego, and Orange counties, without making any reference to these plans as EPO plans or without any disclosure or explanation that these new plans were not PPO plans and did not provide any out-of-network coverage or benefits. Blue Cross similarly trained its customer service agents to suggest these same EPO plans in Los Angeles, San Francisco, San Diego, and Orange counties to any new customer who called asking for a PPO plan. Blue Cross's agents failed to disclose that these were not PPO plans and did not include any out-of-network coverage or benefits.

48. Blue Cross's health service plan informational material was also set up to deceive customers. Blue Cross's health service plan informational material is available on its website and on the Covered California website. This material contains information about the various health service plans offered by Blue Cross. But the information intentionally excludes any mention of out-of-network coverage or benefits available on any of the plans.

49. The informational material also deceptively organizes the plans by Platinum, Gold, Silver, and Bronze categories with no distinction between whether plans were PPO plans, EPO plans or HMOs. Blue Cross organized the materials in this manner to avoid drawing attention to the fact that it did not offer any PPO plans in the four largest counties in California, but instead was only offering an HMO-like product called an EPO plan.

50. The plan material organization deceptively conceals that Blue Cross's non-HMO product offerings in Los Angeles, San Francisco, San Diego, and Orange counties are not PPO plans. For example, in San Francisco County, Blue Cross offers a DirectAcess plan in Platinum, Gold, Silver, and Bronze. In marketing materials, these plans are color-coded by their Platinum, Gold, Silver, or Bronze distinction. The main difference between these plans is

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the deductible amounts.

51. In Napa County, Blue Cross also offers a DirectAccess plan in Platinum, Gold, Silver, and Bronze—again with the main difference being the deductible amounts. The DirectAccess plans in San Francisco County are color-coded exactly the same as the DirectAccess plans in Napa County. The only way a prospective enrollee could tell the Napa County plans apart from the San Francisco County plans is by looking in the grey color "Network Name" column. In Napa County, the plans are listed either with a "Pathway X PPO" network in the Network Name column or a "Pathway X HMO" network. Consumers are familiar with the PPO/HMO distinction and it is easy to select between these two networks.

52. However, in San Francisco County, the plans are listed either with a "Pathway X Tiered" network or a "Pathway X HMO" network. Blue Cross makes it appear as if one is selecting between an HMO product or a non-HMO product, just as is the case in the other counties, like Napa County. But that is not so. The Tiered network, like the HMO network, is also a type of managed care plan, with no out-of-network coverage or benefits. So, while a Platinum DirectAccess plan in Napa is a PPO plan, a Platinum DirectAccess plan in San Francisco County is just a limited network managed care plan. Blue Cross intentionally conceals this major distinction and instead deceptively attempts to confuse potential buyers.

53. Blue Cross also intentionally labeled this new type of network as a "Tiered" network, rather than as an "EPO" network, in order to further confuse and deceptively conceal from customers that this network actually has no similarity to a PPO plan.

54. The only place where Blue Cross describes a Pathway X Tiered network is at the bottom of the page, in extremely small print. There, Blue Cross inconspicuously explains:

> Pathway X Tiered: An exclusive provider organization (EPO) plan is a type of managed care plan. The EPO network is made up of a select group of care providers. With the exception of an emergency situation, you may only get benefits from an in-network provider if you plan is part of this network.

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55. Blue Cross chose to hide this critical information at the bottom of the page rather than conspicuously explain the most important health service plan product feature to potential new customers.

56. The plan materials also do not discuss the distinctions between the in-network coverage and benefits and the out-of-network coverage and benefits, thereby further concealing that in California's four most populous counties no out-of-network coverage or benefits are offered. For example, Blue Cross knew it would have looked very strange if there was out-of-network information listed for a Platinum DirectAccess plan in Napa County but absolutely no out-of-network information listed for the Platinum DirectAccess plans in San Francisco County.

C. Blue Cross misrepresented and concealed that its PPO plans imposed much higher deductibles for out-of-network providers.

57. In counties other than Los Angeles, San Francisco, San Diego, and Orange, where Blue Cross does offer PPO plans, Blue Cross deceptively misrepresented and concealed that its new PPO plans imposed much higher deductibles for out-of-network benefits than the deductible listed for the plan.

58. Blue Cross's plan materials contain information about deductibles applicable to each health service plan. The plans are listed according to varying deducible amounts. For instance, in Napa County, Blue Cross offers DirectAccess PPO plans in Platinum with a zero deductible, Gold with a zero deductible, Silver with a $2,000 deductible, and Bronze with a $5,000 deductible. But nowhere in Blue Cross's materials does Blue Cross explain that these plans impose a much higher out-of-network deductible. For instance, even though the Platinum and Gold plans are listed as zero deductible plans, their out-of-network deductible is actually $5,000 for an individual enrollee and $10,000 for a family enrollee. The out-of-network deductible is not listed anywhere in the plan materials and there is no indication that the out-of-network deductible differs from the in-network deductible.

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59. Blue Cross's agents are also trained to misrepresent and conceal these higher deductibles on its PPO plans. Blue Cross's agents refer to the plans as "no deductible" or "$2,000 deductible" plans without disclosing that this moniker only applies to payments for in-network providers. Blue Cross's agents never disclose that out-of-network deductibles are much higher and impose more restrictive access to out-of-network coverage and benefits.

D. Blue Cross intentionally misrepresented its provider network—concealing that its new networks were significantly more limited than its previous networks.

60. At all relevant times, Blue Cross's website offered, and continues to offer, users a feature that allows potential enrollees to search Blue Cross's network of providers. Blue Cross also allows enrollees to obtain provider network information over the phone, subject to excessive hold times, through its customer service agents.

61. Blue Cross has admitted that between October 2013 through April 2014 its database of network providers was inaccurate, causing at least 1,000 doctors to be erroneously listed on Blue Cross's website, on Covered California's website, and in plan materials as in-network for its new individual ACA-compliant plans.

62. Plaintiffs allege upon information and belief, that Blue Cross intentionally caused an inaccurate provider list to be disseminated to potential enrollees in order to fraudulently induce customers to purchase health service plans during the Open Enrollment Period.

63. The network of Blue Cross providers available to Plaintiffs and Class Members is drastically more limited than the network of providers previously available to enrollees. Blue Cross intentionally failed to update its provider list, and allowed the outdated provider information to be disseminated to potential enrollees in order to make its new health service plans appear more attractive than they really are. Blue Cross knew that many of the potential customers would check to ensure that certain providers were listed as in Blue Cross's network before selecting a new ACA-compliant policy. Therefore, Blue Cross intentionally allowed an

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inaccurate provider list to be disseminated during this crucial Open Enrollment Period so that potential customers would purchase the plans before finding out that their providers were actually no longer included in Blue Cross's network.

64. Blue Cross did not correct the mistake or admit to the inaccurate information until after the Open Enrollment Period. Millions of enrollees are now finding out for the first time that they were provided inaccurate information, either over the phone (and therefore subjected to excessive wait times), on Blue Cross's website, or on the Covered California website. As a result, millions of enrollees have sought treatment from providers that were previously listed as in-network—only to later have claims denied based on these inaccurate representations and new, reduced networks.

65. Blue Cross's marketing, sales, and plan informational materials also concealed that its new ACA-compliant plans had much more restrictive networks than Blue Cross had traditionally offered. Blue Cross's sales and marketing materials led consumers to believe that the only changes Blue Cross made to its older health service plans were changes to ensure compliance with ACA requirements.

E. Betsy Felser was fraudulently induced into purchasing a Blue Cross EPO plan with a drastically reduced network of providers, that was misrepresented as a PPO plan with a full network of providers.

66. Betsy has been a Blue Cross PPO enrollee for the past twenty years. Her minor son, Oliver, has been a Blue Cross enrollee since he was born.

67. At the end of 2013, Blue Cross sent a series of letters to Betsy notifying her that her and Oliver's existing PPO plans were being canceled, effective December 31, 2013. The Blue Cross letters informed Betsy that they needed to move to ACA-compliant plans by January 1, 2014. The letters also suggested a replacement plan for Betsy and Oliver. But, unbeknownst to Betsy, the suggested plans were EPO plans, not PPO plans, and contained no out-of-network coverage or benefits.

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68. None of the Blue Cross letters explained that since Betsy lived in Los Angeles County, Blue Cross no longer offered any PPO plans in that area and therefore the suggested plans were EPO plans, not PPO plans. There was no indication in the letters that the suggested plans were not PPO plans. The letters also did not inform Betsy of the major differences between her existing PPO plans and the new plans that were being suggested to her—including the fact that the new plans did not provide any out-of-network coverage or benefits.

69. When Betsy received the cancelation letters she was diligent in trying to confirm that she received a plan similar to her PPO plans that were being canceled so she called the telephone number listed in the letters. Betsy spoke to five different Blue Cross agents in separate phone calls totaling multiple hours, including excess hold times, in order to ensure she picked equivalent PPO plans. On the telephone calls Betsy specifically asked for a PPO plan that was similar to her existing plans. None of the Blue Cross agents ever notified her that Blue Cross no longer offered a PPO plan in Los Angeles County. Each agent always suggested the same two plans with varying deductible options, but no agent ever told her these plans were not PPO plans. The Blue Cross agents also never used the term EPO to describe the plans or informed Betsy that the new suggested health service plans did not offer any out-of-network coverage or benefits.

70. During at least one of these phone calls Betsy also confirmed that Oliver's regular pediatrician was included in Blue Cross new provider network. The Blue Cross agent confirmed that Oliver's pediatrician, Dr. Mark Powell, was included in the network on the suggested Blue Cross replacement plans. Betsy was never informed that these suggested plans only allowed her access to an extremely limited network of providers.

71. Betsy also contacted an insurance agent to go over the plans suggested by the Blue Cross agents. Her insurance agent showed her various Blue Cross plan marketing materials, including a color-coded chart of available health service plans. The chart focused primarily on varying deductibles available on the different health service plans. The Blue Cross plan material was so confusing and misleading that the agent did not understand that

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none of the plans available in Los Angeles county were PPO plans, but rather they were EPO plans with no out-of-network coverage or benefits. Betsy elected to purchase one of the health service plans suggested by the Blue Cross agents with whom she had previously spoken.

72. When Betsy received the ID cards for their new Blue Cross plans, a PPO symbol was conspicuously placed on the bottom portion of the cards. There was no EPO symbol on the cards. The ID cards made no mention that the plans were EPO's and the cards gave no indication that the plans provided no out-of-network coverage or benefits. The ID cards reassured Betsy that she had purchased PPO plans for her and Oliver.

73. Betsy did not realize that she did not actually purchase PPO plans until May 2014. On May 14, 2014, she took Oliver to see his pediatrician, Dr. Powell, who she had previously confirmed was in-network on her new plans. While visiting this doctor, Betsy discovered that what she thought was a PPO plan was actually an EPO plan with no out-of-network coverage or benefits. She also found out that Blue Cross had inaccurately listed Dr. Powell as in-network. In actuality, Blue Cross had elected to drop Dr. Powell from its new, limited network, along with many other longstanding in-network providers.

74. Betsy was forced to pay out-of-pocket for her son's medical visits with Dr. Powell—a provider that Blue Cross represented as in-network. Additionally, Betsy will continue to incur further medical bills for Oliver's ongoing treatment with Dr. Powell. Betsy is now forced to continue paying for her Blue Cross health service plans until the next open enrollment period, even though the plans provide zero coverage for any of her or Oliver's providers. [If you can prove a material violation, you can change now. Covered CA does not require proof]

F. Patricia Griffin was fraudulently induced into purchasing a Blue Cross EPO plan that was misrepresented as a PPO plan.

75. Patricia Griffin has been a Blue Cross PPO enrollee since 1996. Patricia has several ongoing medical conditions, including a serious heart condition and end stage arthritis in her hip. Patricia's conditions require ongoing follow-up with her providers.

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76. In December 2013, Blue Cross sent a series of letters to Patricia notifying her that her existing PPO plan was being canceled, effective March 31, 2014. The Blue Cross letters informed Patricia that she needed to move to an ACA-compliant plan by April 1, 2014, the end of the Open Enrollment Period. The letters also suggested a replacement plan for Patricia. Unbeknownst to Patricia, the plan suggested by Blue Cross to Patricia was an EPO plan, not a PPO plan, and provided no out-of-network coverage or benefits.

77. None of the Blue Cross letters explained that since Patricia lived in Orange County, Blue Cross did not offer any PPO plans in that area and therefore her suggested plan was an EPO plan, not a PPO plan. The letter simply referred to the plan as a DirectAccess Plan and there was no indication that this was not a PPO plan. The letters also did not inform Patricia of the major differences between her old health service plan and the new health service plan that was being suggested to her—including the fact that her new health service plan did not provide any out-of-network coverage or benefits.

78. When Patricia received the cancelation letters she was confused, so she called the Blue Cross telephone number listed in the letters. Patricia spent days trying to get through to a Blue Cross representative, but she was put on hold for hours and was not able to reach anyone.

79. Finally, on January 15, 2014, Patricia was able to reach a Blue Cross representative by the name of Gwen. Patricia described her current Blue Cross plan and medical needs to Gwen. She also explained to Gwen that she wanted a PPO plan similar to the Blue Cross health service plan that she was enrolled in that Blue Cross was canceling.

80. The Blue Cross representative stated that the DirectAccess plan suggested in Blue Cross's cancelation letter would essentially provide the same coverage as her existing health service plan. Gwen never informed Patricia that neither of these suggested health service plans was a PPO plan or that Blue Cross no longer offered PPO plans in Patricia's market. Gwen also never informed Patricia that the plans being suggested were EPO plans and provided no out-of-network coverage or benefits, with a very limited network of

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providers.

81. When Patricia received her ID card for her new Blue Cross Platinum plan it included a PPO symbol on the bottom of the card. The ID card made no mention of the fact that the plan was an EPO plan and provided no out-of-network coverage or benefits.

82. Patricia did not realize that that she did not have a PPO plan until April 2014. Patricia had fallen while on vacation on March 4, 2014, badly injuring her knee. In March, while she was still covered under her old plan, she went to see her regular orthopedic surgeon, Dr. Lawrence Fiewell, who had previously been treating her for the arthritis in her hip. Dr. Fiewell advised her that surgery would be necessary.

83. But in a pre-surgical appointment with Dr. Fiewell's office, Patricia was told that his services were not covered under her new plan. According to Dr. Fiewell, Blue Cross refused to allow him to continue to be an in-network provider under its new individual health service plans. Patricia was forced to pay more than $3,000 out-of-pocket for her surgery and related procedures.

84. Patricia has continued to encounter these same denials of benefits as she continues to receive treatment with her other regular providers. Most importantly, her regular Cardiologist, Dr. Chesnie, is no longer included in Blue Cross's network and since she has no out-of-network coverage or benefits under her new health service plan, she has also been forced to pay out-of-pocket to continue to see Dr. Chesnie.

G. Felicia Moghadam was fraudulently induced into purchasing a Blue Cross EPO plan that was misrepresented as a PPO plan.

85. Felicia Moghadam has been a Blue Cross PPO enrollee for the past five years.

86. At the end of 2013, Blue Cross sent a series of letters to Felicia notifying her that her existing PPO plan was being canceled, effective December 31, 2014. The Blue Cross letters informed Felicia that she needed to move to an ACA-complaint plan before January 1, 2014. The letters also suggested a replacement plan for Felicia. The letter stated "If the health benefit plan we've suggested above seems like a good fit, just pay your bill when it arrives

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and we'll send you a new ID card."

87. Felicia trusted Blue Cross's suggested plan so she simply paid the Blue Cross bill for the new health service plan when it arrived. The bill made no mention that the new health service plan was an EPO plan rather than a PPO plan. It also did not include any explanation that Felicia's new health service plan did not include out-of-network coverage or benefits. Shortly after, Felicia received her new ID card in the mail. The ID card contained a PPO logo, so she assumed her new plan was a PPO plan. There is no reference to an EPO plan anywhere on the card.

88. Unbeknownst to Felicia, the health service plan suggested by Blue Cross was an EPO plan, not a PPO plan, and contained no out-of-network coverage or benefits.

89. None of the Blue Cross letters explained that since Felicia lived in Los Angeles County, Blue Cross did not offer any PPO plans in that area and therefore her suggested plan was an EPO plan, not a PPO plan. There was no indication in the letter that this was not a PPO plan. The letters also did not inform Felicia of the major differences between her old plan and the new health service plan that was being suggested to her—including the fact that her new health service plan did not provide any out-of-network coverage or benefits.

90. Felicia did not become aware that she did not have a PPO plan until May 2014, after she received a bill from her gynecologist. Recently, she also received a corrected ID card from Blue Cross, identifying the plan as an EPO plan rather than a PPO plan.

H. Steven Moore was fraudulently induced into purchasing a Blue Cross "no deductible" plan that included his family's regular physicians—but in actuality the plan imposed a high deductible for out-of-network providers and none of his family's providers were included in Blue Cross's new limited network.

91. As of the fall of 2013, the Moore family had four different individual health service plans covering the four members of their family. Their daughters, Laura and Sarah had been insured through Blue Cross since 2003 and 2005, respectively. The parents, Steven and Kathleen Moore, were insured through PacifiCare and Aetna, respectively. Health

[Yeah, it would have been nice if these companies were not forced out of CA. Fine thing Health Reform did!]

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coverage is very important to the Moore family because of their ongoing medical conditions. Laura has a congenital heart defect and neurofibromatosis, a disease of the nerve tissue. Both conditions require ongoing treatment and follow-up. Sarah has experienced growth problems and was previously diagnosed with "failure to thrive"—which requires monitoring through their family pediatrician, Dr. Mary Ann Zetes. Kathleen has high cholesterol and early onset coronary artery disease, which requires ongoing treatment with her cardiologist, Dr. Catherine Collings.

92. In September 2013, Blue Cross sent Laura and Sarah a series of letters notifying them that their plans were "grandfathered" and that there was no requirement to change plans as of January 1, 2014. But the letters were written in such a way as to persuade them to switch to an ACA-compliant plan. For example, the letters contained numerous warnings that their current plans did not comply with the ACA and would offer fewer benefits, such as preventive care. [Then were mandated to say that]

93. Around this same time, Steven and Kathleen both received separate notices that their Pacificare and Aetna health plans were being canceled because the companies were leaving the California market.

94. The Moores then began researching the various family plans offered through the state's Covered California website. They also went online to Blue Cross's website to determine if their family pediatrician, Dr. Zetes, was included as an in-network provider on Blue Cross's Covered California plans. On the Blue Cross website, the only way to find a provider was to search an alphabetical list of all providers in the state, not separated by specialty, geography, language, gender, or any other parameter. Using this list, they were able to confirm that Dr. Zetes was an in-network provider on Blue Cross's Covered California plans. The single most important factor in deciding whether to choose Blue Cross and whether to switch their daughters from their grandfathered plan was the ability to continue care with Dr. Zetes.

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95. After searching the plans online, the Moores chose Blue Cross's Premier DirectAccess no deductible PPO plan for the family. This was the Platinum-level plan, the highest level plan offered. The website listed the premium, deductible, co-pay, and out-of-pocket maximum. But the website contained no information about out-of-network coverage and benefits, and made no distinction between in-network and out-of-network features.

96. On December 10, 2013, the Moores called Blue Cross and spoke to a customer service representative named Denise. Denise informed the Moores that the platinum plan for the Premier Direct Access PPO costs $1,895.35 per month, has a 90%/10% payment schedule, no deductible, and an $8,000 out-of-pocket maximum. They also asked Denise to go over the out-of-network coverage and benefits, which were not listed on the website. Denise told the Moores that the Premier Direct Access PPO pays 60% for out-of-network benefits such as diagnostic tests and surgery. For out-of-network hospital stays, there is a $1,000 per admission charge plus a 40% co-payment. She also informed them that there is a $40 co-pay for Urgent Care.

97. Neither the Blue Cross representative nor the Blue Cross website mention anything about the fact that the health service plan had a $10,000 deductible for out-of-network providers.

98. Denise then transferred the Moores to another Blue Cross representative, Michael Goodwin, who filled out a short application for the Moores over the phone and within minutes confirmed the purchase of the Moore's health service plan.

99. On February 25, 2014, Kathleen had an office visit with her cardiologist, Dr. Collings, for continued follow-up care. While at this office visit, she presented her new ID card and they processed the claim.

100. In early April, the Moores received a letter from Blue Cross dated March 21, 2014 informing them that Kathleen's cardiologist is out-of-network and her February 25, 2014 visit was not covered. The letter states:

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> As a goodwill gesture, we will pay these claims at the in-network level. We're doing this because we realize you may not have known the doctor was out-of-network. Starting March 31, 2014, we will have to bill any services by the same doctor as out-of-network.

101. After receiving the letter, Kathleen called her cardiologist's office to ask about their network status. They informed Kathleen that they still take Blue Cross employer plans, but that they have never taken Blue Cross Covered California plans.

102. When Kathleen was reviewing the claim forms associated with this office visit she noticed that she would have been charged over $1,600 for her normal lab work and follow-up office visit. She also noticed, for the first time, that her plan had a $10,000 out-of-network deductible. Blue Cross never disclosed that there were two different deductibles on the plan or that there was any difference between the in-network deductible and the out-of-network deductible. This was especially deceiving since Sarah and Laura's previous Blue Cross plans had just one $550 dollar deductible that applied to both in-network and out-of-network providers.

103. A few days later, Kathleen received an Evidence of Benefit ("EOB") form for a January 14, 2014 office visit with her gynecologist, Dr. Katherine Sutherland. The EOB showed that Dr. Sutherland is an out-of-network provider and that Kathleen would be responsible for the full charges. This EOB was not accompanied by a "goodwill gesture" letter that she received associated with Dr. Collings office visit.

104. On April 20, 2014, Kathleen went on Blue Cross's website to search for cardiologists within a 20-miles radius of her zip code. She decided to call two doctors on the list she recognized as partners of Dr. Collings. Both doctors confirmed that the website was in error, as they do not accept Blue Cross Covered California plans. Kathleen then decided to call all the cardiovascular disease specialists on the list but not one of them in her area code accepts Blue Cross Covered California. Every one of the doctors she called told her that the website was in error.

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[Problem is Covered CA and the new direct plans have the SAME narrow network 42 USC 18021]

105. On April 23, 2014, Kathleen then took her youngest daughter Sarah for a follow-up appointment with her dermatologist, Dr. Sia Vossough. His office informed Kathleen that in two months he will no longer take Blue Cross Covered California plans because they only wanted to pay him 30% of the average Medicare rate across the state, which was a rate he could not afford to accept.

106. On April 28, 2014, Kathleen took her oldest daughter to her pediatrician, Dr. Zetes. When she entered the doctor's office, there was a sign posted informing patients that the office did not take Blue Cross Covered California plans. Kathleen immediately went to the front desk to check the meaning of that sign since the Blue Cross Covered California website listed Dr. Zetes as in-network. The office manager explained the website was in error. The office manager told Kathleen that they had been informed of the error for some time—even before December 31, 2013. Their office had been repeatedly calling Blue Cross "many, many times" to have Dr. Zetes and all their pediatricians taken off the list, but that Blue Cross had continued to erroneously list them on their website. It was her opinion that Blue Cross had intentionally left the doctors in their practice on its website as "in-network" to mislead patients into signing up.

107. As a result of Blue Cross's fraudulent conduct, the Moores have incurred and will continue to incur substantial medical bills for out-of-network providers that Blue Cross previously represented as in-network providers. Additionally, the Moores will have to satisfy the $10,000 family deductible for out-of-network providers before being able to access any out-of-network benefits, despite the fact they specifically paid for Blue Cross's top of the line "no deductible" plan.

I. Josh Worth was fraudulently induced into purchasing a Blue Cross EPO plan with a drastically reduced network of providers, that was misrepresented as a PPO plan with a full network of providers.

108. Plaintiff Josh Worth had been covered by Blue Cross since 2006. From 2006 to January 1, 2014, Josh and his family were enrolled in a Blue Cross "Lumenos HSA"

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individual health service plan contract, terminated by Blue Cross as of December 31, 2013.

109. Blue Cross sent Josh a packet dated September 27, 2013, which included a "Notice of Open Enrollment" and a "Notice of Individual Health Benefit Plan Withdrawal."

110. In the Notice of Open Enrollment, Blue Cross informed Josh that that his family's health service plan would "no longer be available after January 1, 2014." Blue Cross stated, "If you want to purchase an Anthem plan through Covered California, visit the Covered California website. You may also speak with your agent or call one of our Health Plan Advisors and they will help you choose a new Anthem plan."

111. In the Notice of Individual Health Benefit Plan Withdrawal ("Notice"), Blue Cross listed Josh's options: (1) "You can choose a different Anthem plan that will become effective January 1, 2014"; (2) "You can choose an Anthem plan through Covered California"; or (3) "We will move you to a new suggested Anthem Plan." The Notice directed Plaintiff Worth to "talk to one of our Health Plan Advisors to find a plan that's right for you."

112. On November 15, 2013, Josh visited the Covered California website to explore his options. Josh discovered he did not qualify for financial assistance through Covered California.

113. Josh and his wife were expecting a baby due in March 2014, so he wanted to ensure he picked the right plan for him and his growing family. In December 2013, Josh contacted a Blue Cross "Health Plan Advisor" by phone to learn about the different plans available outside the Covered California exchange. Based on his conversation with the Blue Cross Health Plan Advisor, Josh was interested in enrolling in what Blue Cross's Health Plan Advisor called the "essential plan." Before enrolling in the Anthem Essential DirectAccess – cbmm plan, Josh wanted to make sure that his family's providers would be in the plan's network and their services would be covered.

114. Josh visited Blue Cross's website multiple times to use Blue Cross's provider search tool to confirm that Josh's obstetrician, pediatrician, and hospital would be in-network under the new plan. On one visit, Blue Cross's provider search tool was not functioning at all.

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On subsequent visits, Blue Cross's provider search tool listed the obstetrician and pediatrician as in-network.

115. In mid-January 2014, Josh called Blue Cross's Health Plan Advisor telephone line several times to try and enroll in the Anthem Essential DirectAccess – cbmm plan. Each time, Josh experienced hold times of up to 45 minutes, as well as re-routing to the wrong departments and disconnections. Because Josh had work and family obligations, he often would need to hang up after waiting for 45 minutes without reaching a Blue Cross representative that could help him.

116. After several failed attempts, in mid-January 2014, Josh finally reached a Health Plan Advisor who confirmed Josh was enrolled in the Anthem Essential DirectAccess – cbmm plan. The Health Plan Advisor told Josh that he would be receiving the first premium bill in the mail.

117. By mid-February 2014, Josh had not received a bill for his new plan in the mail. After several failed attempts to reach a Blue Cross Health Plan Advisor and Blue Cross's billing department over the phone, Josh finally reached a representative in Blue Cross's billing department who informed Josh that his coverage had been cancelled for non-payment of premium.

118. Josh then made numerous attempts to reinstate his coverage through phone calls to Blue Cross's billing department and Health Plan Advisor line, and visits to Blue Cross's website, but could not get in contact with a Blue Cross representative who could help him. At one point, Josh called Blue Cross's Health Plan Advisor telephone line, and was told that he would need to re-enroll and would not be eligible for coverage until April 2014.

119. On February 24, 2014, Josh submitted a new application for coverage.

120. On February 28, 2014, Josh called Blue Cross and spoke to a Health Plan Advisor who reinstated his initial coverage that Josh had enrolled in over the phone on the condition that he pay premiums for January through March, 2014. Josh made the payment over the phone on February 28, 2014.

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121. Josh then received a second ID card in the mail, identifying his plan as the Pathway Tiered PPO, effective January 1, 2014.

122. On March 31, 2014, Josh's wife gave birth to their son at Good Samaritan Hospital.

123. Josh began receiving EOB forms from Blue Cross showing that his wife's visits to the obstetrician on March 10, 17 and 24, 2014 were not covered because the obstetrician was "out-of-network." The EOBs showed that Josh owed the obstetrician $1,023.00 for the office visits. Josh called the obstetrician, who said all Blue Cross individual plans were still accepted by the office.

124. Josh then once again checked Blue Cross's provider search tool for his providers. The obstetrician's name no longer appeared on Blue Cross's website, but the pediatrician's name was still listed as in-network.

125. In April 2014, Josh visited the pediatrician with his new baby, presented his card and was told that the pediatrician would not accept Plaintiff Worth's plan. Josh paid for the visit out-of-pocket.

126. In April 2014, Josh noticed that charges from Good Samaritan were being covered. However, when Josh called the Blue Cross billing department, Josh was told by a Blue Cross representative that the pediatrician, obstetrician, and Good Samaritan Hospital were *all* out-of-network.

127. In May 2014, Josh received a new ID card, identifying his plan as a Pathway Tiered EPO instead of the Pathway Tiered PPO.

J. Deborah Nitasaka paid premiums for two months before she received an ID card and confirmation of new coverage.

128. In October 2013, Deborah began the process of enrolling in a new ACA-compliant Blue Cross health service plan through Covered California.

129. In a letter dated December 11, 2013, Blue Cross informed Deborah that her application for health coverage had been received and she should make a payment to

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complete her enrollment. Deborah made the payment, and Blue Cross deposited the check.

130. Concerned she had not yet received her ID card, on January 16, 2014, Deborah called Blue Cross to speak with a customer service representative. She connected with a representative after about one hour waiting on hold. The representative stated that Blue Cross had not yet received Deborah's payment.

131. Again on January 22, 2014, Deborah called Blue Cross to speak with a customer service representative. She connected with a representative after about 80 minutes. This representative claimed that Blue Cross did not have sufficient staff to handle the influx of Covered California enrollees. As a result, the representative could not estimate when Blue Cross would properly process Deborah's payment and start providing health coverage.

132. During the month of January, Deborah wanted to get a flu shot but did not get one because she did not have health coverage.

133. On January 28, 2014, Deborah remitted a check for her February bill. Blue Cross once again deposited the check.

134. On February 6 and 10, 2014, Deborah contacted an insurance agent assigned to her by Blue Cross to resolve Blue Cross's failure to complete her enrollment. According to this agent, Deborah's January and February payment had been correctly applied to her account and her ID card was in the mail.

135. Between January and February, Deborah phoned Blue Cross approximately 10-15 times to resolve Blue Cross's failure to finalize her enrollment and issue an ID card.

136. Still awaiting her ID card, on February 25, 2014, Deborah filed a grievance with Blue Cross requesting that Blue Cross credit her account for the January and February payments since she had not received the services for which she had paid.

137. On March 3, 2014, Deborah finally received her Blue Cross ID card.

138. In a letter dated March 24, 2014, Blue Cross responded to Deborah's grievance. According to the letter, Blue Cross would not credit Deborah's account for the January and February payments.

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139. On April 14, 2014, Deborah filed a complaint with the Department of Managed Health Care ("DMHC") in which she sought a refund of her January and February premium payments. In a letter dated April 30, 2014, the DMHC responded to Deborah's complaint. The DMHC refused to act, claiming Blue Cross had not violated any laws.

140. In a letter dated May 15, 2014, Blue Cross notified Deborah her that her insurance had been cancelled effective April 1, 2014.

SUMMARY OF BLUE CROSS'S ILLEGAL ACTS

141. As discussed in more detail herein, through its conduct of misrepresenting provider networks, misrepresenting EPO plans as PPO plans, misrepresenting the deductible amounts of its ACA-compliant PPO plans, failing to complete enrollment and provide proof of coverage to consumers in a timely manner, and operating a telephone customer service call center where consumers are unable to obtain information due to long hold times and technical difficulties, Blue Cross:

- Intentionally misrepresented and concealed material facts to each Plaintiff about Blue Cross's new ACA-compliant individual health service plans.
- Violated Health and Safety Code section 1360, which bars companies providing health service plans from using any advertising or solicitation that is untrue or misleading. Blue Cross's misrepresentations and untrue statements about the providers included in its individual health service plan networks violate Health and Safety Code section 1360.
- Violated Health and Safety Code section 1367.26, which requires health care service plans to furnish provider lists to consumers upon request. Blue Cross's incorrect provider lists and inaccurate provider search tool on Blue Cross's website violate Health and Safety Code section 1367.26.
- Violated a provision of the California Code of Regulations requiring that "the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes." (28 CCR § 1300.67.2.2(c)(10).)
- Violated provisions of the Health and Safety Code and California Code of Regulations requiring that health service plans have sufficient provider networks to ensure the provision of covered health care services in a timely manner. (Health & Saf. Code § 1367.03(f)(1), 28 CCR § 1300.67.2.2.)

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- Violated Health and Safety Code section 1373.96, which requires health service plans to arrange for the completion of covered services by a terminated provider or by a nonparticipating provider for certain conditions, such as pregnancies or care of a newborn child.

- Violated Health and Safety Code section 1367, subdivision (h)(1), which requires that health care service plans' contracts with subscribers and enrollees be fair, reasonable, and consistent with the objectives of the Knox-Keene Act. Blue Cross's failure to complete enrollment and provide proof of coverage under individual health service plan contracts to consumers who made premium payments to Blue Cross violates Health and Safety Code section 1367, subdivision (h)(1).

142. Blue Cross engaged in various unfair and deceptive acts in violation of the CLRA by:

- Representing health service plans as having certain providers in-network during the Open Enrollment Period when those providers were not in the network of the health service plans in violation of Civil Code section 1770, subdivision (a)(5).

- Advertising health service plans as having certain providers in-network with intent not to sell them as advertised in violation of Civil Code section 1770, subdivision (a)(9).

- Representing and advertising that its health service plans provide coverage for services rendered by a network of certain providers and then announcing the network of providers had changed after the Open Enrollment Period closed in violation of Civil Code section 1770, subdivision (a)(14).

- Adopting unconscionable contract provisions requiring undisclosed higher deductible limits for out-of-network providers, adopting inadequate provider networks, and concealing material terms of the coverage in violation of Civil Code section 1770, subdivision (a)(19).

CLASS ALLEGATIONS

143. The third, fourth, fifth, sixth, seventh and eighth causes of action alleged below are brought on behalf of the Plaintiffs individually and on behalf of all others similarly situated pursuant to Code of Civil Procedure section 382 and Civil Code section 1781. Plaintiffs seek to represent the following class:

> All current California residents who enrolled in an individual Blue Cross health service plan between October 1, 2013 through and including March 31, 2014 and (i) whose health service plan provider network was misrepresented, or (ii) whose EPO coverage was misrepresented as PPO coverage, or (iii) whose PPO out-of-

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network deductible was misrepresented, or (iv) who were provided inadequate networks of physicians and hospitals causing delays and interruptions in accessing needed health care; or (v) whose enrollment was not completed in a timely manner thereby depriving them of access to coverage they purchased, or (vi) who were subjected to excessive hold times and delays on telephone customer service telephone lines.

144. Plaintiffs reserve the right under Rule 3.765(b) of the California Rules of Court to amend or modify the class description with greater specificity, by further division into subclasses or by limitation to particular issues.

145. The proposed Class is composed of thousands of persons dispersed throughout the State of California and joinder is impractical. The precise number and identity of Class Members are unknown to Plaintiffs but can be obtained from Blue Cross's records.

146. There are questions of law and fact common to members of the Class, which predominate over questions affecting only individual Class Members.

147. Plaintiffs are members of the Class and Plaintiffs' claims are typical of the claims of the Class.

148. Plaintiffs are willing and prepared to serve the Court and the proposed Class in a representative capacity. Plaintiffs will fairly and adequately protect the interests of the Class and have no interests adverse to or which conflict with the interests of the other members of the Class.

149. The self-interest of Plaintiffs are co-extensive with and not antagonistic to those of absent Class members. Plaintiffs will undertake to represent and protect the interests of absent Class members.

150. Plaintiffs have engaged the services of counsel indicated below who are experienced in complex class litigation, will adequately prosecute this action, and will assert and protect the rights of and otherwise represent Plaintiffs and absent Class Members.

151. The prosecution of separate actions by individual members of the Class would create a risk of inconsistency and varying adjudications, establishing incompatible standards of conduct for Blue Cross.

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152. Blue Cross has acted on grounds generally applicable to the Class, thereby making relief with respect to the members of the Class as a whole appropriate.

153. A class action is superior to other available means for the fair and efficient adjudication of this controversy. Prosecution of the complaint as a class action will provide redress for individual claims too small to support the expense of complex litigation and reduce the possibility of repetitious litigation.

154. Plaintiffs do not anticipate any unusual or difficult management problems with the pursuit of this Complaint as a class action.

FIRST CAUSE OF ACTION

Fraud - Intentional Misrepresentation

(Brought by Plaintiffs in their Individual Capacities)

155. Plaintiffs refer to all preceding paragraphs and incorporates them as if set forth in full in this cause of action.

156. Plaintiffs Felser, Griffin, Moghadam, Moore, Worth, and Nitasaka have each been harmed because Blue Cross intentionally misrepresented or concealed material facts about its new individual ACA-compliant health service plans, including:

a) misrepresenting or concealing EPO plans as PPO plans;

b) misrepresenting or concealing EPO plans, with no out-of-network coverage or benefits, as suggested replacement coverage for PPO plans, without any disclosure of the significant differences between the plans;

c) misrepresenting or concealing EPO plans as PPO plans by sending out ID cards with a PPO symbol printed on the card rather than an EPO symbol;

d) misrepresenting or concealing that its PPO plans imposed much higher deductibles for out-of-network providers than the deductible listed for the plan;

e) misrepresenting or concealing the significant difference between in-network deductibles and out-of-network deductibles on its PPO plans;

f) misrepresenting or concealing that its new individual health service plans only

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provide access to a drastically reduced network of providers rather than the provider network Blue Cross had previously offered its health service plan enrollees;

g) misrepresenting that enrollees would have access to Blue Cross's traditional network of providers, which is significantly larger than the network of providers actually available;

h) concealing that enrollees would only have access to a new, extremely narrow network of providers;

i) misrepresenting and intentionally disseminating inaccurate provider lists to existing and potential customers with knowledge this information was inaccurate; and

j) misrepresenting that enrollees would receive coverage under their new ACA-compliant plans upon payment of premium to Blue Cross.

157. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Blue Cross intentionally misrepresented, concealed, or failed to disclose these material facts about its new ACA-compliant individual health service plans to each Plaintiff. Plaintiffs did not know of these concealed facts and each of these representations were false.

158. Blue Cross knew that these representations were false when Blue Cross made the misrepresentations to each Plaintiff. Blue Cross made each misrepresentation recklessly and without regard for its truth.

159. Blue Cross intended for each Plaintiff to rely on these misrepresentations. From October 2013 through March 31, 2014, Blue Cross knew that millions of new and existing enrollees would be shopping for new individual health service plans. Blue Cross intentionally made the misrepresentations in order to make its ACA-complaint health service plans appear more attractive than they really were and concealed the limitations of these new plans.

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160. Each Plaintiff reasonably relied on these misrepresentations when purchasing a new or replacement health service plan from Blue Cross. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs were fraudulently induced into purchasing a Blue Cross health service plan based on one or more of these misrepresentations during the October 1, 2013 through March 31, 2014 time period.

161. Each Plaintiff was harmed as a result of Blue Cross's misrepresentations. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs did not discover the severe limitations of their health service plans until after the end of the Open Enrollment Period so they were not able to switch health service plans. Additionally, as specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs continue to face significant out-of-pocket losses because they have had medical claims denied by Blue Cross as a result of Blue Cross's misrepresentation that its provider network included doctors and hospitals that it does not include. These medical claims would have been covered had Blue Cross not misrepresented the plan coverage to Plaintiffs. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs also have been forced to choose between paying out-of-pocket to continue treatment with their regular providers or finding a new provider in Blue Cross's limited network.

162. Each Plaintiff's reliance on Blue Cross's representations was a substantial factor in causing his or her harm. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs signed up for Blue Cross plans during the Open Enrollment Period based on Blue Cross's misrepresentations. Now, after Plaintiffs have found out that the coverage was misrepresented, the Open Enrollment Period is over and it is too late to select a replacement plan. Additionally, Plaintiffs sought medical care from providers based on Blue Cross's representations that these providers were included in their provider network, but have now had their medical claims denied as not covered under their plans. Plaintiffs' reliance on Blue Cross's misrepresentations have also caused them to choose

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between paying out-of-pocket to continue care with their regular providers or to chose a new provider from Blue Cross's limited network.

163. As a result of each Plaintiff's reliance on Blue Cross's misrepresentations, each Plaintiff sustained damage in an amount to be determined at trial..

SECOND CAUSE OF ACTION

Fraud - Concealment

(Brought by Plaintiffs in their Individual Capacities)

164. Plaintiffs refer to all preceding paragraphs and incorporates them as if set forth in full in this cause of action.

165. From October 1, 2013 through March 31, 2014, Blue Cross misrepresented, concealed or failed to disclose the following material facts about its new individual health service plans:

a) misrepresenting or concealing EPO plans as PPO plans;

b) misrepresenting or concealing EPO plans, with no out-of-network coverage or benefits, as suggested replacement coverage for PPO plans, without any disclosure of the significant differences between the plans;

c) misrepresenting or concealing EPO plans as PPO plans by sending out ID cards with a PPO symbol printed on the card rather than an EPO symbol;

d) misrepresenting or concealing that its PPO plans imposed much higher deductibles for out-of-network providers than the deductible listed for the plan;

e) misrepresenting or concealing the significant difference between in-network deductibles and out-of-network deductibles on its PPO plans;

f) misrepresenting or concealing that its new individual health service plans only provide access to a drastically reduced network of providers rather than the provider network Blue Cross had previously offered its health service plan enrollees;

g) misrepresenting that enrollees would have access to Blue Cross's traditional

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network of providers, which is significantly larger than the network of providers actually available;

h) concealing that enrollees would only have access to a new, extremely narrow network of providers;

i) misrepresenting and intentionally disseminating inaccurate provider lists to existing and potential customers with knowledge this information was inaccurate; and

j) misrepresenting that enrollees would receive coverage under their new ACA-compliant plans upon payment of premium to Blue Cross.

166. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Blue Cross misrepresented, concealed, failed to disclose, and omitted these material facts to each Plaintiff.

167. Blue Cross was under a duty to disclose these material facts to each Plaintiff.

168. Blue Cross intentionally failed to disclose these material facts about its new plans to each Plaintiff. These facts were known only to Blue Cross, and each Plaintiff had no practical means of ascertaining these concealed facts.

169. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, each Plaintiff did not know these concealed facts at the time they purchased their plans.

170. Blue Cross intended to deceive each Plaintiff by concealing these facts. Blue Cross wanted to make its new ACA-compliant plans appear as if they provided similar or better coverage than its prior Blue Cross plans so it could retain its existing customer base and increase its individual market share. Blue Cross had an incentive to conceal these facts about its new ACA-compliant plans because they would have exposed the limitations of these new plans.

171. Each Plaintiff reasonably relied on Blue Cross's deception in purchasing their Blue Cross plans. Plaintiffs would not have purchased their respective health service plans

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had Blue Cross stated the true facts regarding these misrepresentations, concealments, and failures to disclose.

172. Each Plaintiff has been harmed by Blue Cross's concealment. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs did not discover the severe limitations of their health service plans' provider network until after the end of the Open Enrollment Period so they were not able to switch health service plans. Additionally, as specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs face significant and on-going out-of-pocket losses because they have had medical claims denied by Blue Cross contending claims were not covered under their plans. These medical claims would have been covered had Blue Cross not misrepresented the plan provider network to Plaintiffs. As specifically alleged above in the factual allegations pertaining to each named Plaintiff, Plaintiffs also have been forced to chose between paying out-of-pocket to continue treatment with their regular providers or finding a new provider in Blue Cross's limited network.

173. Because of Blue Cross's concealment and/or suppression of the facts, each Plaintiff sustained damage in an amount to be determined at trial.

THIRD CAUSE OF ACTION

Violations of Business & Professions Code § 17200, et seq. –

Unlawful Business Acts and Practices

(Brought by Plaintiffs in their Individual and Representative Capacities)

174. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

175. Business and Professions Code section 17200, et seq. prohibits acts of "unfair competition" which is defined by Business and Professions Code section 17200 as including "any unlawful, unfair or fraudulent business act or practice . . . ."

176. Blue Cross's conduct, and the conduct of Does 1 through 100, as described above, constitutes unlawful business acts and practices.

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177. Blue Cross and Does 1 through 100 have violated and continue to violate Business and Professions Code section 17200's prohibition against engaging in "unlawful" business acts or practices, by, inter alia, violating provisions of the Health and Safety Code, California Code of Regulations, and the CLRA as follows:

a. By its conduct of engaging in the following acts, Blue Cross is "us[ing] or permit[ting] the use of any advertising or solicitation which is untrue or misleading," "us[ing] or permit[ting] the use of any verbal statement which is untrue, misleading, or deceptive[,]" and "mak[ing] any representations about coverage offered by the plan or its cost that do[] not conform to fact" in violation of Health and Safety Code section 1360, subdivisions (a) and (b):

a) misrepresenting or concealing EPO plans as PPO plans;

b) misrepresenting or concealing EPO plans, with no out-of-network coverage or benefits, as suggested replacement coverage for PPO plans, without any disclosure of the significant difference between the coverage;

c) misrepresenting or concealing EPO plans as PPO plans by sending out insurance cards with a PPO symbol printed on the card rather than an EPO symbol;

d) misrepresenting or concealing that its PPO plans imposed much higher deductibles for out-of-network providers than the deductible listed for the plan;

e) misrepresenting or concealing the significant difference between in-network deductibles and the out-of-network deductibles on its PPO plans;

f) misrepresenting or concealing that its new individual health service plans only provide access to a drastically reduced network of providers rather than the provider network Blue Cross had previously offered its plan members;

g) misrepresenting that Plaintiffs and Class Members would have access to Blue Cross's traditional network, which is significantly larger than the network of providers actually available to plaintiffs;

h) concealing that Plaintiffs and Class Members only had access to a new, extremely

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narrow network of providers;

i) misrepresenting and intentionally disseminating an inaccurate provider list information to existing and potential customers with knowledge this information was inaccurate; and

j) misrepresenting that Plaintiffs and Class Members would receive coverage under their new ACA-compliant plans upon payment of premium to Blue Cross.

b. By providing written provider lists with inaccurate information to Plaintiffs and Class Members, Blue Cross is failing to provide to enrollees and prospective enrollees with a list of "contracting providers, within the enrollee's or prospective enrollee's general geographic area" in violation of Health and Safety Code section 1367.26, subdivision (a).

c. By failing to direct Plaintiffs and Class Members to a functioning provider search tool on Blue Cross's website, Blue Cross is failing to "satisfy the requirements of [providing a provider list] by directing the enrollee or prospective enrollee to the plan's provider listings on its Internet Web site" in violation of Health and Safety Code section 1367.26, subdivision (d).

d. By maintaining a customer service telephone system that subjected Plaintiffs and Class Members to exceedingly long waiting times, regularly lasting several hours in duration, such that Plaintiffs and Class Members must repeatedly call Blue Cross when seeking information about their plans, Blue Cross has failed to ensure that "the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes" in violation of 28 CCR § 1300.67.2.2(c)(10).

e. By misrepresenting the providers that would be in-network under Plaintiffs' and Class Members' plans and consequently forcing Plaintiffs and Class Members to forego care and/or seek new providers, Blue Cross has failed to "establish and maintain provider networks" that provide services to enrollees "in a timely manner consistent with

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good professional practice" in violation of 28 CCR § 1300.67.2.2(c)(1).

f. By requiring Plaintiffs and Class Members to devote more than ten days to finding an in-network primary care physician with whom Plaintiffs and Class Members can make an appointment, Blue Cross is failing to "ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the [ten day] timeframe[]" for "non-urgent appointments for primary care" in violation of 28 CCR § 1300.67.2.2(c)(5)).

g. By operating provider networks that violate 28 CCR § 1300.67.2.2(c)(1) and (5), as set forth above, Blue Cross is failing to "ensure [its health service plans] have sufficient numbers of contracted providers to maintain compliance with the standards established by [28 CCR § 1300.67.2.2(c)]" in violation of 28 CCR § 1300.67.2.2(c)(7).

h. By operating provider networks that violate 28 CCR § 1300.67.2.2(c)(1) and (5), as set forth above, Blue Cross's "[c]ontracts between health care service plans and health care providers" fail to "assure compliance with the standards" set forth in 28 CCR § 1300.67.2, et seq. in violation of Health and Safety Code section 1367.03, subdivision (f)(1).

i. By refusing to provide continuity of care with a patient's physician for an acute condition, serious chronic condition, pregnancy, terminal illness, a newborn child, or performance of surgery to consumers who enrolled in a new health service plan during their course of treatment, Blue Cross is failing to provide covered services for "a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider" in violation of Health and Safety Code section 1373.96.

j. By collecting premium payments from Plaintiffs and Class Members without initiating coverage such that they cannot access benefits under their individual health service plan contracts, Blue Cross is failing to provide "contracts with subscribers and enrollees" that are "fair, reasonable, and consistent with the objectives of [the Knox-Keene

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Act]" in violation of Health and Safety Code section 1367, subdivision (h)(1).

178. Finally, Blue Cross's and Does 1 through 100's conduct also constitutes unlawful acts under the CLRA, as set forth herein.

179. Plaintiffs and Class Members have suffered injury in fact and lost money and/or property as a result of Blue Cross's and Does 1 though 100's unlawful business acts and practices by, inter alia, receiving lesser coverage under their health service plan contracts, paying unexpected out-of-pocket costs and inflated premiums, and/or paying out-of-pocket costs and premium amounts in excess of what a Class Member would have paid if Defendants had accurately disclosed the health service plans' provider networks.

180. As a result of Blue Cross's and Does 1 though 100's violations of the Business and Professions Code section 17200, Plaintiffs seek an order of this Court enjoining Blue Cross's continued violations. Plaintiffs also seek an order for restitution of all monies paid for Blue Cross health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the networks of providers that were listed during the Open Enrollment Period and the value of the health service plans now that the network is narrowed, including the difference in value between PPO and EPO coverage, and (ii) premium payments made by consumers for the period for which consumers had not received ID cards.

FOURTH CAUSE OF ACTION

Violations of Business & Professions Code § 17200, et seq. –

Unfair Business Acts and Practices

(Brought by Plaintiffs in their Individual and Representative Capacities)

181. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

182. Acts of Blue Cross and Does 1 through 100, as described above, and each of them, constitute unfair business acts and practices.

183. Plaintiffs and other members of the Class suffered a substantial injury in fact resulting in the loss of money or property by virtue of Blue Cross's and Does 1 through 100's

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conduct.

184. Blue Cross's and Does 1 through 100's conduct does not benefit consumers or competition. Indeed the injury to consumers and competition is substantial.

185. Plaintiffs and Class Members could not have reasonably avoided the injury each of them suffered.

186. The gravity of the consequences of Blue Cross's and Does 1 through 100's conduct as described above outweighs any justification, motive or reason therefore and is immoral, unethical, oppressive, unscrupulous, and offends established public policy delineated in California law, the Knox Keene Act, and regulatory provisions as well as their underlying purposes.

187. As a result of Blue Cross's and Does 1 though 100's violations of the Business and Professions Code section 17200, Plaintiffs seek an order of this Court enjoining Blue Cross's continued violations. Plaintiffs also seek an order for restitution of all monies paid for Blue Cross health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the networks of providers that were listed during the Open Enrollment Period and the value of the health service plans now that the network is narrowed, including the difference in value between PPO and EPO coverage, and (ii) premium payments made by consumers for the period for which consumers had not received ID cards.

FIFTH CAUSE OF ACTION

Violations of Business & Professions Code § 17200, et seq. –

Fraudulent Business Acts and Practices

(Brought by Plaintiffs in their Individual and Representative Capacities)

188. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

189. Such acts of Blue Cross and Does 1 through 100, as described above, and each of them, constitute fraudulent business practices under Business and Professions Code section 17200, et seq.

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190. Defendants' misleading and fraudulent representations, advertising, marketing, and communications are likely to deceive reasonable California consumers. Plaintiffs and other members of the Class were unquestionably deceived regarding the provider networks, the differences between PPO and EPO health service plans, the amount of out-of-network deductibles for PPO plans, and Blue Cross's other misrepresentations and omissions as more fully described herein.

191. Blue Cross's misrepresentations and omissions were material and were a substantial factor in Plaintiffs' decisions to enroll in and renew their health service plan contracts. Such acts are fraudulent business acts and practices.

192. These acts and practices resulted in and caused Plaintiffs and Class Members to pay more for their health service plans than they would have absent Defendants' fraud.

193. Plaintiffs and Class Members have been injured by Defendants' fraudulent business acts and practices by receiving lesser coverage under their individual plan contracts.

194. As a result of Blue Cross's and Does 1 though 100's violations of the Business and Professions Code section 17200, Plaintiffs seek an order of this Court enjoining Blue Cross's continued violations. Plaintiffs also seek an order for restitution of all monies paid for Blue Cross health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the networks of providers that were listed during the Open Enrollment Period and the value of the health service plans now that the network is narrowed, including the difference in value between PPO and EPO coverage, and (ii) premium payments made by consumers for the period for which consumers had not received ID cards..

SIXTH CAUSE OF ACTION

Violations of the California False Advertising Law,

Business & Professions Code § 17500, et seq.

(Brought by Plaintiffs in their Individual and Representative Capacities)

195. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

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196. Defendants violated California's False Advertising Law, Business and Professions Code section 17500, et seq. by making false and misleading representations in advertising, marketing, and communications regarding provider networks, the differences between PPO and EPO health service plans, the amount of out-of-network deductibles for PPO plans, and making other misrepresentations and omissions as more fully described herein.

197. These representations have deceived and are likely to deceive Plaintiffs and Class Members in connection with their decision to purchase their individual health service plan contracts. Defendants' representations also have deceived and are likely to deceive Plaintiffs and Class Members with respect to the expected costs they would be spending out-of-pocket under their individual health care service plan contracts. Defendants' representations were material and were a substantial and material factor in Plaintiffs' decisions to purchase their health service plans. Had Plaintiffs known the actual facts, they would not have purchased the health service plans and paid out-of-pocket costs and premiums in excess of what they would have paid if Defendants had accurately disclosed provider networks and the real terms, coverage and benefits provided by the health service plans.

198. Defendants directly and indirectly, have engaged in substantially similar conduct with respect to each Plaintiff and to each member of the Class.

199. Defendants, and each of them, aided and abetted, encouraged and rendered substantial assistance in accomplishing the wrongful conduct and their wrongful goals and other wrongdoing complained of herein. In taking action, as particularized herein, to aid and abet and substantially assist the commission of these wrongful acts and other wrongdoings complained of, each of the Defendants acted with an awareness of his/her/its primary wrongdoing and realized that his/her/its conduct would substantially assist the accomplishment of the wrongful conduct, wrongful goals, and wrongdoing.

200. Plaintiffs and Class Members have suffered injury by Defendants' violation of Business and Professions Code section 17500, et seq.

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201. As a result of Blue Cross's and Does 1 though 100's violations of the Business and Professions Code section 17500, Plaintiffs seek an order of this Court enjoining Blue Cross's continued violations. Plaintiffs also seek an order for restitution of all monies paid for Blue Cross health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the networks of providers that were listed during the Open Enrollment Period and the value of the health service plans now that the network is narrowed, and (ii) premium payments made by consumers for the period for which consumers had not received ID cards.

SEVENTH CAUSE OF ACTION

Violations of the Consumers Legal Remedies Act, Civil Code § 1750, et seq.

(Brought by Plaintiffs in their Individual and Representative Capacities)

202. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

203. Under Civil Code section 1770, subdivision (a), of the CLRA, the following "unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in a transaction intended to result or which results in the sale or lease of goods or services to any consumer are unlawful":

- "Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he or she does not have." (Civ. Code § 1770(a)(5).)
- "Advertising goods or services with intent not to sell them as advertised." (Civ. Code § 1770(a)(9).)
- "Representing that a transaction confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law." (Civ. Code § 1770(a)(14).)
- "Inserting an unconscionable provision in the contract." (Civ. Code § 1770(a)(19).)

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204. Here, in connection with Blue Cross engaging in the initial offering and monthly transactions with consumers that were intended to result, or actually resulted in, the sale of services, Defendants have violated the CLRA, Civil Code section 1770, subdivisions (a)(5), (a)(9), (a)(14), and (a)(19) by:

a. Representing that health service plans have provider network characteristics and other terms and benefits which they do not have.

b. Advertising health service plans as having provider network characteristics and other terms and benefits with the intent not to sell them as advertised.

c. Representing that a transaction confers or involves provider network rights, remedies, or obligations which they do not have.

d. Adopting unconscionable contract provisions requiring undisclosed higher deductible limits for out-of-network providers, adopting inadequate provider networks, and concealing material terms of the coverage.

205. Such acts and practices were designed or intended by Blue Cross to convince Class Members to initially purchase and renew their health service plan contracts each month. The CLRA "shall be liberally construed and applied to promote its underlying purposes, which are to protect consumers against unfair and deceptive business practices and to provide efficient and economical procedures to secure such protection." For purposes of the CLRA, a "'[t]ransaction' means an agreement between a consumer and any other person, whether or not the agreement is a contract enforceable by action, and includes the making of, and the performance pursuant to, that agreement." (Civil Code § 1761(e).) Here, the "transactions" at issue governed by the CLRA include both the original sale and the renewals of the individual EPO and PPO health service plan contracts made and entered into by Blue Cross, Plaintiff and Class Members, as well as Blue Cross's performance of its obligations under such agreements. In making decisions whether to initially purchase and renew their health service plan contracts, and pay the rates imposed by Blue Cross, Plaintiffs and other Class Members reasonably acted in positive response to Blue Cross's misrepresentations as set forth

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in detail herein, or would have considered the omitted facts detailed herein material to their decisions to do so.

206. Section 1761, subdivision (b), of the CLRA defines "services" as "work, labor, and services for other than a commercial or business use, including services furnished in connection with the sale or repair of goods." Blue Cross's ongoing "work and labor" to establish, maintain, and improve provider networks of hospital and doctors is the core of the PPO and EPO health service plans at issue here. Blue Cross provides extensive services that do not exist for consumers enrolled in pure indemnity coverage like life insurance. For example:

- Blue Cross advertises its PPO coverage by promoting the network services it provides and the "work and labor" Blue Cross expends in order to guarantee quality and provide consumer choice. Blue Cross's website promises: "Quality Doctors: When you go to doctors or hospitals in our network—expect, quality affordable care." Blue Cross's "work and labor" to certify the "quality" of its health care providers is not available to consumers enrolled in indemnity health insurance policies.

- In order to access the key benefits of their EPO or PPO health service plans, a consumer must visit one of the preferred providers in Blue Cross's network. EPO and PPO consumers benefit from Blue Cross's "work and labor" to establish networks of high-quality hospitals and doctors, as co-payments and/or coinsurance are lower for in-network services.

- As attested by numerous news reports and Blue Cross's own Press Releases, Blue Cross expends a tremendous amount of "work and labor" to maintain its provider networks, which often requires Blue Cross to engage in substantial contract negotiations with physician groups and hospitals that can last more than a year.

- In an effort to attract new customers and retain existing members, Blue Cross expends significant "work and labor" to continuously improve its provider networks by sponsoring initiatives aimed at providing integrated and cost efficient health care.

- Of the enormous resources – $755,498,000 in just the first nine months of 2012 – that Blue Cross spends on administration of health service plans, a substantial portion is dedicated to the maintenance and improvement of its preferred provider networks

207. The services at issue here are not "ancillary services." Instead, the services discussed above are the core of the Plaintiffs' EPO and PPO health service plans.

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208. Blue Cross violated the CLRA by committing unfair and deceptive acts that directly undermined Plaintiffs' and Class Members' ability to access the provider network they were promised. Blue Cross's unfair and deceptive acts increased patients' costs when accessing provider networks and unilaterally reduced treatments and services available from those provider networks.

209. Plaintiffs and the Class Members have suffered harm as a result of these violations. Plaintiffs purchased individual health service plan contracts, and renewed individual health service plan contracts, reasonably relying on Blue Cross's material misrepresentations, inter alia, that certain providers would be in-network. Plaintiffs and members of the Class have also suffered transactional costs by expending time and resources in the form of correspondence and telephone conversations with Blue Cross's customer service representatives in an attempt to avoid the consequences of Blue Cross's unfair methods of competition and unfair or deceptive acts. Plaintiffs and members of the Class have also suffered opportunity costs by foregoing the opportunity to switch to other coverage offered by other companies during the Open Enrollment Period.

210. Defendants' misrepresentations and omissions described in the preceding paragraphs were intentional, or alternatively, made without the use of reasonable procedures adopted to avoid such an error.

211. Defendants, directly or indirectly, have engaged in substantially similar conduct to Plaintiffs and to each member of the Class.

212. Such wrongful actions and conduct are ongoing and continuing. Unless Defendants are enjoined from continuing to engage in such wrongful actions and conduct, the public will continue to be harmed by Defendants' conduct.

213. Defendants, and each of them, aided and abetted, encouraged, and rendered substantial assistance in accomplishing the wrongful conduct and their wrongful goals and other wrongdoing complained of herein. In taking action, as particularized herein, to aid and abet and substantially assist the commission of these wrongful acts and other wrongdoings

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complained of, each of the Defendants acted with an awareness of his/her/its primary wrongdoing and realized that his/her/its conduct would substantially assist the accomplishment of the wrongful conduct, wrongful goals, and wrongdoing.

214. Plaintiffs and the Class are entitled to an injunction, pursuant to Civil Code section 1780, prohibiting Blue Cross from continuing to engage in the above-described violations of the CLRA.

215. Blue Cross's conduct as described herein was intended by them to cause injury to members of the Class and/or was despicable conduct carried on by Blue Cross with a willful and conscious disregard of the rights of members of the Class, subjected members of the Class to cruel and unjust hardship in conscious disregard of their rights, and was an intentional misrepresentation, deceit, or concealment of material facts known to Blue Cross with the intention to deprive Class Members of property or legal rights, or to otherwise cause injury, such as to constitute malice, oppression or fraud under Civil Code section 3294, thereby entitling Plaintiffs and members of the Class to exemplary damages in an amount appropriate to punish or set an example of Blue Cross.

EIGHTH CAUSE OF ACTION

Declaratory Relief

(Brought by Plaintiffs in their Individual and Representative Capacities)

216. Plaintiffs incorporate by reference each of the preceding paragraphs as though fully set forth herein.

217. California Code of Civil Procedure section 1060 provides that any person "interested under … a contract … may, in cases of actual controversy relating to the legal rights and duties of respective parties" bring an action in Superior Court for a declaration of his or her rights and the "the court may make a binding declaration of these rights or duties, whether or not further relief is or could be claimed at the time."

218. An actual controversy has arisen between Plaintiffs and the members of the Class they represent, on the one hand, and Blue Cross and Does 1 through 100 on the other

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hand, as to their respective rights and obligations under the individual health service plan contracts between them. Specifically, Plaintiffs and the Class contend that Blue Cross's and Does 1 through 100's misrepresentation of provider networks, failure to provide proof of insurance to consumers while accepting premium payments, misrepresentation of the differences between PPO and EPO health service plans, misrepresentation of the amount of out-of-network deductibles for PPO plans, and Blue Cross's other misrepresentations and omissions as more fully described herein, as well as the operation of a telephone customer service call center where consumers are unable to obtain information due to long hold times and uninformed call center representatives, is prohibited by California law. Defendants contend that their conduct was proper.

219. Plaintiffs seek a declaration as to the respective rights and obligations of the parties.

PRAYER FOR RELIEF

Plaintiffs respectfully request that this court enter judgment against Blue Cross. The final judgment should set forth the following relief as appropriate for each cause of action:

1. For Plaintiffs, in their individual capacities: actual and compensatory damages, according to proof, including all economic losses sustained resulting from Blue Cross's intentional misrepresentations and concealment of material facts;
2. As to the third, fourth, fifth, sixth, seventh, and eighth causes of action, an order certifying the case as a class action and appointing Plaintiffs Felser, Griffin, Moghadam, Moore, Worth, Nitasaka and their counsel to represent the Class;
3. For restitution to the extent permitted by applicable law;
4. For an order enjoining Blue Cross from continuing to engage in the conduct described herein;
5. For civil and statutory penalties available under applicable law;
6. For pre-judgment and post-judgment interest;
7. For punitive damages;

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8. For a declaration of the rights and obligations of Plaintiffs and the Class, on the one hand, and Blue Cross, on the other, with regard to the business practices described herein;
9. For an award of attorneys' fees, costs and expenses as authorized by applicable law; and
10. For such other and further relief as this Court may deem just and proper.

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable.

DATED: July 8, 2014

Respectfully Submitted,

SHERNOFF BIDART ECHEVERRIA BENTLEY LLP

By: _____
MICHAEL J. BIDART
TRAVIS M. CORBY

CONSUMER WATCHDOG

By: _____
LAURA ANTONINI
JERRY FLANAGAN

Attorneys for Plaintiffs

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AFFIDAVIT

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AFFIDAVIT

1. I am a staff attorney for Consumer Watchdog duly licensed to practice before all the courts of the State of California and counsel of record for Plaintiffs in the above-captioned matter. I am personally familiar with the facts set forth herein, and if called upon to do so, I could and would testify competently thereto.

2. Civil Code section 1780, subdivision (d), of the Consumers Legal Remedies Act provides that "[a]n action under subdivision (a) or (b) may be commenced in the county in which the person against whom it is brought resides, has his or her principal place of business, or is doing business, or in the county where the transaction or any substantial portion thereof occurred. In any action subject to this section, concurrently with the filing of the complaint, the plaintiff shall file an affidavit stating facts showing that the action has been commenced in a county described in this section as a proper place for the trial of the action."

3. As describe in more detail in the Class Action Complaint, which is incorporated herein by reference, this action was filed in the county of Los Angeles which is a proper place for the trial of the action because Defendant Blue Cross resides in Los Angeles county, has its principal place of business in Woodland Hills, California which is located in Los Angeles County, is doing business in Los Angeles county, and the operative transactions, or a substantial portion thereof, occurred in Los Angeles county.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this Declaration was executed this 8th day of July 2014, at Santa Monica, California.

LAURA ANTONINI

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